Attachment A: Compliance Chart

Settlement Agreement Reference		Provision	Rating	Comments
III. A.		The State agrees to develop and implement effective measures to prevent inappropriate institutionalization and to provide adequate and appropriate public services and supports in the most integrated setting appropriate to meet the needs of individuals with SMI, who are in or at risk of entry to an adult care home (ACH).		
III. B.		**COMMUNITY-BASED SUPPORTED HOUSING SLOTS**		
III.B.1.		The State will develop and implement measures to provide individuals outlined in Section III (B)(2)(a)-(e).access to community-based Supportive Housing (SH).		
III.B.2		Priority for the receipt of housing slots will be given to the following individuals:		
1.	III.B.2.a.	Individuals with SMI who reside in an ACHs determined by the state to be an IMD	NR	There were no reports of newly designated IMDs in FY 2017
2.	III. B.2.b.	Individuals with SPMI who reside in an ACH licensed for at least 50 beds and in which 25% or more of the residents has a mental illness	C	Individuals in this category are given priority, but when combined with B.2.(a.) and (c.), is not yet on pace to meet FY 2020 requirement for 2000 individuals to have access to SH.
3.	III.B.2.c.	Individuals with SMI who reside in an ACH licensed for between 20 and 49 beds and in which 40% or more of the residents has a mental illness	C	Individuals in this category are given priority, but when combined with B.2.(a.) and (b.), is not yet on pace to meet FY 2020 requirement for 2000 individuals to have access to SH.
4.	III.B.2.d.	Individuals with SMI who reside who are or will be discharged from a state psychiatric hospital (SPH) and who are homeless or have unstable housing	NC	The state has yet to develop effective measures for individuals hospitalized in SPHs to access SH directly upon discharge.
5.	III.B.2.e.	Individuals diverted from entry into ACHs pursuant to the preadmission screening and diversion provisions of Section III (F).	NC	The state has made SH available to individuals at "risk of" inappropriate institutionalization but does not divert individuals from ACH placement.
III.B.3.		The state will provide access to 3000 housing slots in accordance with the following schedule:		
The state has not met the housing access requirements; each year a new row will be added to report the state's performance in meeting the Settlement Agreement (SA) Housing slots requirements.				
6.	III.B.3.a.	By July 1, 2017 the State will provide housing slots to at least 1,624 individuals.	NC	The state did not meet this requirement in FY 2017 providing housing slots for 1159 individuals.
7.	III.B.4.	The State shall develop rules to establish processes and procedures for determining eligibility for the Housing Slots consistent with this Agreement.	C	Rules and procedures are in place. It is recommended the state maintain records of time required for determining eligibility its effects on meeting requirement for immediate placement for individuals being diverted from ACHs".
8.	III.B.5.	Over the course of the agreement, 1000 slots will be provided to individuals described in Section III.(B) (2) (a)(b-c) and 2000 slots will be provided to individuals described in Section III. B. 2. (d- e) by June 30, 2020.	NR	The percent of slots provided to individuals in Section III (B) (2)[a-c] has increased in FY 2017. This item will be rated after June 30, 2020. This is not a reduction in number of individuals in other categories, the rate of slots being offered to individuals in III(B)(2)[a-c] has grown at a faster pace.

Rating Taxonomy:
C: The State is in full compliance with this requirement
NC: The State is not in compliance with this item either because the steps taken are not effective to meet the requirements, there have be no steps taken or there have not been enough steps taken to rate full Compliance.
D: Deferred, there is not enough information available to rate this item.
NR: Not rated this fiscal year

9.	III.B.6.	The State may utilize ongoing programs to fulfill its obligations under this Agreement so long as the Housing Slots provided using ongoing programs meets all the criteria.	NR	The State does not utilize ongoing programs. This provision is not rated because the term "may use" is used in the Agreement.
	III.B.7.	Housing Slots will be provided for individuals to live in settings that meet the following criteria:		
10.	III.B.7.a	they are for permanent housing with Tenancy Rights;	C	The State has consistently met this requirement.
11.	III.B.7.b.	they include tenancy support services that enable residents to attain and maintain integrated, affordable housing. Tenancy supports offered to people living in supported housing are flexible and are available as needed and desired, but are not mandated as a condition of tenancy;	C	Results of individual reviews indicates the State is that tenancy support is being provided. The State and LME/MCOs need to work closely with providers (including ACT) to assure tenancy support is as flexible, as available or as desired. DHHS and the LME/MCOs should develop performance measures consistent with the SA.
12.	III.B.7.c.	they enable individuals with disabilities to interact with individuals without disabilities to the fullest extent possible;	NC	Slots are typically located in multi-family complexes but many complexes are located isolated areas limiting interaction to the fullest extent possible..
13.	III.B.7.d.	they do not limit individuals' ability to access community activities at times, frequencies and with persons of their choosing;	NC	Slots are located isolated areas or places where transportation limits individuals' access to community activities at times, frequencies and with persons of their choosing; this is also a "services access" not a housing slot issue..
14.	III.B.7.e. and (i.)	they are scattered site housing, where no more than 20% of the units in any development are occupied by individuals with a disability known to the State (Up to 250 Housing Slots may be in disability-neutral developments, that have up to 16 units, where more than 20%);	C	The State has consistently met this requirement.
15.	III.B.7.f.	they afford individuals choice in their daily life activities, such as eating, bathing, sleeping, visiting and other typical daily activities	NC	Individuals do not always have choice in typical daily activities; this is a services limitation.
16.	III.B.7.g.(i.) and (ii.)	The priority is for single-site housing. *does not include full text*	C	The State has consistently met this requirement.
17.	III.B.8.	Housing Slots made available under this Agreement cannot be used in adult care homes, family care homes, group homes, nursing facilities, boarding homes, assisted living residences, supervised living settings, or any setting required to be licensed	C	The State has consistently met this requirement.
18.	III.B.9.	Individuals will be free to choose other appropriate and available housing options, after being fully informed of all options available.	C	The State has consistently met this requirement.

III. C.		**COMMUNITY BASED MENTAL HEALTH SERVICES**		
19.	III. C. 1.	The State shall provide access to the array and intensity of services and supports necessary to enable individuals with SMI in or at risk of entry in adult care homes to successfully transition to and live in community-based settings. The State shall provide each individual receiving a Housing Slot under this Agreement with access to services for which that individual is eligible that are covered under the North Carolina State Plan for Medical Assistance, the Centers for Medicare and Medicaid Services ("CMS") approved Medicaid 1915(b)/(c) waiver, or the State-funded service array.	NC	As reported in FY 2016, the array and intensity of services available remains limited and variable depending on where an individual lives (catchment, county or community) and where housing is available. Network management oversight, network sufficiency, eligibility, county of origin problems slow down the process and interfere with timely access. There are not sufficient services provided in a timely manner for individuals to be diverted from ACHs. The current array (and use of current array) does not yet provide opportunity for all the individuals who could live in the community to transition to and live in community-based settings.
20.	III. C. 2.	The State shall also provide individuals with SMI in or at risk of entry to adult care homes who do not receive a Housing Slot under this Agreement with access to services for which that individual is eligible that are covered under the North Carolina State Plan for Medical Assistance, the CMS-approved Medicaid 1915(b)/(c) waiver, or the State funded service array. Services provided with State funds to non-Medicaid eligible individuals who do not receive a Housing Slot shall be subject to availability of funds in accordance with State laws and regulations regarding access services.	NC	Same as above
20	III. C.3.a.- d.	The services and supports referenced in Sections III(C)(1) and (2), above, shall: a. be evidence-based, recovery-focused and community-based; b. be flexible and individualized to meet the needs of each individual; c. help individuals to increase their ability to recognize and deal with situations that may otherwise result in crises; and d. increase and strengthen individuals' networks of community and natural supports, as well as their use of these supports for crisis prevention and intervention.	NC	Reviews and data indicate there is still variability in the degree to which services are strengths based and recovery oriented with attention provided to strengthening individual's networks of community and natural supports.

21.	III. C. 4.	The State will rely on the following community mental health services to satisfy the requirements of this Agreement: Assertive Community Treatment ("ACT") teams, Community Support Teams("CST"), case management services, peer support services, psychosocial rehabilitation services, and any other services as set forth in Sections III(C)(1) and (2) of this Agreement.	NC	The State is meeting ACT and tenancy support availability. There is still variability in availability and quality of all services across LME/MCOs. The variation is related to network sufficiency, lack of providers in some geographic areas, authorization practices, financing constraints and/or to services either not being offered either being consistent with recipient need. Providers are much less engaged than TCLI staff and lack a focus on recovery and community integration. Some services are not as available as needed because of definition restrictions, their availability and/or authorization practices. Performance requirements for services referenced in the SA are not written in contracts with the necessary specificity for the State to meet its services array requirements.
22.	III. C. 5.	All ACT teams shall operate to fidelity to either, at the State's determination, the Dartmouth Assertive Community Treatment ("DACT") model or the Tool for Measurement of Assertive Community Treatment ("TMACT"). All providers of community mental health services shall adhere to requirements of the applicable service definition.	C	TMACT Fidelity is monitored regularly. Results from the 2nd round of Fidelity reviews, indicates a gradual improvement on those scores. Sub-scores varied but overall were lower on rehabilitation and recovery related interventions, frequency and intensity of services. In FY 2018, the review will include more questions regarding provider adherence to requirements of the service definition.
23.	III. C. 6.	A person-centered service plan shall be developed for each individual, which will be implemented by a qualified professional who is clinically responsible for ensuring that all elements and components of the plan are arranged for the recipient in a coordinated manner. Individualized service plans will include psychiatric advance directives and/or crisis plans so that such measures can be incorporated into the response to any behavioral health crisis.	NC	PCPs are being completed as required. However plans are not individualized at an acceptable level, there is little evidence of coordination among providers on a single PCP.
24.	III. C. 7.	The State *has implemented* capitated prepaid inpatient health plans ("PIHPs") as defined in 42 C.F.R. Part 438 for Medicaid-reimbursable mental health, developmental disabilities and substance abuse services pursuant to a 1915(b)/(c) waiver under the Social Security Act. The State will monitor services and service gaps and, through contracts with PIHP and/or LMEs, will ensure that the number and quality of community mental health service providers is sufficient to allow for successful transition of individuals with SMI, who are in or at risk of entry to an adult care homes, to supported housing, and for their long-term stability and success as tenants in supported housing. The State will hold the PIHP and/or LMEs accountable for providing	NC	The PIHP (MCO) and DMH contracts identifying TCLI requirements are in place statewide. The DMH contract improved in FY 2017. There have been improvements in the LME/MCOs network management however there is still a lack of intensity and focus on arranging for services that match the needs individuals have to move to and live successfully in the community. There are significant problems with LME/MCOs maintaining contact and making good connections on behalf of an individual when they move from one catchment area to another. Specific care coordination practices need to be adopted for this process. THE DMA and DMH contracts do not include requirements that specific required performance. The GAPS analysis is also not acceptable for

		access to community-based mental health services in accordance with 42 C.F.R. Part 438, but the State remains ultimately responsible for fulfilling its obligations under the Agreement.		identifying gaps for individuals in the TCLI program, especially IPS-SE but other services as well.
25.	III. C. 8.	Each PIHP and/or LME will provide publicity, materials and training about the crisis hotline, services, and the availability of information for individuals with limited English proficiency, to every beneficiary consistent with federal requirements at 42 C.F.R. § 438.10 as well as to all behavioral health providers, including hospitals and community providers, police departments, homeless shelters, and department of corrections facilities. Peer supports, enhanced ACT, including employment support from employment specialists on ACT teams for individuals with SMI, Transition Year Stability Resources, Limited English Proficiency requirements, crisis hotlines and treatment planning will be implemented in coordination with the current PIHP implementation schedule. Finally, each PIHP and/or LME will comply with federal requirements related to accessibility of services provided under the Medicaid State Plan that they are contractually required to provide. *The State will remain accountable for implementing and fulfilling the terms of this Agreement*	C	The LME/MCOs meet this requirement although focus group responses revealed some key stakeholders have little information or knowledge of TCLI.
26.	III. C. 9.	Assertive Community Treatment Team Services: ACT teams will be expanded according to the below timelines, contingent upon timely CMS approval of a State Plan Amendment ("SPA") requiring all ACT teams to comply with a nationally recognized fidelity model (e.g., DACT or TMACT), if one is necessary. By July 1, 2013, all individuals receiving ACT services will receive services from employment specialists on their ACT teams. *The state has selected the TMACT as their fidelity model.*	NC	The State has met its expansion requirements in each year of the Settlement Agreement. However these is not yet evidence that individuals receiving ACT, who are in the TCLI program, are receiving acceptable employment services.
The state met the requirements for the number of persons served by ACT in FY 2013 through FY 2017; each year a new row will be added to report the state's performance in meeting the ACT team requirements.				
27.	III.C.9.c.	By July 1, 2017, the State will increase the # of individuals served by ACT to 43 teams serving 4,307 individuals at any one time, using the TMACT model.	C	72 teams are operating at fidelity to TMACT. (2 scores were not finalized before this report was finalized but appear to be easily meeting requirements)..
28.	III.C.10.a.	Crisis Services: The State shall require that each PIHP and/or LME develops a crisis service system that includes crisis services sufficient to offer timely and	C	Each LME/MCO is developing a crisis system.

		accessible services and supports to individuals with SMI experiencing a behavioral health crisis. The services will include mobile crisis teams, walk-in crisis clinics, community hospital beds, and 24-hour-per-day/7-days per week.		
29.	III. C. 10.b.	The State will monitor crisis services and identify service gaps. The State will develop and implement effective measures to address any gaps or weaknesses identified.	NC	The State has not yet developed effective measures to address gaps and weaknesses of crisis services, specifically mobile services.
30.	III.C.10.c.	Crisis services shall be provided in the least restrictive setting (including at the individual's residence whenever practicable), consistent with an already developed individual community-based crisis plan or in a manner that develops such a plan as a result of a crisis situation, and in a manner that prevents unnecessary hospitalization, incarceration or institutionalization.	NC	Crisis services expansion has been directed more toward facility based services than mobile crisis. TSM staff who see individuals most often in their home are not permitted to intervene or have been trained in crisis intervention. Crisis plans, which often are focused on preventing crisis or interventions in the least restrictive setting are not used.
	III. D.	**SUPPORTED EMPLOYMENT**		
31.	III.D.1.	The State will develop and implement measures to provide Supported Employment Services to individuals with SMI, who are in or at risk of entry to an adult care home, that meet their individualized needs. Supported Employment Services are defined as services that will assist individuals in preparing for, identifying, and maintaining integrated, paid, competitive employment. Services offered may include job coaching, transportation, assistive technology assistance, specialized job training, and individually- tailored supervision.	NC	The State is making significant progress to build an adequate IPS-SE network but measures to effectively provide these services to individuals exiting ACHs and SPHs have not been developed. The IPS-SE services are now available in 86 of the State's counties all the major metropolitan areas of the State. Only 25 counties have more than one provider. Reimbursement policies are not yet sufficient for IPS-SE teams to meet requirements and serve an adequate number of individuals. Many team caseloads are not at capacity. LME/MCOs need to provide more support to providers and fill gaps in their IPS-SE network.
32.	III.D.2.	Supported Employment Services will be provided with fidelity to an evidence- based supported employment model for supporting people in their pursuit and maintenance of integrated, paid, competitive work opportunities. Supported Employment Services will be assessed by an established fidelity scale such as the scale included in the Substance Abuse and Mental Health Services Administration supported employment toolkit.	C	The State has employed a strong IPS-SE fidelity review system and is building capacity to complete these reviews on a timely basis. The State increased its technical assistance capacity in FY 2017 to improve and expand services with fidelity to IPS-SE.
33.	III.D.3.	By July 1, 2017 , the State will provide Supported Employment Services to a total of 1,624 individuals with SMI who are in or at risk of entry into ACHs that meet their individual needs;	NC	The State fell short of this requirements with 1,199 individual in the in or at risk population receiving services, an increase of 39% in FY 2017

III. E.		**DISCHARGE AND TRANSITION PROCESS**		
34.	III.E.1	The State will implement procedures for ensuring that individuals with SMI in, or later admitted to, an adult care home or State psychiatric hospital will be accurately and fully informed about all community-based options, including the option of transitioning to supported housing, its benefits, the array of services and supports available to those in supported housing, and the rental subsidy and other assistance they will receive while in supported housing.	NC	The procedures for ensuring individuals will be accurately and fully informed of community options in accordance with this requirement are in place. However, some individuals who qualify for TCLI housing and services cannot be found after they move (problem with Pre-admission screening and diversion). In-reach staff are not always aware of all the array of services and supports.
35.	III.E.2.	In-Reach: The State will provide or arrange for frequent education efforts targeted to individuals in adult care homes and State psychiatric hospitals. The State will initially target in-reach to adult care homes that are determined to be IMDs. The State may temporarily suspend in-reach efforts during any time period when the interest list for Housing Slots exceeds twice the number of Housing Slots required to be filled in the current and subsequent fiscal year. The in-reach will include providing information about the benefits of supported housing; facilitating visits in such settings; and offering opportunities to meet with other individuals with disabilities who are living, working and receiving services in integrated settings, with their families, and with community providers. The in-reach will be provided by individuals who are knowledgeable about community services and supports, including supported housing, and will not be provided by operators of adult care homes. The State will provide in-reach to adult care home residents on a regular basis, but not less than quarterly.	NC	Funding for In Reach doubled in FY 2016 enabling LME/MCOs to make more frequent contacts a necessary. Staff are not always knowledgeable about community supports and in many situations have not built trusting relationships with individuals. In reach staff do not facilitate visits or offer opportunities for individuals to meet with other individuals with disabilities who are living, working and receiving services in integrated settings, with their families, and with community providers.
36.	III.E.3.	The State will provide each individual with SMI in, or later admitted to, an adult care home, or State psychiatric hospital operated by the Department of Health and Human Services, with effective discharge planning and a written discharge plan. The goal of discharge planning is to assist the individual in developing a plan to achieve outcomes that promote the individual's growth, well being and independence, based on the individual's strengths, needs, goals and preferences, in the most integrated setting appropriate in all domains of the individual's life (including community living, activities, employment, education, recreation, healthcare and relationships).	NC	For individuals in the TCLI database there are written discharge plans. There are no indications individuals in the Individual Reviews were being discharged to segregated settings who could have been offered and may have chosen a more integrated setting. There were more individuals being discharged to segregated settings (ACHs, group homes, shelters and boarding homes) than TCLI Housing Slots. The SPH discharge planning process does not meet the terms of this requirement.

III.E.4		Discharge planning will be conducted by transition teams that include:		
37.	III.E.4.a.	persons knowledgeable about resources, supports, services and opportunities available in the community, including community mental health service providers;	NC	Transition teams in general have knowledge of formal community resources but either are less aware or do not feel individuals could benefit from IPS, education, social supports or other nontraditional community supports and/or specialty services. Referrals to these services and supports are not routinely included in plans.
38.	III.E.4.b.	professionals with subject matter expertise about accessing needed community mental health care, and for those with complex health care needs, accessing additional needed community health care, therapeutic services and other necessary services and supports to ensure a safe and successful transition to community living;	NC	See reference above
39.	III. E.4.c.	persons who have the linguistic and cultural competence to serve the individual;	C	No issues with linguistic or cultural competence were seen in the Individual reviews.
40.	III. E. 4. d.	Peer specialists when available	NC	Peer specialists, typically as In Reach Specialists are included in discharge planning but not routinely available to individuals after the transition process is completed.
41.	III.E.5	For individuals in State psychiatric facilities, the PIHP and/or LME transition coordinator will work in concert with the facility team. The PIHP and/or LME transition coordinator will serve as the lead contact with the individual leading up to transition from an adult care home or State psychiatric hospital, including during the transition team meetings and while administering the required transition process.	C	The Transition Coordinator fills this role with ACH and SPH discharges. There are few SPH discharges to Supported Housing. The facility team and the LME/MCOs only directly transitioned 26 individuals to Supported Housing in FY 2017.
42.	III.E.6	Individuals shall be given the opportunity to participate as fully as possible in his or her treatment and discharge planning.	C	There was ample evidence individuals are being given the opportunity to participate as fully as possible in treatment and discharge planning..
III. E.7		Discharge planning:		
43.	III.E.7.a.	begins at admission	NC	SPH discharge planning does not begin at admission and does not always begin at admission for individuals admitted to ACHs
44.	III.E.7.b.	is based on the principle that with sufficient services and supports, people with SMI or SPMI can live in an integrated community setting;	NC	Not all staff, particularly SPH staff and Guardians ascribe to this principle so in theory this is State position, in practice it is still not reality.
45.	III.E.7.c.	assists the individual in developing an effective written plan to enable the individual to live independently in an integrated community setting;	NC	Improvements should be made in developing written plans that are going to be effective for individuals to live independently in an integrated setting, with less extraneous, often repetitive detail and less time consuming; writing about being strengths based is not the same as being strengths based.
46.	III.E.7.d.	is developed and implemented through an effective written plan to enable the individual has a primary role and is based on the principle of self-determination.	NC	This is the State's policy but requires further attention to be consistently practiced.

47.	III.E.8	The discharge planning process will result in a written discharge plan that:	NC	See E.7.c. comments above.
48.	III.E.8.a.	identifies the individual's strengths, preferences, needs, and desired outcomes;	NC	See E.7.c. comments above.
49.	III.E.8.b.	identifies the specific supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes, regardless of whether those services and supports are currently available;	NC	See E.7.c. comments above.
50.	III.E.8.c.	includes a list of specific providers that can provide the identified supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes;	NC	Specific lists are still quite limited because of availability and adequacy of provider networks.
51.	III.E.8.d.	documents any barriers preventing the individual from transitioning to a more integrated setting and sets forth a plan for addressing those barriers;	NC	Barriers are often documented but plans are sometimes limited; there are many exceptions where staff have worked with individuals to eliminate barriers and develop very creative plans.
52.	III.E.8.d.(i)	Such barriers shall not include the individual's disability or the severity of the disability.	NC	This view continues to still persist with insufficient attention to developing plans that can overcome these barriers.
53.	III.E.8.d.(ii.)	For individuals with a history of re-admission or crises, the factors that led to re-admission or crises shall be identified and addressed	NC	Staff were able to articulate triggers although not always successfully addressed
54.	III.E.8.e.	sets forth the date that transition can occur, as well as the timeframes for completion of all needed steps to effect the transition; and	NC	Many performance issues and obstacles still exist creating delays in transition and discharge planning; The State is not meeting the SA requirement for timeliness of transitions. In part this is attributable to lack of timely actions
55.	III.E.8.f.	prompts the development and implementation of needed actions to occur before, during, and after transition.	NC	Same issue as III.E.8.[f}, transitions are still slowed by actions not being taken in a timely or satisfactory manner.
56.	III.E.9	The North Carolina Department of Health and Human Services ("DHHS") will create a transition team at the State level to assist local transition teams in addressing and overcoming identified barriers preventing individuals from transitioning to an integrated setting. The members of the DHHS transition team will include individuals with experience and expertise in how to successfully resolve problems that arise during discharge planning and implementation of discharge plans.	NC	Transition teams are operational but have not been effective in addressing timeliness issues.
57.	III.E.10.	The DHHS transition team will ensure that transition teams (both State hospital facility staff and leadership and PIHP and/or LME Transition Coordinators) are adequately trained. It will oversee the transition teams to ensure that they effectively inform individuals of community opportunities. The training will include training on person-	NC	Training has been occurring on a regular basis. The quality of the training is rated as high but needs to be continued given priority given the enormity of systems and practice issues. State staff assist local transition teams on an ongoing basis although State level barriers still exist and the Division of Social Services/ County DSS offices need to be brought into the planning.

		centered planning. The DHHS transition team will assist local transition teams in addressing identified barriers to discharge for individuals whose teams recommend that an individual remain in a State hospital or adult care home, or recommend discharge to a less integrated setting (e.g., congregate care setting, family care home, group home, or nursing facility). The DHHS transition team will also assist local transition teams in addressing identified barriers to discharge for individuals whose teams cannot agree on a plan, are having difficulty implementing a plan, or need assistance in developing a plan to meet an individual's needs.		
58.	III.E.11	If the individual chooses to remain in an adult care home or SPH, the transition team shall identify barriers to placement in a more integrated setting, describe steps to address the barriers and attempt to address the barriers (including housing). The State shall document the steps taken to ensure that the decision is an informed one and will regularly educate the individual about the various community options open to the individual, utilizing methods and timetables described in Section III(E)(2).	NC	Transition teams are documenting barriers and steps being taken to address barriers but the extent to which barriers can be eliminated and timeliness of removing barriers is an ongoing issue.
59.	III.E.12	The State will re-assess individuals with SPMI who remain in adult care homes or State psychiatric hospitals for discharge to an integrated community setting on a quarterly basis, or more frequently upon request; the State will update the written discharge plans as needed based on new information and/or developments	NC	Challenges with meeting this requirement are documented in this report. It will likely be some time before In Reach capacity and effectiveness can be achieved.
III.E.13		Implementation of the In-Reach, Discharge and Transition Process		
60.	III. E. 13.a.	Within 90 days of signing this Agreement, the State will work with PIHP and/or LMEs to develop requirements and materials for in-reach and transition coordinators and teams.	C	The requirements of this provision and the next two provisions are not being met although there are challenges with timeliness and assignments. Transition teams are doing a good job of maintaining contact once the transition process is initiated.
61.	III.E.13.b.	Within 180 days after the Agreement is signed, PIHP and/or LMEs will begin to conduct ongoing in-reach to residents in adult care homes and State psychiatric hospitals, and residents will be assigned to a transition team, consistent with Section III(E)(2).	C	See above
62.	III.E.13.c.	Transition and discharge planning for an individual will be completed within 90 days of assignment to a transition team. Discharge of assignment to a transition team provided that a Housing Slot, as described in Sections II(A) and III(B), is	NC	Transition planning is completed on average within 156 days rather than the 90 day from assignment criteria. There are multiple reasons for this requirement not being met including but limited to housing access and lack of available housing, County of Origin issues and other

		then available. If a Housing Slot is not available within 90 days of assignment to the transition team, the transition team will maintain contact and work with the individual on an ongoing basis until the individual transitions to community-based housing as described in Section III(B)(7).		eligibility delays, The State and LME/MCOs are demonstrating progress in making more timely transitions.
III.E.13.d.		The State will undertake the following procedures with respect to individuals with SMI in an adult care home that has received a notice that it is at risk of a determination that it is an IMD, in addition to any other applicable requirements under this Agreement:		
63.	III.E.3.d. (i.)	Within one business day after any adult care home is notified by the State that it is at risk of being determined to be an IMD, the State will also notify the Independent Reviewer, DRNC, and the applicable LME or PIHP and county Departments of Social Services of the at-risk determination.	NR	No homes were identified in FY 2017.
64.	III.E.3.d .(ii.)	The LME and/or PIHP will connect individuals with SMI who wish to transition from the at-risk adult care home to another appropriate living situation. The LME and/or PIHP will also link individuals with SMI to appropriate mental health services. For individuals with SMI who are enrolled in a PIHP, the PIHP will implement care coordination activities to address the needs of individuals who wish to transition from the at-risk adult care home to another appropriate living situation.	NR	See above.
65.	III.E.13.d. (iii.)	The State will use best efforts to track the location of individuals who move out of an adult care home on or after the date of the at- risk notice. If the adult care home initiates a discharge and the destination is unknown or inappropriate as set forth in N.C. Session Law 2011-272, a discharge team will be convened.	NR	See above
66.	III.E.13.d.(iv.)	Upon implementation of this Agreement, any individual identified by the efforts described in Section III(E)(13)(d)(iii) who has moved from an adult care home determined to be at risk of an IMD determination shall be offered in-reach, person-centered planning, discharge and transition planning, community-based services, and housing in accordance with this Agreement. Such individuals shall be considered part of the priority group established by Section III(B)(2)(a).	NR	See above
67.	III.E.14.	The State and/or the LME and/or the PIHP shall monitor adult care homes for compliance with the Adult Care Home Residents' Bill of Rights requirements contained in Chapter 131D of the North Carolina General Statutes and 42 C.F.R. § 438.100, including the right to be treated		

		with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy; to associate and communicate privately and without restriction with people and groups of his or her own choice; to be encouraged to exercise his or her rights as a resident and a citizen; to be permitted to make complaints and suggestions without fear of coercion or retaliation; to maximum flexibility to exercise choices; to receive information on available treatment options and alternatives; and to participate in decisions regarding his or her health care. In accordance with 42 C.F.R. § 438.100, the State will ensure that each individual is free to exercise his or her rights, and that the exercise of rights does not adversely affect the way the PIHP, LME, providers, or State agencies treat the enrollee.	NC	The State's is reported to not be as responsive to LME/MCO complaints as earlier reported. This can be remedied with a timely feedback loop to LME/MCOs on complaints.
III. F.		**PRE-ADMISSION SCREENING AND DIVERSION**		
68.	III.F.1	Beginning January 1, 2013, the State will refine and implement tools and training to ensure that when any individual is being considered for admission to an adult care home, the State shall arrange for a determination, by an independent screener, of whether the individual has SMI. The State shall connect any individual with SMI to the appropriate PIHP and/or LME for a prompt determination of eligibility for mental health services.	NC	The State acknowledges the current PASSR arrangements are not effective. The State is on schedule to re-vamp these processes to bring the State into compliance in either late FY 2018 or FY 2019. Changes require rule changes, extensive re-design, orientation and training, changes LME/MCO contract responsibilities and independent screener arrangements. These functions align closely with other MCO Care Coordination responsibilities.
69.	III.F.2	Once an individual is determined to be eligible for mental health services, the State and/or the PIHP and/or LME will work with the individual to develop and implement a community integration plan. The individual shall be given the opportunity to participate as fully as possible in this process. The development and implementation of the community integration plan shall be consistent with the discharge planning provisions in Section III(E) of this Agreement.	NC	Once an individual is determined eligible and the LME/MCO can locate the individual they begin In Reach and often Transition Planning. Community integration planning is not initiated as required in the SA § III(E). According to State and LME/MCO staff, the existing process continues to improve but there are frequent questions regarding the service eligibility determination accuracy or appropriateness. Individual reviews revealed inconsistencies.
70.	III.F.3	If the individual, after being fully informed of the available alternatives to entry into an adult care home, chooses to transition into an adult care home, the State will document the steps taken to show that the decision is an informed one. The State will set forth and implement individualized strategies to address concerns to objections to placement in integrated settings and shall offer in-reach, person centered planning, and other services in accordance with this agreement.	NC	Individuals are not being fully informed of alternatives. In-reach, person centered planning and other services are being offered.

III. G.		QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT		
71.	III.G.1.	The State will develop and implement a quality assurance and performance improvement monitoring system to ensure that community-based placements and services are developed in accordance with this Agreement, and that the individuals who receive services or Housing Slots pursuant to this Agreement are provided with the services and supports they need for their health, safety, and welfare. The goal of the State's system will be that all mental health and other services and supports funded by the State are of good quality and are sufficient to help individuals achieve increased independence, gain greater integration into the community, obtain and maintain stable housing, avoid harm, and decrease the incidence of hospital contacts and institutionalization.	NC	The State has not contractually delegated an acceptable number of SA requirements to LME/MCOs necessary to "ensure" that community based services are developed in accordance with this Agreement and that are of good quality and sufficient for individuals to meet goals set forth in this requirement; the State is collecting some data (outside contracts) to establish a quality assurance and performance system as required in III.G.1. The system does not yet include measures of effectiveness at a level required in the SA.
72.	III.G.2.	A Transition Oversight Committee will be created at DHHS to monitor monthly progress of implementation of this Agreement, and will be chaired by the DHHS Designee The DMA, DMHDDSA, DSOHCF, State Hospital Team Lead, State Hospital CEOs, Money Follows the Person Program, and PIHPs and/or LMEs will be responsible for reporting on the progress being made. PIHPs and/or LMEs will be responsible for reporting on discharge-related measures, including, but not limited to: housing vacancies; discharge planning and transition process; referral process and subsequent admissions; time between application for services to discharge destination; and actual admission date to community-based settings.	NC	The staff listed on this page meet in various configurations but not as a Transition Oversight Committee. Meeting minutes and/or documentation has not been provided for attestation this requirement is being met nor is clear all the required individuals participate in a Transition Oversight Committee. LME/MCOs are reporting on some but not all of the required items listed as part of this requirement.
III.G.3.		DHHS agrees to take the following steps related to Quality Assurance and Performance Improvement:		
73.	III.G.3.a.	Develop and phase in protocols, data collection instruments and database enhancements for on-going monitoring and evaluation;	NC	The State is taking steps to develop and phase in protocols, instruments and enhancements for on-going monitoring and evaluation; however additional steps are necessary for monitoring to consistently be effective. Monthly reports generate 60% of required information. Per the narrative reference regarding this requirement, it is recommended the State identify items to be reported monthly, quarterly and annually.
74.	III.G.3.b.	Develop and implement uniform application for institutional census tracking;	C	The ACH tracking system is in place. The SPH tracking is in for individuals who get PASSRs; ACH tracking is not always accurate but as a result of problems with the application.
75.	III.G.3.c.	Develop and implement standard report to monitor institutional patients length of stay, readmissions and community tenure;	NC	The State contracts include requirements are reporting hospitalization per 1000 Medicaid members or Uninsured Persons, 30-day Readmission Rate, ALOS, but not TCLI specific

				data in these categories. SH tenure reported but not community tenure.
76.	III.G.3.d.	Develop and implement dashboard for daily decision support;	C	The State has generated a new dashboard, reporting on LME/MCO performance in housing (4 items), supported employment (2 items), in-reach (2 items), transition (4 items), quality of life (1 item). The dashboard indicators track reasonably well with SA requirements but will need to be changed or broadened to capture information that is found to be more fully driving compliance.
77.	III.G.3.e.	Develop and implement centralized housing data system to inform discharge planning;	NC	A housing data system is functional but does not have functionality to inform discharge planning.
78.	III.G.3.f.	Develop and utilize template for published, annual progress reports.	C	The State has developed requirements and a template for a comprehensive annual progress report. The State has provided accomplishment documents they are not fully tied to performance. in all the key the Settlement provisions
79.	III.G.3.g	Develop and utilize monitoring and evaluation protocols and data collection regarding personal outcomes measures, which include the following:	NC	Steps are being taken to develop and expand data monitoring capacity in some of the categories; where outcomes have not been reported the item is marked as not yet in compliance
80.	III.G.3.g. (i.)	number of incidents of harm	C	Incidents of harm are reported for review
81.	III.G.3.g. (ii.)	number of repeat admissions to State hospitals, adult care homes, or inpatient psychiatric facility	NC	The Reviewer has been provided information provided by the Office of State Healthcare Operations on admissions but not patterns of re-admissions and cross tabulations of admission and re-admission patterns.
82.	III.G.3.g. (iii.)	use of crisis beds and community hospital admissions	NC	Data on of use on crisis beds and community hospital days are reported but patterns of use and re-admissions are not reported.
83.	III.G.3.g. (iv.)	repeat emergency room visits	NC	This information has not been reported
84.	III.G.3.g. (v.)	time spent in congregate day programming	NC	This information has not been reported
85.	III.G.3.g. (vi.)	number of people employed, attending school, or engaged in community life; and	C	This information has been reported
86.	III. G.3.g .(vii.)	maintenance of a chosen living arrangement.	NC	The State reports tenure in housing slots but not maintenance of other living arrangements

87.	III.G.4.	Quality Assurance System: The State will regularly collect, aggregate and analyze in-reach and person-centered discharge and community placement data, including information related to both successful and unsuccessful placements, as well as the problems or barriers to placing and/or keeping individuals in the most integrated setting. The State will review this information on a semi-annual basis and develop and implement measures to overcome the problems and barriers identified.	NC	The State has taken steps to implement a comprehensive system, their lack of LME/MCO and other contracts obligations notwithstanding. Improvements have been made in collecting and reporting data, Trainings on how to use the TCLI database have been held. Notices on overdue reports are now made in a more systematic fashion. Adding the dashboard has increased awareness and interest in collecting and responding to reporting requirements. With the infrastructure in place, the State and LME/MCOs have the tools available to focus on identifying and reducing or eliminating barriers.
88.	III.G.5.	Quality of Life Surveys: The State will implement three quality of life surveys to be completed by individuals with SMI who are transitioning out of an adult care home or State psychiatric hospital. The surveys will be implemented (1) prior to transitioning out of the facility; (2) eleven months after transitioning out of the facility; and (3) twenty-four months after transitioning out of the facility. Participation in the survey is completely voluntary and does not impact the participant's ability to transition.	NC	The Reviewer has not received copies of Quality of Life surveys for review. However the Dashboard reflects slight improvement in submission of QOL measure submitted in a timely fashion on a monthly basis. Only 58% of surveys submitted on time; this does not meet reasonable standard test for compliance.
89.	III.G.6.	External Quality Review ("EQR") Program: As part of the quality assurance system, the State shall complete an annual PIHP and/or LME EQR process by which an EQR Organization, through a specific agreement with the State, will review PIHP and/or LME policies and processes for the State's mental health service system. EQR will include extensive review of PIHP and/or LME documentation and interviews with PIHP and/or LME staff. Interviews with stakeholders and confirmation of data will also be initiated. The reviews will focus on monitoring services, reviewing grievances and appeals received, reviewing medical charts as needed, and any individual provider follow up. EQR will provide monitoring information related to:	C	The EQRs are scheduled and conducted on time. TCLI requirements have been added and findings have been reported. However due to scheduling difficulties, a full analysis of IIIG(6)[a-i] was not completed. These are referenced as NR, not reviewed.
90.	III.G.6.a.	Marketing	NR	See above
91.	III.G.6.b.	Program integrity	NR	See above
92.	III.G.6.c.	Information to beneficiaries	NR	See above
93.	III.G.6.d.	Grievances	NR	See above
94.	III.G.6.e.	Timely access to services	NR	See above
95.	III.G.6.f.	Primary care provider/specialist capacity	NR	See above
96.	III.G.6.g.	Coordination/continuity of care	NR	See above
97.	III.G.6.h.	Coverage/authorization	NR	See above
98.	III.G.6.i.	Provider selection	NR	See above

99.	III.G.6.j.	Quality of care	NR	See above
100.	III.G.7.	Use of Data: Each year the State will aggregate and analyze the data collected by the State, PIHPs and/or LMEs, and the EQR Organization on the outcomes of this Agreement. If data collected shows that the Agreement's intended outcomes of increased integration, stable integrated housing, and decreased hospitalization and institutionalization are not occurring, the State will evaluate why the goals are not being met and assess whether action is needed to better meet these goals.	NC	The State has not provided this information.
	III.G.8.	Reporting		
102.	III.G.8.a.	The State will publish, on the DHHS website, an annual report identifying the number of people served in each type of setting and service described in this Agreement.	C	The FY 2016 Annual Report is being finalized and will be published on the DHHS website. The FY 2015-2016 Annual report was published in August 2016.
103.	III.G.8.b.	In the annual report, the State will detail the quality of services and supports provided by the State and its community providers using data collected through the quality assurance and performance improvement system, the contracting process, the EQRs, and the outcome data described above.	NC	The report does not yet include details required for this provision. However the Annual Report is useful and the State is improving its attention to analytical data and use of data.