STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

January 26, 2021

SENT VIA ELECTRONIC MAIL

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

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

Dear Chairmen:

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

Should you have any questions, please contact Kody Kinsley, Deputy Secretary for Behavioral Health and Intellectual/Developmental Disabilities, at 984-236-5000.

Sincerely,

Mandy Cohen, MD, MPH
Secretary

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

cc:

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2019 - 2020 Annual Report
of the North Carolina
Transition to Community Living Initiative

NC General Statute 122C-20.15

Report to the Joint Legislative Oversight Committee on Health and Human Services

By

North Carolina Department of Health and Human Services

January 26, 2021

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I. OPENING REMARKS

The Transitions to Community Living Initiative (TCLI) in the North Carolina Department of Health and Human Services (DHHS) continues to open doors for individuals with serious mental illness (SMI) who want to live in integrated community settings. The TCLI makes a reality the right to choose to receive services in the community, accorded to all people with disabilities in the United States Supreme Court case, *Olmstead v. L.C.*[1] The innovative approach that is the TCLI provides a pathway to recovery, restoring dignity and improving functioning across multiple life domains. Stable housing and supportive community-based services are the core tenets of the TCLI. These provide a solid foundation so that people who have been institutionalized can successfully build a life alongside friends, families and neighbors. The TCLI's participants are individuals with lived experience of psychiatric disability. The TCLI, however, looks beyond disabilities to abilities and finds in its participants people who are ready to show others that recovery is possible and that being a productive, contributing member of the community is within reach, when the right services and supports are in place. TCLI affirms the inherent value and worth of all individuals living with SMI and provides opportunities for integration that benefit the whole community. Moving forward, the TCLI seeks to guide North Carolina in expanding the promise of *Olmstead*, opening the door to community to others with disabilities.

II. ACKNOWLEDGEMENTS

The Transitions to Community Living Initiative (TCLI) is widely recognized for its innovations in advancing community integration and inclusion for people with Serious Mental Illness (SMI) and Severe and Persistent Mental Illness (SPMI). The Office of the Senior Advisor on the Americans with Disabilities Act, Office of the Secretary, North Carolina Department of Health and Human Services, organizational home to the TCLI, acknowledges the expert technical assistance and support the initiative and the State have received in 2020. We wish to also thank the following individuals for their contributions to the annual report this year:

- Kevin Martone, President, Technical Assistance Collaborative
- Sherry Lerch, Senior Consultant, Technical Assistance Collaborative
- Gina Verne, Technical Assistance Collaborative, Trainer on Permanent Supported Housing
- Lorna Moser, Ph.D., Director, UNC Institute for Best Practices
- Mark Saltzer, Ph.D., Professor of Social and Behavioral Sciences, Director, Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities
- Stacy Smith, Trainer and ACT Consultant, UNC Institute for Best Practices
- Heather Dominique, NC Housing Finance Agency, Community Living Programs Administration Coordinator
- Thea Craft, NC Housing Finance Agency, Manager of Community Living Operations

[1] 527 U.S. 581 (1999).

- Jennifer Olson, NC Housing Finance Agency, Community Living Program Administrator & Strategic Coordinator
- LME-MCO TCLI & Housing Staff-

The TCLI also expresses gratitude to the thousands of people who have found a place in the community for their faith in the staff of the TCLI and its partners. We honor each of you for your work with us to open the doors to community for all people with disabilities.

Sandra K. (Sam) Hedrick, J.D.
Director

III. COMMUNITY-BASED MENTAL HEALTH SERVICES

A. SUMMARY

Since the beginning of the Transitions to Community Living Initiative (TCLI) in 2013, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and the Division of Health Benefits (DHB) have implemented significant changes to policies, service definitions, contract terms, and quality measures. These systematic changes are designed to have a continued positive impact on the quality of community-based mental health services accessible to North Carolinians across the State. The 2019-2020 Annual Report will follow the progression of community mental health services from 2013 to 2020.

B. ASSERTIVE COMMUNITY TREATMENT

Assertive Community Treatment (ACT) has been part of the North Carolina mental health services system since the 1990s. Originally, ACT services were managed at the provider level with minimal oversight by the State. This led to limited access for people who needed the service and it was difficult to measure quality. In recognition of issues, the State began making concerted efforts to enhance the accessibility and quality of ACT teams in North Carolina, prior to the implementation of TCLI in 2013. Soon after implementation of the Settlement Agreement began, the Department of Health and Human Services (DHHS) identified the Tool for Measurement of ACT (TMACT) as the fidelity tool to ensure quality statewide. Policy and service definitions were written for both Medicaid and state-funded services to reflect its required use. Language was added into the Local Management Entity – Managed Care Organization (LME-MCO) contract with both NC Medicaid and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), identifying a minimum score that teams had to achieve to contract as an ACT provider. The DMH/DD/SAS initiated a contract with the Department of Psychiatry, University of North Carolina (UNC) School of Medicine, to develop, as part of the Center for Excellence in Community Mental Health, an ACT Technical Assistance (TA) Center, later rebranded as the Institute for Best Practices.[2]

[2] As of March 2013, the ACT TA Center was comprised of the Director, Lorna Moser, Ph.D., co-author of the TMACT, and ACT consultant and trainer, Stacy Smith, M.Ed.

During the first two years of its involvement, the Institute for Best Practices, then the "ACT TA Center," partnered with the DMH/DD/SAS to identify existing ACT providers, gauge practice fidelity, and create and implement a plan for the more comprehensive TMACT evaluations. Providers' participation in TMACT evaluations were a part of policy expectation as of August 2013 (Table 1). To that end, the DMH/DD/SAS sponsored a "TMACT Kick-Off" event in March 2013, attended by over 100 ACT providers, behavioral health agency management leaders, and LME-MCO staff across the state. This event-oriented stakeholders to the upcoming changes; defined the expectations around ACT fidelity monitoring; and introduced the TMACT tool.

Table 1. NC DHHS ACT Certification

No Certification	Below 3.0
Basic Fidelity (Provisional Certification)	3.0 – 3.6
Moderately High Fidelity (Full Certification)	3.7 – 4.2
High Fidelity (Exceptional Practice)	4.3+

Table 2. TMACT Data Distribution for Certified Teams Across Three Reviews				
		Time 1 (N = 78 teams)	**Time 2** (N=76 teams)	**Time 3**[a] (N = 54 teams)
TMACT Total Rating	Mean	3.63	3.80	3.73
	Min	2.49[b]	2.74[b]	2.89[b]
	Max	4.53	4.41	4.38
Operations & Structure (OS)	Mean	4.08	4.22	4.26
	Min	3.17	3.17	3.50
	Max	4.83	4.83	4.83
Core Team (CT)	Mean	3.86	3.97	3.93
	Min	2.29	2.57	2.29
	Max	4.71	4.86	4.71
Specialist Team (ST)	Mean	3.45	3.72	3.62
	Min	1.83	1.50	1.67
	Max	4.63	4.75	4.75
Core Practices (CP)	Mean	3.54	3.65	3.54
	Min	2.63	2.63	2.63
	Max	4.38	4.50	4.25
Evidence-Based Practices (EP)	Mean	3.18	3.51	3.33
	Min	1.58	2.38	2.25
	Max	4.63	4.63	4.63
Person-Centered Planning & Practices (PP)	Mean	3.24	3.23	3.14
	Min	2.00	3.25	2.25
	Max	4.75	2.25	4.50

[a] Time 3 summary data do not include fidelity review results for 21 teams, of which the average TMACT rating for those 22 teams in Time 2 was 4.04 and median was 4.13. [b] One ACT team did not meet the 3.0 threshold for certification; another agency assumed administrative responsibilities and the team remains in operation under new management.

Initially, it was unclear what entities, beyond participants in the grassroots NC ACT Coalition,[3] could be considered ACT teams. To address this, the DMH/DD/SAS identified those billing for ACT services. Initial estimates placed the number at over 100 ACT teams. From April – July 2013, the Institute led an effort to screen teams' fidelity by conducting a systematic phone survey using the Dartmouth Assertive Community Treatment Scale (DACTS). Results allowed the Institute and the DMH/DD/SS staff to identify teams providing lower fidelity ACT, or no ACT services at all. Data gathered in this process was used to develop the queue for the first-round, baseline TMACT reviews. This queue included 88 ACT teams and gave priority to teams whose screening indicated poor fidelity. A series of daylong trainings on the relevance of fidelity monitoring was offered to the LME-MCOs during the summer of 2013 in preparation for the launch of TMACT reviews. Institute staff contacted each LME-MCO to confirm the list of ACT providers in their network and solicit nominations of teams that the LME-MCO wanted to prioritize.

Over the first two years, four cohorts of TMACT evaluators were trained as either lead evaluators or as ACT "second" provider-evaluators.[4] The use of ACT provider-evaluators built upon similar efforts in other states, creating a cost-effective opportunity to enlist resources[5] to support the evaluation process and reinforce learning and mastery of higher fidelity practice. The TMACT authors led the initial TMACT evaluator training efforts, a series of progressively advanced steps of training. The TMACT provider-evaluators were represented by ACT team leaders, program managers and one ACT psychiatrist with affiliations across ten behavioral health agencies.

As noted earlier, service quality monitoring/ fidelity evaluations were not completed on ACT prior to 2013. Up until then, the LME-MCOs' monitoring largely focused on staff qualifications, completion of required training and documentation audits. In the first round of baseline reviews, where 88 teams were reviewed between September 2013 and December 2014, 11 teams did not meet the minimum 3.0 required by policy and contract. As a result, these teams were required to cease provision of ACT services. In subsequent years, a few more teams were identified as not meeting fidelity and were either required to cease services or were absorbed by another administrative agency. As depicted in Table 2, including only certified teams[6], there has been a steady growth in program fidelity across NC ACT teams. This is a result of ongoing, periodic fidelity assessment, quality feedback and guidance, and the DMH/DD/SAS-sponsored training and technical assistance.

In Reviews 2 and 3, there was clear improvement in fidelity for the majority of ACT teams, with the percent of "exceptional practice" (4.3 or higher) teams doubling across Reviews 1 and 2, and those in provisional certification status (3.0 – 3.6) decreasing by nearly 50%. Teams had access to robust fidelity and quality improvement plans through the full fidelity reports. The DMH/DD/SAS invested in the expansion of the Institute for Best Practices in 2016 to offer a fuller menu of technical assistance for providers. Since 2013, the Institute has continued to offer coaching and consultation to facilitate the grassroots NC ACT Coalition, and either facilitated or coordinated the following series of DMH/DD/SAS-sponsored trainings:

[3] The NC ACT Coalition was founded in 2008.
[4] This evaluation process requires a minimum two-person evaluation team.
[5] ACT provider-evaluators were reimbursed for travel expenses only.
[6] "Certified" teams include both those with provisional and full certification. As depicted in Table 2 where the minimal (Min) rating was less than 3.00, teams that did not meet the 3.0 threshold may have been absorbed by another administering behavioral health agency and effectively remained in business.

- **Motivational Interviewing Training**. Motivational Interviewing (MI) trainings commenced in FY15 through current contract FY20 and have included a series of Introductory MI, Advanced MI, MI practice circles, and MI specific to employment services.
- **Psychiatric Rehabilitation and Tenancy Supports Training.** A series of trainings to orient providers to enhancing the functional and participatory skills of those in community mental health services, particularly in TCLI, were offered by the Institute in FY15 and continue through FY20. These include a quarterly Tenancy Supports Training; Psychiatric Rehabilitation Workshop; Psychiatric Rehabilitation for Enhanced Social and Community Inclusion; development and training in the use of the Profile of Participation; and monthly web-based consultations on the topic of Tenancy Supports.
- **Integrated Treatment for Co-Occurring Disorders** (COD). In 2016, the Institute subcontracted with the Evidence-Based Practice Center at Case Western Reserve University to kick-start a program of ongoing trainings in integrated treatment for COD. This series of two-day trainings, across the State, aimed for both a broader audience and a smaller group of COD "champions" and continued with yearly offerings through 2018.
- **Person-Centered Planning Workshop.** In FY16, the State undertook challenges in ACT Providers' practice of person-centered planning by bringing on international experts,[7] in partnership with Institute staff. Consultation calls with the LME-MCOs focused on the challenges of creating person-centered plans, and targeted both providers and the LME-MCO utilization management staff responsible for authorizing ACT services. Additional consultation addressed the current Person-Centered Planning template.
- **ACT team shadowing.** In spring 2016 and spring 2017, Institute staff worked closely with the two UNC ACT teams to host, each year, eight to ten provisionally certified NC ACT Teams. Shadowing was used to teach ACT best practices. Selected teams sent three to four team members and were required to include the ACT team leader and psychiatrist.
- **Training in Violence Risk Assessment and related Short-Term Assessment of Risk and Treatability (START).** In the context of person-centered planning and providing personalized supports, this training focused on the use of the START. The FY17 and FY18 series included a web-based overview for the LME-MCOs, a broader introductory training, and advanced training workshops. In addition to its use to plan and to assess the need for more assertive engagement interventions, the training also assisted in making a case for the medical necessity for some individuals on ACT.
- **Recovery-Oriented Cognitive Therapy (CT-R).** This series of trainings focused on implementing evidence-based psychotherapies for ACT and TCLI. It included Community Support Team (CST), ACT, Transition Management Services (TMS), the DMH/DD/SS, and the LME-MCO staff. Institute staff created an application process for clinicians to request to be a part of trainings for CT-R "champions." A dozen CT-R champions, representing agencies across regions and the LME-MCOs, participated in monthly case-based consultations. In subsequent years, Institute staff and a champion hosted more local learning circles.

Over time, the Institute for Best Practice refocused its resources on trainings, coaching and consultations and on developing materials to support learning (e.g., website, recorded video skits).

[7] Diane Grieder, M.Ed. and Janis Tondora, Psy.D.

This shift was due, in part, to a titrated schedule of fidelity reviews[8] and the continued investment in ACT TA resources, e.g., additional full-time consultants and trainers and part-time media assistance.

As of January 2018, the DMH/DD/SAS shifted its focus from directly completing fidelity evaluations to engaging the LME-MCOs in utilizing fidelity evaluations as a provider network quality management tool. The DMH/DD/SAS facilitates fidelity evaluation reviews for each of the LME-MCOs at least annually. In these reviews, the DMH/DD/SAS staff analyze fidelity evaluation results; review quality improvement plans; discuss steps the LME-MCO is taking to improve ACT teams; and make recommendations for quality improvement actions. The DMH/DD/SAS staff also explore LME-MCO protocols and practices that could be directly or indirectly impacting fidelity. Looking to the future, the DMH/DD/SAS will continue to use fidelity information to assess and then address practice issues at a State level. Currently, focus is on the provision of high-quality Individual Placement and Support – Supported Employment (IPS-SE) services as part of the ACT team, as well as ensuring that this service is available to individuals that are seeking support in employment or education.

There is a continued need to provide ongoing, robust support to ACT Teams. Such support can promote continued improvements in fidelity, as well as help to identify and address program fidelity drift. Areas of practice for targeted training include working with natural supports, person-centered planning, and revisiting training needs in co-occurring substance use disorders. In addition to ACT providers, directing these trainings to other community mental health providers and managing entities can assist in keeping everyone "on the same page" around practice expectations. Future fidelity reviews will feature the eTMACT, a "software as a service" (SaS) designed to reduce the time devoted to reviews, while increasing reliability and accuracy of ratings. Other areas to address include offering providers examples of practice; propelling efforts to develop recorded practice demonstrations and companion guides for use in training; and adapting practices, in response to COVID-19, from in-person to telehealth. Going forward, the State and its partners will continue to ensure that quality care is offered, even during uniquely challenging times.

C. INDIVIDUAL PLACEMENT AND SUPPORT – SUPPORTED EMPLOYMENT

Individual Placement and Support – Supported Employment (IPS-SE) did not exist in North Carolina prior to 2013. In fact, the Transitions to Community Living (TCLI) settlement agreement was the driving force behind establishing and expanding this innovative employment service to adults with mental illness. Before 2013, adults with mental illness that wanted support in finding employment would have to access the Division of Vocational Rehabilitation (DVR) independently or seek traditional supported employment services. The TCLI elected to advance a more efficient, effective approach to supporting individuals with mental illness in finding and maintaining competitive employment.

In 2013, the State joined the Dartmouth IPS-SE Learning Community (now Westat). The Learning Community not only provided partial funding to support five sites in start-up, but also offered extensive training, technical assistance and support. Four "Dartmouth Sites" were selected in 2013. These were the University of North Carolina (UNC) Center for Excellence in Community Mental Health, Easter Seals - Raleigh, Monarch - Albemarle and Meridian. By March 2014, there were 29

[8] For example, full certification teams were reviewed less frequently than provisional certification teams.

IPS-SE teams across the state. Additionally, the DMH/DD/SAS had 1.5 full-time equivalent (FTE) staff dedicated to training, technical assistance and fidelity support of IPS-SE and a contract with the North Carolina Employment First Technical Assistance Center (NC EF TAC), adding an additional 2.0 Full time equivalent (FTE) to support IPS-SE implementation. The DVR had 1.0 FTE at the state level dedicated to IPS-SE implementation.

The State subsequently transferred the IPS-SE training and technical assistance work to the UNC Institute for Best Practices and hired a new trainer. The DMH/DD/SAS advocated for increased funding to support additional IPS-SE trainers and proposed they be regionally located and work with no more than five IPS-SE teams, with the goal of improving the quality and fidelity of IPS-SE services. That funding was secured through the TCLI budget in 2015, and the Institute added two IPS-SE trainers in the eastern part of the State, one additional trainer in the central part of the State, and two IPS-SE trainers in the western part of the State.

In 2016-2017, the DMH/DD/SAS leveraged technical assistance through the Office of Disability Employment Policy's (ODEP) Employment First State Leadership Mentoring Program (EFSLMP) to collaborate with the DVR to develop a sequential funding structure for the payment of IPS-SE services. The State funds IPS-SE through either Medicaid (b)(3) funds or State funds combined with DVR funds. Both State and Medicaid funds were, at that time, being paid on a fee-for-service (FFS) basis, while DVR reimbursed their providers using milestone payments. [9] This was problematic, as providers were unsure which entity to bill for services rendered. As a result, too often they only billed Medicaid or State funds and underutilized the DVR milestone payments. The DMH/DD/SAS requested that the IPS-SE trainers address this as part of the technical assistance they provided. When this intervention failed to have a significant impact on milestone utilization, it led to the development of a new approach: the North Carolina Collaborative for Ongoing Recovery through Employment (NC CORE) initiative.

NC CORE is an innovative payment structure that addresses the discrepancy between FFS and milestone payments by switching both the State and Medicaid FFS payments to milestones. The milestones align with the IPS-SE evidence-based practice and focusing providers on the quality of service they are delivering versus the quantity of service they provide. Most importantly, the approach ensures providers can seamlessly transition from State or Medicaid funds to the DVR funds, maximizing all funding streams.

Vaya Health LME-MCO (Vaya), that was also involved in the development of NC CORE, volunteered to pilot NC CORE in 2019 across all IPS-SE teams in their network. They facilitated a soft start in November 2019, with the full payment pilot going live on December 1, 2019. The DMH/DD/SAS and the DVR continued to provide technical support and to adapt the model to fit the needs of both Vaya and their network. While COVID-19 has had an impact on the implementation of NC CORE, the pilot continues to produce positive results. The IPS-SE staff report a decrease in administrative burden, allowing them to spend more time supporting individuals in employment and educational pursuits. The percent of shared cases is significantly higher in Vaya than in any other LME-MCO, exceeding 80% of people receiving IPS-SE being open to the DVR milestone payment model. All IPS-SE teams in the Vaya network have had their DVR contracts increased to serve more individuals as they have quickly approached the initial maximum of their contracts.

[9] Milestone payments are "results driven payments" based on established outcomes.

Since its inception in North Carolina, the evolution of collaboration between the DVR and the IPS-SE teams has, as times, been challenging; but continued work together has yielded substantial improvements. Initial technical assistance included education on the model; shifting culture within the DVR; and increasing the understanding of sequential funding. A targeted, technical assistance webinar series for the DVR staff in 2019, as well as a webinar series for IPS-SE teams on collaboration, proved successful. Technical assistance during 2020 has focused on the LME-MCOs leveraging their support for utilization of the DVR milestones, promoting model sustainability. Currently, the DVR's Program Specialist for Behavioral Health participates in monthly meetings with the DVR and IPS-SE teams; participates in monthly Team Lead calls led by the IPS trainers at UNC Center of Excellence Institute of Best Practices; and partners closely with local DVR offices and IPS teams to continue building positive working relationships. Finally, the DVR's monthly technical assistance calls with DVR IPS-SE liaison counselors, as well as IPS-SE Teams, has led to additional refinements to IPS-SE service delivery. The DVR leadership remains committed to increasing collaboration, with high expectations that local DVR offices will work in tandem with the IPS-SE teams. The DVR, moreover, continues to be a willing partner in funding the employment components of IPS-SE, increasing funds when evidence suggests high utilization of milestones.

Individual Placement and Support – Supported Employment will remain a critical component of the adult mental health service array, even after the State successfully exits the TCLI settlement agreement. It has been included in the Tailored Plan service array, and the DMH/DD/SAS continues to explore ways to tie employment-specific outcomes to its contracts. The DVR and the DMH/DD/SAS both continue to advocate for additional LME-MCOs to adopt NC CORE. These developments clearly promote a valued life outcome for people with mental illness and provider stability.

D. COMMUNITY SUPPORT TEAM, TRANSITION MANAGEMENT SERVICES, AND PERMANENT SUPPORTED HOUSING

While Community Support Team (CST), Transition Management Services (TMS), and Permanent Supported Housing (PSH) were not linked at the beginning of the Transitions to Community Living Initiative (TCLI), these services are now closely tied together and carefully aligned to promote inclusion into the community.

Prior to the TCLI, CST was a Medicaid and State billable service; however, it was not routinely used due to limitations in the policy and in the service definition. Specific issues included:

- Six-month maximum length of treatment, making it difficult to support individuals in achieving their goals.
- Entrance criteria, as written, prevented CST from functioning as a stepwise service. Individuals that had received ACT and needed a lower level of care were often deemed "too stable" to qualify for CST. Individuals who were not meeting their goals at lower levels of care often qualified for CST and ACT and would get referred directly to ACT for the more intensive, wrap around service.
- The training requirements for CST could be costly and difficult to meet. The CST was expected to select one of the interventions listed in the policy and then to ensure that all staff had training on that specific intervention.

- Providers that operated CST found that the model was financially unsustainable due to the training requirements, rate of reimbursement, and prohibitions to working with individuals past six months.
- Psychiatric Rehabilitation and Supportive Housing Interventions were not included as required areas for which the team assisted.
- Many teams were not fully equipped to treat individuals with primary substance use disorder, as there was no requirement to have a substance abuse professional as a staff member.

Transition Management Services (TMS) was not a service before 2013. It was established to address the needs of individuals participating in the TCLI who did not clinically qualify for, or want to receive, existing services in the Adult Mental Health Service array, but who did need some supports specific to maintaining tenancy. The original service that was developed was Tenancy Supports Team (TST), which eventually transitioned into Transition Management Services (TMS.) A temporary revision to the TMS service was made on April 17, 2020, due to COVID-19, to include the use of telehealth.[10] Contacts with individuals can now be in-person or provided using telehealth. In addition, TMS staff training deadlines were extended to 120 days from hire, to allow new staff additional time to receive required trainings.

In the early years of the TCLI, providers had difficulty providing services that aligned with the Permanent Supported Housing (PSH) evidence-based practice. Initially, the Institute for Best Practices developed a brief tenancy supports training. That training provided a high-level overview of how to support individuals in finding and maintaining housing. The training was four hours long and was required for all TMS staff, as well as at least one staff on each ACT team. Based on housing separation data, emails from landlords, and feedback from the LME-MCOs, the DHHS determined that providers would benefit from a more in-depth training that was centered around the PSH evidence-based practice. The DHHS contracted with the Technical Assistance Collaborative (TAC) to facilitate PSH training across the state and to train a pool of trainers to meet on-going needs. An intensive, 15-hour training was developed, as a result, that is an in-depth exploration of the PSH model. It includes lecture, question and answer, and role-playing exercises, all designed for staff to better their understanding of the Housing First[11] approach and its goals.

The DHHS requested that each LME-MCO and the Institute for Best Practices identify staff that had the experience and background to serve as PSH trainers. The DHHS additionally reached out through Peer Voice NC to identify individuals with lived experience to become PSH trainers. The call was for peers who had experienced homelessness or had lived in a congregate living setting. The DHHS felt it was critical for these individuals to be selected as PSH trainers, since they were able to dispel any myths or misconceptions, such as "readiness to be housed," and could also speak from firsthand experience about what had supported them in living in the community as well as what had not. In several of the trainings, individuals with lived experience were able to bring attention to the use of non-person-centered language, explaining how that can carry over into the way staff engage with

[10] Telehealth is the use of two-way, real time interactive audio and video to provide care and services when participants are in different physical locations.

[11] Housing First is a proven approach in which people experiencing homelessness are offered permanent housing with few to no preconditions or barriers. It is based on significant evidence that with the appropriate levels of services, people experiencing homelessness can achieve stability in permanent housing. Housing First yields higher housing retention rates, reduces the use of crisis services and institutions, and improves people's health and social outcomes. See http://www.tacinc.org/technical-assistance-consultation/knowledge-areas/housing-first/

individuals. Those with lived experience underlined how to be person-centered when supporting individuals and shared their successful experiences with a Housing First approach.

Permanent Supported Housing (PSH) training became a requirement for TMS teams, ACT teams, and CST providers. Additionally, the CST policy and service definition underwent significant revisions, as well as a rate evaluation, to support the CST teams to better align practice using a PSH approach. The staffing requirements for CST were modified to allow for the hiring of a Certified Peer Support Specialist (CPSS). A 30-day pass through was added to permit CST to engage with individuals and start providing services on "day one" instead of having to focus on intake and person-centered planning work as a priority. When an individual has been identified as needing support in searching for housing, the CST team can request additional units for the purpose of providing permanent supportive housing interventions and increasing supports during the housing search. The CST caseload size was decreased from one staff working with 15 individuals to one staff working with 12 individuals, with a maximum of 48 individuals served by one CST team. Every team is now required to have a substance use professional. Finally, tenancy support interventions were added into the service definition scope of work, as well as the requirements to complete a functional assessment, provide psychiatric rehabilitation interventions and actively support individuals with skill acquisition and development. The DMH/DD/SAS has audited at least one training by each LME-MCO as well as that of the Institute for Best Practices and a Peer Voice NC partner to ensure that both the content and practice principles align with the TAC's training. The DMH/DD/SAS intends to continue the monitoring of PSH trainings and oversight of the training of new PSH trainers. This will promote training free of "practice drift," and ensure that providers are receiving information aligned with the PSH evidence-based practice.

The DHHS has reached out to those doing community inclusion work for this annual report. These individuals speak from the perspective of working with the State on TCLI, but they are not State entities. They are well positioned to compare the systems change work in North Carolina to that of other states and to identify approaches to sustaining change beyond TCLI.

Sherry Lerch and Gina Verne, TAC: The Technical Assistance Collaborative's (TAC) approach to the North Carolina PSH training and the curriculum was modeled after the work that the TAC completed in Louisiana. The TAC views this training and curriculum as a best practice approach. While we have implemented parts of the approach in other states, the TCLI embraced and implemented a robust approach to best practice.

The TAC's intent has been to prepare trainers who can deliver the training on an ongoing basis. The LME-MCO staff and representatives from UNC were invited to participate as it was the clear intent for them to serve as future trainers. The TAC not only shared all of its training materials; TAC trainers also added suggested comments/talking points to the PowerPoint Training Modules for future PSH trainers to use.

Following the trainings, the TAC developed a CST PSH Readiness Assessment Tool that the LME-MCOs distributed it to their providers. Provider agencies completed the self-assessments and returned them to the LME-MCOs. The LME-MCOs, in turn, forwarded the provider assessments to the TAC to review for trends to address in training/ technical assistance (TA), as well as unique needs. The LME-MCOs were also encouraged to reach out to TAC directly if more immediate assistance with training or PSH Readiness Assessment was needed.

The TAC had planned to host a Zoom meeting in February of 2020 with the LMEs-MCOs to discuss its analysis of the provider assessments and recommendations for further training and technical assistance. The LME-MCOs identified these topics:

- Their own capacities to deliver training and TA.
- Their plans for soliciting others to deliver training and TA.
- Their needs for TAC support to deliver training and TA.

When the pandemic hit, efforts were paused. In April of 2020, the TAC accommodated a request to modify the in-person training curriculum for the LME-MCOs to deliver virtually. In August, the TAC and the DHHS started to re-engage with the LME-MCOs around their needs for training and TA support. In September, the TAC facilitated a virtual session with all LME-MCOs to review their providers' progress with implementation of PSH services. The TAC then conducted focus groups with each LME-MCO and their providers to assess their challenges with PSH service implementation and their needs for ongoing training and TA.

The TAC strongly encourages the inclusion of peers with lived experience as part of any direct service training. While the TAC's trainers are highly knowledgeable, by their own admission, none have experienced homelessness or what it is like to navigate the system. Peers offer that insight. Inclusion of peers in the training sessions has brought the voice of experience, along with lived examples of interventions that are beneficial and those interventions that engender distrust and disengagement. Peers as trainers are beneficial in providing the therapeutic use of stories to punctuate the value of working within the three phases of PS, which include pre-tenancy, tenancy, and post-tenancy. Moreover, their inclusion ensures that staff are teaching persons receiving services about the PSH phases while incorporating those phases within each person's housing goal(s). Peer trainers have kept the focus on the person, the skill building, meeting the person where he /she is, and person-centered care, complementing and strengthening training on the clinical aspects of PSH.

To date, North Carolina has:

- Established LME-MCO contract requirements for Housing Specialists;
- Established expectations for LME-MCOs to provide PSH training directly or to contract with a recognized entity;
- Embedded housing-related services and supports into Medicaid policy and the State-funded service definition, so functions are reimbursable; and
- Contracted for a Strategic Housing Plan to quantify need and create additional affordable housing resources.

The TAC has the following recommendations for future efforts:

- Monitor the integrity of PSH training;
- Include requirements for PSH training in Tailored Plans;(which has been done) and
- Include performance measurements related to housing stability in Tailored Plans, with incentives for high performance.

E. PEER SUPPORT SERVICES (PSS)

Going into the Transitions to Community Living Initiative (TCLI), North Carolina already had a long history of peer supports. There was, for example, an established certification process that established and utilized core standards to certify peer support specialists in NC to provide services peer support services; and the creation of Medicaid "In Lieu Of"[1] service definitions and State Alternative Service definitions that expanded the access to and funding to support PSS . Initially, most peer supports were delivered by behavioral health providers instead of consumer-operated providers; this tended to dilute the peer voice in the service system. Early in the TCLI, concern arose over the vetting of individuals that obtained their Certified Peer Support Specialist (CPSS) credential. During the Tool for Measurement of Assertive Community Engagement (TMACT) evaluations, some peers would identify their lived experience as "quitting smoking," "going through a bad divorce," or "living in a neighborhood with a lot of people with mental illness." In response, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) reached out to UNC School of Social Work Springboard program[2] to oversee and manage the certification process including reviewing and approving, through the use of an CPSS workgroup that includes peers with lived experience, the certification training curricula that are used to certify PSS in NC, and managing a statewide database which now has more than 4000 CPSS registered certified PSS. In April 2020, the Division issued a call-for-action and the convening of a group of PSS to explore and develop recommendations for establishing a state CPSS credentialing and accountability board. The response to the call was the convening and establishment of a Peer Support Expert Commission[3] that has developed recommendations. The recommendations from the Peer Support Expert Commission address ways to have peer support specialists identified as professionally credentialed service providers, including the creation, powers and duties of a proposed certification oversight board; board membership and selection process; and procedures for responding to complaints, investigations and disciplinary actions. In the summer of 2020, the Commission shared its recommendations with peers

[1] Federal law allows LME-MCOs operating under the 1915(b)(c) waiver to develop services that are cost-effective options to behavioral health services offered by the state. These services are called In Lieu Of or Alternative Services, depending on the funding source. Medicaid-funded services are known as In Lieu Of Services; those supported with state funds are called Alternative Services. Regardless of the funding source, In Lieu Of and Alternative Services are extra supports that may not be covered in the state's approved service array. See https://www.cardinalinnovations.org/Resources/Blog/In-Lieu-Of-and-Alternative-Services#:~:text=Medicaid%2Dfunded%20services%20are%20known,funds%20are%20called%20Alternative%20Services.&text=The%20North%20Carolina%20Division%20of,oversees%20state%2Dfunded%20Alternative%20Services.

[2] University of North Carolina-Chapel Hill (UNC-CH) Behavioral Health Springboard (BHS) at the School of Social work links current research to initiatives in mental health and substance use prevention and treatment. BHS offers curricula development, technical assistance, program consultation, and face-to-face and online educational programs.

[3] The Commission was established with the task to deliver recommendations to the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services on the occupational regulation of peer support practice and related matters. The Commission is composed of a diverse group of experts with representation from various geographical areas, age groups, racial, ethnic, and cross-disability groups, as well as the LGBTQIA community. Members have experience working within organizations that provide Medicaid services and state-funded Peer Support services. Members also are working in peer-run organizations and many are individuals who have lived experience in recovery with mental health and substance use disorders. See https://pss.unc.edu/pss-commission/about

in the field for public comment and continue to meet with DMHDDSAS staff to collaborate on process and path forward to implement the recommendations. The establishment of an independent oversight/credentialing PSS board is one of the Division's core goals.

While enhancing the certification and oversight process, the DMH/DD/SAS partnered with the Division of Health Benefits (DHB) to add Peer Support Services (PSS) to the Medicaid State Plan, in the process ensuring that PSS is an entitlement service for Medicaid beneficiaries. The process involved three, stakeholder webinars on the proposed changes, as well as a 45-day public comment period. The PSS Medicaid policy went live December 12, 2019.

The DMH/DD/SAS sought technical assistance from the Georgia Mental Health Consumer Network. This network focused attention on fully engaging individuals with lived experience in program development, service delivery and oversight of CPSS. The DMH/DD/SAS staff subsequently secured funding for a Request for Applications (RFA) for a peer-run organization to establish Peer Operated Respite (PORS). PORS fills a unique gap in the State's community-based crisis service array. It is a consumer-run, short-term respite program for individuals in the early stage of a behavioral health crisis. Services are voluntary and people seeking support from the respite program are called guests. All staff are CPSSs, and the supports they provide are aligned with peer support services. The program offers no clinical interventions and there is no requirement to meet participation expectations by staying at the respite center. Because the service is voluntary, guests can come and go as they need, and can continue to work, go to school, or engage in clinical treatment, as they choose.

In State Fiscal Year (SFY) 2018, Sunrise Community for Recovery and Wellness (Sunrise) received funding to establish the Brian H. Clark Respite Center[4]. The Center began renting a three-bedroom house in Asheville and has done significant outreach to increase awareness of PORS and how to access its supports. Guests are asked, but not required, to leave feedback regarding their stay, and have said the following about the Brian H. Clark Respite Center:

- "I was feeling overwhelmed with my problems and would have ended up hospitalized [if I hadn't stayed at the respite center]."
- "In a hospital, you are expected to get better. In respite, you are provided an atmosphere to get better."
- "I think [respite] is a better alternative for people who are suicidal and experiencing emotional distress."
- "[I experienced] stress from the gauntlet of services that I am theoretically supposed to navigate while depressed and [felt] obliged to camp out way out of town in order to be safe. In many ways, autism is a social disability and forced interactions are ridiculously draining. The respite center became my headquarters and place to retreat while recovering my balance."
- "There is no comparison [between hospital and respite]. You made me feel like I was at home; at the same time, staff were there to help. Respite is heaven… infinitely better than a hospital in all areas."

In addition, DMHDDSAS invested funding to a service provider network—United Partners of Health—to increase CPSS in areas that have high rates of COVID cases with a particular focus on Highly Marginalized Populations (HMPs). This contractor is hiring and training CPSS to work in partnership with community health workers and serve as liaisons between BH/IDD consumers, Public

[4] See http://www.bhcrc.sunriseinasheville.org/

Health, and DSS agencies in rural NC communities with high numbers of COVID19 cases and/or limited access to testing and access to care. Peers will assist individuals experiencing mental health crisis or who are at-risk of emergency department utilization, in navigating multiple healthcare systems and service delivery modalities including telehealth, testing and contact tracing, along with agencies providing services to address social determinants of health including housing, food distribution, and supporting BH/IDD consumers with adherence to treatment plans to reduce escalation or worsening of conditions and crisis. Peers will also lead in the development of positive relationships, in efforts to reduce stigma as a barrier to whole-person care, and in the building of inclusive communities.

F. COMMUNITY INCLUSION

At the inception of the Transitions to Community Living Initiative (TCLI), there was no direct focus on community inclusion. There was indirect work occurring, e.g., technical assistance on psychiatric rehabilitation to Assertive Community Treatment (ACT) teams and increased access to employment in the community through Individualized Placement and Support – Supported Employment (IPS-SE). Still, nothing in the early years of TCLI focused on actively supporting people to become a part of the community; nor was there any overt consideration of the impact that being included has on individuals remaining in community housing.

In 2017, this changed. Key staff from the DMH/DD/SAS, along with the Executive Director of the Alliance of Disability Advocates of North Carolina (ADANC), attended the Temple University Summer Institute on Community Inclusion. The conference highlighted existing and emerging research basis for community inclusion; illustrated how community inclusion can be woven into and directly impact specific domains of everyday community life; and reviewed the work of targeted community inclusion programs. This new knowledge base directly led to the TCLI staff seeing community inclusion as in and of itself essential and central, as opposed to an add-on to another service definition.

The TCLI then made, a significant change to enhance its focus on community inclusion. It developed a contract with the Alliance of the Disability Advocates of North Carolina (ADANC)[12] to provide community inclusion supports to individuals participating in TCLI, initially in the Eastpointe Local Management Entity-Managed Care Organization (LME-MCO) catchment area. The DMH/DD/SAS provided funding to support the ADANC and Eastpointe staff to access training and technical assistance provided by Temple University. This included how to use Temple's engagement and assessment tools, as well as, more broadly, how to support individuals to engage in their communities. All staff working with the ADANC on this pilot have a disability, and both staff and TCLI participants indicate that peer-to-peer engagement has enhanced the service.

Incident to the pilot, the Eastpointe LME-MCO has seen an improvement in its TCLI housing retention numbers. The US Department of Justice (DOJ) has called the partnership between a Center

[12] The ADANC is a federally recognized Center for Independent Living that uses Title VII funding to provide services to the citizens of Raleigh, Durham, and the surrounding area. Although ADANC's services focus on Raleigh-Durham surrounding areas, our services have the potential for statewide systemic change. By design, CILs are consumer-controlled, community-based, cross-disability, non-residential private non-profit agencies that serve their surrounding communities. See https://adanc.org/about-us/history/

for Independent Living, the ADANC, and an LME-MCO an “innovative approach to addressing the TCLI settlement agreement”. The Independent Reviewer for the settlement agreement has noted the positive impact the focus on community inclusion has had on housing retention.

The TCLI has advanced a second significant change by dedicating funds to support the National Alliance on Mental Illness North Carolina (NAMI NC) affiliates in community inclusion work. In 2019-2020, NAMI NC provided funding to five NAMI affiliates to develop and implement community inclusion pilots, using Temple’s online community inclusion tools. That same year, NAMI NC held four Community Inclusion (CI) Trainings across the state for two members of each NAMI affiliate. NAMI NC developed a process, in partnership with NC DMH/DD/SAS, to help affiliates implement events in their local communities. Five affiliates applied for and received grants for seven CI projects.

In 2020, CI projects and events carried on, despite COVID-19. These projects included initiatives such as pet adoption classes, library “read and share” programs and a mental health symposium. In the upcoming year, 2020-2021, NAMI NC will continue its efforts, providing additional trainings for affiliates across the State and encouraging affiliates to apply for mini grants to implement CI events/ projects of their own. The NAMI NC’s goal is for nine affiliates to implement a CI pilot project using the Temple University Community Inclusion resources. According to the Executive Director of NAMI NC, "Community Inclusion is near and dear to NAMI North Carolina because it's so central to our mission. We're grateful that our local affiliates have had the opportunity to create and expand local spaces that celebrate difference and welcome individuals with serious mental illness and their families."

The DHHS wanted to ensure that the voice of entities doing community inclusion work was included in this annual report. The individuals, below, speak from the perspective of working with the State on the TCLI, but they are not State entities. They compare the systems change work North Carolina is doing to other states and use their experience to identify ways to ensure the positive work that TCLI has done is sustainable past the end of TCLI’s settlement agreement.

"Community Inclusion is near and dear to NAMI North Carolina because it's so central to our mission. We're grateful that our local affiliates have had the opportunity to create and expand local spaces that celebrate difference and welcome individuals with serious mental illness and their families."

Mark Salzer, Director of Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities. The Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities (Temple) has had conversations and done some training over the years with other states who have either had DOJ settlements or were threatened with settlements; however, we have never been asked to be as engaged as we have in North Carolina. In other settlements, states have been allowed to focus exclusively on housing and do a little in the area of employment. Most court monitors seem to have been satisfied with a focus on housing.

My engagement with the State started about three years ago. I have come to believe that North Carolina is engaged in truly unique, broad-based efforts to raise awareness about the importance of promoting community inclusion and participation in multiple domains, including supporting person-

directed initiatives to promote participation in meaningful activities. These initiatives for individuals with serious mental illness include:

- The novel engagement of a Center for Independent Living, the Alliance of Disability Advocates of North Carolina (ADANC) in partnership with an LME-MCO, to provide person-directed supports that are aimed at enhancing inclusion and participation among the TCLI's participants;
- Engagement of a family- and consumer-directed organization, NAMI NC, to create inclusion initiatives that are tailored to specific communities throughout North Carolina, each led by local NAMI affiliates; and
- A statewide campaign that is now led by consumer organizations to educate the consumer, provider, and LME-MCO communities about community inclusion and encourage additional innovation.

I will briefly comment on my impressions of each below.

The ADANC has had contact with 62 individuals in the TCLI program through the Eastpointe LME-MCO since 10/19/2018. The ADANC staff have had a total of 646 contacts with program participants through 7/30/20, with an average of slightly over 10 contacts per participant. We at Temple are still in the process of examining data regarding the impact of this effort, but anecdotal evidence suggests that it is having a positive impact on the lives of individuals with Serious Mental Illness (SMI) in the TCLI program and that it may be having a positive impact on housing outcomes.

The ADANC produced a video that offered the experience of one program participant. It is an excellent example of how the program is intended to work through the use of peer support and the promotion of self-direction to enable the individuals in the TCLI program to live the lives they want to live.[13] Another positive outcome of the ADANC /Eastpointe LME-MCO collaboration is the attention it has drawn from federal policymakers in the Administration on Community Living (ACL) as a potential model initiative. The ADANC/Eastpointe/ Temple team had a meeting with ACL[14] in Fall 2019 to discuss the initiative. Overall, I believe that ADANC is providing an excellent service to the TCLI participants, at a very good "dose" (e.g., about 10 contacts each). This is likely enhancing community tenure and meaningful engagement of participants in their communities, using an approach that facilitates their empowerment and promotes hope.

The NAMI NC leadership[15] have been truly exceptional in promoting community inclusion efforts through the NC NAMI affiliates throughout the State. I have had the opportunity to interact with the affiliates a few times and have been impressed with the unique efforts they have undertaken in their local communities to promote opportunities for participation of individuals with SMI. The initiatives have included knowledge fairs and other efforts to make individuals aware of resources in their communities with which they can get more engaged, as well as outings to increase participation in various ways, especially in leisure and recreation. Family members and consumers who are affiliate members have increased their knowledge about the importance of community inclusion and will continue to make inclusion a priority to promote mental health and wellness long-term. This will, I believe, inspire further efforts of the NAMI affiliates to outreach into their local communities. Such

[13] See https://youtu.be/Jr7ATYvlaqs
[14] The team met with ACL's Shawn Terrell <Shawn.Terrell@acl.hhs.gov>.
[15] I refer to Peg Morrison and Mikayla Cordona, specifically.

efforts can address stigma and increase access to community resources locally, as well as encourage LME-MCOs and local providers to strengthen their focus on community inclusion.

The "I'm IN" campaign, previously led by The i2i Center,[16] focused on educating consumers, family members, providers and LME-MCO staff about the importance of community inclusion and strategies to promote inclusion. So far, more than 200 people have been engaged in one of the day-long trainings offered throughout the State. We have also provided a multi-day training and resource materials to train individuals about how to disseminate information on community inclusion in their own trainings. The NAMI NC has used some of these materials in their own trainings as has The i2i Center in its trainings. We also offered a unique training on taking a social marketing approach with mainstream community organizations (e.g., employers, educational institutions, faith communities, etc.) to assist these entities to become more welcoming and embracing of individuals with SMI. I have been impressed with the engagement of individuals in these sessions and have seen some indicators that our training information is being used by others to spread the word about community inclusion throughout the mental health system.

The I'm IN campaign has now transitioned to being led by a broad consortium of consumer leaders from throughout the state and I am very excited about future dissemination initiatives they will lead. Consumer leadership is critical to the success of community inclusion initiatives. I am especially excited about the likely focus on addressing environmental barriers that is being emphasized by advocates who are speaking out about the "exclusion" that people with SMI experience in the community.

Transforming a system toward meaningful and sustained community inclusion in a broad range of participation domains (i.e., not just housing and employment) is a difficult endeavor. While there is always much more that needs to be done, I have been impressed by what I believe have been sincere and determined efforts funded by the North Carolina Department of Health and Human Services (DHHS) to pursue greater inclusion of adults with SMI. Other states are doing a smattering of things here and there, but none have truly adopted such a broad-based set of initiatives.

Here are some of the factors that I believe are setting the foundation for long-term, sustained policies and programming aimed at promoting inclusion.

- Knowledge: I believe that past and future efforts to enhance knowledge of key stakeholders about the importance of community inclusion and fundamentals for making it happen has been critical to the development of current and future initiatives. This was kicked off by a day-long training from the Temple team in February 2018 that has been followed by further training activities.
- Seed funding: Offering such funding has likely been important to assist various groups in gaining more familiarity and experience with community inclusion and what it will take to make it a reality. The challenge will be assisting various groups in keeping things going once the funding has run out.
- Expansion of the ADANC effort: As mentioned earlier, the ADANC collaboration is a truly novel program that I have not seen elsewhere. The state's commitment to expanding this approach elsewhere, and enthusiasm from LME-MCOs, is impressive and encouraging for long-term sustainability.

[16] See https://i2icenter.org/about/

- Consumer-driven initiatives: Consumers already know why community inclusion is critical, are passionate about making it happen, and apply their experiential knowledge to generate successful inclusion outcomes. The consumer leadership underlying ADANC's efforts is likely one attribute that makes it successful. The consumer and family leadership from the NAMI NC is also critical for their success. I am also very enthusiastic about the consortium of consumer organizations that has taken over the lead for the I'm IN efforts. This bodes well for long-term sustainability and success.
- Engagement of LME-MCOs: Getting funders onboard is essential for long-term sustainability. I have been very impressed with the staff and leadership at Eastpointe LME-MCO. This staff has a deep understanding of and commitment to community inclusion and to working with ADANC in their TCLI program. I have also worked closely with the ADANC and am equally impressed by the interest from their organization to promote community inclusion as well. I have also heard some about the work of other LME-MCOs from throughout the state. This buy-in, and continued buy-in and expansion of efforts, is critical for long-term sustainability.

While a solid foundation is being established in NC, more work and commitment–likely for many years—is needed for it to "stick." It will take further effort to see the full benefits for enhancing the lives of people with SMI and their loved ones, including decreased use of crisis services and inpatient hospitalization.

Vicki Smith, Executive Director, ADANC: Peer-to-peer engagement is a cornerstone of Centers for Independent Living (CILs) and is one of the five core services CILs are required to provide their consumers. CILs are required to maintain a staff of at least 51% people living with a disability. Seventy-five percent of the ADANC's staff have a disability and all of the staff working with the TCLI have a disability and/or a close family member with a mental illness. The ADANC's model includes cross-disability peer support[17] which both staff and TCLI participants have indicated has enhanced the service.

To our knowledge, no other CIL in the country has provided this type of service related to the implementation of an Olmstead settlement. The ADANC has been able to expand its reach beyond the five counties funded through their federal grant with the Administration on Community Living (ACL).

The success of this model is also built on the very effective partnership between the ADANC, the Eastpointe LME-MCO, the DMH/DD/SAS and Temple University. Monthly calls allow for proactive problem-solving and have enhanced communication between all parties. Issues and concerns are candidly discussed and resolved. The focus is always on the TCLI participants.

It is hoped that the relationships cultivated among this CIL, the LME-MCOs and the TCLI will serve as a model to ensure that North Carolinians experiencing any disability will have better access to and support for maintaining community living in the future.

[17] The ADANC staff have a wide range of disabilities, including cerebral palsy and other disabilities, as well as mental illness.

IV. TCLI COMMUNITY-BASED MENTAL HEALTH SERVICE PATTERNS

The following tables provide numbers of participants who received core Transition to Community Living Initiative (TCLI) services in calendar year (CY) 2019. Service summaries are based on NCTracks Medicaid and DMHDDSAS adjudicated behavioral health service claims for the TCLI participant populations described in Table 1.[18,19]

Table 1: CY 2019 Service Claims Query Participant Populations

TCLI Participant Status	Description	Unduplicated Count
TCLI Housing	Individuals in TCLI supportive housing for one or more days of CY 2019 or who were previously housed and subsequently rehoused by March 31, 2020	2,791
Pre-Transition	Individuals initially housed by March 30, 2020 and for whom one more of the 90 days immediately preceding transition occurred in CY 2019	1,136
In-Reach[a,b]	Individuals with a seven-day or longer Transitions to Community Living Database (TCLD) status of "In Process" in CY 2019 and who matched to clients in NCTracks	9,255
Community	Individuals with a seven-day or longer period of CY 2019 TCLD status of housed in the community without a TCLI slot and who matched to clients in NCTracks	2,900
Total		13,453

a- Approximately 14% of these individuals had CY 2019 Diversion attempt activity that coincided or overlapped with the In-Process status. For this group, some services reported under In-Reach may have been provided during an open Diversion attempt.

b- Approximately 8% of these individuals are also included in the claims query for Pre-Transition status for the segment of the 90-days period prior to transition that fell within CY 2019. If active pre-transition planning exceeded 90 days, some services reported under In-Reach may have been provided during the pre-transition planning period.

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

[19] Analysis is based on claims for CY 2019 dates of service that were adjudicated through May 27, 2020; 98.1% of retrieved claims were adjudicated to paid status as of the May 27, 2020 check write date. Timely filing limits may affect data completeness, especially for services provided late in CY 2019.

The total unduplicated count of 13,453 individuals in the initial claims query included 22 (0.2%) participants who had all four statuses at different points during the year, 572 (4.3%) duplicated across three status categories, and 1,426 (10.6%) with two statuses. The large majority, 11,433 (85%), had one status during the year.

As shown in Table 2, the most common status changes within the year occurred between pre-transition and TCLI housing, In-Reach and pre-transition, and In-Reach and community housing without a TCLI slot.

Table 2: CY 2019 Participant Status Transitions

		Subset (Percentage) with Additional CY19 Status			
Status	**Number**	**TCLI Housing**	**Pre-Transition**	**In-Reach**	**Community**
TCLI Housing	2,791	100%	34%	23%	5%
Pre-Transition	1,136	83%	100%	63%	4%
In-Reach	9,255	7%	8%	100%	8%
Community	2,900	5%	2%	26%	100%

Table 3 shows the average length of individual status periods by LME-MCO.

Table 3: Average Length of CY 2019 Status Periods (Number of Days)

LME-MCO	TCLI Housing	Pre-Transition	In-Reach	Community
Alliance	282	69	288	327
Cardinal	289	74	294	280
Eastpointe	264	77	278	304
Partners	286	77	281	314
Sandhills	280	75	268	266
Trillium	276	72	272	296
Vaya	258	79	236	290
Statewide Total	279	74	277	295
Minimum Possible	*1*	*1*	*7*	*7*
Maximum Possible	*365*	*90*	*365*	*365*

Professional (non-institutional) fee-for-service and Medicaid encounter behavioral health service claims for the full calendar year were initially queried for all 13,453 individuals. Claims for services provided while participants had one of the active program status categories in Table 1 were retained for further analysis; all other claims were excluded from further analysis.

Individuals are included in the service claims analysis for each status they had during the year, with dates of service limited to the period of the corresponding status. Status periods of In-Reach or living in the community were end dated 91 days before individuals transitioned to TCLI supportive housing; claims for the 90 days before transition are reported under Pre-Transition status.

Table 4 shows numbers of individuals for whom the NCTracks query returned claims for mental health (MH), substance use disorder (SUD), and/ or intellectual/ developmental disabilities (I/DD) services within the date range of the status. Percentages of individuals served reported in the tables that follow are calculated using denominators in Table 4.

Table 4: Participant Population Sizes for Community Mental Health Services Analysis

LME-MCO [a]	TCLI Housing	Pre-Transition	In-Reach	Community
Alliance	337	143	1,041	158
Cardinal	778	275	1,656	302
Eastpointe	238	88	401	253
Partners	344	84	589	150
Sandhills	267	102	320	117
Trillium	393	180	746	281
Vaya	326	173	1,039	353
Statewide Total	2,725	1,045	5,790	1,614
Total Queried	*2,791*	*1,139*	*9,255*	*2,900*
Percent with CY 2019 Service Claims	*97.6%* [b]	*91.7%* [c]	*62.5%*	*57.8%*

a- Reported percentages of individuals served are based on housed individuals' LME-MCO at the time of the claims query or the LME-MCO on record in TCLD for the period of the corresponding status category. Approximately five percent of TCLI participants have transferred across catchment areas since initially transitioning to community-based supportive housing, and some services reported under the LME-MCO on record may have been managed by a different LME-MCO. Small numbers of individuals also are duplicated across status/LME-MCO combinations.

b- Individuals for whom the NCTracks query did not return service claims for the period in housing spent an average of 123 fewer days of CY 2019 in housing than housed individuals with adjudicated service claims.

c- Individuals for whom the NCTracks query did not return service claims for the pre-transition period spent an average of 23 fewer days of CY 2019 in that status compared to individuals with adjudicated service claims.

Table 5 summarizes the range of services and supports included in the analysis for each service category. Data tables that follow show statewide and LME-MCO numbers and percentages of individuals within each TCLI status category with adjudicated claims for core TCLI services and other supports provided within the date range of the status period.

Table 5: Core TCLI Services and Support Groupings

Service Category	Services Included
ACT	Assertive Community Treatment Team
CST	Community Support Team
Crisis Services	Behavioral Health Urgent Care (BHUC) Mobile Crisis Management (MCM) Facility-Based Crisis (FBC)
Evaluation & Management Office and Outpatient Visits	New and Established Patient Office/ Outpatient Visits Office Consultations Behavioral Health Counseling Outpatient Psychiatric Services Community Psychiatric Treatment Mental Health Partial Hospitalization
IPS-SE	Individual Placement and Support - Supported Employment (IPS-SE) b(3) IPS-SE
Peer Support Services	Individual, Group, and Self-Help Peer Support Recovery Education Center Peer Support
Psychological Diagnostic, Evaluation, and Testing	Alcohol/Drug Screening Behavioral Assessment Program Screening Neuropsychological Testing and Evaluation Psychological Testing and Evaluation Psychiatric Diagnostic Evaluation
PSR	Psychosocial Rehabilitation Services
Psychotherapy	Individual Psychotherapy Group Psychotherapy Family Psychotherapy Multi-Family Group Therapy Outpatient Dialectical Behavior Therapy

Substance Use Services and Treatment	Alcohol/ Drug Group Counseling, Halfway House, and Residential Ambulatory, Inpatient, and Social Setting Detox Counseling for smoking and tobacco use Medication Assisted Treatment (MAT) Substance Abuse Comprehensive Outpatient Treatment (SACOT) Substance Abuse Intensive Outpatient Treatment (SAIOP)
Transition Management and Tenancy Support Services	Tenancy Management Services (TMS) Critical Time Intervention (CTI) b(3) Individual Supports

Table 6: Individuals Who Received Core TCLI Services and Supports While in TCLI Supportive Housing, Calendar Year 2019

	All Services		Assertive Community Treatment Team (ACT)		Community Support Team (CST)		Crisis Services		Evaluation & Management Office/ Outpatient Visits		Individual Placement and Support-Supported Employment (IPS-SE)	
	Denominator		N	%	N	%	N	%	N	%	N	%
Alliance	379		177	47%	114	30%	23	6%	130	34%	40	11%
Cardinal	778		276	35%	127	16%	39	5%	272	35%	44	6%
Eastpointe	238		85	36%	39	16%	7	3%	83	35%	8	3%
Partners	344		172	50%	32	9%	20	6%	94	27%	30	9%
Sandhills	267		144	54%	36	13%	5	2%	70	26%	15	6%
Trillium	393		128	33%	63	16%	38	10%	141	36%	59	15%
Vaya	326		169	52%	50	15%	31	10%	85	26%	15	5%
Statewide	2,725		1,151	42%	461	17%	163	6%	875	32%	211	8%
	Peer Support Services		**Psychological Diagnostic, Evaluation, and Testing**		**Psychosocial Rehabilitation (PSR)**		**Psychotherapy (Individual, Group, and/or Family)**		**Substance Use Services and Treatment**		**Transition Management and Tenancy Support Services**	
	N	%	N	%	N	%	N	%	N	%	N	%
Alliance	36	9%	151	40%	20	5%	83	22%	15	4%	199	53%
Cardinal	257	33%	186	24%	63	8%	188	24%	24	3%	481	62%
Eastpointe	54	23%	50	21%	13	5%	48	20%	23	10%	122	51%
Partners	88	26%	68	20%	35	10%	97	28%	11	3%	183	53%
Sandhills	53	20%	73	27%	27	10%	40	15%	7	3%	105	39%
Trillium	110	28%	78	20%	21	5%	78	20%	10	3%	281	72%
Vaya	58	18%	55	17%	19	6%	66	20%	9	3%	170	52%
Statewide	656	24%	661	24%	198	7%	600	22%	99	4%	1,541	57%

a, b- Statewide percentages who received MCM (5%), FBC (2%), SACOT (1%), SAIOP (2%), Detox (0.4%), and MAT (1%) were comparable to previous years.

Table 7: Individuals Who Received Core TCLI Services and Supports While in the Pre-Transition Period, Calendar Year 2019

	All Services		Assertive Community Treatment Team (ACT)		Community Support Team (CST)		Crisis Services[a]		Evaluation & Management Office/ Outpatient Visits		Individual Placement and Support-Supported Employment (IPS-SE)	
	Denominator		N	%	N	%	N	%	N	%	N	%
Alliance	143		60	42%	27	19%	3	2%	39	27%	13	9%
Cardinal	275		84	31%	61	22%	3	1%	51	19%	10	4%
Eastpointe	88		31	35%	28	32%	5	6%	33	38%	3	3%
Partners	84		33	39%	8	10%		0%	12	14%	5	6%
Sandhills	102		55	54%	15	15%	1	1%	25	25%	1	1%
Trillium	180		69	38%	36	20%	4	2%	40	22%	21	12%
Vaya	173		98	57%	16	9%	8	5%	31	18%	6	3%
Statewide	1,045		430	41%	191	18%	24	2%	231	22%	59	6%
	Peer Support Services		**Psychological Diagnostic, Evaluation, and Testing**		**Psychosocial Rehabilitation (PSR)**		**Psychotherapy (Individual, Group, and/or Family)**		**Substance Use Services and Treatment[b]**		**Transition Management and Tenancy Support Services**	
	N	%	N	%	N	%	N	%	N	%	N	%
Alliance	17	12%	27	19%	7	5%	30	21%	5	3%	62	43%
Cardinal	112	41%	40	15%	13	5%	52	19%	6	2%	72	26%
Eastpointe	11	13%	24	27%	2	2%	12	14%	4	5%	7	8%
Partners	12	14%	14	17%	10	12%	26	31%	2	2%	20	24%
Sandhills	3	3%	27	26%	5	5%	18	18%	3	3%		0%
Trillium	14	8%	15	8%	9	5%	31	17%	3	2%	97	54%
Vaya	29	17%	19	11%	6	3%	41	24%	5	3%	59	34%
Statewide	198	19%	166	16%	52	5%	210	20%	28	3%	317	30%

a, b- Statewide percentages who received MCM (1%), FBC (1%), SACOT (0.4%), SAIOP (1%), Detox (0.3%), and MAT (1%) were comparable to previous years.

Table 8: Individuals Who Received Core TCLI Services and Supports During In-Reach, Calendar Year 2019

	All Services		Assertive Community Treatment Team (ACT)		Community Support Team (CST)		Crisis Services[a]		Evaluation & Management Office/ Outpatient Visits		Individual Placement and Support-Supported Employment (IPS-SE)	
	Denominator		N	%	N	%	N	%	N	%	N	%
Alliance	1,041		283	27%	170	16%	85	8%	422	41%	31	3%
Cardinal	1,656		345	21%	113	7%	71	4%	511	31%	29	2%
Eastpointe	401		60	15%	22	5%	9	2%	146	36%	2	0.5%
Partners	589		151	26%	12	2%	40	7%	146	25%	10	2%
Sandhills	320		56	18%	9	3%	11	3%	107	33%	5	2%
Trillium	746		107	14%	53	7%	50	7%	334	45%	29	4%
Vaya	1,039		455	44%	102	10%	109	10%	243	23%	16	2%
Statewide	5,790		1457	25%	481	8%	375	6%	1909	33%	122	2%
	Peer Support Services		**Psychological Diagnostic, Evaluation, and Testing**		**Psychosocial Rehabilitation (PSR)**		**Psychotherapy (Individual, Group, and/or Family)**		**Substance Use Services and Treatment[b]**		**Transition Management and Tenancy Support Services**	
	N	%	N	%	N	%	N	%	N	%	N	%
Alliance	91	9%	356	34%	150	14%	234	22%	36	3%	56	5%
Cardinal	313	19%	516	31%	221	13%	538	32%	38	2%	72	4%
Eastpointe	16	4%	102	25%	66	16%	76	19%	18	4%	8	2%
Partners	72	12%	156	26%	62	11%	272	46%	13	2%	18	3%
Sandhills	13	4%	101	32%	41	13%	101	32%	6	2%	1	0%
Trillium	33	4%	240	32%	124	17%	178	24%	25	3%	69	9%
Vaya	180	17%	234	23%	98	9%	329	32%	34	3%	57	5%
Statewide	718	12%	1705	29%	762	13%	1728	30%	170	3%	280	5%

a, b- Statewide percentages who received MCM (4%), FBC (2%), SACOT (1%), SAIOP (2%), Detox (0.3%), and MAT (1%) were comparable to previous years.

Table 9: Individuals Living in the Community Without a TCLI Slot Who Received Core Services and Supports, Calendar Year 2019

	All Services		Assertive Community Treatment Team (ACT)		Community Support Team (CST)		Crisis Services		Evaluation & Management Office/ Outpatient Visits		Individual Placement and Support-Supported Employment (IPS-SE)	
	Denominator		N	%	N	%	N	%	N	%	N	%
Alliance	158		44	28%	18	11%	12	8%	87	55%	2	1%
Cardinal	302		73	24%	36	12%	26	9%	121	40%	6	2%
Eastpointe	253		56	22%	27	11%	23	9%	125	49%		0%
Partners	150		37	25%	8	5%	12	8%	58	39%	2	1%
Sandhills	117		30	26%	5	4%	2	2%	60	51%	2	2%
Trillium	281		47	17%	19	7%	26	9%	157	56%	6	2%
Vaya	353		131	37%	41	12%	55	16%	109	31%	2	1%
Statewide	1,614		418	26%	154	10%	156	10%	717	44%	20	1%
	Peer Support Services		Psychological Diagnostic, Evaluation, and Testing		Psychosocial Rehabilitation (PSR)		Psychotherapy (Individual, Group, and/or Family)		Substance Use Services and Treatment		Transition Management and Tenancy Support Services	
	N	%	N	%	N	%	N	%	N	%	N	%
Alliance	13	8%	64	41%	38	24%	42	27%	3	2%	4	3%
Cardinal	42	14%	86	28%	39	13%	83	27%	13	4%	10	3%
Eastpointe	19	8%	96	38%	41	16%	66	26%	31	12%	5	2%
Partners	18	12%	37	25%	8	5%	54	36%	3	2%	4	3%
Sandhills	4	3%	29	25%	15	13%	25	21%	6	5%	1	1%
Trillium	19	7%	98	35%	47	17%	95	34%	8	3%	28	10%
Vaya	52	15%	85	24%	31	9%	113	32%	13	4%	13	4%
Statewide	167	10%	495	31%	219	14%	478	30%	77	5%	65	4%

V. IN-REACH

A. SUMMARY

In FY19-20, the Department of Health and Human Services (DHHS) continued to work with the Local Management Entities-Managed Care Organizations (LME-MCOs) to oversee the provision of In-Reach and frequent education of individuals and/ or guardians about community-based services and supports. These efforts are critical to transition planning, supporting individuals to acquire supported housing and to exit Adult Care Homes (ACHs) and State Psychiatric Hospitals (SPHs). With a strategic focus on areas in which the state has not yet met the Transitions of Community Living Initiative (TCLI) settlement agreement standard of "substantial compliance," the DHHS

shifted its efforts in 2020 to address ongoing monitoring and guidance; staff education and training; and additional education on the guiding principle of "informed consent."

B. SETTLEMENT AGREEMENT REQUIREMENTS

With regard to In-Reach, active monitoring has occurred for individuals currently residing in Adult Care Homes (ACHs) and State Psychiatric Hospitals (SPHs). Monitoring ensures contacts are as frequent as requested, but not less than quarterly. The development of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services' (DMH/DD/SAS) Community Transitions and Integration (CTI) Team, in the winter of 2020, increased collaboration with the LME-MCOs. The result was effective monitoring and identification of individuals who are already in ACHs and SPHs. In addition, collaboration lessened the notification time for individuals who had previously been considered for admission to ACHs but, after being "diverted" and returning to the community, were later admitted to ACHs. The LME-MCOs received guidance and clear expectations from the State that individuals with Serious Mental Illness (SMI), that choose to reside in an ACH, must receive In-Reach upon admission.

For 2021, the DHHS will be working to promptly identify individuals in ACHs that are receiving In-Reach and indicate they choose to transition back into the community. The CTI Team Lead will develop a statewide working In-Reach list to monitor and update as individuals move through the TCLI process, from In-Reach to Transition. The CTI Team will assist with targeting gaps in In-Reach contacts and delays in the transition process.

For the first three quarters of FY19-20, In-Reach Specialists conducted the majority of monitoring onsite in ACHs. These in-person evaluations allowed In-Reach coaches to provide one-on-one guidance to the In-Reach Specialists about strengthening assertive engagement strategies, when encountering individuals and/ or guardians who are reluctant to consider the option of supported housing. Understanding that knowledge acquisition precedes application, the CTI Team developed and provided training, as well as technical support/ assistance, to In-Reach Specialists across the state. Through site observations and shadowing of In-Reach Specialists--in-person or by phone or virtually due to COVID-19, strengths and training needs were identified. Trainings conducted during FY 19-20 included: In- Reach (IR)/ Transition to Community Living (TCL) Tool review webinar for the DHHS website; Services and Supports; In-Reach-Outreach (IR/ OR) Priority Populations; SPH Discharge Planning: Role of IR; and the TCLI Informed Decision-Making (IDM) tool. Exploring Engagement training has also been developed but has been put on hold due to COVID-19, as it requires a face to face presentation with interactive exercises. All trainings, with the exception of the IR/ TCL Tool webinar, provided a link for participants to complete a post-training evaluation through Survey Monkey.

i. In-Reach/ TCL Tool review webinar

This webinar for the LME-MCOs is utilized for new staff hires, as well as a refresher for current In-Reach Specialists. The training provides an overview of the guidance document for use of the tool and instructions for completing it. Feedback received has been positive. Staff reports that the webinar serves as a helpful guide and appreciates that it is readily available on the website. This training was first provided to In-Reach Specialists and Transition staff at Vaya LME-MCO in the Fall of 2019.

ii. Services and Supports

This training addresses the need for In-Reach Specialists/ TCLI staff to be knowledgeable about and aware of community supports and services. It provides a review of 13 services provided throughout North Carolina, including community- and office-based services. Feedback from surveys indicates that the training is a good refresher; provides a better understanding of services; increased staff's understanding of their role; and will assist staff to access needed services and supports for the TCLI's participants.

iii. In-Reach/ Outreach Priority Populations and SPH Discharge Planning: Role of In-Reach

This training defines the differences between In-Reach (IR) and Outreach (OR) functions. It includes a review of the TCLI's five priority populations, as well as the expectations of In-Reach along with In-Reach and Outreach reminders. The State Psychiatric Hospital (SPH) Discharge Planning: Role of In-Reach training reviews the In-Reach Specialists' role in discharge planning, including how to complete the updated SPH In-Reach/ TCL tool. In addition, the training provides tips for use when talking with individuals/ guardians. Feedback from surveys notes the following: the training was easy to follow and informative; provided clarification of In-Reach roles and responsibilities; and it improved participants' understanding of the different populations, as well as the difference between In-Reach and Outreach.

iv. Exploring Engagement

This training was developed to provide an overview to In-Reach Specialists regarding positive engagement for individuals eligible for TCLI. Specifically covered are the key components of engagement; getting to know the person; challenges to engagement; and practicing/ role-playing. Since this training was intended to be an in-person/ interactive training, it has not been provided to In-Reach Specialists due to COVID-19 restrictions; however, plans are to provide a virtual training in the Fall 2020.

v. Guardianship and Informed Decision-Making

During the Spring 2020, the Department of Health and Human Services (DHHS) worked with NC Medicaid's Money Follows the Person program, Rethinking Guardianship[27], and a Certified Peer Specialist to develop an Informed Decision-Making (IDM) tool. The tool was developed to align with and support a core principle, derived from the *Olmstead* decision: "informed choice."[28] The IDM tool helps guide conversations about community living between potential Transitions to Community Living Initiative (TCLI) participants and In-Reach staff. The tool assists its user in covering such topics as community living options, available resources, and services. Its use assists staff in better understanding whether the person is making an "informed decision" based on

[27] Rethinking Guardianship is an initiative of the NC Council on Developmental Disabilities. It describes its mission as developing a sustainable infrastructure to effect long-term changes in North Carolina's guardianship system and promote less restrictive alternatives to guardianship. https://rethinkingguardianshipnc.org/mission

[28] In 1999, the US Supreme Court (SCOTUS) held in *Olmstead v. L.C.* that the "unjustified segregation" of people with disabilities in institutional settings was unlawful discrimination under the ADA. Public entities must provide community-based services to people with disabilities when: (1) such services are appropriate; (2) the affected person doesn't oppose treatment that takes place in the community; and (3) providing such services is feasible (services can be "reasonably accommodated, taking into account the resources available… and the needs of others who are receiving disability services...").

experience, diagnosis, and other critical factors. The IDM tool is used with people who are residing in an Adult Care Home (ACH) or are hospitalized in a State Psychiatric Hospital (SPH) who have been deemed eligible for TCLI. The tool aids the TCLI staff in documenting and addressing perceived barriers to community living. In sum, the innovative tool operationalizes some key requirements around informed consent that appear in the TCLI settlement agreement and improves engagement with participants.

The DHHS developed and implemented training on the IDM tool shortly after the tool was completed. The training defined IDM; engagement in the context of IDM; the use of IDM within the TCLI program, specifically during the In-Reach process; and offered a question and answer period. Training was provided to all seven LME-MCOs' In-Reach Specialists and Managers in August 2020, to prepare for implementation on September 1, 2020. The DHHS will continue to offer ongoing support and technical assistance as needed. Feedback from surveys included: increased knowledge of talking points helps to ensure that participants exercise choice and are as informed as possible; provides a streamlined format for the user; promotes an intentional approach to informed decision-making; and helps to build trust and rapport.

VI. HOUSING

A. SUMMARY

As North Carolina continued its efforts in FY19-20 to meet the housing mandates of the Department of Justice (DOJ) Settlement Agreement, the State's supportive housing programs played a major role in creating opportunities for people with disabilities to live in integrated communities. The strong partnership among the NC Department of Health and Human Services (DHHS)/ Transitions to Community Living (TCLI), the Local Management Entity-Managed Care Organizations (LME-MCO) and North Carolina Housing Finance Agency (NCHFA) helped to rebuild lives, offer hope, and provided real housing solutions. The DHHS further supported TCLI's housing efforts by providing additional funding to the LME-MCOs, advancing partnerships with temporary housing providers and both expanding and establishing new contracts with community service providers. The DHHS' continued use of Bridge Housing[29] remains a proven and successful tool for getting individuals into permanent supportive housing (PSH). The LME-MCOs increased Bridge Housing opportunities this fiscal year through using several different models such as hotels, leased apartments and single room occupancy arrangements in socially diverse areas. This program is vital for many individuals who were at risk of institutional placement during the peak of the spread of the coronavirus. Notably, over 90 percent of those individuals who utilized Bridge Housing were able to successfully transition to permanent supportive housing.

[29] Bridge Housing is an approach that allow the LME-MCOs to stabilize individuals who are in need of immediate housing while they plan for living in the community. The Bridge Housing program is a transitional program for individuals diverted from Adult Care Homes and individuals transitioning out of State Psychiatric Hospitals. The program offers settings located in areas with ready access to essential resources, such as bus lines, employment opportunities and places to shop for basic needs. Teams for these housing units help people successfully transition to permanent housing in their community of choice. See, e.g., https://pss.unc.edu/pssjobs/peer-support-specialist-bridge-housing.

LME/MCO	Completed TUTP	Moved into Supportive Housing during TUTP	Moved into Supportive Housing Post TUTP	Moved into Targeted Unit	Moved into Non-Targeted Unit
Alliance	74	69	4	21	48
Cardinal	69	58	5	14	44
Eastpointe	87	75	1	13	62
Partners	32	31	1	12	19
Sandhills	29	26	1	0	26
Trillium	54	48	1	7	41
Vaya	72	66	5	20	46
Total	417	373	18	87	286

TCLI June Report/LME-MCO Totals for End of June, 2020

Provided permanent housing and supportive services to:

2550

Individuals.

LME-MCOs helped increase opportunities for individuals who have been identified as eligible for housing through TCLI, who are awaiting permanent supportive housing and who are in immediate need of interim housing.

417

served through Bridge Housing.

To ensure safe housing, all housing units for TCLI participants are required to be inspected using Housing and Urban Development (HUD) Quality Standards (HQS). Due, however, to the spread of the coronavirus in the early spring of 2020, the DHHS implemented a hybrid inspection model to ensure safe, sanitary and secure housing for TCLI participants. The LME-MCOs completed either a virtual inspection with the landlord/ owner representative using a habitability checklist or a HUD Quality Standards (HQS) inspection for initial move-in and annual inspections. Units are re-inspected annually, as well as on an ad hoc basis, if a health and safety issue arose or a tenant or support provider "had cause" to request a re-inspection. In FY 19-20, the State spent $218,300 to ensure housing units subsidized for TCLI participants met the HUD Quality Standards (HQS) upon initial lease execution.

The DHHS and the NCHFA have worked over the years to improve upon data collection with respect to housing. The Community Living Integration Verification (CLIVe) system is now fully operational and actively utilized. The CLIVe is a payment reimbursement system that supports LME-MCO housing activity by providing a mechanism to input data and receive reimbursement consistent with the DHHS' established program policy and procedures. The CLIVe also manages and organizes workflow, as well as serves as the system of record for Transition to Community Living Voucher (TCLV)[30] tenancies. Ultimately, the CLIVe is the system of record for tenancies for all individuals participating in the TCLI. The system provides oversight functions that allow for quality review of the TCLV program. These include, but are not limited to: rental costs incurred by each LME/MCO; tracking of late inspections; a record of reasons for "move outs"; and data regarding length of stay in housing.

B. EXPANDING IMPACT

In 2018, Technical Assistance Collaborative (TAC) recommended that the DHHS seek more rental financing and funding opportunities, including funding from the HUD Mainstream[31] program; make changes to the Qualified Allocation Plan (QAP)[32] to provide more incentives in the Low-Income Housing Tax Credit[33] (LIHTC) program for the target population; and apply for the HUD 811 Project Rental Assistance (PRA) funds. The DHHS and the NCHFA followed through with these recommendations to meet the TCLI settlement agreement goals and, more broadly, to make more affordable housing available for all eligible populations

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

[31] Mainstream Vouchers are tenant-based vouchers that serve households that include a non-elderly person with a disability.

[32] The Qualified Allocation Plan sets out the state's eligibility priorities and criteria for awarding federal tax credits to housing properties.

[33] Low Income Housing Tax Credit ("LIHTC") is a federal housing program administered by NCHFA. Low-Income Housing Tax Credit provides a tax incentive to construct or rehabilitate affordable rental housing for low-income households.

under the DHHS umbrella. The DHHS, in coordination with the TAC, developed the TCLI Housing Pipeline[34] in 2018 and continues to utilize the tool to reach the number of units and subsidies requisite to meeting the TCLI settlement agreement goal of 3000 individuals in housing by June of 2021.

With that goal in mind, the DHHS and the NCHFA collaboration bolstered expansion, across the State, of supportive housing initiatives through the Integrated Supportive Housing Programs (ISHP)[35] and the Targeting Program. Earlier, in FY 18-19, the DHHS partnered with the NCHFA to develop the Integrated Supportive Housing Program (ISHP), a program providing interest-free loans to community developments where up to 20 percent of the units are integrated and set aside for households participating in the TCLI program. These developments are affordable and integrated into the community, with a focus on access to services, grocery stores and other amenities. This collaborative effort now funds 17 developments, garnering a total of 247 housing units in six LME-MCO catchment areas.

In FY19-20, the Targeting Program[36] expanded to more than 6,007[37] apartments in 733 properties. The Targeting Program is a partnership between the NCHFA and the DHHS to provide access to affordable housing for low income households in which people with disabilities reside. Properties developed using the federal LIHTC are required to participate in the Targeting Program. To comply, LIHTC properties must set aside at least 10 percent, but no more than 20 percent, of their units and make them available for eligible participants as identified by DHHS.

Status of ISHP Projects	Total ISHP Units per Project	Units filled	Utilization Rate
Placed in Service (Active with referrals)	110	52	47%
To Be Placed in Service Next (Active – no referrals yet)	63	0	0%
Pipeline (under construction – Not Active)	73	0	0%
Total	**246**	**52**	**21%**

[34] The Housing Pipeline lays out processes and strategies to increase available housing throughout North Carolina.
[35] ISHP is a program providing interest-free loans to community developments where up to 20 percent of the units are integrated and set aside for households participating in the TCLI program.
[36] The Targeting Program is a disability neutral housing program for low-income persons with disabilities who need supportive services to help them live independently in the community. Through a partnership between NC Department of Health and Human Services and NC Housing Finance Agency, the program provides access for eligible participants to Low Income Housing Tax Credit properties. The program aims to connect eligible persons to housing that is: affordable, decent, permanent, integrated, accessible, and independent. https://www.ncdhhs.gov/divisions/aging-and-adult-services/permanent-supportive-housing
[37] These numbers represent properties with executed Targeted Unit Agreements at the end of FY19-20, which is a little different than reporting on total funded units or total units placed in service.

The hard work of revisions of policies, procedures and documentation requirements have made the Targeted Units more accessible to individuals in TCLI. The NCHFA in collaboration with the DHHS, has been diligent in its review of Tenant Selection Policies and Targeting Unit Agreements of LIHTC properties to ensure access to the community for vulnerable, underserved, and at-risk populations. Prior to each Targeting Program property opening, property profiles and pre-leasing notifications provide information to the LME-MCOs and providers so that TCLI participants have opportunities to exercise a choice in favor of community and the necessary planning for community inclusion occurs, consistently. Additionally, the DHHS and the NCHFA hold bi-weekly operational and monthly strategic meetings to review efficiency and effectiveness of the program.

Furthermore, to support substantial compliance with the settlement agreement, the Targeting Program continues to prioritize available units for TCLI participants. The Vacancy and Referral System (V&R), operated through the NCHFA, assists the process by generating real-time reports of all vacant LIHTC units. The V&R is primarily used by property management companies and the DHHS' housing coordinators to manage the Targeting program. The LME-MCOs also have new tools, notably, the ability to search for vacancies in the Targeting Program through CLIVe. Searches can be as broad or as specific as an LME-MCO would like, based on selection for county, city, unit size, accessibility features, etc. As a result of what TCLI often calls "barrier removal," DHHS housing coordinators can more efficiently coordinate with LME-MCO staff to offer TCLI participants units that meet their needs. The results speak for themselves: as of June 2020, there were 628 TCLI households residing in Targeted Units.

C. STRATEGICALLY EXPANDING HOUSING THROUGH FEDERAL VOUCHER AWARDS

Much focus has gone into expanding access and utilization of Mainstream Vouchers and Section 8 Housing Choice Voucher Program[38] set-asides for the TCLI population. Through competitive solicitations in FY 2018 and FY 2019, the DHHS and the LME-MCOs worked with 21 local Public Housing Authorities (PHAs) to apply for vouchers through the Mainstream Voucher Program. These efforts brought the State 556 additional federal vouchers, adding to the dollars available to support housing resources and offset expenses for state-funded rental subsidies. Each of the PHAs that received the awards got supplemental funds in FY 2020 without having to apply for these. Through the strong partnership between one LME-MCO and PHA, 15 housing choice vouchers were set aside for the settlement population.

[38] The Section 8 Housing Choice Voucher Program is the federal government's major program for assisting very low-income families, the elderly and people with disabilities to afford decent, safe and sanitary housing. It is for eligible families regardless of race, religion or political affiliation in the private market. Program funds are awarded to the program by HUD through Annual Contributions Contracts and are used to subsidize the difference between the cost of rent and a maximum of 30 percent of the household's adjusted gross income.

In April 2019, DHHS petitioned HUD, requesting a remedial preference for the life of the settlement agreement for individuals in the TCLI. This remedial preference allows all of the State's PHAs to amend their administrative plans to ensure that individuals involved in TCLI are provided preference on their respective housing waitlists. The remedial preference was granted and DHHS began working to implement these preferences throughout North Carolina's PHAs in FY2020. As of the time of this report, 28 TCLI participants are utilizing a Mainstream Voucher as a source of rental assistance in their housing unit.

In the summer of 2020, the NCHFA was awarded $7,000,000 from HUD under its Section 811 Project Rental Assistance (PRA) program for a five-year project period. The HUD 811 program provides project-based rental assistance funding to eligible state housing finance agencies for extremely low-income persons with disabilities, aged 18 - 61. This grant will provide rental assistance for approximately 188 apartments for extremely low-income people with disabilities who are either transitioning from institutions or at risk of institutionalization.

D. ATTRACTING MORE TCLV PROPERTY OWNERS

In 2020, the Local Management Entity-Managed Care Organizations (LME-MCOs) continued to expand the use of private market units. Through the use of Risk Mitigation Tools, LME-MCOs have encouraged new property owners to participate in the Transition to Community Living Voucher (TCLV) program. Using the Risk Mitigation Tool, LME-MCOs may reimburse landlords for expenses incurred in excess of the security deposit in the following circumstances:

- Tenant caused unpaid property damage
- Tenant has unpaid rent and late fees
- Tenant abandoned the unit, creating a vacancy
- Landlord/ property owner incurred costs incident to eviction

Combined with an increased investment in property owner outreach and a strong emphasis on customer service, the State's LME-MCOs have expanded the number of participating landlords, broadening the housing choices available to TCLI participants. During FY 19-20, 244 new property owners joined the TCLV program. To establish and maintain good working relationships, property owners/ landlords were awarded approximately $109,543 in risk mitigation funds.

Of the TCLI members who receive permanent supported housing…

Almost all remain permanently housed.

67%

remain in stable, permanent housing

State Housing Programs are Cost Effective

	Average Monthly Subsidy
TCLV	$585
Key Rental Assistance	$392

E. BEST PRACTICES IN HOUSING

The Department of Health and Human Services (DHHS), the Local Management Entities-Managed Care Organizations (LME-MCOs) and the North Carolina Housing Finance Authority (NCHFA) have implemented a number of best practices to address barriers to accessing housing. These have improved TCLI households' experiences during tenancy and decreased separations from housing.

i. Tenancy Issues Tracking

Socialserve[32] continues to contact landlords for satisfaction surveys. When landlords are dissatisfied, the NCHFA follows up with the LME-MCO. The LME-MCOs then conduct outreach to the landlord, service provider and/ or tenant, resulting in many saved tenancies. For purposes of the Transition to Community Living Initiative's (TCLI) Quality Assurance and Performance Improvement, the data is compiled and analyzed, allowing DHHS to determine training needs, accessibility issues, areas of concern and successes. Socialserve also continues to provide assistance to the LME-MCOs in landlord outreach and engagement.

vi. Risk Mitigation Tools

The Targeting and Transition to Community Living Voucher (TCLV) programs strive to keep landlords satisfied and engaged, helping to assure housing options for future tenants. As noted above, landlords may receive reimbursement for expenses incurred in excess of the security deposit through a special claims process, after submittal and approval of required documentation.

vii. Housing Policy "Barrier Busters"

The NCFA requires landlords who participate in agency-administered rental programs to have a written, property-specific Tenant Selection Plan (TSP). The criteria contained in a TSP must not be so restrictive that it creates a disparate impact on groups protected by the federal Fair Housing Act. The criteria must also align with HUD's requirement for housing entities to further fair housing affirmatively and to conform to any applicable HUD guidance.

The NCHFA published the Fair Housing and Tenant Selection Plan policy, initially enforcing it through review and approval of Tenant Selection Plans (TSP). Subsequently, it is enforced based on investigation of complaints, which are checked for adherence to or violation of the approved TSP language. Provisions that advance increased access to housing, particularly for individuals with disabilities include, but are not limited to, the following:

[32] Social serve is a nonprofit, bilingual call center that connects people to housing and provides supportive, second chance employment. See https://www.socialserve.com

- Prohibition of application fees for those in Targeting units and TCLI applicants, in general
- Provision to waive credit screening criteria for applicants participating in programs which provide landlords the ability to recover economic losses related to the tenancy
- Model policy on screening applicants with criminal records and factors to consider when individualized assessments are appropriate and necessary.[33]
- Guidance related to reasonable accommodations/ modifications under the Americans with Disabilities Act (ADA), including a provision that companies hold units during the negotiation of reasonable accommodations occurring at the time of application
- Mandatory tax credit lease addendum provision[34] related to unit access

viii. Community Service Provider Housing Trainings

The NCHFA, the DHHS, and the NC Justice Center continued to work together in 2020 to offer fair housing trainings across the state.

Number of Basic Fair Housing Trainings: 28 total (14 for housing providers, 14 for service providers)
Number of Advanced Fair Housing Trainings: 6 total (for service providers only)
Basic Fair Housing trainings for providers of housing : 192 attendees
Basic Fair Housing trainings for service providers: 170 attendees
Advanced Fair Housing trainings for service providers: 114 attendees

The LME-MCOs themselves have sponsored housing trainings to increase providers' knowledge of housing strategies. For instance, Alliance Health contracted with the Corporation for Supportive Housing (CSH) to provide a three-hour training for ACT team leads and housing specialists on the following topics: Overview-Tenancy Support Services through the Lens of Supportive Housing and Housing First Principles; Recovery-Focused Services; Best Practices in Housing Navigation; and Theories and Practice: Incorporating Harm Reduction, Trauma-Informed Care, and Motivational Interviewing into Tenancy Support Services. DMH staff have observed several of the MCO-facilitated trainings to evaluate the effectiveness of the trainers.

FY 2021, the DHHS and NCHFA will be working to implement quick, interactive, scenario-based trainings on fair housing and other permanent supportive housing strategies and will target "low to medium knowledge" learners. Topics in the housing skills refresher modules will include:

- Eviction Due to Non-Payment of Rent

[33] The criteria must be no more restrictive than the Model Policy on Screening Applicants with Criminal Records. https://www.nchfa.com/sites/default/files/page_attachments/TenantSelectionPlanPolicy.pdf
[34] The tax credit lease addendum outlines the provisions of Section 42 of the Internal Revenue Code of 1986, as amended, which are applicable to the lease term. https://www.nchfa.com/sites/default/files/page_attachments/MandatoryTaxCreditReleaseAddendum.pdf

- Section 8 Made Simple for Practitioners, Understanding Your PHA's Housing Choice Voucher Program
- Understanding Reasonable Accommodations and Reasonable Modifications
- Section 8 Made Simple for Practitioners, Understanding Your PHA's Housing Choice Voucher Program
- The Power of Community Connections in Permanent Supportive Housing

The DHHS implemented the Permanent Supportive Housing Training (PSH) for providers in the Summer 2019. The initial Keys to Community Living summits provided an overview of the changes to Community Support Team; an introduction to Psychosocial Rehabilitation; and an introduction to Permanent Supportive Housing (PSH). The Technical Assistance Collaborative (TAC) facilitated PSH trainings from fall 2019 through January 2020 for providers and MCO staff who were selected to become PSH trainers, for a total of 5 trainings. Each LME-MCO has either facilitated at least two PSH trainings or contracted with the University of North Carolina (UNC) and Peer Voices of North Carolina (PVNC) to facilitate PSH trainings for their network providers. Due to COVID-19, the PSH trainings were provided virtually in the last half of the fiscal year.

ix. Housing Stabilization

Each LME-MCO has implemented at least one housing best practice, and many have chosen to implement several to ameliorate separation from housing. Some of the innovative practices that LME-MCOs implemented this year included the following:

- Vaya Health implemented landlord mediation for its TCLI members to increase empowerment, decrease communication barriers, and streamline the housing process for Vaya and its network providers. As a result, TCLI participants were able to address landlord and tenant matters in an efficient and effective manner.
- In one of its rural catchment areas, Cardinal Innovations forged a partnership through the Continuum of Care (CoC) to address social determinants of health (e.g., food, housing, transportation). The NC 360 Initiative in Vance, Franklin and Warren Counties helps those experiencing homelessness, or at risk of homelessness, to adequately meet food, housing and transportation needs, improving overall household stability.
- Sandhills Center embarked on a community/ resident engagement initiative to link TCLI participants with community activities in the community of their choice. Those in TCLI were more likely to participate in the life of their community, resulting in more successful, long-term housing outcomes.
- Alliance Health, Cardinal Innovations and Vaya Health implemented Assertive Community Treatment Teams (ACTT) and Community Support Team (CST) Learning Collaboratives to address tenancy support issues and to reduce preventable, housing separations. Case studies were used as a springboard for peer-to-peer learning.
- Alliance Health began hosting a monthly TCLI Separations Workgroup in 2020. This workgroup brings together Alliance Health leadership to review housing

separations from a systems level, make recommendations and discuss strategies to address issues.

- Eastpointe's use of Alliance of Disability Advocates (ADANC) services, via a pilot program this fiscal year, assisted them with housing stabilization for many TCLI participants. Working with ADANC, individuals are provided assistance in becoming a part of their new community. These relationships have remedied feelings of boredom and loneliness and also improved housing stability.
- Trillium explored the use of technology to assist people who felt isolated in the community. The LME-MCO acquired small robots. The devices are used to set reminders, explore recipes, tell jokes and check the weather. They are also able to follow participants around in their homes, assisting with various tasks.
- Partners developed a Value Based Contracting method that included incentives to maintaining TCLI participants in housing.
- Each LME-MCO's transition coordination team made concerted efforts to make weekly contact with members during COVID-19 to ensure continuity of care and to promote wellness and stability in housing.

To continue the DHHS' work in improving housing retention for TCLI members in FY2021, DHHS will pilot monthly, housing stabilization meetings among DHHS regional housing coordinators, LME-MCOs and their network providers. The meetings will address tenancy issues, historical interventions, and suggested new interventions, along with developing and sharing plans with landlords/ property managers. It is expected that the effort will preserve tenancies and long-term housing successes for TCLI participants.

VII. PRE-ADMISSION SCREENING AND DIVERSION

A. COMMUNITY INTEGRATION PLANNING

To be clear, successful community living doesn't just happen. It requires intentional, informed support on the part of Local Management Entity-Managed Care Organization (LME-MCO), providers, natural supports (when available), and NC DHHS staff. Community Integration Planning (CIP) is the process through which LME-MCO staff assist an individual in developing a plan to achieve those outcomes that promote a person's growth, well-being and independence. Person-centered in nature, the CIP is based on the individual's strengths, needs, goals and preferences, considered in the context of the most appropriate integrated setting, across all domains of the individual's life. As such, the Community Integration Plan is a key component of Transition and Discharge planning.

The conversation that informs the CIP should begin during the Diversion process. For the CIP to be effective, the LME-MCO staff who assist Transition to Community Living (TCLI) participants must be adequately trained and knowledgeable about resources, supports, services and opportunities available in the community, including available community mental health service providers and access to mental health supports. Working with knowledgeable staff ensures that individuals are fully informed when making decisions that involve consideration of entry into an Adult Care Homes

(ACH). The Department has been monitoring the CIP process quarterly and has gathered information and documentation from each of the LME-MCOs to assess the CIP and the LME-MCOs' utilization of the CIP Guidance document. The LME-MCOs receive a tracking spreadsheet each quarter that requests information and feedback about the CIP process. The State then analyzes responses to ensure that processes promote success and advance substantial compliance with the TCLI Settlement Agreement.

B. TECHNICAL ASSISTANCE

Monitoring has allowed the State to identify and address training needs regarding the CIP, including issues concerning personal care services (PCS) and the Department of Social Services (DSS) guardianships. Concerning PCS, NC Medicaid and the independent assessment entity, Liberty Healthcare of North Carolina, presented a webinar, titled, "*A Review of Medicaid Personal Care Services and the Expedited Review Process*", on September 11, 2020. The webinar training was designed to support the LME-MCO transition coordinators and others who play a vital role in supporting individuals served through the TCLI.

Regarding the DSS guardianships, the TCLI has collaborated with the Division of Aging and Adult Services (DAAS) to secure DSS guardians' participation in TCLI's Diversion efforts. The DHHS developed a guidance document for guardians working with TCLI participants and the DAAS distributed it to all public guardians on April 30, 2020. The document addressed the State's key Olmstead responsibilities and that of its contractors, among whom are public guardians.

C. TRAINING

The State offered Diversion Outreach staff an opportunity to participate in the In-Reach Services and Supports training conducted in the Spring and Summer of 2020. This training addressed the need for In-Reach Specialists/ TCLI staff to be knowledgeable about and aware of community supports and services. It provided a review of 13 services, provided throughout North Carolina, inclusive of community-based services and office-based services (e.g., therapy and medication management).

The State also provided an In-Reach/ Outreach functions, power point presentation, to the TCLI's leadership in each of the seven LME-MCOs. The presentation defined the difference between In-Reach and Outreach functions; included a review of TCLI's priority populations; covered expectations for In-Reach staff; and offered a review of basics for both In-Reach and Outreach staff. Additionally, the training provided tips when talking with individuals/ guardians. Finally, the training reviewed Joint Communication Bulletin (JCB) #327[35]and the utilization of the CIP guidance

[35] JCB #327 was sent to LME-MCOs on 6/5/29. The purpose of JCB #327 was to provide links to Transitions to Community Living Initiative (TCLI) In-Reach resources and clarification and additional resources to support LME-MCO Diversion activities and Community Integration Planning. The additional resources included the introduction of the Community Integration Guidance document. The JCB defined Diversion and who was eligible for diversion. It also defined community integration, community integration planning, and informed choice. The Community Integration Guidance document was sent out along with the JCB.

document. Six LME-MCOs opted for the online training, provided during the Spring and Summer of 2020. One LME-MCO opted to provide its own training to In-Reach Specialists and that of the LME-MCO's own staff.

D. RSVP AND DIVERSION

x. Technical Assistance and Monitoring.

The State continues to provide technical assistance for the Referral Screening and Verification Process (RSVP), as needed, to the LME-MCOs, providers, individuals and referral sources. The State also conducts monthly and quarterly monitoring of the RSVP and Diversion data and processes.

xi. LME-MCO RSVP to Diversion Workflow

On a quarterly basis, the State monitors each LME-MCO's RSVP to Diversion workflow, by requesting information pertaining to their process flow. The State sends a tracking spreadsheet to the LME-MCOs and analyzes responses to identify any gaps or needs. Additional technical assistance has been made available to four of the seven LME-MCOs to ensure workflows and processes are aligned to achieving substantial compliance with the settlement agreement. Email exchanges further clarified issues/ concerns, along with conference calls that were held with two LME-MCOs.

xii. RSVP Prompt Determination of Eligibility

TCLI also monitors for promptness, by means of data reviews, of the LME-MCO eligibility determinations. Notification of all RSVPs pending for over 30 days goes to the relevant LME-MCO staff on a monthly basis with a request for response, inclusive of actions taken. State staff review responses and data to ensure that the LME-MCOs are working towards meeting the settlement agreement's 'substantial compliance, standard. As a result of the DHHS' training, education, and technical assistance with both LME-MCOs and referral sources, the number of individuals in the RSVP "pending" status has been reduced substantially. Improvements are also evident in processing timeframes, eliminating duplications, and reducing the volume of requests for individuals who are not eligible for TCLI. Additionally, the number of "individuals housed" from participants in Category 5, "diversions from institutions," increased to 34% as compared to an average of 20%, for each of the five previous years. In other words, the number of Category 5 TCLI eligible people housed, increased from 20% diverted: housed with a slot in FY19 to 34% diverted: housed with a slot in FY20, demonstrating that the implementation of RSVP was effective in "diverting individuals". This accomplishment is attributed to the implementation of RSVP's 'independent screening' and its prompt determination of eligibility. As a result, TCLI is on track to meet the housing requirement for the Category 5 priority population, in Fiscal Year (FY) 2021.

E. DATA

xiii. Chart A: LME-MCO Pre-Admission Screening Cumulative Totals from November 1, 2018 through the end of June 30, 2020

The Referral Screening Verification Process (RSVP) database is the source for obtaining Pre-Admission screening data. Data was reported monthly in prior months. Beginning with the October 2019 report, data is reported cumulatively.

Totals reflect the number of screenings, not the number of individuals screened.

LME-MCO	Total RSVP Category 5[36] Referrals Submitted	RSVP Screenings Determined TCLI Eligible	RSVP Screening Determined TCLI Ineligible	RSVP Screenings Pending	RSVP Screenings Withdrawn (duplicate, not considered for admission. other)
Alliance Behavioral Healthcare	1577	517	304	1	755
Cardinal Innovations	3243	723	495	0	2025
Eastpointe	761	188	153	0	420
Partners Behavioral Health Mgmt.	1349	185	371	3	790
Sandhills Center	866	240	55	32	539
Trillium	1638	433	320	19	866
Vaya Health	2114	779	518	11	806
Total	**11548**	**3065**	**2216**	**66**	**6201**

[36] Persons diverted from entry into an Adult Care Home fall into the Transitions to Community Living Initiative Category 5 target population if the living arrangement meets the criteria of the Department of Justice (DOJ) settlement agreement.

xiv. Prescreening Metrics Over Time

- **RSVP Pending referrals decreased (data determined based on RSVP implementation date of 11/1/18):**
  - November 30, 2018: 187 Pending
  - November 30, 2019: 14 Pending
- **TCLD In Process decreased:**
  - June 30, 2019: 1,250 In Process
  - June 30, 2020: 986 In Process
- **LME-MCO Screening Time Metrics for RSVP (Time from RSVP submission date until RSVP determination of eligibility for TCLI date)**
  - 11/1/18 – 6/30/19: LME-MCO average time was 41.95 days
  - 11/1/19 – 6/30/20: LME-MCO average time was 18.48 days
  - *As a result of ongoing technical assistance, training, and monitoring conducted with the LME-MCOs by state staff, we have greatly reduced the # of days it takes to complete a screening (prompt determination) to determine TCLI eligibility.*

xv. Chart B: Diversion Results from July 1, 2019 through the end of June 30, 2020

LME-MCO	Diverted (with & w/out slots)	Not Diverted	In Process	Withdrawn /Removed	Total Diversion Attempts
Alliance Behavioral Healthcare	5	50	138	5	198
Cardinal Innovations	17	196	148	11	372
Eastpointe	46	28	22	5	101
Partners Behavioral Health Mgmt.	14	52	23	1	90
Sandhills Center	15	65	25	1	106
Trillium	48	92	92	7	239
Vaya Health	57	128	171	9	365
Total	**202**	**611**	**619**	**39**	**1471**

***** Tableau is the data source from which Diversion data is obtained from TCLD

Total Diversion attempts are the screenings that resulted in a determination of TCLI Eligible. Withdrawn/Removed includes deaths, moved out of State, or does not meet criteria (Dementia/ Alzheimer's/ TBI/ I/ DD are the primary diagnosis).

xvi. Chart C: Diversion Status of Individuals with PASRR Screenings[37] Processed from January 2013 to the end of Fiscal Year 19-20

LME-MCO	Diverted (with & w/out slots)	Not Diverted	In Process	Withdrawn / Removed	Total Diversion Attempts
Alliance Behavioral Healthcare	580	1017	267	119	1983
Cardinal Innovations	913	2182	271	312	3678
Eastpointe	372	830	23	40	1265
Partners Behavioral Health Mgmt.	388	1132	33	68	1621
Sandhills Center	295	715	36	23	1069
Trillium	527	1248	117	83	1975
Vaya Health	590	1431	239	91	2351
Total	**3665**	**8555**	**986**	**736**	**13942**

***** Tableau is the data source from which "Diversion" data is obtained from TCLD. TCLD data clean-up is currently underway and may cause data fluctuations, based on the number of required corrections. Decreases in numbers of overall "Diversion" attempts has occurred due to clean-up. Individuals in Category 4, "State Psychiatric Discharges", that were incorrectly coded as Category 5, "Diversions," have been re-coded correctly. Theses corrections in status resulted in a reduction in the withdrawn/ removed category for FY19-20. Total "Diversion" attempts are the screenings that resulted in a determination of people who are TCLI-eligible. "Diversion" withdrawn/ removed includes deaths, moves out of State, and those that do not meet criteria for the program (Dementia/Alzheimer's/ TBI/ I/ DD are the primary diagnosis). Withdrawn/ removed no longer includes people referred to Category 4, State Psychiatric Hospital discharges (SPH) that were coded as Category 5 during FY18-19.

[37] See https://medicaid.ncdhhs.gov/blog/2018/10/05/pre-admission-screening-and-resident-review-pasrr-program-update

VIII. STATE PSYCHIATRIC HOSPITALS (SPH)

A. SUMMARY

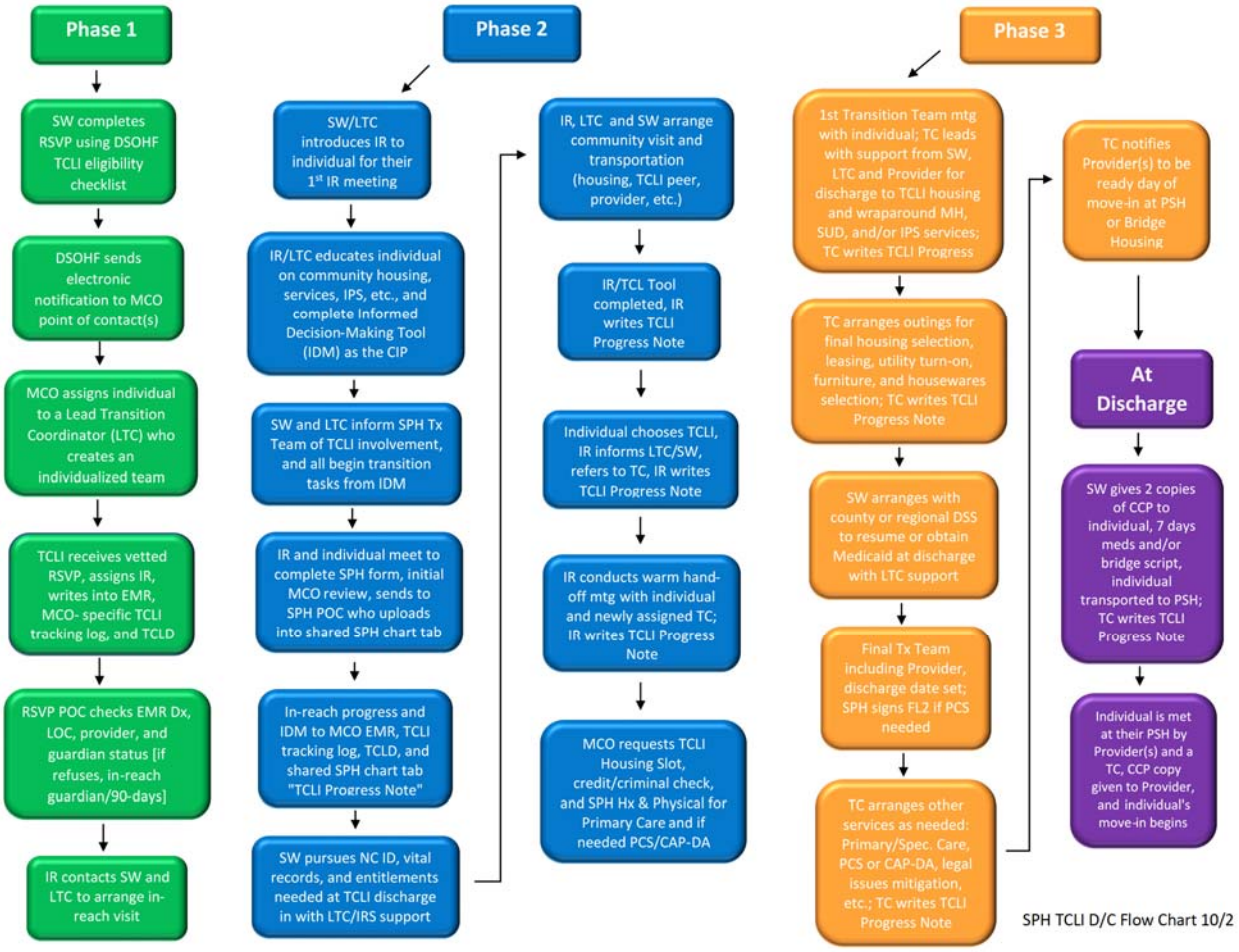
State Psychiatric Hospital (SPH) discharges not only improved in terms of percentages of people discharged to Permanent Supported Housing or to Bridge Housing, but also in the quality of shared information between the Local Management Entity-Managed Care Organization (LME-MCO) and the SPH.

In fiscal year (FY) 2020, the number of individuals discharged to the TCLI and supported housing increased by 28% from FY 2019 and the number of individuals referred to adult care homes (ACHs) decreased by 33%. Referrals to Bridge Housing and supported housing increased to 11.5% of the total SPH discharges, an increase of 3.2% of the total discharges from FY 2019.

Improvements in shared documentation came about through the SPH's designation of a shared LME-MCO Transition to Community Living (TCLI) section in the patient chart. Within the chart, the TCLI teams are able to document the In-Reach and transition progress and barriers to community living. This information informed not only an individual SPH social worker of preparations for receiving the person in the community, allowing for proper discharge planning, but also fostered improved SPH decision-making regarding needs identified for successful community living.

The myriad details for TCLI discharges from a SPH require unique coordination and collaboration across, and at times, outside of an LME-MCO catchment. To that end, the LME-MCO's increased their in-hospital care coordination presence, either through increases in the number of days on units, or through embedding care coordination at the SPH. This increase in care coordination staffing allowed the generalist liaison role, across all units, to support the work of lead transition coordinators. The coordinators then worked as the clinical lead for all of the LME-MCOs' patients, including those in TCLI, to ensure proper discharge and transition to the community. The coordinators' onsite presence helped to keep TCLI discharges as a focus area for treatment teams; increased community In-Reach and transition visitations through logistics coordination with SPH staff and providers; and promoted transition team participation. Through frequent collaboration with the SPH and the LME-MCO leadership, a work-flow process (shown in 7.1.1 figure below) from admission to post-discharge, along with a set of best practices for discharge planning, was developed to standardize discharge planning practices across the State. The process also supports continuous quality improvement in discharge planning.

B. THE THREE PHASES OF STATE PSYCHIATRIC HOSPITAL DISCHARGE PRACTICES



In the future, the person-centered "Informed Decision-Making" Tool (IDM) will be more widely used in the SPH for empowering the person to better express her personal goals with the In-Reach worker, provider, or Transition Coordinators. The LME-MCO TCLI staff and the individual will map the person's preferences and choices for housing, services, employment, and more. The IDM tool, administered within days of admission, will serve as an individual's community transition planning, whether they choose TCLI, or not. In cases where the person declines a community setting, such as when returning to a group home, his/ her choice will be documented but, engagement with In-Reach will continue, in case a future transition might occur. Regardless, use of the IDM tool will launch transition actions at discharge.

Moving forward, discharge and best practice improvements will include an effort to increase participation of community providers in discharge planning, and even in pre-discharge community transition activities. The State and the LME/MCOs should use assertive engagement, within and outside the SPH, to synergize TCLI service transition. Improvements will be sought to enhance the participation and utilization of primary care physicians, personal care services, and, if applicable, the Community Alternatives Program for Disabled Adults (CAP-DA) waiver practices, or that of Home Health services for persons with chronic and significant health and functional impairments. Another area of focus for the upcoming year, will be practices that improve transitions for people in State Psychiatric Hospitals deemed incapable to proceed to trial. For this population, the State will seek to improve communications between lead Transition Coordinators with TCLI, the SPH Social Worker staff, and community service providers with that of county jails or State-level prisons to better coordinate essential medications with jail formularies, and timing for incarceration release into TCLI-type housing.

IX. QUALITY MANAGEMENT

A. SUMMARY

The State's Quality Assurance and Performance Improvement (QAPI) System is designed to ensure that community-based placements and services provided through the Transitions to Community Living Imitative (TCLI) are developed and delivered in accordance with the settlement agreement with US Department of Justice (DOJ), and that individuals who receive services or housing slots pursuant to the agreement are provided with the services and supports they need for their health, safety, and welfare. Completion and implementation of a comprehensive Quality Assurance and Performance Improvement (QAPI) Plan was a key focus of the DHHS TCLI Quality Assurance Committee again his year. When fully implemented, the Plan is designed to ensure that all mental health and other services and supports funded by the State are of good quality and are sufficient to help individuals achieve increased independence and greater community integration; obtain and maintain stable housing; avoid harms; and reduce the incidence of hospital contacts and institutionalization.

The TCLI QAPI Plan includes compliance and quality assurance data and processes associated with all aspects of the TCLI and all substantive provisions of the State's Settlement Agreement with the DOJ. The Plan outlines measures taken to implement the processes and meet the requirements associated with each provision; identifies relevant data systems and activities for compliance and quality monitoring of all TCLI processes; indicates the frequency of data collection and review and the parties responsible; specifies the formal reports used for tracking and communicating program progress; documents which program data and reports are compiled for TCLI Oversight Committee review; and incorporates by attachment the policies, guidelines, manuals, requirements, standards, plans and other documents and communications that govern the implementation and execution of major TCLI functions and processes.

The State's Senior Advisor on the Americans with Disabilities Act (ADA) oversees implementation of the TCLI QAPI Plan. Quality assurance and performance improvement activities are planned, carried out, and evaluated by agencies, committees and personnel of DHHS, the North Carolina Housing Finance Agency, and the State's Local Management Entities-Managed Care Organizations (LMEs-MCOs) and External Quality Review Organization (EQRO). State oversight and working committees include the TCLI Oversight Committee, chaired by the DHHS Deputy Secretary of Behavioral Health and IDD; the DHHS Transition Team and Barriers Subcommittee, which includes representatives from multiple DHHS agencies and LMEs-MCOs; the TCLI Quality Assurance Committee, chaired by the State's Special Advisor on ADA; and the Intradepartmental Monitoring Team (IMT), led by NC Medicaid with collaboration from DMH/DD/SAS, which provides monitoring and oversight of LME-MCO/ Pre-Paid Inpatient Health Plan (PIHP)[38] contract functions. The composition and functions of each constituent of the State's QA System are provided in the Plan.

The TCLI QAPI system is modeled on a Continuous Quality Improvement (CQI) approach. Insights from data collection, analysis, monitoring, reporting and evaluation activities are used to inform process and system changes to address and improve performance, service gaps, the quality of various program elements and, ultimately, the experiences and outcomes of program participants. The system incorporates data from multiple sources to monitor and evaluate progress toward TCLI goals, program quality and effectiveness, and the impacts of program changes and performance improvement activities.

B. MONITORING OF SERVICE GAPS AND TCLI SERVICES QUALITY[39]

[38] Prepaid Inpatient Health Plan (PIHP): An entity that: (1) provides medical services to Enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use state plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its Enrollees; and (3) does not have a comprehensive risk contract. See https://files.nc.gov/ncdhhs/Provider%20Agency%20Contract.pdf

[39] Due to the COVID-19 pandemic, the LME-MCO due date for the broader 2020 annual DHHS Network Adequacy and Accessibility Analyses (NAAA, "gaps and needs" analysis) has been extended and gaps analysis reports are not available as of the time of the development of this report. NAAA requirements include detailed analysis of TCLI service gaps and needs; analysis results will be provided when available. Summaries of LME-MCO Intradepartmental Monitoring Team (IMT) submissions regarding TCLI service gaps and quality are provided in this report to illustrate the State's ongoing monitoring of LME-MCO network adequacy and service quality monitoring and improvement activities, and to highlight ongoing LME-MCO activities to identify and address service gaps and to monitor, ensure and improve the quality of TCLI services.

Effective in SFY 2020, quarterly Intradepartmental Monitoring Team (IMT) meetings include a representative from the TCLI QA Committee to enhance program monitoring of service gaps and the quality of services provided to TCLI participants. The IMT monitoring of the LME-MCO TCLI programs this year emphasized activities to address identified service gaps; service quality monitoring and assurance; and the LME-MCO network adequacy and implementation of the recently revised Community Support Team (CST) service definition.

As of the Summer 2020 quarterly IMT review, all LMEs-MCOs have reported sufficient numbers of CST teams to meet projected service demand. The LMEs-MCOs have employed a variety of methods to ensure the quality of CST services, such as establishing cross-departmental and cross-functional teams to monitor CST provider requirements and to address implementation issues; requiring Provider Readiness Self-Assessments and Supportive Housing Training; implementing a CST Learning Collaborative to address tenancy support issues; including case presentations and provider technical assistance; providing ongoing training to CST providers via the DHHS and the UNC Center for Excellence; establishing a list serve for CST providers; notifying providers of trainings, such as Legal Aid's Fair Housing training and the NC Coalition to End Homelessness' training on housing and homelessness; adding provider contract scope of work requirements around additional required training; conducting Person-Centered Planning (PCP) reviews; and using CST encounter claims to monitor patterns of team member contacts.

Service quality monitoring and improvement activities for other core TCLI services include conducting Focused Clinical Quality Reviews; establishing post-transition teams to monitor the progress and members in housing and who contact members and providers at least monthly to assess needs; convening Assertive Community Treatment (ACT) Teams and Individual Placement and Support Supported Employment (IPS-SE) Learning Collaboratives; conducting bi-weekly calls with ACT providers to discuss each member's progress and barriers; reviewing outcomes data with service providers during ACTT Collaboratives; meeting quarterly with providers to discuss services and concerns; working collaboratively with the DHHS to identify and address barriers to meeting IPS-SE fidelity requirements; contracting for provider training with the Corporation for Supportive Housing (CSH); expanding provider contract scopes of work to include additional required training and greater focus on ACT employment/ educational services; planning to implement value-based contracting; surveying TCLI members about the quality of their services and addressing any issues immediately in treatment team meetings; conducting ACT PCP reviews and training; referring health and safety or rights violation concerns to an internal quality of care committee; tracking provider concerns; offering TCLI participants support with Community Inclusion through the work of the Alliance of Disability Advocates of North Carolina and the Temple University; and assisting members in acquiring new technologies to assist with member loneliness.

C. SFY 2020 PERSONAL OUTCOMES

The State's approach to the measurement of TCLI participant outcomes reflects the best practice principle articulated in the TCLI settlement agreement that services are to "be flexible and individualized to meet the needs of each individual." Rather than taking a utilization management approach to defining standards of sufficiency in, e.g., terms related to service amounts, billing units, or the frequency of service delivery, the State's TCLI personal outcomes measures emphasize fundamental objectives related to participant health, safety, and welfare; independence and

community integration; housing stability; harm avoidance; and reduced incidence of hospital contacts and institutionalization. Key activities of the State's Quality Assurance System include collecting, monitoring, evaluating, and reporting data on a variety of personal outcomes related to use of institutional settings, quality of life/ community integration, housing stability, and incidents of harm.

i. Use of Institutional Settings

Institutional census tracking and length of stay are monitored through the State Psychiatric Hospital (SPH) Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) data system and the NCTracks claims data warehouse. The SPH census, admissions, and discharge data are reported in other sections of this report.

Institutional admissions and readmissions and Emergency Department (ED) visits and repeat visits reported here are based on calendar years 2018 and 2019 NCTracks Medicaid community hospital and psychiatric facility inpatient and emergency department claims and HEARTS State Psychiatric Hospital (SPH) and Alcohol and Drug Abuse Treatment Center (ADATC) admissions data.

Institutional claims and encounters and SPH and ADATC admissions records were retrieved for all TCLI participants in supportive housing for one or more days of calendar year 2019 or who had previously been housed and were subsequently housed through March 2020. For all institutional data reported in this section, admission and visit rates are expressed as percentages of the total number of individuals in these categories, as shown in Table 1.

Table 1: Individuals in Housing in Calendar Year 2019

LME-MCO	N (Percentage Housed Denominators)
Alliance	388
Cardinal	798
Eastpointe	246
Partners	353
Sandhills	286
Trillium	393
Vaya	327
Statewide Total	2,791

ii. State Psychiatric Hospital Admissions and Readmissions

Table 2 shows numbers of individuals with admissions and readmissions during 2019 while housed, and numbers with readmissions while housed after having one or more 2018 or 2019 pre-transition admissions or 2018 admissions while housed. Less than two percent (1.4%) of individuals had SPH admissions while housed in 2019, and 21 percent of those had two or more admissions during that

period. Of 38 individuals with SPH admissions, 58 percent had a previous admission prior to transitioning to supportive housing in 2018 or 2019 or while housed in 2018.[40]

Table 2: Calendar Year (CY) 2019 SPH Admissions and Readmissions While in Housing

Repeat Admissions I					
	N with SPH Admits[a]	**% of Housed[b]**	**N with >1 Admission**	**% of N with SPH Admits**	**% of Housed**
Alliance	18	4.6%	2	11.1%	0.5%
Cardinal	6	0.8%	1	16.7%	0.1%
Eastpointe	6	2.4%	3	50.0%	1.2%
Partners	4	1.1%	1	25.0%	0.3%
Sandhills	1	0.3%	0	0.0%	0.0%
Trillium	2	0.5%	1	50.0%	0.3%
Vaya	1	0.3%	0	0.0%	0.0%
Total	38	1.4%	8	21.1%	0.3%
Repeat Admissions II					
	N with SPH Admits[a]	**% of Housed[b]**	**N with Prior Admits[c]**	**% of N with SPH Admits**	**% of Housed**
Alliance	18	4.6%	8	44.4%	2.1%
Cardinal	6	0.8%	4	66.7%	0.5%
Eastpointe	6	2.4%	6	100.0%	2.4%
Partners	4	1.1%	3	75.0%	0.8%
Sandhills	1	0.3%	1	100.0%	0.3%
Trillium	2	0.5%	0	0.0%	0.0%
Vaya	1	0.3%	0	0.0%	0.0%
Total	38	1.4%	22	57.9%	0.8%

a- These individuals were in housing an average of 292 days of CY 2019, compared to an average of 279 days for all 2,791 individuals in housing during CY 2019.

b- A slightly higher percentage, 1.7%, had 2019 admissions either while housed or after separation from supportive housing; comparable rates for 2017 and 2018, included in the previous annual report, were 2.6% and 3.3%, respectively.

c- Approximately 81% of the previous admissions occurred before the initial transition to supportive housing.

[40] Administrative re-admissions following direct discharges or transfers to and from medical visits or other facilities are excluded.

Table 3 shows, among individuals in supportive housing in 2019 who had prior SPH admissions, the number and percent who had readmissions in 2019 while in housing. Approximately eight percent of all individuals in housing had an SPH admission in 2018 or 2019 prior to their transition or in 2018 while in housing. These individuals were far less likely (10%) to experience an SPH admission in 2019 while in supportive housing; SPH admissions for 90 percent of individuals were reduced to zero during this period.

Table 3: CY 2019 SPH Readmissions for Individuals with Prior Admissions

	Total N with Prior Admits[a]	Percent of Housed	Subset with Readmissions	% with Readmissions	% of Housed
Alliance	59	15.2%	8	13.6%	2.1%
Cardinal	32	4.0%	4	12.5%	0.5%
Eastpointe	50	20.3%	6	12.0%	2.4%
Partners	9	2.5%	3	33.3%	0.8%
Sandhills	34	11.9%	1	2.9%	0.3%
Trillium	25	6.4%	0	0.0%	0.0%
Vaya	7	2.1%	0	0.0%	0.0%
Total	216	7.7%	22	10.2%	0.8%

a- Approximately 81% of the previous admissions occurred before the initial transition to supportive housing

iii. Inpatient Psychiatric Admissions and Readmissions

Table 4 shows numbers of individuals with inpatient psychiatric and community hospital admissions and readmissions during 2019 while housed, and numbers with readmissions while housed after having one or more 2018 or 2019 pre-transition admissions or 2018 admissions while housed. Nine percent of individuals had inpatient admissions while housed in 2019. Approximately one-third (35%) of those had two or more during that period, and 46 percent had a previous 2018 or 2019 inpatient admission.

Table 4: CY 2019 Inpatient Admissions and Readmissions While in Housing

			Repeat Admissions I		
	N with Inpatient Admits[a]	**% of Housed[b]**	**N with >1 Admission**	**% of N with Inpatient Admits**	**% of Housed**
Alliance	45	11.6%	20	44.4%	5.2%
Cardinal	68	8.5%	19	27.9%	2.4%
Eastpointe	24	9.8%	8	33.3%	3.3%
Partners	25	7.1%	15	60.0%	4.2%
Sandhills	19	6.6%	4	21.1%	1.4%
Trillium	37	9.4%	15	40.5%	3.8%
Vaya	32	9.8%	7	21.9%	2.1%
Total	250	9.0%	88	35.2%	3.2%
			Repeat Admissions II		
	N with Inpatient Admits[a]	**% of Housed[b]**	**N with Prior Admits**	**% of N with Inpatient Admits**	**% of Housed**
Alliance	45	11.6%	19	42.2%	4.9%
Cardinal	68	8.5%	28	41.2%	3.5%
Eastpointe	24	9.8%	11	45.8%	4.5%
Partners	25	7.1%	15	60.0%	4.2%
Sandhills	19	6.6%	10	52.6%	3.5%
Trillium	37	9.4%	20	54.1%	5.1%
Vaya	32	9.8%	12	37.5%	3.7%
Total	250	9.0%	115	46.0%	4.1%

a- These individuals were in housing an average of 292 days of CY 2019, compared to an average of 279 days for all 2,791 individuals in housing during CY 2019.

b- A slightly higher percentage, 10%, had 2019 admissions either while housed or after separation from supportive housing; comparable rates for 2017 and 2018 included in the previous annual report were 12.7% and 13.3%, respectively.

c- Approximately 67% of the previous admissions occurred before the initial transition to supportive housing.

Figure 1 shows estimated numbers of participants with between one and five or more admissions. Approximately two-thirds (65%) of individuals with any admissions had a single admission, while just over one-fifth (22%) had two, and the remaining 13 percent had three or more.

Figure 1: CY 2019 Estimated Inpatient Psychiatric Admissions While Housed (N = 250)

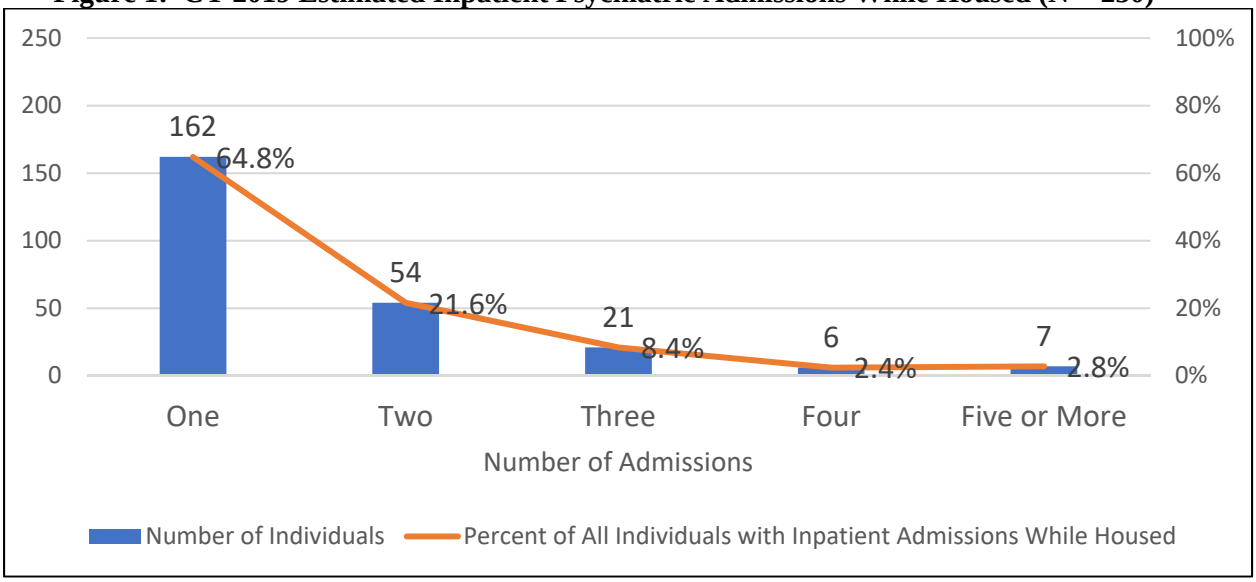


Table 5 shows, among individuals in supportive housing in 2019 who had prior inpatient admissions, the number and percent who had readmissions in 2019 while in housing. Seventeen percent of all individuals in housing had an inpatient admission in 2018 or 2019 prior to their transition or in 2018 while in housing. These individuals were far less likely (24%) to experience an SPH admission in 2019 while in supportive housing. The SPH admissions for 76 percent of individuals were reduced to zero during this period.

Table 5: CY 2019 Inpatient Admissions for Individuals with Prior Admissions

	Total N with Prior Admits[a]	Percent of Housed	Subset with Readmissions	% with Readmissions	% of Housed
Alliance	77	19.8%	19	24.7%	4.9%
Cardinal	106	13.3%	28	26.4%	3.5%
Eastpointe	47	19.1%	11	23.4%	4.5%
Partners	47	13.3%	15	31.9%	4.2%
Sandhills	55	19.2%	10	18.2%	3.5%
Trillium	84	21.4%	20	23.8%	5.1%
Vaya	58	17.7%	12	20.7%	3.7%
Total	474	17.0%	115	24.3%	4.1%

a- Approximately 67% of the previous admissions occurred before the initial transition to supportive housing.

iv. Emergency Department Visits and Repeat Visits

Table 6 shows numbers of individuals with emergency department (ED) visits and repeat visits during 2019 while housed, and numbers with repeat visits while housed after having one or more 2018 or 2019 pre-transition visits or 2018 visits while housed. Thirteen percent of individuals had ED visits while housed in 2019. Approximately one-third (37%) of those had two or more during that period, and 49 percent had a previous 2018 or 2019 ED visit.[41,42]

[41] Emergency Department claims with consecutive service dates are counted as single events. Each new series of claims with consecutive dates is counted as a repeat visit if the date of service is more than three days after the previous date of service. This method may result in overestimates due to claims lag and missing data and/or in underestimates in cases of true repeat visits within three days. Completeness of ED visit claims data also may be affected by timely filing limits.

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

Table 6: CY 2019 ED Visits and Repeat Visits While in Housing

			Repeat Visits I		
	N with ED Visits[a]	% of Housed[b]	N with >1 ED Visit	% of N with ED Visits	% of Housed
Alliance	58	14.9%	15	25.9%	3.9%
Cardinal	91	11.4%	31	34.1%	3.9%
Eastpointe	42	17.1%	16	38.1%	6.5%
Partners	52	14.7%	22	42.3%	6.2%
Sandhills	33	11.5%	12	36.4%	4.2%
Trillium	49	12.5%	28	57.1%	7.1%
Vaya	35	10.7%	10	28.6%	3.1%
Total	360	12.9%	134	37.2%	4.8%
				Repeat Visits II	
	N with ED Visits[a]	% of Housed[b]	N with Prior Visits[c]	% of N with ED Visits	% of Housed
Alliance	58	14.9%	25	43.1%	6.4%
Cardinal	91	11.4%	39	42.9%	4.9%
Eastpointe	42	17.1%	23	54.8%	9.3%
Partners	52	14.7%	24	46.2%	6.8%
Sandhills	33	11.5%	18	54.5%	6.3%
Trillium	49	12.5%	28	57.1%	7.1%
Vaya	35	10.7%	19	54.3%	5.8%
Total	360	12.9%	176	48.9%	6.3%

a- These individuals were in housing an average of 300 days of CY 2019, compared to an average of 279 days for all 2,791 individuals in housing during CY 2019.

b- A slightly higher percentage, 14%, had 2019 ED visits either while housed or after separation from supportive housing; comparable rates for 2017 and 2018 included in the previous annual report were 16.7% and 18.1%, respectively.

c- Approximately 60% of the previous ED visits occurred before the initial transition to supportive housing.

Figure 2 shows estimated numbers of individuals with between one and five or more ED visits. Nearly two-thirds (63%) of individuals with any ED visits had a single visit, while just over one-fifth (21%) had two, and the remaining 16 percent had three or more.

Figure 2: CY 2019 Estimated ED Visits and Repeat Visits (N = 360)

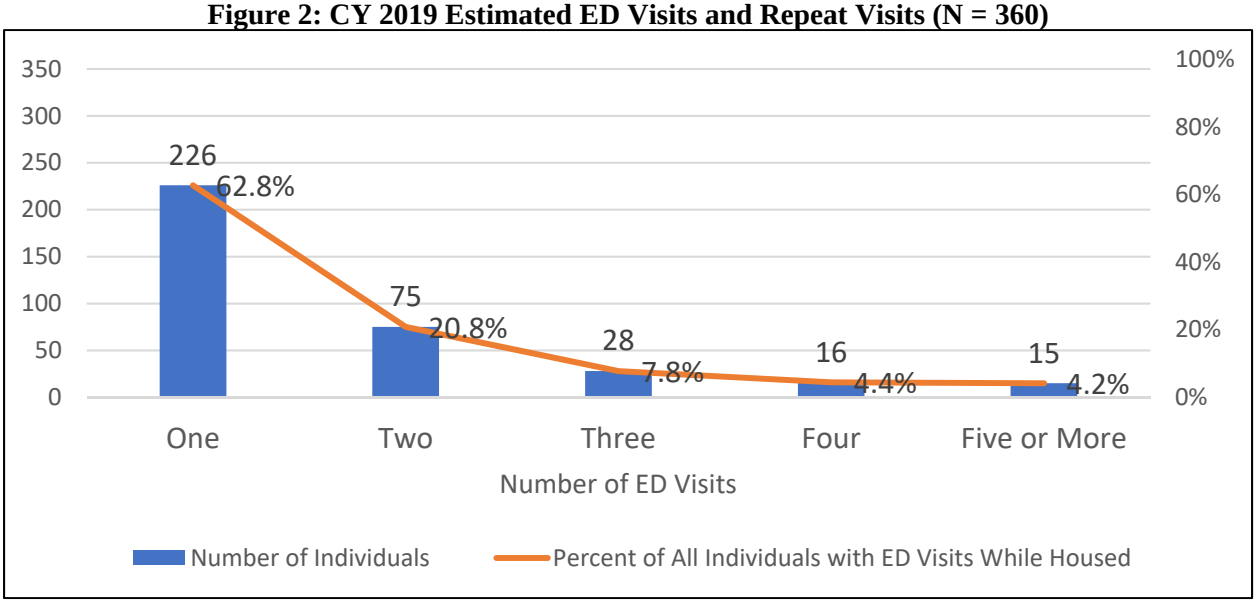


Table 7 shows, among individuals in supportive housing in 2019 who had prior ED visits, the number and percent who had repeat visits in 2019 while in housing. Twenty-one percent of all individuals in housing had an ED visit in 2018 or 2019 prior to their transition or in 2018 while in housing. These individuals were far less likely (30%) to experience a repeat visit in 2019 while in supportive housing; ED visits for 70 percent of individuals were reduced to zero during this period.

Table 7: CY 2019 ED Visits for Individuals with Prior ED Visits

	Total N with Prior ED Visits[a]	Percent of Housed	Subset with Repeat Visits	% with Repeat Visits	% of Housed
Alliance	80	20.6%	25	31.3%	6.4%
Cardinal	152	19.0%	39	25.7%	4.9%
Eastpointe	69	28.0%	23	33.3%	9.3%
Partners	75	21.2%	24	32.0%	6.8%
Sandhills	65	22.7%	18	27.7%	6.3%
Trillium	83	21.1%	28	33.7%	7.1%
Vaya	72	22.0%	19	26.4%	5.8%
Total	596	21.4%	176	29.5%	6.3%

a- Approximately 60% of the previous ED visits occurred before the initial transition to supportive housing.

v. Other Crisis Bed Use

As reported in the Services section of this Annual Report, NCTracks claims analysis indicated that two percent of housed individuals in CY 2019 used Facility-Based Crisis beds. Table 8 shows Alcohol and Drug Abuse Treatment Center (ADATC) admissions for 10 individuals (0.4%) while housed, and few readmissions within or across calendar years. Of those with ADATC admissions while housed in 2019, nine (90%) had one admission, and one (10%) had two admissions.

Table 8: CY 2019 Inpatient Admissions and Readmissions While in Housing

			Repeat Admissions I		
	N with ADATC Admits[a]	**% of Housed[b]**	**N with >1 Admission**	**% of N with ADATC Admits**	**% of Housed**
Alliance	4	1.0%	0	0.0%	0.0%
Cardinal	2	0.3%	1	50.0%	0.1%
Eastpointe	1	0.4%	0	0.0%	0.0%
Partners	0	0.0%	0	N/A	0.0%
Sandhills	3	1.0%	0	0.0%	0.0%
Trillium	0	0.0%	0	N/A	0.0%
Vaya	0	0.0%	0	N/A	0.0%
Total	10	0.4%	1	10.00%	0.04%
			Repeat Admissions II		
	N with ADATC Admits[a]	**% of Housed[b]**	**N with Prior Admits[c]**	**% of N with ADATC Admits**	**% of Housed**
Alliance	4	1.0%	0	0.0%	0.0%
Cardinal	2	0.3%	0	0.0%	0.0%
Eastpointe	1	0.4%	0	0.0%	0.0%
Partners	0	0.0%	0	N/A	0.0%
Sandhills	3	1.0%	1	33.3%	0.3%
Trillium	0	0.0%	0	N/A	0.0%
Vaya	0	0.0%	0	N/A	0.0%
Total	10	0.4%	1	10.0%	0.04%

a- These individuals were in housing an average of 330 days of CY 2019, compared to an average of 279 days for all 2,791 individuals in housing during CY 2019.

b- Two additional individuals had 2019 admissions after separation from supportive housing, for a total of 0.4%; the comparable rate for 2017 and 2018 included in the previous annual report was 0.6% both years.

c- This individual was in TCLI supportive housing at the time of the previous admission.

Table 9 shows, among individuals in supportive housing in 2019 who had prior inpatient admissions, only one individual (4%) had a readmission in 2019 while in supportive housing, while admissions for 96 percent were reduced to zero during this period.

Table 9: CY 2019 ADATC Admissions for Individuals with Prior Admissions

	Total N with Prior Admits[a]	Percent of Housed	Subset with Readmissions	% with Readmissions	% of Housed
Alliance	5	1.3%	0	0.0%	0.0%
Cardinal	4	0.5%	0	0.0%	0.0%
Eastpointe	3	1.2%	0	0.0%	0.0%
Partners	1	0.3%	0	0.0%	0.0%
Sandhills	3	1.0%	1	33.3%	0.1%
Trillium	3	0.8%	0	0.0%	0.0%
Vaya	9	2.8%	0	0.0%	0.0%
Total	28	1.0%	1	3.6%	0.001%

a- Approximately 68% of the previous admissions occurred before the initial transition to supportive housing.

vi. Community Integration and Quality of Life

Transitions to Community Living Initiative (TCLI) participant quality of life is assessed through structured interviews, administered to individuals during the transition planning period and again at 11 and 24 months after transition. An updated summary of results for surveys administered through SFY 2020 is presented in Appendix A to this Annual Report.

In each full state fiscal year (SFY) of the TCLI, participants surveyed in follow-up interviews after 11 and 24 months in supportive housing have reported improvements in quality of life. They also reported more positive assessments of their life circumstances than did individuals who had not yet transitioned from congregate living facilities and other settings to supportive housing. These patterns are observed across LME-MCO catchment areas as well as over time.

Survey results from SFY 2020 again indicate that the transition to supportive housing is associated with reports of substantially greater community integration, choice and control in daily activities, and satisfaction with housing and other community resources. Similarities in responses at 11- and 24-month surveys suggest that quality of life gains from the initial transition are largely maintained through the second year in housing. While most individuals report positive experiences and quality of life improvements, survey responses also indicate that some continue to face challenges associated with unmet needs; physical and mental health; obstacles to community integration; engagement of natural supports; and problems associated with housing

Results of analysis of the Quality of Life Survey items that most relate to community integration and engagement are also reported in Appendix A. On average, compared to those surveyed pre-transition, 20 percent more individuals in supportive housing reported satisfaction with daily activities, having enough to do, and going out into the community to do things when they want or choose.

Pre- and post-transition respondents also differed in their reports of typical daily activities. For example, individuals in supportive housing were more likely to report cooking/ cleaning and less likely to report listening to music as typical ways they spend their time. Individuals in supportive housing were less likely to report working in the community as a typical daily activity compared to those surveyed before transition (9% vs. 14%), although the rate of individuals working in the community nearly doubled among those in supportive housing compared to the previous year. Six percent of individuals in supportive housing reported school as a typical daily activity, slightly higher than the comparable percent among pre-transition respondents and a slight increase over the previous year percentage.

More survey respondents in supportive housing also reported positive experiences and perceptions related to their natural support networks compared to individuals in pre-transition settings. On average, approximately 15% more individuals in supportive housing reported visiting or talking in the past 30 days with family or friends who support their recovery; having someone to talk to when sad, angry, upset or lonely; and that family or friends help them become the person they want to be. Individuals in supportive housing were approximately one-third less likely to report feeling lonely in the past week.

vii. Time Spent in Congregate Day Programming

Calendar Year (CY) 2019 rates of Psychosocial Rehabilitation (PSR) services among individuals in housing are shown in the Service section of this report. Results of additional analysis of paid NCTracks claims for PSR are shown in Table 10.

Table 10: CY 2019 Time Spent in Congregate Day Programming (Psychosocial Rehabilitation)

	N with PSR	% of Housed	Average Duration[a] (Weeks)	Average Hours/ Week
Alliance	20	5.2%	24.5	14.7
Cardinal	63	7.9%	28.9	7.8
Eastpointe	13	5.3%	33.3	19.7
Partners	35	9.9%	27.9	13.8
Sandhills	27	9.4%	29.9	16.3
Trillium	21	5.3%	22.6	8.7
Vaya	19	5.8%	32.1	8.1
Total	198	7.1%	28.4	11.6

a- Duration is calculated as the length of the interval between the earliest and latest PSR service claim dates of service within the calendar year and during the period the individual was in TCLI supportive housing. Hours per week is expressed as the average number of PSR hours per week for the duration of the service while in housing.

viii. Community Tenure and Separations

For the life of the program, 66.5 percent of individuals who transitioned to supportive housing were in supportive housing at the end of SFY 2019, with an average of 785 days from their initial transition

dates.[43] Table 11 shows numbers and percentages of individuals in housing three months to two years after the initial transition date. Table 12 shows attrition rates by year. Table 13 shows the total number of individuals who have left housing over the life of the program, including numbers and percentages deceased or who returned to Adult Care Homes (ACH) or other facilities.

Table 11: Life of Program Maintenance of Housing

Threshold	Total Possible	Number Housed This Long	Percent Meeting Threshold
Not applicable (housed less than 3 months)	200	N/A	N/A
3 Months	3683	3352	91%
6 Months	3515	2812	80%
1 Year	3086	2314	75%
1.5 Years	2452	1692	69%
2 Years	2084	1334	64%

Table 12: Housing Attrition Rates by State Fiscal Year and Year Housed

SFY Housed	Number Housed	SFY 13	SFY 14	SFY 15	SFY 16	SFY 17	SFY 18	SFY 19	SFY 20
2013	46	2%	15%	11%	11%	8%	9%	11%	2%
2014	201	-	10%	21%	11%	9%	9%	4%	2%
2015	210	-	-	7%	16%	11%	14%	10%	5%
2016	331	-	-	-	10%	16%	14%	11%	7%
2017	600	-	-	-	-	10%	21%	14%	8%
2018	692	-	-	-	-	-	9%	21%	11%
2019	971	-	-	-	-	-	-	8%	16%
2020									7%

[43] As of April 2020, 1,093 program participants with an ongoing status of housed in the community without a TCLI slot had an average community tenure of 889 days.

Table 13: Life of Program Housing Separation Outcomes and Destinations

Outcome or Destination	Number	Percent
Adult Care Home	282	21.9%
Alternative Family Living (Unlicensed)	8	0.6%
Adult Living Facility	18	1.4%
Deceased	272	21.1%
Family/Friends	191	14.8%
Hospice	3	0.2%
Independent	228	17.7%
Jail/ Prison	61	4.7%
Medical Hospital	35	2.7%
Mental Health Group Home	32	2.5%
Skilled Nursing Facility	23	1.8%
State Psychiatric Hospital	28	2.2%
Substance Use Facility	26	2.0%
Unknown	80	6.2%
Total	1,287	100.0%

ix. Incidents of Harm

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

Level II includes any incident which involves a consumer death due to natural causes or terminal illness, or results in a threat to a consumer's health or safety or a threat to the health or safety of others due to consumer behavior. Level III includes any incident that results in (1) a death, sexual assault or permanent physical or psychological impairment to a consumer; (2) a substantial risk of death, or permanent physical or psychological impairment to a consumer; (3) a death, sexual assault or permanent physical or psychological impairment caused by a consumer; (4) a substantial risk of death or permanent physical or psychological impairment caused by a consumer; or (5) a threat caused by a consumer to a person's safety.

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

Incidents involving the TCLI participants are retrieved, reviewed, and reported in aggregate on a monthly basis. Table 14 summarizes by LME-MCO the number of incidents returned each month.

Table 14: Aggregate Number of Incidents Reported in IRIS, SFY 2020

LME-MCO	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Alliance	4	1	2	1	4	2	2	2	1	1	3	4	27
Cardinal	1		1	1					1			2	6
Eastpointe	1	1	2	2		2	1	1	2	1	1	2	16
Partners													0
Sandhills	1	2	2	3		2	4	2	4	2	3	5	30
Trillium	1	1		1			1						4
Vaya	1	4	5	3	3	4	4	6	1	4	2	2	39
Total	9	9	12	10	7	10	11	11	9	8	9	15	120

X. BUDGET

A. SUMMARY

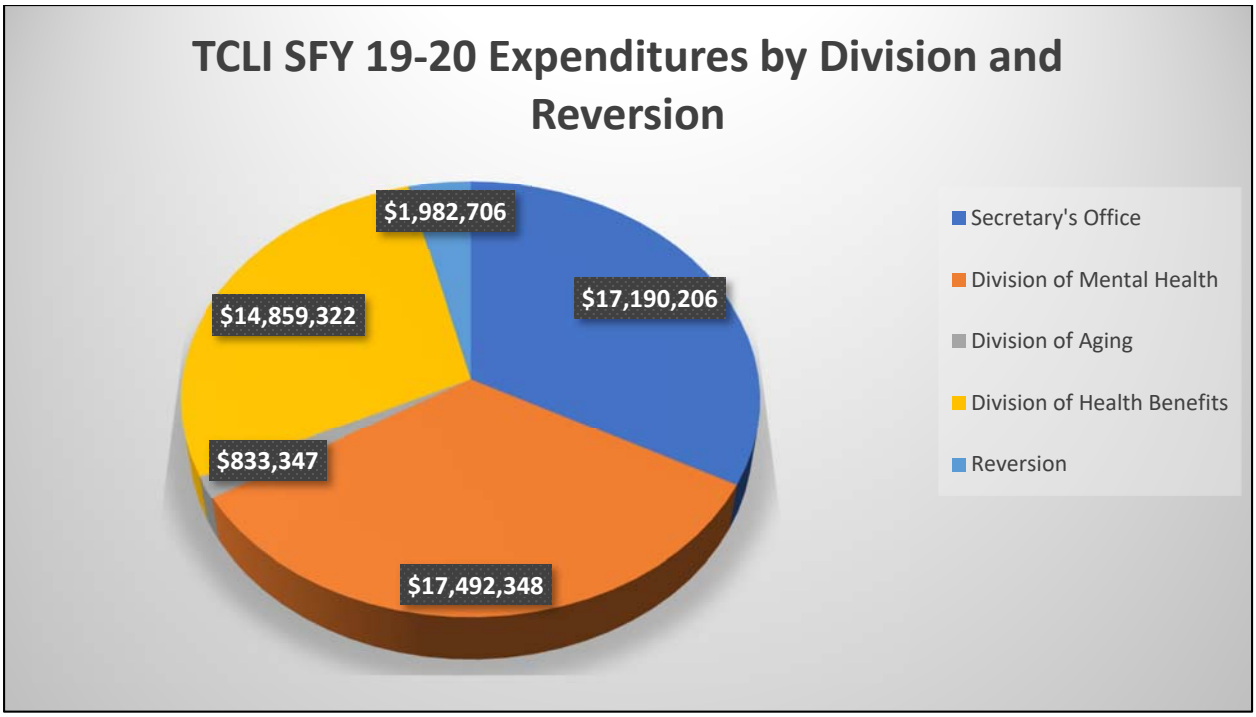
For SFY19-20, the Transitions to Community Living Initiative (TCLI) continued to follow and refine the following processes, implemented in SFY18-19, for increased optimization and management of the TCLI funds.

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

With an annual budget of 52.3 million, expenditures continued to increase in SFY19-20 as TCLI total individuals placed increased and services expanded. The initiative has maintained budget oversight to address shortfalls, with allocation shifts and additional appropriations as necessary.

See Appendix B for breakdown of funds expended by each LME/MCO.

An appropriation occurred near the end of the fiscal year in May 2020 to address some expenditure shortfalls. This appropriation included funds to assist with COVID-19 safety measures, i.e., funding for electronic devices to provider safer services and limit face-to-face contact. The LME-MCOs were, however, not able to spend all allocated funds before spending closed for the year. As a result, TCLI reverted funds of 1.9 million.



XI. MANAGING THROUGH COVID-19

A. SUMMARY

In March of 2020, the efforts and progress of the Department were stymied by the world-wide pandemic, COVID-19. As we write this annual report, 210,000 people have died in America. In North Carolina, Adult Care Homes (ACH) and other congregate settings were hard-hit by the virus and some residents died. The ACHs closed their doors as a result and TCLI was temporarily unable to continue its work to help those who said "yes to community" to make the transition to community life.

Housing efforts continued through the fiscal year 2019-20 until the Summer of 2020 for people who were discharged from the State Psychiatric Hospitals (SPHs) or were "at risk" of entering institutions, through Diversions. The TCLI is grateful for the on-going work of these partners; however, transitions to the community for people living in ACHs was reduced to a slow trickle. It was not until the Fall of 2020 that congregate settings were re-opened by the Governor in his Executive Order: *September 4, 2020 EXECUTIVE ORDER NO. 163 (WITH TECHNICAL CORRECTIONS) REVISED PROHIBITIONS AND RESTRICTIONS TO PROTECT LIVES IN RESPONDING TO THE COVID-19 PANDEMIC* followed by the DHHS Secretary's order, *SECRETARIAL ORDER No. 3- Visitation for Nursing Homes September 1, 2020* and guidance. People living in supported housing were also significantly impacted. Providers were given the flexibility to provide services via tele-health but, unfortunately, people in supported housing, along with so many other North Carolinians, struggled with loneliness

and isolation. The TCLI saw people leave housing as a result. Challenging behaviors increased and, because providers could not always provide direct services, it is possible that some evictions may follow. The TCLI housing team is presently working with the LME-MCOs to stave off evictions by working with landlords. The TCLI has offered a number of flexibilities during the crisis, some of which are discussed below.

B. IN-REACH: RESPONSE TO COVID-19

- Shadowing of In-Reach contacts and trainings have continued so that team members are staying abreast of In-Reach activities of each LME-MCO and are conducting the work through virtual methods.
- Exploring Engagement training was developed to provide education to In-Reach Specialists regarding positive engagement for individuals eligible for TCLI. The training provides an overview engagement; key components of engagement; getting to know the person; challenges to engagement; and practicing/ role-playing. This training was originally intended to be an in-person/ interactive training, but it will now be delivered virtually in the Fall of 2020.

C. STATE PSYCHIATRIC HOSPITALS: RESPONSE TO COVID-19

- Daily screenings are conducted on anyone who enters an SPH.
- Each hospital has reserved space for a COVID isolation unit for people who test positive.
- All new TCLI admissions or those returning from a medical hospital are placed in a quarantine unit for 14 days and required to have a negative COVID test.
- SPH staff are assigned to areas of the hospital to reduce the possible asymptomatic spread by staff.
- MCO staff and providers may come to the hospitals but as under the same restrictions as staff.
- Video conferencing has increased to allow for the safe involvement of family, MCO staff, providers and guardians.

D. BEHAVIORAL HEALTH SERVICES: RESPONSE TO COVID-19

- Sites implemented flexibilities identified by CMS to allow telehealth and telephonic services, ensuring that services were accessible.
- Training requirements were temporarily relaxed for services with required training.
- Flexibilities implemented for State-funded services to allow telehealth and telephonic services.
- Some services expanded to support provision of supports (e.g., allowing Individual Placement and Support Supported Employment (IPS-SE) teams to help participants apply for unemployment benefits and to provide some case management functions). This helped to ensure that people had access to important supports during the pandemic.

XII. OLMSTEAD PLAN INITIATIVE

A. OLMSTEAD CASE

The significance of *Olmstead v. L. C.*,[44] for people with disabilities is often compared to *Brown v. Board of Education* and with good reason. The *Olmstead* case, which derives from the Americans with Disabilities Act (ADA), provided a sweeping, transformative interpretation of the ADA's integration mandate. Writing for the Court, Justice Ruth Bader Ginsburg set out the holding: the "unjustified segregation" of people with disabilities in institutional settings was unlawful discrimination under the ADA. The high court's ruling established that public entities, such as North Carolina's Department of Health and Human Services (DHHS), must provide community-based services to people with disabilities when: (1) such services are appropriate; (2) the affected person doesn't oppose treatment that takes place in the community; and (3) providing such services can be "reasonably accommodated, taking into account the resources available… and the needs of others who are receiving disability services..."[45] Since the ruling, the country's work to implement *Olmstead* has brought thousands of people with disabilities into the mainstream of American life.

Olmstead Plans. Generally, Olmstead Plans offer a description of a state's current system of providing community-based services and supports to people with disabilities; an assessment of the strengths and weaknesses of that system; and a description of the state's plan and goals for expanding opportunities for providing community-based services and supports to people with disabilities.[46] Among the key ingredients of any Olmstead Plan are populations to be addressed; data; housing; employment; wellness and healthcare; transportation; supports and services; funding; policies, rules and regulations; outcomes; and training and workforce development.[47][48]

Scope and Timeline. The DHHS Secretary charged the Office of the Senior Advisor on the ADA with the development of the Department's Olmstead Plan. The plan, designed to be a "living, breathing document" that is reviewed and updated regularly, covers all eligible individuals, whether served directly by the DHHS in public, state and regional facilities or indirectly by the Department through Local Management Entities/ Managed Care Organizations (LME/ MCOs) and the private provider networks they operate. The DHHS will finalize its Olmstead Plan by December of 2021.

DHHS Mission and OPSA Vision Statements. Shortly after the first meeting of the Olmstead Plan Stakeholder Advisory (OPSA; see below), the DHHS adopted as its mission statement for the Olmstead initiative the following: "In collaboration with our partners, the NC DHHS provides essential services to assist people with disabilities to reside in and experience the full benefit of inclusive community." After discussion with its membership, the OPSA adopted this vision statement "North Carolina champions the right of all people to choose to live life fully included in the community."

Olmstead Technical Assistance Contract with TAC. The Office of the Senior Advisor on the ADA began 2020's work on the Olmstead Plan initiative by awarding a technical assistance contract

[44] 527 U.S. 581 (1999).
[45] Ibid.
[46] Kevin Martone, Technical Assistance Collaborative. Presentation to Olmstead Plan Stakeholder Advisory, July 8, 2020.
[47] Ibid.
[48] In North Carolina, this workforce includes Peer Specialists.

to the Boston-based Technical Assistance Collaborative (TAC). During the early months of 2020, the Office of the Senior Advisor hosted a series of meetings to familiarize key leadership with the role of the TAC; consider leadership's role and focus; develop key relationships; define inter-departmental collaborations and partnership; and discuss the process for assessing the DHHS' strengths and risks. By spring, the initiative had identified target audiences and topics for a series of statewide listening sessions; hired a project manager to assist the Olmstead Manager; and developed a stakeholder engagement process. With an infrastructure for plan development in place, the Office of the Senior Advisor turned its attention to a process that would ensure that stakeholders both understood the purpose of the Olmstead Plan and had a variety of venues for influencing its direction.

TAC Listening Sessions and Quantitative Analysis. The TAC initiated its analysis of information for the Olmstead Plan by hosting 15 listening sessions, all held online due to the pandemic. Most occurred in the middle of August with two taking place later, in October. The listening sessions created venues in which interested stakeholders could freely share their insights and observations about the DHHS' approach to Olmstead, inclusive of identification of barriers to community integration as well as strengths and strategies for the future. Each session was hosted by one or more members of the OPSA. The 15 sessions were: 1) Family Members – Mental Health and Substance Use Disorder; 2) Children's System; 3)Providers – Mental Health/ Developmental Disabilities/ Substance Use Disorder (MH/DD/SUD) and Traumatic Brain Injury; 4) Traumatic Brain Injury – families and persons with lived experience; 5) Housing; 6) Statewide Independent Living Center; 7) Family Members – Intellectual and Developmental Disabilities (IDD); 8) LME/MCOs; 9) Mental Health and Substance Use Disorder – families and persons with lived experience; 10) Persons with IDD; 11) Employment; 12) NC Coalition on Aging; 13) The Coalition for MH/DD/SUD; 14) Providers – Aging; and 15) Guardians. The TAC complemented the sessions with a two-week, online survey, creating yet another opportunity for the public to input into the planning process.

The TAC will augment its qualitative analysis with a cross-DHHS, quantitative data pull and analysis, focusing in large part on data sets from NC Medicaid and the DMH/DD/SAS. Among other issues, this portion of the analysis will cover, for example, population data (e.g., numbers served, numbers waiting); workforce shortages and pay rates; budgetary comparisons between community-based and facility-based services; length of stay in various facilities; housing capacity and service array; policies and regulations; and gaps in services. TAC will present a report of its findings to the DHHS in January of 2021.

Engaging Stakeholders: Olmstead Plan Stakeholder Advisory.[49] In the early summer, the DHHS Secretary announced appointments to the Olmstead Plan Stakeholder Advisory (OPSA). The OPSA is comprised of a diverse mix of stakeholders from the disability advocacy community, including individuals with lived experience and their families; providers; managers of provider networks (e.g., LME--MCOs); professional associations; policymaking leadership within the DHHS; and legislators from both sides of the aisle. It is co-chaired by the recent past chair of The Coalition on and the current chair of the NC Coalition on Aging. These Community Co-Chairs are joined by a Departmental Co-Chair, the Deputy Secretary for Behavioral Health and IDD. The Deputy Secretary ensures that the Department stays abreast of and engaged in OPSA's deliberations, while its Community Co-Chairs provide dynamic leadership for a large, representative body. The OPSA held

[49] For details on the OPSA and Olmstead Plan developments generally, see the DHHS Olmstead website at https://www.ncdhhs.gov/advanced-search?s=Olmstead#gsc.tab=0&gsc.q=Olmstead&gsc.page=1.

its first, quarterly meeting on July 8, 2020. Its second quarterly meeting is scheduled for October 27, 2020.

OPSA Meetings Advance Policy Innovations. To date, the quarterly meetings of the OPSA have spotlighted key policy innovations, featuring presentations from national experts. In July, TAC President Kevin Martone presented on best practices in Olmstead Plan development in a session attended by OPSA members, staff and over 115 guests. Martone, who has consulted widely on Olmstead plan development, addressed factors to consider in developing an Olmstead plan; what good Olmstead plans should include; what challenges are presented in Olmstead planning; and how to overcome those challenges.

The second quarterly meeting seeks to address alternatives to guardianship and informed choice for individuals considering transition from facilities to community living. The Burton Blatt Institute Senior Director for Law and Policy, Jonathan Martinis, has been tapped to present to the OPSA. A disability rights attorney, Martinis leads the Institute's supported decision-making[50] research and policy initiatives. He is well known for his work on the "Justice for Jenny" case.[51] The case was the first to propose successfully that a person with disability has the right to engage in supported decision making, rather than face unnecessary guardianship.

In late October, the full OPSA, through invitation of its Committee on Workforce Development, was set to hear from two of the country's leading experts on the frontline workforce: Joe Macbeth, Executive Director of the National Alliance for Direct Support Professionals (NADSP) and Amy Hewitt, Ph.D., Director of the Institute for Community Integration (ICI). Discussion is expected to include strategies for recruiting, retaining and training the frontline workforce, including the emergence of credentialing as a strategy for building a competent, committed workforce.

OPSA Committees. The OPSA conducts the bulk of its work through eight committees: Housing; Employment; Community Capacity Building; Transition to Community; Children, Youth and Families; Workforce Development; Older Adults; and Quality Assurance and Quality of Life. These committees are supported by senior staff from six DHHS divisions and three offices (Division of Medical Assistance (DMA)/ NC Medicaid; Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS); Division of State Operated Healthcare Facilities (DSOHF); Division of Vocational Rehabilitation (DVR); Division of Social Services (DSS); Division of Aging and Adult Services (DAAS); NC Council on Developmental Disabilities (NCCDD); Money Follows the Person (MFP); and Office of the Secretary/ Office of the Senior Advisor on the ADA and Office of the General Counsel. The Olmstead Staff Work Group channels OPSA's insights to the TAC for plan development and will assist the TAC and OPSA in plan review.

Informed Decision-Making Tool. The TCLI's contributions to the DHHS Olmstead "tool kit" are varied. One, in particular, merits highlighting in this portion of the report: the development for the TCLI population of an Informed Decision-Making Tool (IDM). The tool is discussed at length in other sections of this report. The TCLI team predicts that this innovation, like others originated in the TCLI, will become part of broader efforts in the State to ensure that people have the information that they need to make an informed decision regarding community life.

[50] Supported decision-making is often defined as supports and services that help an adult with a disability make his or her own decisions by relying on trusted friends, family members, professionals, and others

[51] *Ross v. Hatch*, No. CWF120000426P-03 (Va. Cir. Ct. Aug. 2, 2013).

Role of Transition to Community Living Initiative in Olmstead Plan: Olmstead's vanguard in North Carolina is the Transition to Community Living Initiative (TCLI). TCLI, the implementation of a settlement agreement, was born out of an Olmstead-driven case, litigated by the Department of Justice, on behalf of people with serious or severe and persistent mental illness. As the DHHS Olmstead Plan increasingly moves into its implementation phases, much of State's policy and practice infrastructure will be adapted from the work done under TCLI. Significantly, TCLI's approach to community integration—and, it follows, that of the DHHS' Olmstead Plan--is architected into the State's Tailored Plan.[52] This approach promotes the adaptation of systemic changes, initially effected for one population, to other populations.

[52] As North Carolina transitions its Medicaid and NC Health Choice programs' care delivery system from predominately fee-for-service (FFS) to Medicaid managed care, the DHHS is committed to advancing integrated and high-value care, improving population health, engaging and supporting providers and beneficiaries, and establishing a sustainable program with more predictable costs. While Standard Plans will serve the majority of Medicaid and NC Health Choice beneficiaries enrolling in Medicaid managed care, Behavioral Health and Intellectual/Developmental Disability (Behavioral Health I/DD) Tailored Plans will serve populations with more significant behavioral health conditions—including mental health and substance use disorders (SUD)—I/DD, and traumatic brain injury (TBI). For more information, see *North Carolina's Design for State-Funded Services Under Behavioral Health and Intellectual/Developmental Disability Tailored Plans* at https://files.nc.gov/ncdhhs/State-funded-Services-Policy-Paper-20191230.pdf

XIII. APPENDIX

A. APPENDIX A: TCLI QUALITY OF LIFE SURVEY SUMMARY REPORT

APPENDIX A: TCLI QUALITY OF LIFE SURVEY SUMMARY REPORT

"I just want a better life. I know I can do it. I just want to feel comfortable."
Cardinal participant, pre-transition

The NC Transitions to Community Living Initiative (TCLI) Quality of Life (QOL) 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 experience obstacles and challenges to community integration, housing stability, and harm avoidance. Part of State and LME-MCO Quality Assurance and Performance Improvement (QAPI) monitoring systems, the surveys help to ensure participants receive the services and supports they need for their health, safety, and welfare.

LME-MCO staff and community mental health services providers administer the surveys during the transition planning period and again 11 and 24 months after the individual transitions to supportive housing.[1] Together with regular provider-facilitated interviews administered through the NC Treatment Outcomes and Program Performance System (NC-TOPPS)[2], TCLI QOL Surveys are used to monitor key participant outcomes, including community integration, natural supports network development, and other factors vital for maintaining stable housing and avoiding harms.

The surveys utilize a structured interview format and are designed to directly assess participant perceptions, satisfaction, and outcomes related to housing and daily living, community supports and services, and well-being. Approximately 30 survey questions are presented with defined response options. At twelve points throughout the interview, individuals are invited to provide additional information, elaborate on earlier responses, discuss what they would like to change, and identify and discuss unmet needs, factors limiting daily choice and control, or obstacles to community integration or receiving needed services.

Defined-response questions allow for data tracking and trending over time at both state and regional LME-MCO levels and are the primary focus of this annual summary report. Open-ended survey questions provide a structured opportunity for service providers and LME-MCO contacts to assess individual preferences, needs, and goals during transition planning, and to identify, explore, and discuss with individuals in supportive community housing any factors related to their services and supports, daily activities, and housing that need attention, adjustment, or intervention.

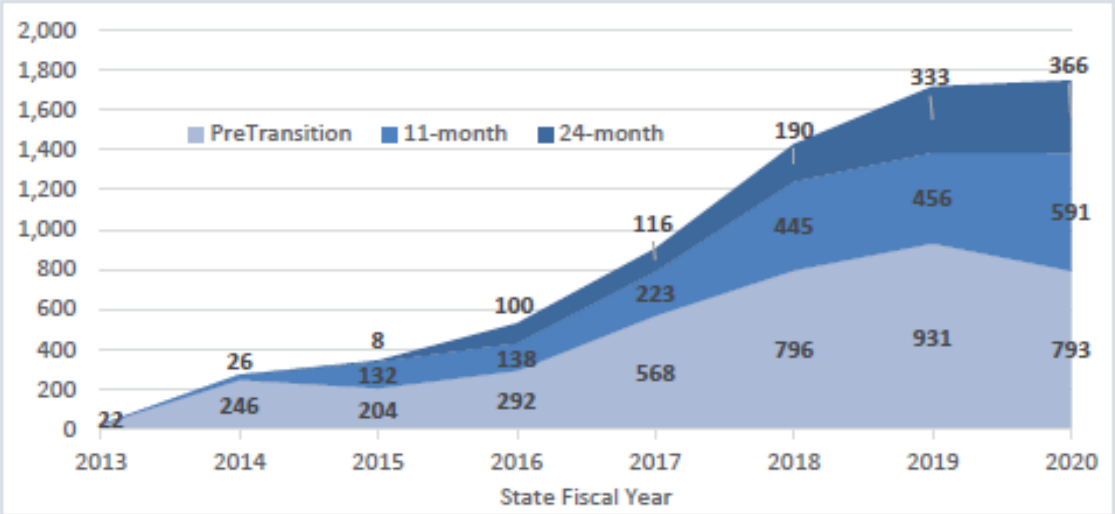
[1] In general, 24-month surveys are administered two SFYs after the transition year, such that 24-month surveys for individuals who transitioned in 2018 occurred in 2020. However, follow-up surveys may be administered substantially later than 11 and 24 months after the initial transition for individuals who leave and later return to supportive housing.

[2] NC-TOPPS interviews are administered upon initiation services, at 3-month and 6-month follow-ups, and every six months thereafter until the individual is discharged from services.

"I would like to go out for a walk and not beg to go out and about. I cook and clean. I love to make friends, to see my place. I want my mental health to get better." Sandhills participant, pre-transition

Survey responses are submitted by the LME-MCO or service provider through the State's secure, web-based survey application. As of June 30, 2020, more than 7,000 surveys for more than 4,000 TCLI participants have been administered and submitted. With this annual report, responses to a total of 3,852 Pre-Transition surveys; 2,011 11-month surveys; and 1,113 24-month surveys have been analyzed.[3] (See Figures 1 and 2.)

Figure 1: Participant Surveys by State Fiscal Year

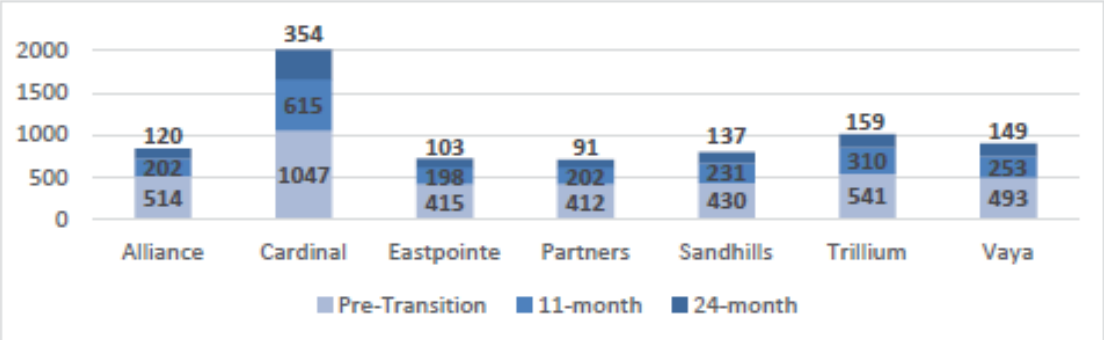


"I'm going to change and look forward to bettering myself." Eastpointe participant, pre-transition

"Just want to be free to be me." Sandhills participant, pre-transition

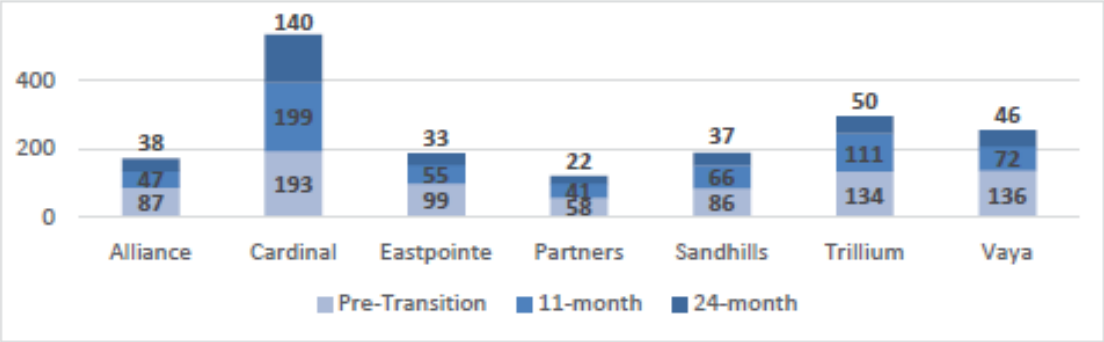
[3] Per Section III.G.5 of the State's Settlement Agreement (SA) with U.S. DOJ, the State implemented Quality of Life surveys in 2013. The SA requires the three surveys for individuals transitioning out of adult care homes or state psychiatric hospitals. The State extended the survey requirement for 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 2013-2020[4]



Analyses of SFY 2020 data reported in this annual update are based on 1,750 surveys, including 793 pre-transition, 591 11-month, and 366 24-month surveys, as shown in Figure 3.

Figure 3: SFY 2020 Completed Participant Surveys by LME-MCO Catchment Area



"I'm proud of myself and I appreciate you all helping me." Trillium participant, pre-transition

"I feel like I'm getting a new lease on life." Vaya participant, pre-transition

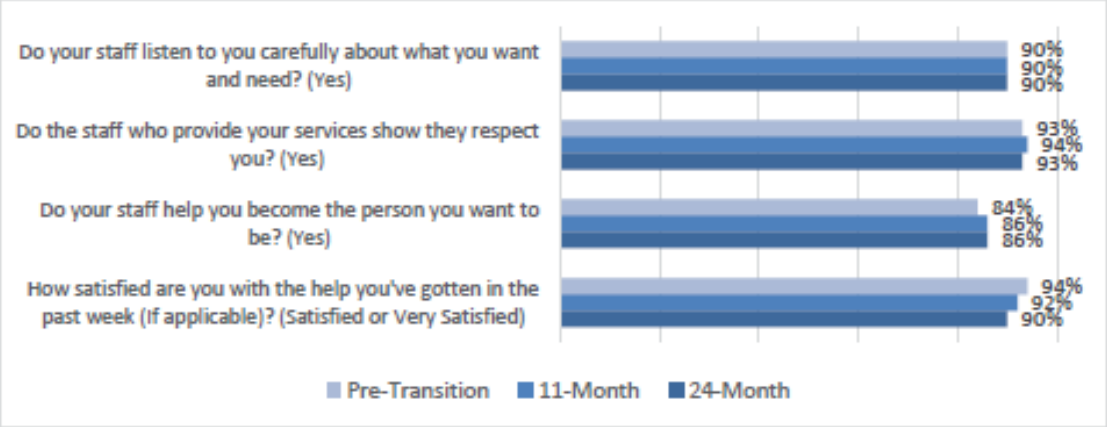
[4] LME-MCO compliance with the Quality of Life survey requirement is an area of ongoing State team performance monitoring. Over the life of the TCLI program, 84% of surveys for individuals housed and/or reaching 11 or 24 months in housing have been submitted. This includes pre-transition surveys for 93% of individuals housed and follow-up surveys for 76% of individuals in housing at 11-month and 24-month follow-ups. The overall submission rate for surveys due in the 2019-2020 State Fiscal Year was 84% and included surveys for 95% of all individuals who transitioned to supportive housing during the year, and 78% and 77% of individuals in housing at 11 and 24 months. Because individual survey participation is voluntary, a 100% submission rate is not expected.

QUALITY OF LIFE AND SATISFACTION WITH HOUSING AND COMMUNITY

"I'm doing great since I got out of the retirement home. I'm in my own place and I'm not bothered with having a roommate or anything. I've even got a cat." Vaya participant, 24-month follow-up

Figures 4A through 4H below show percentages of participants surveyed in SFY 2020 who reported positive experiences related to eight Quality of Life domains.[5,6] 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 that indicates the most positive experiences and satisfaction. In general, participants who had transitioned to supportive housing were significantly more likely to report positive experiences compared to pre-transition survey respondents.

Figure 4A: Staff Support and Satisfaction With Services

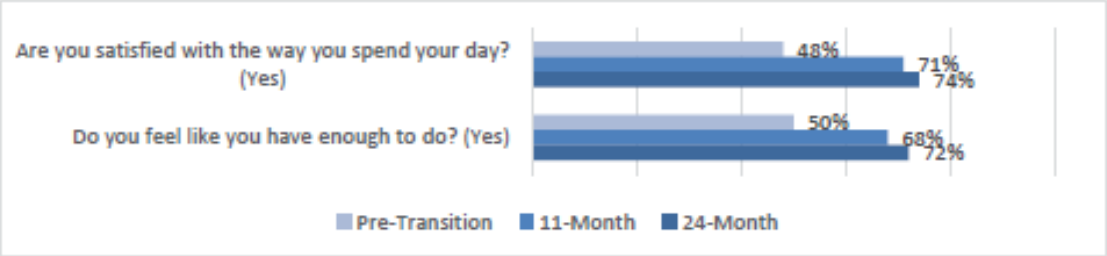


"I am very happy. I was homeless for a long time and did not trust anyone. I have a nice place to live, I feel safe, and my workers help me to get better and they seem to understand and care about me." Trillium participant, 24-month follow-up

[5] 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.

[6] "No Response" and "Unsure" responses are excluded from all percentage denominators.

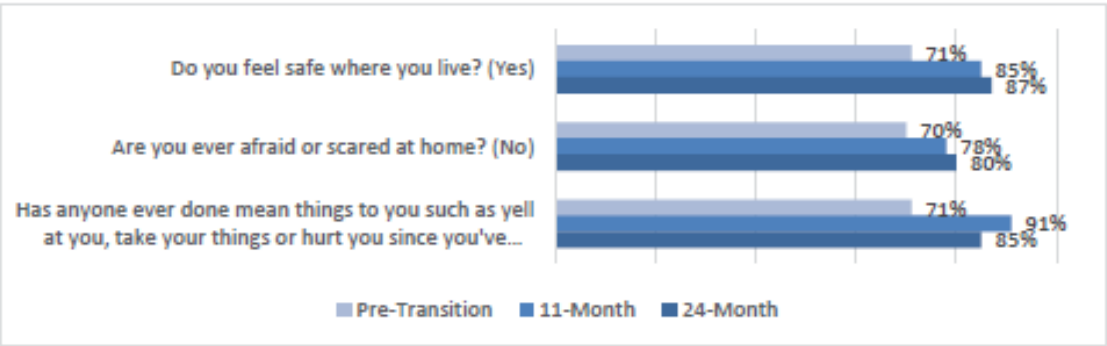
Figure 4B: Meaningful Day



"Everything is good. I work in the afternoon at my father's gas station for two hours a day and my brother does homework on my computer so he visits me sometimes." Eastpointe participant, 11-month follow-up

"I am leaning towards becoming independent. I obtained my peer support certification." Alliance participant, 24-month follow-up

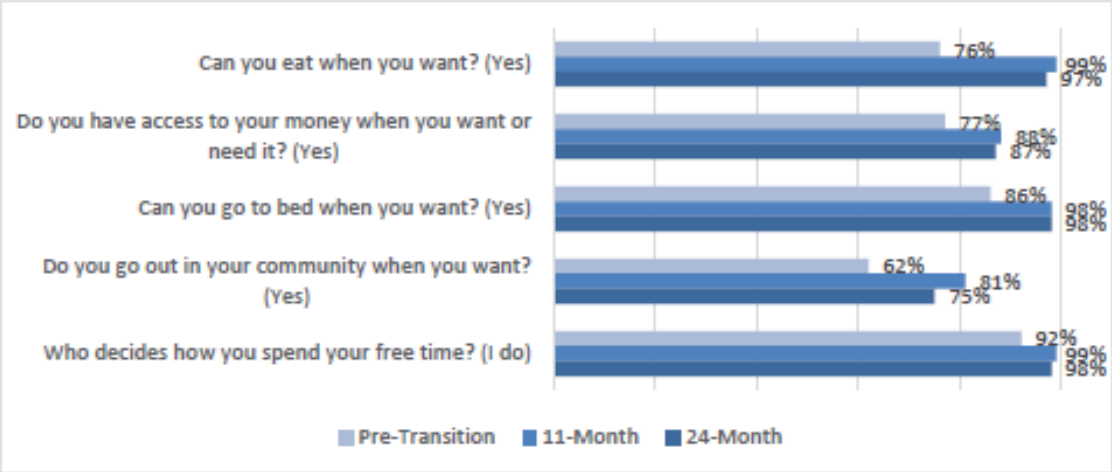
Figure 4C: Safety



"I have concerns about my mental health and my ability to live independently." Sandhills participant, 11-month follow-up

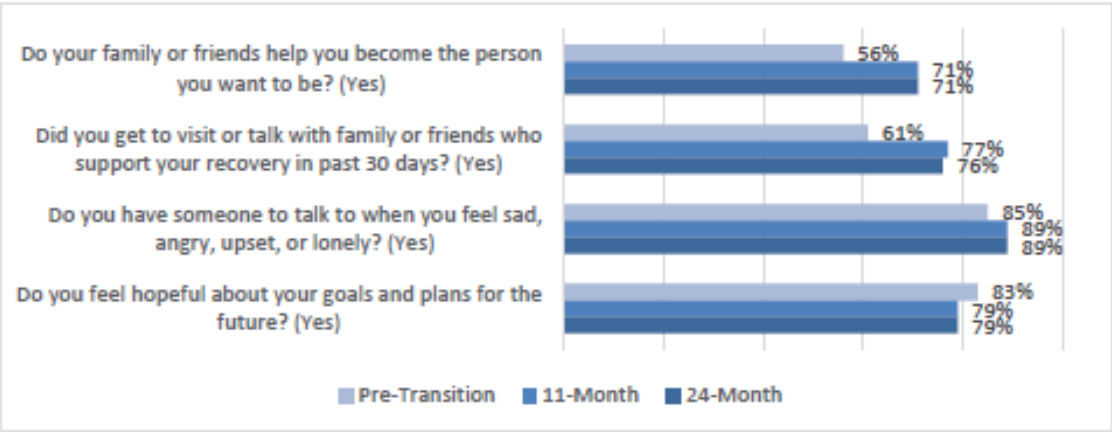
"For years and years I was very suicidal. But the last time I attempted was just before I came onto an ACT team…That was two years ago." Vaya participant, 24-month follow-up

Figure 4D: Choice and Control



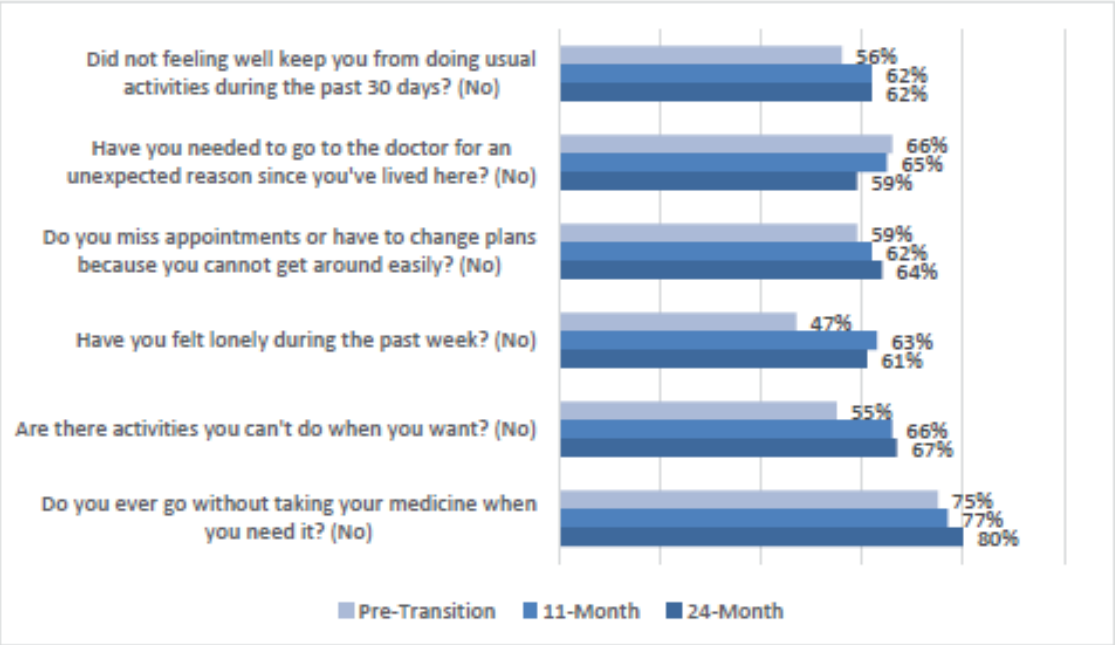
[Member] wants to be outside more. She would like to look at moving into a house where she could do things in the yard. Partners participant, 11-month follow-up

Figure 4E: Natural Supports



"My sisters live in walking distance from me and they do not come to see me. I don't have any support from family except my brother." Trillium participant, 24-month follow-up

Figure 4F: Health and Wellness



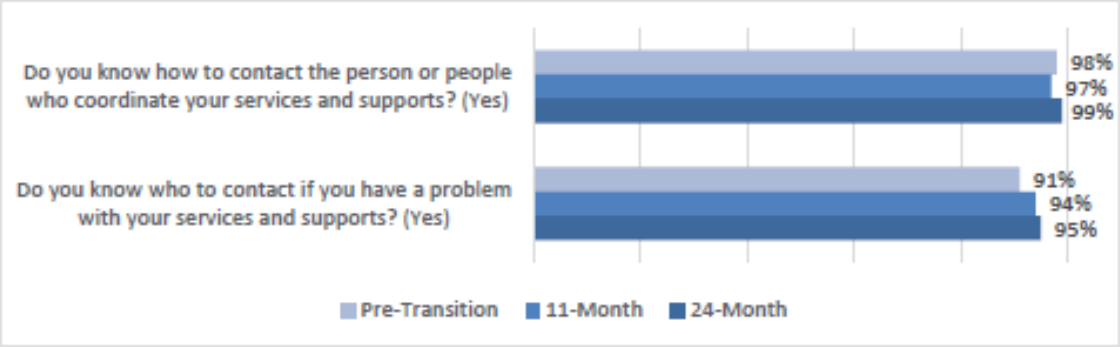
"Once I leave I can work on other things like getting my diabetes under control." Vaya participant, pre-transition

Member hates being depressed and taking medications. Cardinal participant, 11-month follow-up

"I am enjoying being the independent person that I knew I could be. I get lonely sometimes." Trillium participant, 24-month follow-up

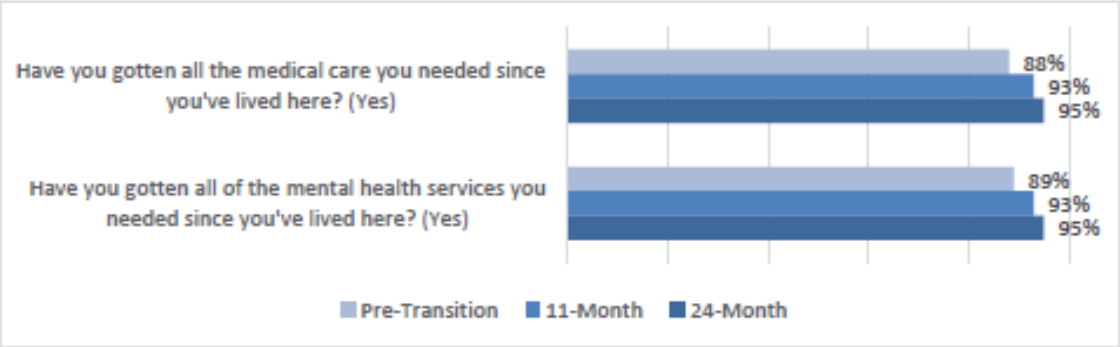
"I have been feeling bad but I'm seeing my doctor for that." Vaya participant, 11-month follow-up

Figure 4G: Service Planning Contacts[7]



"I want to know what is going on with TMS. No one tells me anything. Have not heard from TMS in a couple of weeks. Waiting to hear about [Provider] going forward with their services. I feel like someone is in charge of my life and making decisions about me. I just don't know!" Alliance participant, 24-month follow-up

Figure 4H: Sufficiency of Services



Member shared that she is "somewhat" happy with her services. She noted that she does not see her provider weekly as she was told and she would like to see them more often. Partners participant, 11-month follow-up

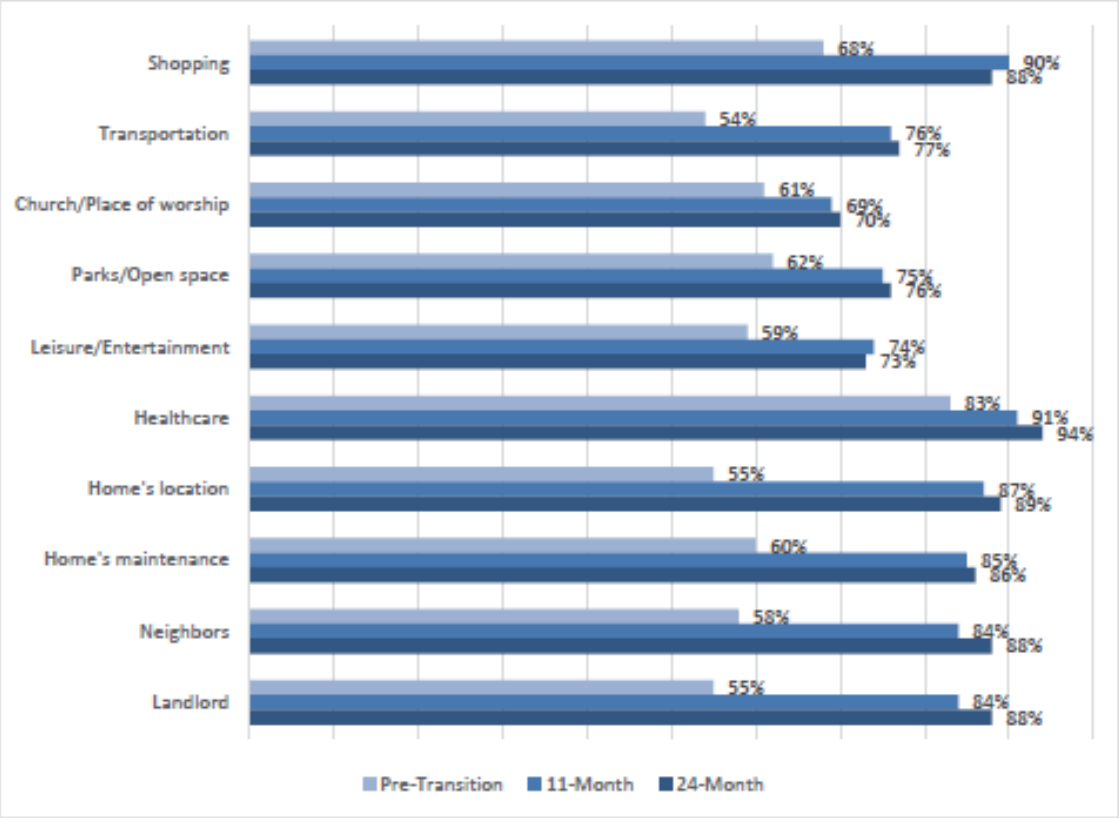
[7] Percentages who answered Yes to, "Do you know who to contact if you have a problem with your services and supports" were incorrectly reported in the 2019 annual report as 72% pre-transition, 82% at 11 months, and 87% at 24 months. The correct percentages were 90%, 96%, and 96%.

Figure 5A shows percentages of SFY 2020 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 had not yet transitioned to supportive housing.

At all three points individuals were most likely to report satisfaction with their Healthcare. The largest differences between individuals in supportive housing and those who had not yet transitioned into the community were again observed in percentages of individuals satisfied with aspects of housing: Location, Landlord, Neighbors, and Maintenance.

Individuals in supportive housing were also substantially more likely to report satisfaction with Transportation, although this was one of the lowest rated areas, along with other community resources such as Parks, Leisure, and Church. As shown in Figure 5B, Transportation also continues to have the highest rates of post-transition dissatisfaction, followed by Home Maintenance, Location, and Landlord. Relatively lower rates of reported satisfaction with Parks, Leisure, and Church reflect in part the percentages of participants who reported No Opinion.

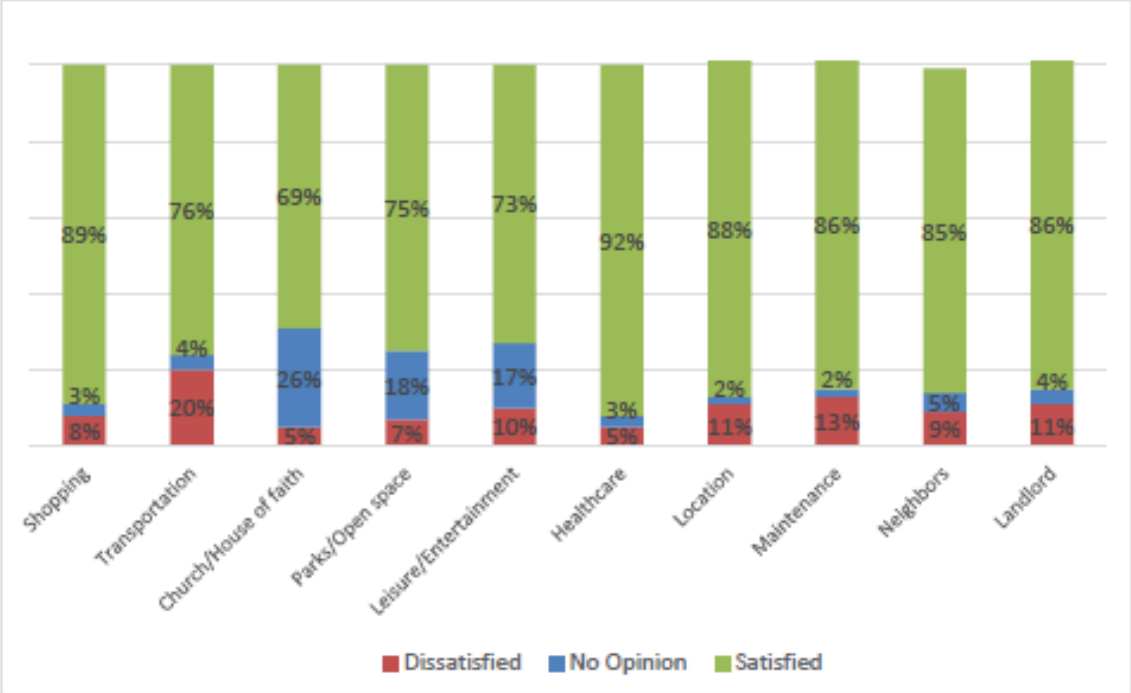
Figure 5A: Satisfaction with Community Resources and Housing



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

"I like my apartment. I get along with my roommate. Maintenance is slow to respond and fix things." Trillium participant, 24-month follow-up

Figure 5B: Satisfaction vs. Dissatisfaction in Supportive Housing



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

"I really need help with transportation." Sandhills participant, 11-month follow-up

"I want to be out of this house. It has had lots of problems and the landlord has not taken good care of this house." Trillium participant, 11-month follow-up

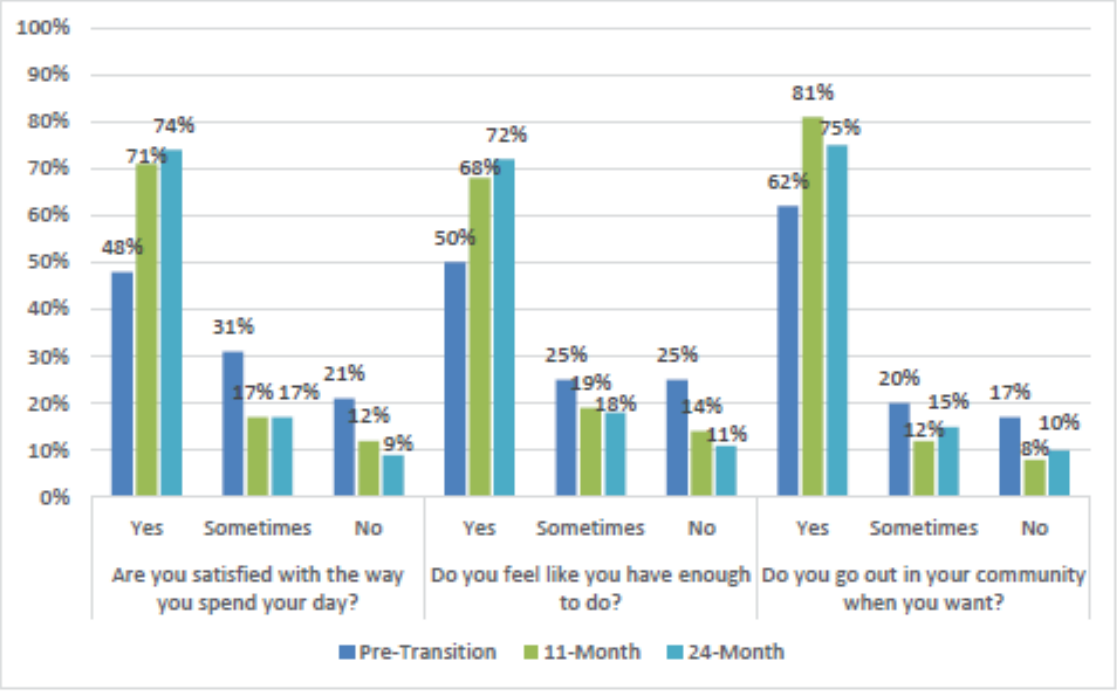
Member is requesting to relocate housing and move closer to her family. Team is working on the request. Partners participant, 11-month follow-up

COMMUNITY INTEGRATION AND NATURAL SUPPORTS

"I would like to be productive in my life again." Cardinal participant, pre-transition

Figure 6 shows detailed response distributions to the survey questions most related to participant community integration and engagement. Pre-transition and post-transition respondents differed substantially in their reports of satisfaction with daily activities, having enough to do, and going into the community when desired. On average, 53 percent of individuals responded affirmatively to these questions prior to transition, compared to 73 percent on average at 11-month and 24-month follow-up surveys.

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



"I would like to go back to school and work on my career pathway." Sandhills participant, 11-month follow-up

"Looking forward to being able to socialize more." Cardinal participant, pre-transition

Pre- and post-transition respondents also differed in their reports of typical daily activities. Participants in supportive housing selected 3.5 activities on average, slightly lower than the 4.0 on average selected by individuals in congregate living and other pre-transition settings. As shown in Figure 7, participants in supportive housing were significantly more likely to select Cooking/Cleaning but less likely to select a variety of other activities.

After Watching TV, which was the most commonly selected activity for both groups, activities selected by more than 50 percent of individuals in supportive housing included Cleaning/ Cooking and Going into the Community. The only activity other than Watching TV selected by more than 50 percent of individuals who had not transitioned to supportive housing was Listening to Music.

Figure 7: How do you usually spend your day?

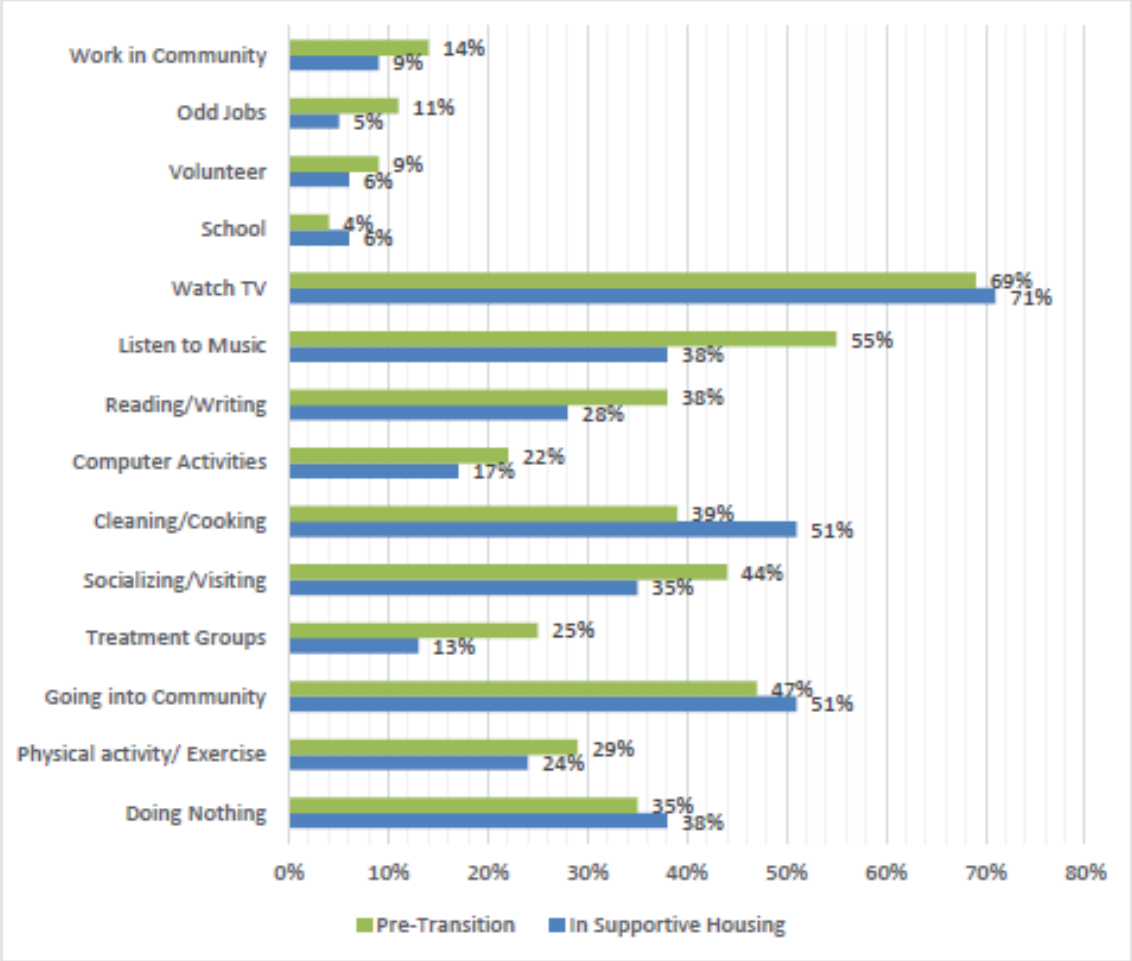
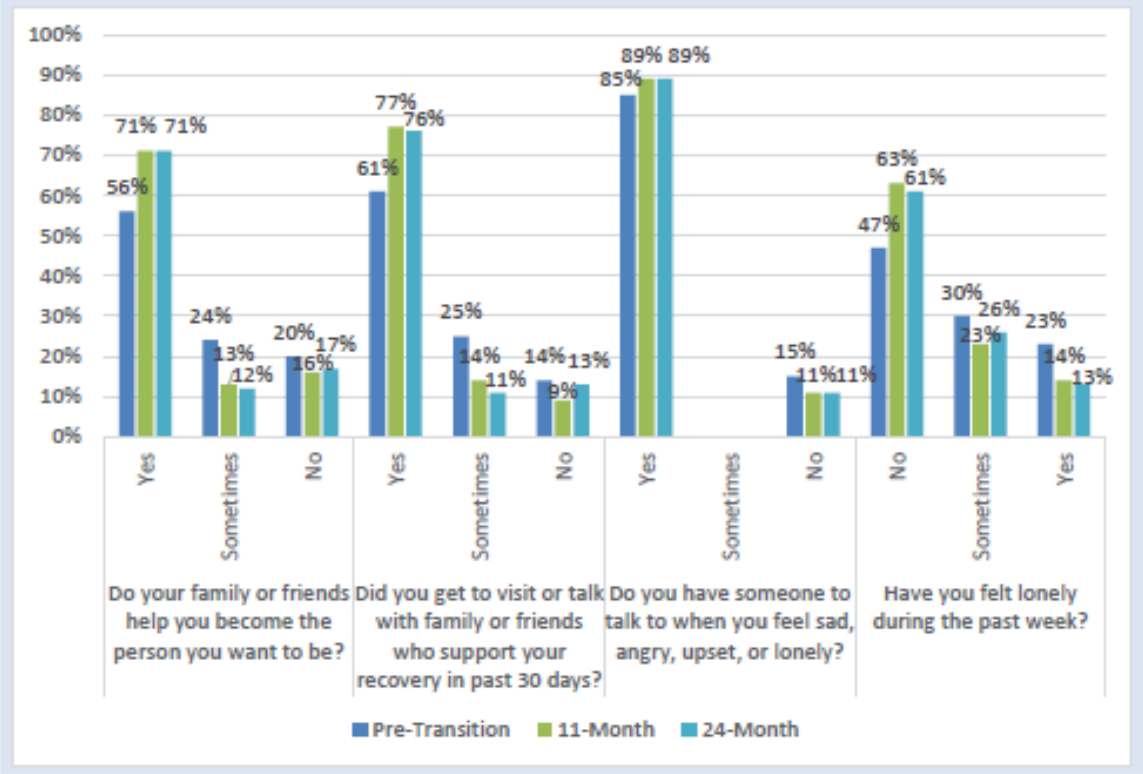


Figure 8 shows detailed response distributions to the survey questions most related to participants' natural support networks and relationships with friends and family. Pre-transition and post-transition respondents differed substantially in response to these questions. On average, 62 percent of individuals selected the answers most indicative of positive support networks prior to transition, compared to 75 percent on average at 11-month and 24-month follow-up surveys.

Figure 8: Natural Supports at Pre-Transition, 11 and 24 Months



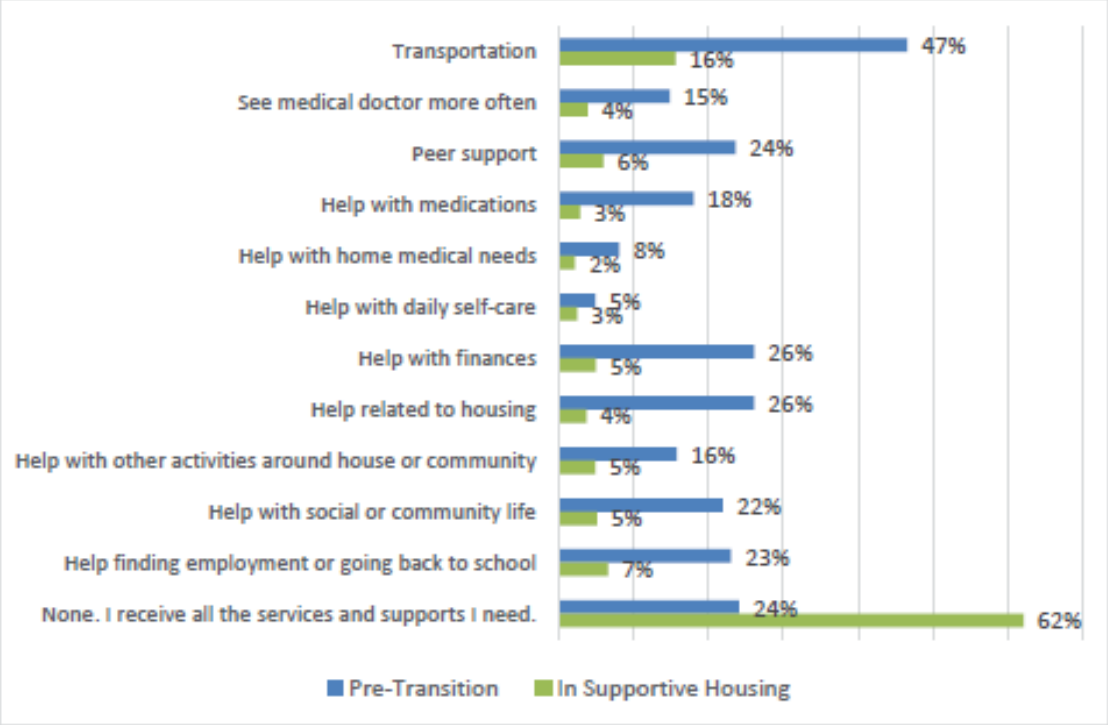
"I would like to have a significant other one day and a dog." Trillium participant, 11-month follow-up

Member reported that she feels she has a good support system that includes family and [Provider] support staff. She feels that she is stable in the community and is looking forward to accomplishing more goals. Partners participant, 24-month follow-up

"I would like to meet more people and get out of the house more." Sandhills participant, 24-month follow-up

Compared to their peers in congregate living facilities and other pre-transition settings, individuals in supportive housing were more than two and a half times as likely to report that they receive all of the services and supports they need. Sixteen percent of individuals in supportive housing reported at their 11-month or 24-month follow-up surveys that they needed additional help with transportation, a need identified by nearly half of individuals prior to transition.

Figure 9: Other Needed Services and Supports



"Finding more extracurricular activities." Vaya participant, 24-month follow-up

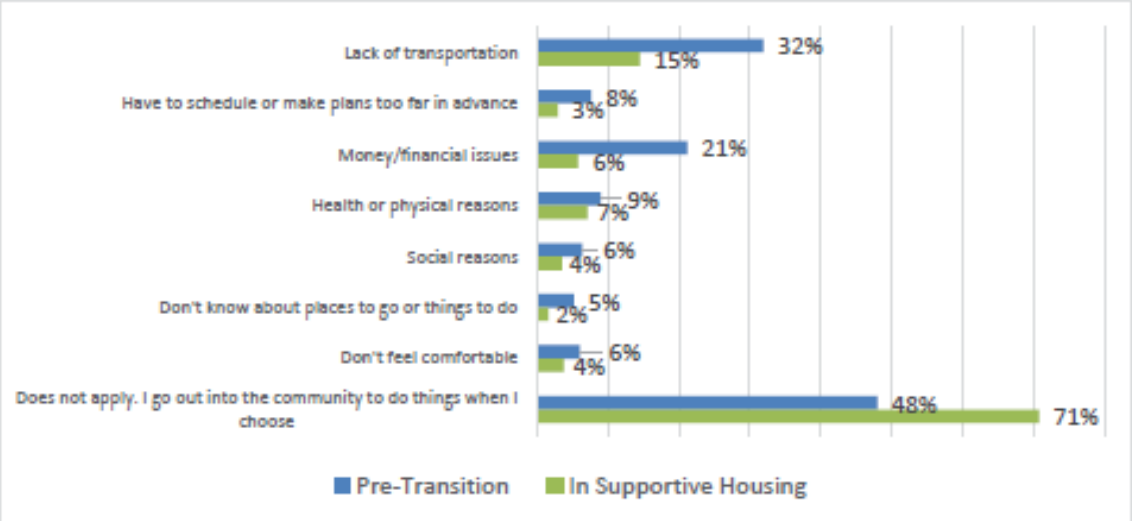
"I just want to keep taking different medicine to battle my depression if I can. I want to find something to really help me with it." Eastpointe participant, 11-month follow-up

Of the 38 percent of individuals in supportive housing who indicated they needed one or more additional service or support, approximately 20 percent elaborated on the response options they selected or cited needs other than the 11 defined response options shown in Figure 9. Physical health services were the most frequently cited category of additional support needed. These included medical specialist services, physical therapy, dental or vision care, assistance with smoking cessation, dietician services, or help changing providers.

Examples of additional needed supports for home medical or physical health needs included home modifications, an electric chair for getting around independently, home nebulizer or oxygen ("breathing machine"), blood pressure cuff, and exercise equipment. Some reported unmet needs around benefits assistance, such as Medicaid, supplemental nutrition assistance, or other disability benefits; other mental health supports, such as AA or other recovery group meetings, additional or more intensive services, or help obtaining an emotional support pet or service dog; and help with daily activities, such as finding volunteer opportunities, obtaining a gym membership, and getting a driver's license.

As previously shown in Figure 6, individuals in supportive housing were significantly more likely than the pre-transition group to report that they go out into the community when they want. Figure 10 shows that higher percentages of individuals who had not yet transitioned to the community also cited each of several obstacles as reasons they do not go out into the community when they want. Among individuals in supportive housing, lack of transportation was again the most commonly identified obstacle to going out into the community when they want.

Figure 10: Obstacles to Community Integration



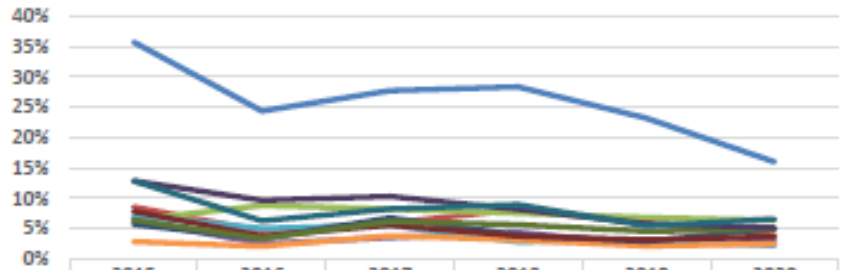
"I just wish I could get up and walk." Sandhills participant, 11-month follow-up

"I don't feel comfortable and I don't want to have a panic attack." Trillium participant, 24-month follow-up

"I would like to have transportation to see my kids more." Sandhills participant, 11-month follow-up

Although transportation continues to be the most cited obstacle, as Figure 11 shows, the percentage of individuals in supportive housing reporting this difficulty has steadily declined to less than half the SFY 2015 rate. The trend of decreasing percentages of participants reporting the problem applies to a majority of obstacles cited, including seeing a medical doctor more often and help with medications, home medical needs, housing-related issues, social or community life, and finding employment or going back to school.

Figure 11: Annual Trends in Reported Obstacles to Community Integration in Supportive Housing

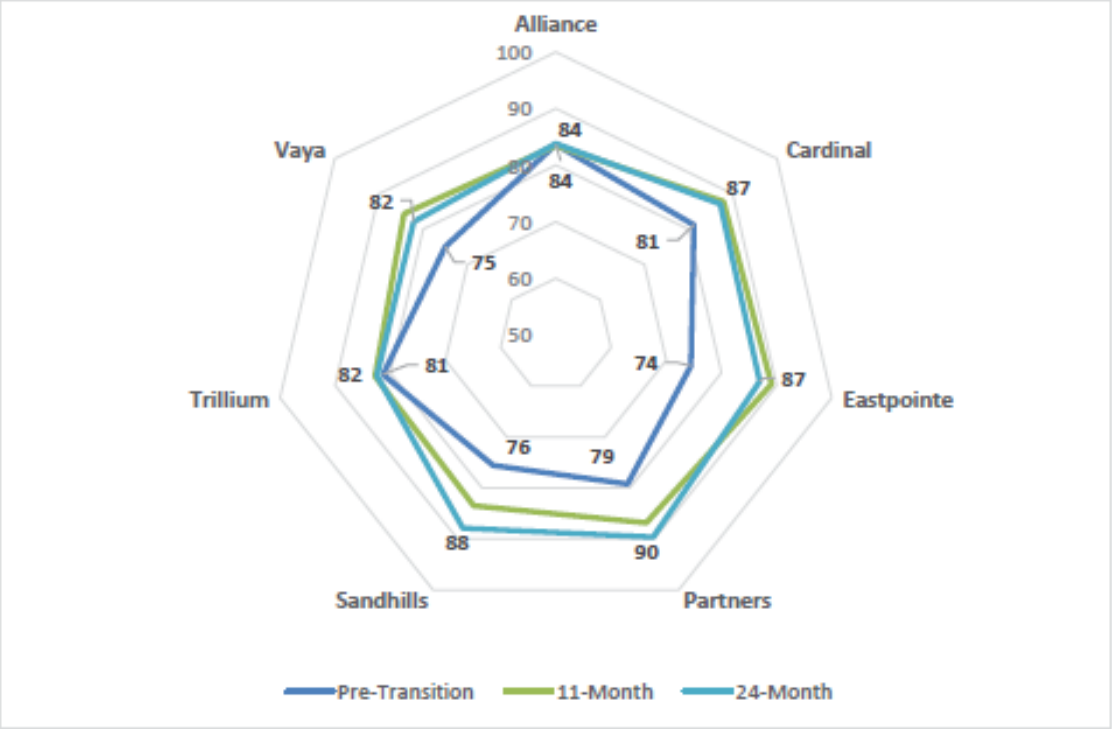


	2015	2016	2017	2018	2019	2020
Transportation	36%	24%	28%	28%	23%	16%
See MD more often	9%	5%	6%	8%	6%	4%
Peer support	6%	9%	8%	8%	7%	6%
Medication assistance	6%	3%	4%	4%	2%	3%
Home medical needs	7%	5%	6%	3%	3%	2%
Daily self-care	3%	2%	4%	3%	2%	3%
Finances	6%	3%	7%	4%	3%	5%
Housing	8%	4%	6%	4%	3%	4%
Other daily living activities	6%	3%	6%	6%	5%	5%
Social or community life	13%	10%	10%	8%	6%	5%
Employment or school	13%	6%	8%	9%	5%	7%

QUALITY OF LIFE AND SATISFACTION TRENDS BY LME-MCO AND TRANSITION YEAR

Aggregate Quality of Life (QOL) and Satisfaction (SAT) Index scores are based on the 28 survey questions listed in Figures 4A through 4H and on the ten housing and community satisfaction ratings in Figure 5. These two aggregate scores for individuals who responded to 11-month and 24-month surveys in SFY 2020 show similar patterns to previous years, with higher score values for individuals surveyed after transitioning to supportive housing, and larger pre- vs. post-transition group differences for SAT than QOL.[8],[9] (See Figures 12 and 13.)

Figure 12: Quality of Life by LME-MCO Catchment Area, Individuals in Supportive Housing, SFY 2020

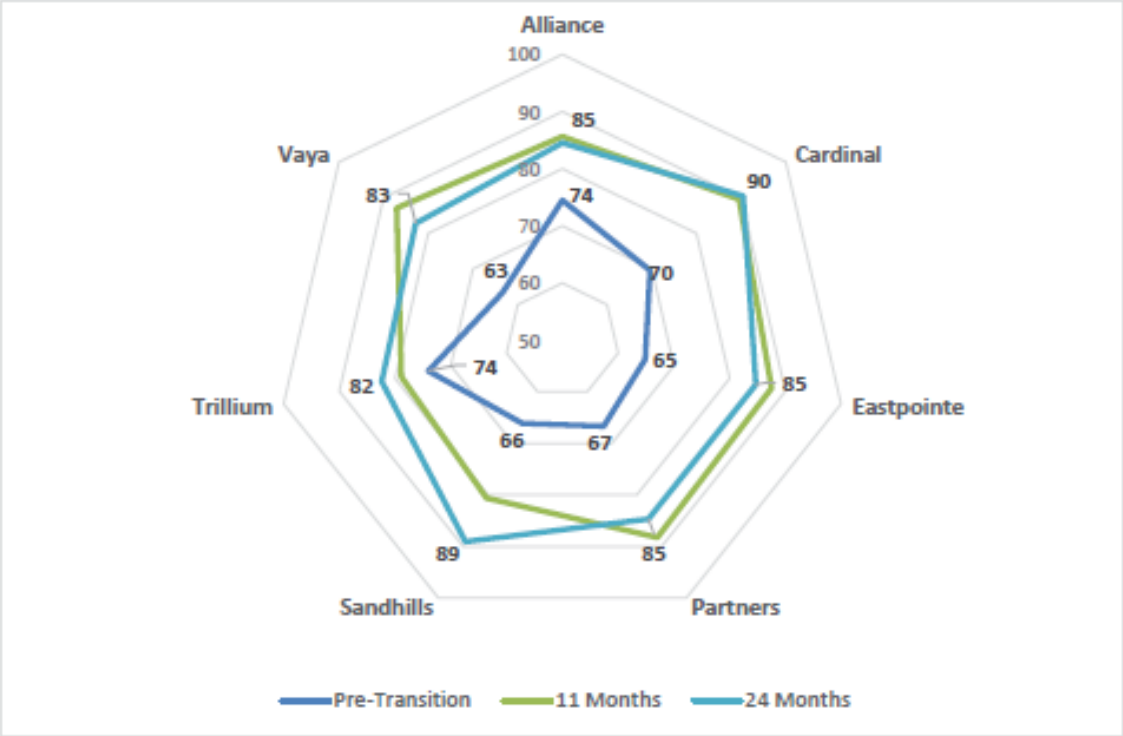


The QoL Index is computed as the average of the 28 re-coded (positive experience = 3, neutral/middle = 2, negative experience = 1) survey items shown in Figures 4A through 4H, rescaled to a 0-100 scale. Interpretation is comparable to a percentage, where a score of 50 would indicate individuals on average selected responses indicating the most positive perceptions or experiences half of the time. In the graph above, Pre-Transition values are shown beside the inner line, 24-month values beside the outer line.

[8] 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.

[9] QOL Index scores reported here for SFY2020 are 6.5 points lower on average than values reported in the SFY 2019 annual report would be if rescaled to a 0-100 scale. This is due to a scoring error in the SFY 2019 report that resulted in Index overestimates of 0.13 points (6.5 points on the rescaled 0-100 scale) on average.

Figure 13: Satisfaction Index by LME-MCO, Individuals in Supportive Housing, SFY 2020



The Satisfaction Index is computed as the average of the 10 re-coded (Satisfied = 3, No opinion = 2, Dissatisfied = 1) housing and community satisfaction ratings for the areas shown in Figure 5, rescaled to a 0-100 scale. Interpretation is comparable to a percentage, where a score of 50 would indicate individuals on average selected responses indicating the most positive perceptions or experiences half of the time. In the graph above, Pre-Transition values are shown beside the inner line, 24-month values beside the outer line.

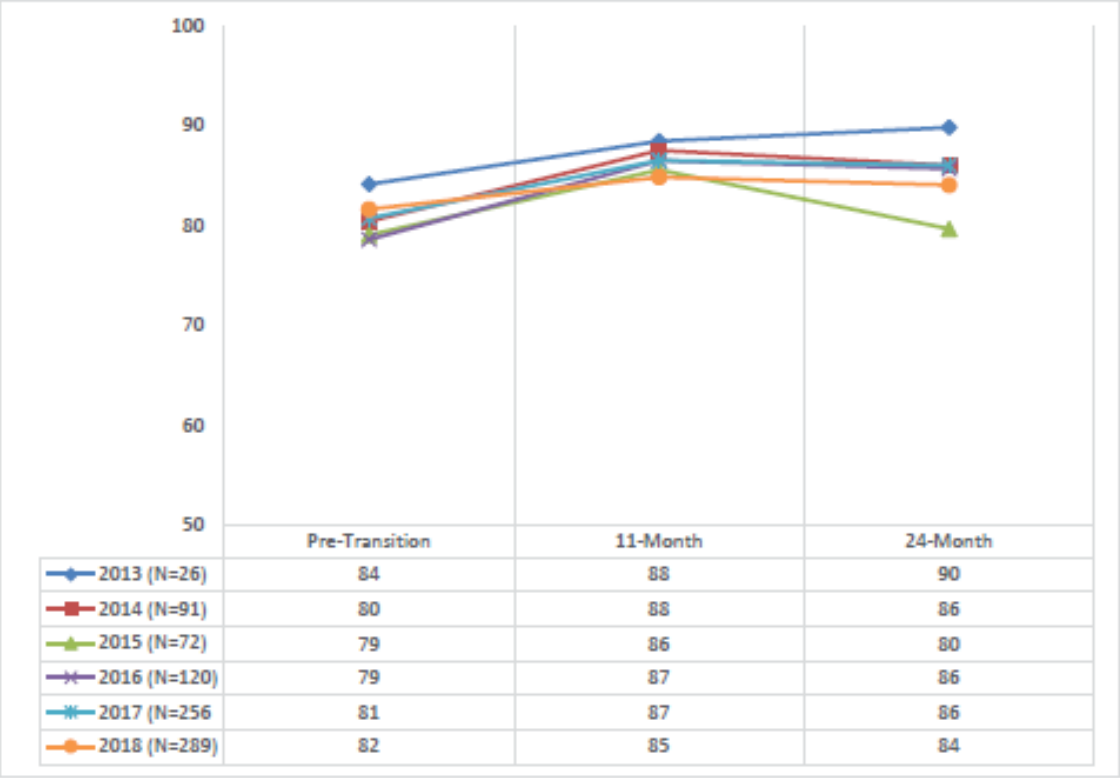
Both Index scores were somewhat more variable across LME-MCO catchment area pre-transition groups compared to post-transition participants. Smaller pre-to-post-transition group score differences also tended to reflect pre-transition respondents' higher scores more than lower scores among post-transition respondents.

Figures 12 and 13, as well as previous graphs in this report, show results of analyses that compare the responses of different groups of individuals who completed pre-transition, 11-month, and 24-month surveys during SFY 2020. These generally demonstrate that individuals surveyed at both follow-up points report more positive experiences and perceptions and fewer unmet needs and obstacles to community integration compared to individuals surveyed before transitioning to supportive housing.

To assess individual change over time, survey index scores for 863 individuals who transitioned to supportive housing over the life of the program and completed all three surveys by the end of SFY 2020 were compared in a series of repeated measures analyses.

Results of repeated measures analyses confirm the interpretation of significant increases in reported quality of life and satisfaction after program participants transitioned to supportive community housing. For both measures, the same individuals' scores were higher on average at both the 11-month and 24-month follow-ups compared to pre-transition, and their 11-month and 24-month scores generally did not significantly differ. A statistically nonsignificant trend overall toward slightly higher scores at 11 than 24 months is more evident in the patterns for individuals who transitioned in some SFYs and within some LME-MCO catchment areas than others. (See Figures 14, 15, 16, and 17.)

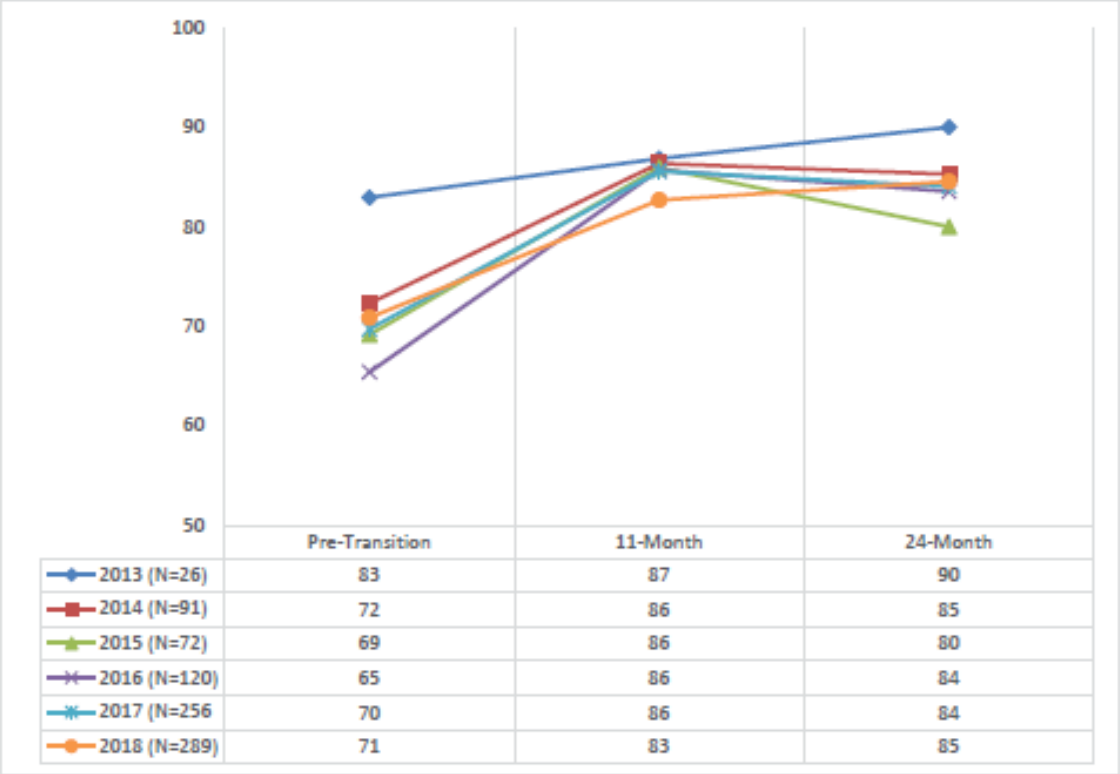
Figure 14: Individual Change in Quality of Life by Transition Year[a,b]



	Pre-Transition	11-Month	24-Month
2013 (N=26)	84	88	90
2014 (N=91)	80	88	86
2015 (N=72)	79	86	80
2016 (N=120)	79	87	86
2017 (N=256	81	87	86
2018 (N=289)	82	85	84

a- Index scores may range from 0 to 100; vertical axis is truncated to show detail.
b- Scores for an additional nine individuals who transitioned in SFY 2019 and completed the 24-month survey by the end of SFY 2020 were included in the analysis and are not shown in the graph above due to the small sample size.

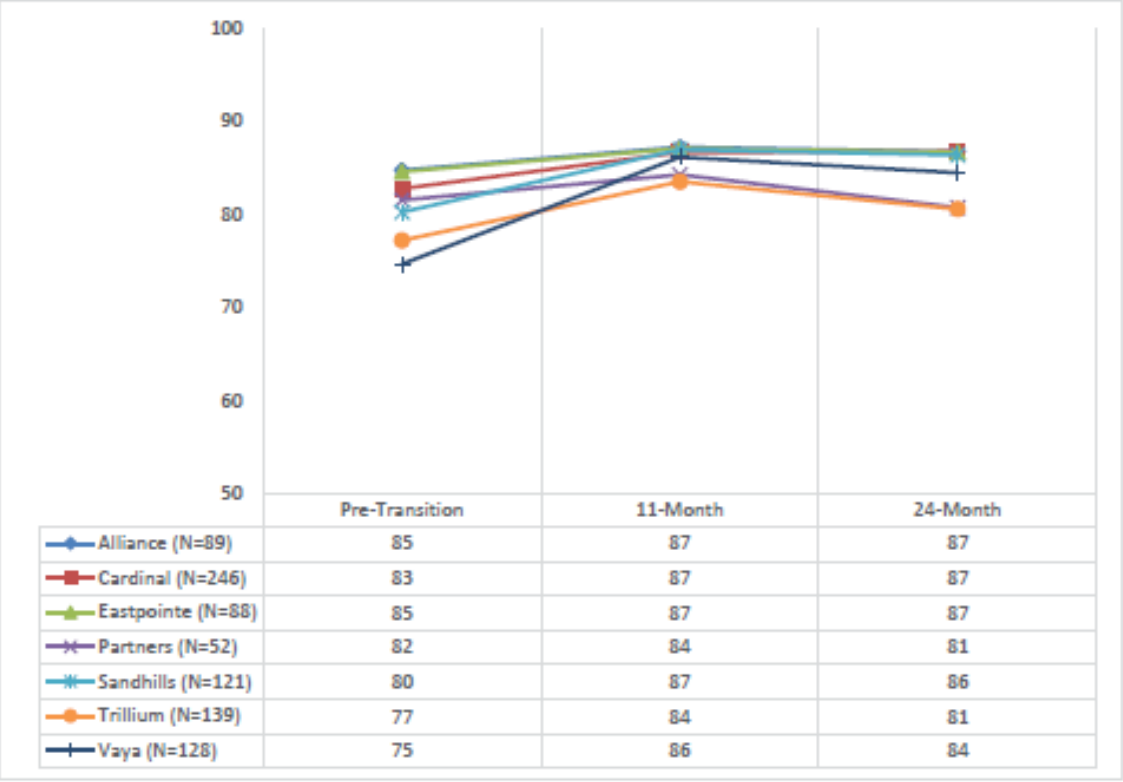
Figure 15: Individual Change in Satisfaction by Transition Year[a,b]



	Pre-Transition	11-Month	24-Month
2013 (N=26)	83	87	90
2014 (N=91)	72	86	85
2015 (N=72)	69	86	80
2016 (N=120)	65	86	84
2017 (N=256	70	86	84
2018 (N=289)	71	83	85

a- Index scores may range from 1.00 to 3.00; vertical axis is truncated to show detail.
b- Scores for an additional nine individuals who transitioned in SFY 2019 and completed the 24-month survey by the end of SFY 2020 were included in the analysis and are not shown in the graph above due to the small sample size.

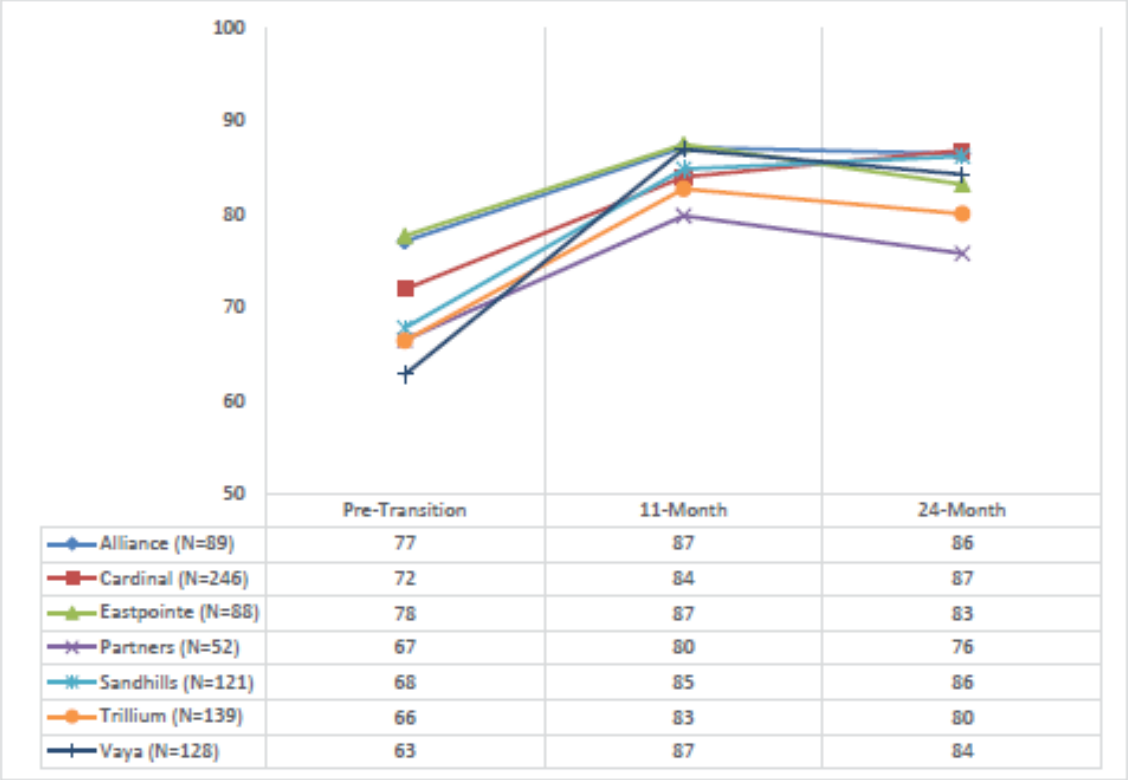
Figure 16: Individual Change in Quality of Life by Participant LME-MCO



	Pre-Transition	11-Month	24-Month
Alliance (N=89)	85	87	87
Cardinal (N=246)	83	87	87
Eastpointe (N=88)	85	87	87
Partners (N=52)	82	84	81
Sandhills (N=121)	80	87	86
Trillium (N=139)	77	84	81
Vaya (N=128)	75	86	84

Index scores may range from 0 to 100; vertical axis is truncated to show detail.

Figure 17: Individual Change in Satisfaction by Participant LME-MCO



	Pre-Transition	11-Month	24-Month
Alliance (N=89)	77	87	86
Cardinal (N=246)	72	84	87
Eastpointe (N=88)	78	87	83
Partners (N=52)	67	80	76
Sandhills (N=121)	68	85	86
Trillium (N=139)	66	83	80
Vaya (N=128)	63	87	84

Index scores may range from 0 to 100; vertical axis is truncated to show detail.

Participant pre-transition scores on both indexes are approximately twice as variable across LME-MCO catchment areas than after 11 and 24 months in supportive housing. Pre-transition scores are also strongly inversely correlated with the magnitude of gain reported, such that individuals in catchment areas who reported the least positive perceptions on average prior to transition experienced the largest reported gains on average after transitioning to community housing.

SUMMARY

"It has taken a turn for the better. I am doing so much better than the last time you saw me." Vaya participant, 24-month follow-up

In each full state fiscal year of the North Carolina Transitions to Community Living Initiative, participants surveyed in follow-up interviews after approximately 11 and 24 months in supportive housing have reported improvements in quality of life, and they reported more positive assessments of their life circumstances than did individuals who had not yet transitioned from congregate living facilities and other settings to supportive housing. These patterns are observed across LME-MCO catchment areas and over time. Trends in SFY 2020 largely resemble prior year patterns, including similarities in responses at 11- and 24-month surveys, which suggest that quality of life gains from the initial transition are largely maintained through the second year in housing.

While the transition to supportive housing in the community appears to have little relationship to participant's reported perceptions of their service providers or satisfaction with aspects of their services other than sufficiency, it is associated with reports of substantially greater community integration, choice and control in daily activities, and satisfaction with housing and other community resources. Larger percentages of individuals also report feeling safe where they live and positive engagement with family and friends supportive of their recovery after the transition to supportive housing. Further, program participants in supportive housing are approximately 30 percent less likely to report having felt lonely in the past week, and they are less likely to report restrictions in their daily activities, including limitations due to not feeling well or being able to get around.

"I am pushing forward to the woman God called me to be. I want to achieve my goals to complete my GED and find a job." Alliance participant, 11-month follow-up

Individuals in supportive housing are more than twice as likely as their pre-transition counterparts to report receiving all of the services and supports they need. They are one-third as likely to report transportation as an additional needed service. As in previous years, transportation is the most frequently cited additional support needed and the most frequently cited obstacle to community integration both before and after the transition to supportive housing.

Annual trends also show substantial progress in the TCL Initiative toward ensuring that individuals in supportive housing receive the services they need. For example, the percentage of individuals in supportive housing who report additional transportation needs has declined steadily from 36 percent in SFY 2015 to 16 percent in SFY 2020.

In the same five-year period, the rate of individuals reporting unmet needs has also declined to half or lower of the SFY 2015 rate for several other supports, including medical doctor visits, medication assistance, help with home medical needs, assistance with housing, help with social and community life, and supports for finding employment or going back to school. For these and other supports, including peer support services, daily self-care, other daily living activities, and help with finances, individuals are also substantially more likely to report unmet needs prior to transitioning to supportive housing.

> *"I thank God that Alliance has this program. For years I went from house to house and was put out on the street. Now I have my own place and this is a blessing."* Alliance participant, 24-month follow-up

As both the quantitative item response summaries and the quotations throughout this report from individuals surveyed in SFY 2020 demonstrate, participant experiences in supportive housing are not uniformly positive. Some individuals face challenges associated with unmet needs, physical as well as mental health, obstacles to community integration, engagement of natural supports, and problems associated with housing. While year-to-year trends illustrate some statewide improvements in addressing obstacles and meeting program participants' needs, QOL surveys continue to provide an important opportunity for service providers to engage program participants in conversations about their goals, challenges, and the changes and supports needed to ensure safety and wellness, promote community integration and engagement, reduce harm, and achieve housing stability.

B. APPENDIX B: BREAKDOWN OF FUNDS EXPENDED BY LME/MCOS

TCLI Service	Partners	Cardinal	Vaya	Alliance	Sandhills	Eastpointe	Trillium
Transition Year Stability Resources	$116,523.67	$386,039.75	$229,556.18	$171,780.63	$167,809.82	$130,477.63	$201,290.00
In Reach Collaborative		$ -		$7,164.10	$ -	-	$ -
Community Living Assistance (CLA)	$299,475.00	$432,150.66	$340,043.78	$464,672.00	$261,938.69	$254,196.00	$ 276,300.00
Emergency Housing Funds	$ 48,173.88	$96,025.13	$15,910.30	$6,549.11	$20,160.00	$12,334.02	$ 27,067.51
MCO Transition Coordinators	$90,000.20	$158,690.62	$90,000.00	$90,000.00	$90,000.00	$82,378.02	$180,000.00
Master Leasing Agreements/ Bridge Housing	$50,266.45	$395,080.84	$31,395.62	$24,064.85	$95,632.91	$125,498.00	$ 57,748.00
Mental Health Services Includes non-medicaid TMS; ACT; CST	$513,795.49	$1,174,350.10	$433,596.14	$796,540.13	$318,996.47	$389,887.09	$567,098.43
Supported Employment	$233,007.94	$1,126,987.00	$30,577.00	$617,602.51	$449,997.84	$621,750.00	$359,626.62
IPS Vaya Pilot/Milestones /EBHT	$30,258.75	$275,360.00	$332,332.16	$8,800.00	$6,750.00	-	$3,333.32
Subsidy Administration	$90,000.00	$260,000.00	$90,000.00	$90,000.00	$90,000.00	$90,000.00	$90,000.00
Diversion	$360,000.00	$600,000.00	$717,357.49	$461,335.03	$101,159.00	$251,160.00	$243,505.42
Total SFY 19/20 Expenditure	**$1,831,501.38**	**$4,904,684.10**	**$2,310,768.67**	**$2,738,508.36**	**$1,602,444.73**	**$1,957,680.6**	**$2,005,969.30**