REPORT OF THE INDEPENDENT REVIEWER

In The Matter Of

UNITED STATES OF AMERICA v. THE STATE OF NORTH CAROLINA

Case 5:12-cv-00557-F

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Table of Contents

INTRODUCTORY COMMENTS

This is the third Annual Report issued on the status of compliance with the provisions of the Settlement Agreement (SA) in United States v. North Carolina (Case 5:12-cv-000557-F) signed on August 23, 2012. The Report documents and discusses the State's efforts to meet obligations required by July 1, 2016.

The State has agreed to develop and implement effective measures to prevent inappropriate institutionalization and to provide adequate and appropriate public services and supports identified through person centered planning in the most integrated setting appropriate to meet the needs of individuals with Serious Mental Illness (SMI) and Serious and Persistent Mental Illness (SPMI), who are in or at risk of entry to an Adult Care Home (ACH) or State Psychiatric hospital (SPH).

The State is making somewhat uneven progress to reach compliance targets as reflected in this Report. This unevenness is largely because the fundamental shift to what services, supports and housing are available for individuals with SMI and SPMI as defined in the Settlement Agreement[1] is still underway. A shift from a system with services provided within institutional structures to a system where community living takes time and rarely happens without groundwork being laid. A services system cannot yield desired outcomes without a robust set of structural pre-conditions in place. Laying a groundwork requires a clear vision, sustained leadership and consensus on making this shift. It requires an array of services and housing appropriate to individual need and choice be funded and made available. It requires a sustained commitment to planning, policy and practices consistent with the principles and operations of an integrated community-based system of supports.

Services researchers have long concluded that simple implementation efforts for new services for individuals with serious mental illness are often wasteful and "fruitless" and quality improvement approaches are only moderately successful. Often when new services are made available, the availability is to conventional treatment models already shown to not be consistently effective for assisting individuals with disabling conditions to live successful lives in the community. Individuals often return to and cycle through or remain in institutions, become homeless, are exploited and/or incarcerated.

[1] Individuals with Serious Mental illness (SMI) and Serious and Persistent Mental Illness (SPMI) are defined in the SA. The SA also defines five categories of Priority Populations, individuals who have priority for receipt of Housing Slots. In **Section III. C(1) and C(2)**, the SA further defines individuals by funding eligibility and service category who shall have access to services and Supported Employment. The references to the "target population" are to individuals with a SMI and SPMI as defined in the SA.

Drake, Bond and Essock conclude a "complex reengineering of systems"[2] is needed. This level of change is necessary for States regardless of the terms of any Settlement Agreement or even if they have not entered into one. Meeting the pre-requisites for having a strong service delivery system where the core interests of individuals in the target population can be met. Meeting the pre-requisites for these compliance requirements and building an effective mental health system for individuals with serious mental illness are effectively the same. Once this is achieved, the daily instrumental activities necessary for individuals to get timely access to services and housing and live a more integrated life in the community can occur more systematically.

The FY 2015 Report to the need for the state to continue a strong emphasis on building a strong foundation, making effective implementation and funding decisions, streamlining decision making processes and further developing strategies required for sustainability. This remains the case today. Though progress is uneven, the state made major strides in FY 2016 in three areas: (1) building capacity, raising rates and more clearly defining Supported Employment; (2) expanding LME/MCO based In-Reach and Transitions staff capacity; and (3) making changes and improving Tenancy Support services arrangements.

State leaders will need to make a substantial commitment of leadership, energy and resources. Rick Brajer was appointed Secretary of the Department of Health and Human Services (DHHS) in August 2015 and immediately turned attention to Settlement Agreement issues. He also began demonstrating a strong commitment to meeting the Settlement terms in a manner that strengthens the public health and human services system and assures the target populations in this matter will be fully served in the most integrated setting possible.

Senior DHHS staff including Jessica Keith, Special Advisor to the Secretary on the Americans' with Disabilities Act (ADA) and lead staff for the Transitions to Community Living Initiative (TCLI), the initiative tasked with implementing the Agreement, her team, Marvin Sanders and Drew Kristel, and Lisa Corbett, Assistant General Counsel were proactive and responsive. All DHHS Divisions and the North Carolina Housing Finance Agency (HFA) have been responsive and special thanks go to Stacy Smith and her team in the Division of Mental Health, Developmental Disabilities and Substance Services (DMHDDSAS) and Alice Farrar in the Division of Vocational Rehabilitation (DVR) for their work on Supported Employment changes.

[2] Bond, GR., Drake, RE and Essock, SE. Implementing Evidence-Based Practices for People with Schizophrenia. *Schizophrenia Bulletin,* 2009; 35, no. 4, 704-713.

The DHHS staff was quick and responsive in assisting the Independent Reviewer with her requests for information and her questions about compliance efforts. The LME/MCOs paid close attention to their obligations to meeting threshold requirements contained in the Settlement Agreement. The LME/MCO CEOs and their senior teams have made themselves available to discuss challenges and opportunities. Their TCLI staff and others have worked diligently to assist the Independent Reviewer with her reviews, requests for information and her questions about compliance efforts. The Division of State Healthcare Facilities operations staff made arrangements for hospital visits and interviews.

The University of North Carolina (UNC) Center for Excellence and Assertive Community Treatment (ACT) and Individual Placement and Support-Supported Employment (IPS-SE) teams have been very helpful making it possible for the Reviewer to observe Fidelity reviews and providing information to the Reviewer and Katherine Burson, the IPS-SE expert. The Disability Rights North Carolina and NC Justice Center have taken a special interest in and been very helpful in the State's housing contractors meet Fair Housing requirements

METHODOLOGY

The methodology for compiling this report is essentially the same as last year's with several noteworthy additions. For each compliance requirement, the state was asked to provide data and documentation of its work. The Department's progress in meeting the provisions of the Settlement Agreement was reviewed in work sessions and Parties' meetings, in discussions with providers and community stakeholders and through site visits to LME/MCOs, ACHs, supported apartments and individuals' residences, provider offices and state psychiatric hospitals. Information contained in this report covers the State Fiscal Year (SFY) 2016 ending on June 30, 2016. The State has continued to provide information since this date, including publishing its 2016 Annual TCLI Report after the time period covered by this Report.

Three experts have been retained by the Independent Reviewer. Elizabeth Jones, a previous hospital and community services director and national expert on institutional reform and development of alternative community-based programs conducts individual compliance reviews. In 2015 and 2016 she conducted reviews in four catchment areas. Katherine Burson, the Statewide Rehabilitation Services Director for the Illinois Department of Human Services, Division of Mental Health and national expert on IPS-SE services requirements, reviewed compliance of Supported Employment requirements in 2015 and again in 2016. Colette Croze, a national expert on CMS requirements, Medicaid managed care options and

compliance, behavioral health systems development including developing best practice services, and quality and performance improvement conducted a review of State-LME/MCO contracts and performance requirements in 2016.

Meetings were held with LME/MCO executive staff in seven catchment areas. Meetings were held with key staff of the Central Regional and Cherry Hospitals[3] during site visits to the hospitals. Meetings were also held with key statewide stakeholder groups and coalitions, including but not limited to the Disability Rights North Carolina, the National Alliance on Mental Illness (NAMI), The NC Council of Community Programs, the Justice Center, the NC Coalition to End Homelessness, the UNC Center for Excellence in Community Mental Health and the UNC ACT Technical Assistance Center.

Frequent meetings were held with DHHS staff including monthly "work days" with TCLI leadership and representatives from a number of Divisions, including Mental Health, Developmental Disabilities and Substance Abuse, Vocational Rehabilitation, Medical Assistance, Aging and Adult Services and State Operated Healthcare Facilities. The Reviewer observed one IPS SE Fidelity Review and one Assertive Community Treatment Fidelity Review.

A number of reviews and documents including Monthly and Annual TCLI Reports, the former Reviewers Reports, Fidelity Review summaries and contract documents, manuals and review documents covering the pertinent areas of compliance inquiries were reviewed. Upon request, the TCLI staff provided additional data for review, some of which is covered in this Report.

Individual recipient reviews (individual reviews) were conducted in the five remaining LME/MCO catchment areas that weren't reviewed in FY15. Three review methods were used: (1) a review of individual recipient records including a review of Person Centered Plans and In-Reach and Transition documents; (2) individual interviews with individual recipients using a short tool to summarize impressions and collect data consistently and (3) interviews and meetings with LME/MCO staff, service providers, family members, Adult Care Home (ACH) and State Psychiatric Hospital (SPH) staff. In a limited number of situations a phone interview and Skpe interview were conducted rather than in person interview.

A proportional random sampling method was used to ensure the review reflects the

[3] A meeting was held with senior Broughton Psychiatric Hospital earlier in 2015.

target population accurately across three LME/MCO catchment areas. Names were drawn across randomly selected LME/MCO areas[4] that cover 49% of the state's population: the Alliance Behavioral Health Care (Alliance), Eastpointe, Partners Behavioral Health Management (Partners), Sandhills Center for Mental Health & Developmental Disabilities (Sandhills) and Smoky Mountain LME/MCO (Smoky) catchment areas. The sample was also stratified to assure at least one individual living in an ACH, one living in their own home (supported housing); one who had moved to their own home but then returned to an ACH and one being served in a state psychiatric hospital were selected in each catchment area.

Six additional types of reviews were conducted in FY 2016. The first was a review of individuals who were screened for admission to Adult Care Homes through the PASSR process. That review was conducted in the Cardinal Healthcare Innovations (Cardinal) and the Alliance catchment areas. The Reviewer submitted a written Report of this review (**Attachment B.)** to the Parties on April 18, 2016. Information from that review is summarized in the Pre-Admission and Screening **(Section III. F.)** section of this Report. Katherine Burson was retained as an IPS-SE Expert in FY 2016 and she submitted two Reports to the Reviewer summarizing her findings and recommendations on IPS-SE which will be referenced in the Supported Employment **(Section 3. D.)** of this Report.

A Point-In-Time survey was conducted by the LME/MCOs over a two-month period ending on June 24, 2016 to provide an accurate snapshot of the number of individuals in active search for housing in each LME/MCO catchment area. This survey was designed by the Reviewer with input from the LME/MCOs and the DHHS and conducted by each LME/MCO.

An analysis of Cardinal in their home closure "HUB"[5] role was conducted in May 2016 in follow-up to the announced closure of Woodhaven II (Enfield, NC). Cardinal was the lead LME/MCO for that closure. This responsibility includes identifying residents and linking residents to services as well as following up with relocated residents. The county based Department of Social Service (DSS) is the local lead agency for emergency closures. A meeting and site visit was held with Sandhills staff on June 17, 2016 following the announcement that Lawson's Adult Enrichment Center in Greensboro was deemed an Institution for Mental Disease (IMD). Likewise, home visits were made on June 16th to five (5) individuals who had gotten into permanent housing after a brief stay in the Cardinal

[4] Individuals selected may not be living in their assigned catchment area at the time their name was drawn but were assigned to the catchment area in the DHHS TCLI data base.

[5] *The DHHS Operational Guide for a Coordinated Response to the Sudden Closure of an Adult Residential Facility*.

"Targeted Unit Transitions Pilot"[6].

In addition to the aforementioned reviews, a series of structured interviews were held between DVR, LME/MCO staff, IPS-SE providers and DHHS staff and Katherine Burson, the Reviewer's IPS-SE Expert and Jennifer Ho, Special Advisor to the Secretary of the US Department of Housing and Urban Development who provided technical assistance and feedback on housing related issues. Four focus groups were held with providers in three different catchment areas. Colette Croze discussed her findings on contracts and the SA Performance requirements with DHHS following the completion of her report.

In November 2015, The U.S. Department of Justice (DOJ) issued a letter to the State referencing ongoing noncompliance issues with the SA. In this letter, the DOJ formally requested the State take corrective action to address gaps in community-based services and supports, gaps in providing community-based housing and providing Supported Employment Services. The State provided the DOJ with a Corrective Action Plan in December 2015 and back-up documentation related to their corrective actions in January 2016. Following additional correspondence between the Parties, the State submitted revised Corrective Action Plans to the DOJ on June 3, 2016. The action steps and sufficiency of these Plans to meet Settlement Requirements are referenced only where directly relevant to the findings set forth in this Report.

Compliance Findings

This Report assesses the State's compliance with each of the Settlement's substantive provisions as of June 30, 2016. The narrative portion of this Report addresses specifically the provisions in the order they are listed in the Settlement Agreement: Supported Housing Slots; Community Based Mental Health Services including Access, Person Centered Planning, ACT, Crisis, other services and PIHP responsibilities; Supported Employment (SE); Discharge and Transition Process including In-Reach; Pre-Screening and Diversion; and Quality Assurance and Performance Improvement. Critical issues and threshold items are highlighted. A complete listing of the Settlement's substantive provisions and compliance to

[6] This pilot, which is now being conducted in four catchment areas, was developed to provide short term living arrangements typically in hotels and motels but also in other facilities for individuals exiting or being diverted from ACHs and state psychiatric hospitals. The rationale for the pilot is that often individuals are in need of a short term living arrangement while they are being approved for the program and/or are searching for supported housing. DHHS funds the arrangement based on one of the LME/MCOs in the pilot making a request. The DHHS and the LME/MCOs are evaluating these arrangements to determine their efficacy in assisting an individual to make a "transition" into supported housing.

each is attached as **Attachment A**. This Report includes a section for broad recommendations although recommendations are also included with each provision. All references to plans, data, meetings and activities refer only to actions taken, plans, meetings or data provided for the fiscal year ending June 30, 2016.

The Settlement is structured in a manner that acknowledges sustainable systems change requires time, attention and deliberative action. The Parties acknowledge implementing and sustaining the structure, systems and services for individuals with serious mental illness will occur in important incremental phases as outlined in the Settlement. The Settlement's last substantive deadline occurs on July 1, 2020.

The Introduction to the **Substantive Provisions (III.)** of the Settlement Agreement states "the State agrees to develop and implement effective measures to prevent inappropriate institutionalization and to provide adequate and appropriate public services and supports identified through person centered planning 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, pursuant to the details and timelines" of the specific provisions of the Settlement Agreement. A partial compliance finding is made when there is evidence the State will likely come into full compliance at a future point. "Low" partial compliance signifies that while progress is being made the State is danger of slipping into non compliance without either immediate and/or more focused attention.

The above paragraph is further instructive for two reasons. One, in some instances the State has met its annual obligations but the measures taken do not appear to be effective as evidenced by other related obligations not being met. Likewise if services and supports are available but are not "adequate and appropriate" or measures are not effective, the State may not be in full compliance with the provision. When a finding in this Report is based on one of these two qualifiers, this will be identified.

Individual Assessments: Information regarding findings of the individuals is referenced throughout the Report in the Sections relevant to the findings. Below is a general description of the sample and specific issues that have broader relevance:

Number of Assessments: In FY 2015, thirty-five (35) individuals were randomly selected and reviewed as part of the Individual Assessment Review. In FY 2016, this number increased by one hundred and five (105) bringing the total number of individuals selected for Individual Reviews to one hundred and forty (140), five other reviews and interviews requested separately. Reviews for twelve (12) individuals were limited either because the

assigned LME/MCO was unable to locate the individual; the individual was being detained or otherwise unable to be interviewed. Where possible, third party reviews were conducted and/or records reviewed so review numbers on some items will not tally 105. The review instrument was changed slightly making some tallies less. Where review data was collected on a smaller sample, it is noted in this Report.

As referenced in **Figure 1.** In FY 2016, sixty (60) or 57% of 105 individuals in the sample were men and 43% were women. The average age of the individuals reviewed was 49.3 however eighty-one percent (81%) were over age forty. Fifty three (53) individuals in the cohort with known ages[7] were age 51 or older; four (4) were over age seventy. Ten (10) were under the age of 30 (3), eighteen (18) between age 31-40, and twenty-two (22) between the age 41-50. Of the information available on 104 individuals, forty-seven (47) were living in their own home with a housing slot; twenty-nine (29) were living in ACHs; nine were hospitalized in a state psychiatric hospital and twenty-nine (29) living in other locations including nine (9) in nursing homes and two (2) in motels.

Figure 1: Demographic, Living Settings, Guardian FY15-FY16 Sample Differences

Categories	FY 2015	FY2016
Average Age	54	49
Female	37%	43%
Male	63%	57%
Living in a SH Unit. with TCLI Housing Slot	37%	45 (43%)
Living in an ACH	28%	29(28%)
Hospitalized in a SPH	11%	9 (9%)
Living in another location	24%	29(27%)
Has a Guardian	70%	37%

An individual from the Alliance catchment area was hospitalized on the deaf unit at Broughton SPH and was interviewed via skpe. One individual who had been homeless when his name was pulled was thought to be missing was found in a motel during the on-site review. One individual had left the program and the Transition Coordinator provided information. Two (2) individuals were hospitalized and their conditions precluded interviews.

Information was provided by Transition Coordinators for both individuals. Ten (10) individuals had mobility issues, most requiring wheelchairs all or part of the time. Analysis indicates sixty percent (60%) of the individuals who had moved to community settings in

[7] There were 103 individuals included in the age cohort.

three of the LME/MCO catchment areas[8] had at least one chronic health condition and of that cohort all but 11% had two or more conditions which is not unusual for individuals in this age cohort with their histories. This has implications for the State meeting Services compliance requirements discussed as part of that Section. Of the information available on 99 individuals, thirty seven or 37.4% had guardians.

Four ACHs visited appeared to be in poor physical condition, with problems in the building structure, maintenance and/or upkeep. Several older single family homes had not been modernized but appeared likely to pass inspection. Visits were not conducted for the purpose of inspecting facilities so the extent of the problems was not assessed. One facility was reported because the air conditioning was running on high in December when it was snowing outside. The two motels were in poor condition and without kitchens or other amenities.

Conversely rental units where individuals were living were mostly in relatively good condition, well maintained and not cluttered to the extent it could create a safety problem. The exceptions, which were few, included a unit where an individual was struggling to retain her unit because of hoarding, a unit where an individual was beginning to hoard and a third was a poorly maintained below ground apartment. This was the third apartment the individual had lived in after being evicted from two apartments since entering the TCLI program. In the first instances staff was working with the individuals and their landlords so the individuals could keep their apartment. Provider performance in helping the individual retain their unit may have been a factor with the third situation. At least two individuals had other individuals living with them, yet neither individual was listed on the lease which is a violation of their lease agreement.

One man was living in his brother's house which was in very bad condition, full of trash and in a very sketchy neighborhood, several individuals were seen in the yard when we arrived and may have been involved in illicit drug activity. They left quickly. This gentleman was living in this house temporarily before moving into his own unit. He had been living on a river bank previously. One gentleman living in a small single family home had been living in a shelter and also an ACH that closed leaving him no place to go. He has a long history of homelessness and medical and psychiatric problems were probably only alive because of the help he was getting in the TCLI program.

One private rental unit was infested with bed bugs, likely brought into the unit by the tenant's mother, who because she was homeless, had come to live with him. The

[8] This information was not collected when the Individual Reviews were first initiated.

LME/MCO, the tenant's provider and Quadel were working closely to get the unit eradicated of bed bugs and work closely with the participant to avoid future issues. One individual is living in a mobile home. He was firm about his choice to live in a mobile home of his choosing. He made his preference for his style of living very clear.

Location remains a concern to a large subset of individuals who feel isolated from friends and family. There was also considerable variation on furnishings and cleanliness; interestingly this variation seemed in part to be related to the interest staff had in helping an individual move in and fix up their apartment. For example a set of units where individuals being served by the same team all seemed to have the same decor, sofas, chairs, etc and the units were sparsely furnished. Conversely other teams went out of their way to help individuals decorate their home, stocking their kitchen, hanging curtains and hanging pictures on the walls. With a few exceptions, women appeared to take more pride and interest in their living space than men.

Sixteen (16) or 30% of the individuals reviewed who were living in supported housing were living in Targeted (LIHTC) units[9]. Most of the units were newer than private units, in excellent condition with new appliances and furnishings and some with a washer and a dryer in the unit. One gentleman living outside a downtown area of the community where he was living, who had been living in an ACH for seventeen years before moving into a targeted unit, had purchased a moped to get around town figuring out that he didn't need a driver's license for a moped. While he was somewhat guarded, he proudly showed us his moped.

The Pre-Screening and Diversion data is included in **Attachment B. Pre-Screening Diversion Brief Report and Point-in-Time** review data is referenced on **pgs. 26-27.**

A draft of this Report was submitted to the Parties for comment on as specified in the Settlement Agreement, **Exhibit A., IV. J.-M**.

COMPLIANCE FINDINGS

I. COMMUNITY-BASED SUPPORTED HOUSING SLOTS

Compliance Summary:

The State is obligated to be in compliance with **III. B. (1-8)** to make available, accessible affordable housing that meet criteria consistent with *Olmstead* requirements for

[9] The State reports the overall percentage of individuals moving into private units versus LIHTC units is 77%.

integration. Meeting requirements for the Supported Housing requirements in the SA remains a challenge for the State. This is both in meeting numerical targets and in developing an "effective measures" to achieve targets. The State has not taken effective measures to assure access and availability or filled the number of housing slots to meet the required July 1, 2016 compliance target of 1,166 filled housing slots. The State is in either partial compliance or compliance with other **3.B** provisions. The State's strengths are meeting SA tenancy requirements, creating a *new* tenancy support service (TSM), and establishing a clear policy on Fair Housing and on executing agreements with LIHTC owners to expand agreements. The impact of the Fair Policy and those agreements will be measured and evaluated in FY 2017. The state has met its funding commitments TCLI program funding requests for housing slots and a Community Living Fund has been established and funding not used for unused housing slots is dispersed into that fund as part of the State's budget request to the General Assembly. One request made by the Governor's Mental Health Task Force that would have added funding for temporary housing arrangements was not funded but it was not part of the previously adopted TCLI budget.

In **Section III. B. (1)** the State must **develop and implement measures to provide individuals with access to community based housing. III. B. (2)(a-e) is the Priority for the receipt of housing slots and III. B. (3)** is the provision for **access to 1,166 Housing Slots by July 1, 2016.** These are reviewed together as the requirements are inter-connected. *Availability* refers to existing safe, decent affordable housing. *Access* refers to the ability of the target population to become eligible and be approved for safe, affordable housing of their choice in a timely manner. Additional requirements are reviewed separately.

Progress is most needed on developing a strategic approach allocating available resources to create housing, capital and rental, making housing available and accessible where needed and improving housing operations that impact the State's effectiveness of measures to provide access to housing.

As evidenced in state Supported housing programs that have or are going to scale, creating Supported housing requires a very organized, efficient plan, agreed upon policies, close working relationships among state and local housing and services organizations and state agencies fulfilling their *Olmstead* responsibilities. Creating and implementing a Plan is essential to the State meeting its housing obligations in this SA.

Availability data will distinguish between occupied (filled) and non-occupied housing (vacant) slots. There is also a difference between units available that likely will be filled

on turnover and units vacant for a longer period of time indicating there may be other problems such as location. Availability is impacted significantly when Priority Populations are being denied housing because of their criminal record, credit or other issues. There is evidence, that regardless of efforts to override objections based on fair housing regulations and statutes or other attempts to secure pledges from owners to give priority to the Priority Populations, the rate of denials has remained the same over time. The review of projected availability and accessibility takes these issues into consideration.

Last year's Report contained an analysis of issues that impact the State's success with filling Housing Slots at the request of the State. The Report contained benchmarks and dimensions that are comparable across states and regions. This year's Report will not contain the detailed description of each of these but will contain specific references to key issues for comparison across the two years as related to this compliance review.

Review of 3.B. (1-3): There are positive but not yet sufficient trends in availability of housing for the State to meet short and long term Supported Housing Slots compliance requirements. There is less of a positive trend line for access with many barriers still in place.

One question raised repeatedly is “what is the availability of safe affordable, accessible, safe rental housing in North Carolina?”. The second question is “can individuals in the Priority Populations access the housing even it were available?” Assessing availability is the first step to determining what steps are needed to create capacity. On November 10, 2015 the HFA submitted a report 'Transitions to Community Living Initiative Twenty-County Housing Stock Gap Analysis".

The HFA concluded "the state should meet its (housing) obligations based purely on stock". The HFA reports these projections can change based on an-ongoing assessment of the feasibility of stock, the ability to compete for and capture it, and the timing when a unit becomes available and when a TCLI participant is transitioning. The HFA offered three strategies for increasing Targeted Unit (LIHTC) stock:

- Recruit up to 10% more units in properties already participating in the Targeting Program in high demand counties.
- Recruit up to 20% of units in properties funded with LIHTC not currently participating in the Targeting Program in high demand counties.
- Recruit of to 20% of units in partially subsidized multifamily housing stock to

participate in the targeting program in high demand counties[10].

On December 3, 2015, the Reviewer wrote a formal response to this report pointing out key issues not addressed in this analysis. These issues included identifying the number of targeted units in LIHTC properties that were vacant and reasons why they were vacant. The reasons ranged from: 1) location generally; 2) location related to renters not having transportation for amenities or medical care; 3) number of units that have been vacant for long periods of time which is typically but not always associated with units not being in locations desirable for renters; 4) number of units in drug hot spots; 5) owners refusal to accept referrals; and 6) number of bedrooms in a unit. The report did not reference to factoring in competition for units in critical high need counties, the variance in turnover of high demand properties and impact of very tight rental markets making it more difficult for individuals in this target population to be approved.

There is a proportional lack of availability of affordable housing units in the state's largest urban counties, especially Wake and Mecklenburg, where there is a tight rental market. The recent Point-in-Time review (discussed below on **pg. 17**) also illustrated that both the Alliance and Cardinal had a higher percentage of individuals who could not find housing because of a criminal record or credit problem, thirty-two (32%) and thirty-three (33%) respectively. This is compared to nineteen percent (19%) of individuals in the statewide Point-in-Time sample who were experiencing difficulties finding housing because of a problem with a criminal record or credit.

LIHTC Targeting, Key and Voluntary Set Aside Programs: The HFA has made changes in the federal Low Income Housing Tax Credit (LIHTC) program. The HFA administers this program in NC and develops an annual policy document, which is reviewed and commented on by multi-family property owners, stakeholders, local government and the DHHS. This document, the Qualified Allocation Plan (QAP) identifies the agencies priorities consistent with federal requirements and includes selection criteria and threshold requirements.

LIHTCs projects are awarded based on proposals that meet these criteria and score consistently well with HFA priorities. Among a range of other QAP priorities, the FY 2016 has proposed FY 2017 QAPs changes that will potentially generate more availability of LIHTC units for the Priority Populations. These include the HFA adding one to three points in their application selection determination for additional one bedroom units and

[10] At the time this report was written, the final FY2016 LIHTC awards had not be announced. These awards and results of adding "voluntary" units will be assessed to determine progress on each of these strategies.

adding one point for projects in the counties with highest demand for TCLI units. The LIHTC program is highly competitive, thus 1 to 3 points could be significant in determining which projects get funded.

The Targeted/Key program created over ten years ago. In May 2016 the State reported there were twenty-seven thousand and fifty-one (27,051) units in projects with executed Targeting Agreements. Of that number, four thousand one hundred and eighty four (4,184) are designated as targeted units[11], with three thousand and eighty five (3,085) required (per commitment from the developer in their LIHTC application) and 1,099 voluntary units per (either executed or pledged) agreement with property owners (see reference to Voluntary units on **pg. 17**). A higher percentage of units are located in low demand counties.

The HFA reports that sixty-three (63%) of LIHTCs units awarded in the last LIHTC round are available in twenty (20) counties identified as the counties where individuals in the TCLI program most want to move. Historically only 50% of the LIHTC units have been in those top twenty (20) counties. The 20 counties represent 76% of the state's population according to the 2014 certified census. These twenty (20) counties are among the top thirty-two (32) counties in the state and tend to be more urban. Every year the more popular counties are growing faster than more rural counties in North Carolina so this disparity will only grow unless further action is taken to increase the availability of housing in the more urban counties where individuals want to live.

The Targeted/Key program has been under utilized for its intended purpose for a number of years. Under staffing, applicant denials and lack of compliance is reported to have created this problem. But with greater visibility of these problems and expanded Regional Housing Coordinator staffing (since July 2015), the Targeted/Key program has seen a twenty six percent (26%) increase statewide going from 1681 units filled to 2121 units filled[12]. This change did not demonstrably impact the Priority Populations' access to units. One hundred and fifty (150) individuals in the Priority Populations applied for a Targeted Unit in FY 2016; this is down from one hundred and eighty three (183) or 19%

[11] units are dispersed throughout the rental property complex and "physical" units are not designated for people with disabilities.

[12] Regional Coordinator data reflects that a number of units not filled by the targeting program population were nineteen hundred and thirty nine (1,939) or 54% of the total available in May 2015 up from nine hundred and thirteen (913) or 38% of the total in December 2015. This percentage grew during the last half of FY 2016 because the HFA entered into "voluntary" agreements with owners to increase the number of units available.

from the previous year. Only forty seven (47) or 31% were successful in securing a Targeted Unit, down sixty-three (63) or 36% from FY 2015. This occurred in a year when three hundred and eighty three (383) individuals moved to units with a housing slot up from or 265 the previous year. This 31% increase signals the LME/MCOs, with support from Regional Housing Coordinators and Socialserve, were able to access private units more easily than Targeted units. This issue will be further discussed in the accessibility section below.

The LME/MCOs report individuals applied to an average of 1.61 LIHTC properties, the same as reported in FY 2015. Additional information reported illustrates the following statewide data:

Figure 2: Individuals Who Applied But Did Not Move Into A LIHTC Property[13]

Category	FY 2015	FY 2016
1. Denials because of a past contact with the criminal justice system	12	14
2. Denials because of credit history	12	13
3. Denials based on both (credit and criminal justice system contact)	4	4
4. Denials for other reasons	5	2
5. # of individuals who stopped their search for other reasons	32	31
6. # of individuals who found other housing	7	9

This data reveals there was essentially no change in application for and access to Targeted units between the two years. Several reports were received anecdotally that many individuals were discouraged or were treated badly by LIHTC property managers and gave up looking at Targeted units.

In May, 2016 the HFA reported recruiting more than 1,100 targeted units[14] by requesting owners move from 10% of targeted units in their properties up to 20% of the units in high demand counties and also be adding new properties not in the Targeted program. This step was focused on LIHTCs with Targeted Units, other properties in the HFA portfolio and other properties outside the portfolio. All but two (2) of the high demand counties were reported have identified properties. Of the properties identified, 70% of the owners approached have signed agreements for this expansion. The HFA did not report how many of these units were actually vacant and meeting the various requirements that would make them desirable for this program.

[13] This is time specific information; individuals may have or could resume their search after LME/MCOs reported this information

[14] also referenced as “voluntary” units

The HFA reports that as units turn over in those properties, there may be access to those units. What isn't known yet is what the actual turnover rate will be, what number of those units would be chosen because of their location, what will be the rate of denials slowing down use of those units and other factors. From the data referenced above regarding referrals to LIHTC units, owner and property manager views on taking TCLI applicants would have to change for even a small percentage of the units that might become available to be accessed by individuals in the TCLI Priority Populations. Nonetheless taking this approach will likely expand availability overtime. This reluctance makes it impossible to accurately estimate the increase in the number of individuals who could access these units in FY 2017 at this time. It is recommended the state regularly analyze the access to these units to assure access issues can be ameliorated quickly if possible.

One of the more encouraging steps toward greater availability has been the recruitment of a new Executive Director at Socialserve, the well respected Call Center/Housing Locator service based in Charlotte. Socialserve and its affiliate organizations provide outreach to landlords, disaster housing interventions, rent reasonableness reviews and housing inventories for various communities with tools to identify livability, GIS mapping, surveys, customized reporting, tenant pre-screening and marketing. Their ability to customize their program and respond to state requests is unique. LME/MCOs were previously critical of Socialserve's responsiveness and based on an analysis of their listings that criticism appeared to have at least some validity. With a change in leadership and clarity by the State on what is needed from the organization, Socialserve can become a more valuable asset to increasing availability and matching individuals to housing.

In the early versions of the proposed State's Supported Housing Corrective Action Plan, the Supported Housing plans were very detailed at the task and sub-task level. They included describing meetings to be held and technical fixes to reporting tools being developed but without clear objectives for increasing availability of housing. The data, which hasn't improved from what was reported in the FY 2015 Report, is clear. There are not enough available affordable units accessible to these Priority Populations in North Carolina for the State to meet its goals. The State has effectively ruled out working with HUD and the PHAs in any formal way leaving the State to scramble for housing on its own.

In April 2015, the reviewer recommended the State develop a strategic action plan for housing, with a focus on analyzing access and availability and proposing steps to address

these and other issues. An outline proposing action items and an approach to such a plan was provided by the Reviewer. In May 2016, the HFA contracted with the Technical Assistance Collaborative (TAC) to conduct an assessment and report on barriers, opportunities and areas for improvement. The request also included TAC recommending an affordable housing action plan and timeline with short and long term action items for access, financing, production, services and rental strategies for the Priority Populations to meet the terms of the Settlement Agreement. A final report is due on October 28, 2016. Part of the scope of work is to conduct a gaps analysis at the LME/MCO level in high demand counties which appears similar to a request made by DHHS for LME/MCOs last fall to develop a housing plan with a gaps analysis.

In the State's Corrective Action Plan submitted on June 3, 2016, the DHHS took the lead developing a much more focused, strategic approach to increasing availability. The DHHS advanced new ideas for strategic investment strategies including targeted capital investments for production, rehabilitation and/or preservation and operating subsidies, and strategies for master leasing. These new proposals correct the earlier attempts made by the State to say there will be sufficient available, accessible housing during this Settlement Agreement period to meet the needs of the Priority Populations. DHHS appears to appreciate the potential for redundancies and the need for less, not more work covering the same topics and territory.

It is still too early to determine with precision to what extent the State's projections in the new, bolder Corrective Plan will enable the State to be closer to achieving the 3,000 slot requirement. It is unlikely, though, the actions will lead to 3,000 units being available and accessible. A preliminary analysis conducted in preparation of this Report[15] indicates the following:

- **500** units made available by end of FY 2020 through expanding the number of the targeted units;

- **300** units placed in service by end of FY 2020 through new investments, master leasing units; and

- 250 units made available annually or **1000** units through end of FY 2020 using current strategies and new LIHTC units placed in service each year based on

[15] These numbers factor in the likely percentage of units in desirable locations, landlords and property managers denying fewer tenants and fewer potential tenants being discouraged and stopping their housing search. It does not factor in turnover.

number of units accessed over the past six months.

It is recommended the State continue to explore opportunities for strategic investments, reduce turnover and improve access in order to increase the availability of housing.

The second issue, access, falls into three broad categories:

- accessibility to units that match the individual's choice based the unit itself such as, getting a first floor unit or a unit that is quiet, one that allows pets or allows smoking (even though smoking never encouraged), one located in a neighborhood with sidewalks for better wheelchair maneuverability, off main roads, accessible for an individual with equipment such as a wheelchair and units and having doorway, bathtub and countertop/sink accessibility features;

- access to desirable locations, including but not limited to places considered safe, being close to amenities, including places of worship, schools, work, family and friends, grocery stores, pharmacy and other retail, medical care (including dialysis centers) and behavioral health services, a library and services and where possible, public transportation as needed; and/or

- lack of access because an individual is being denied a unit is or discouraged and giving up housing search.

Often when an individual is being discharged from a general or state psychiatric hospital and housing is not available in their desirable location or they are concerned about too many rules or responsibilities, they may choose to live in an ACH, a motel or even a homeless shelter.

The length of time required for an individual to access a unit, on average 133 days after housing slot approval, provides some indication about the difficulty not just with availability but with location. TCLI staff report individuals are discouraged from living in drug hot spot areas or request to avoid those neighborhoods. On two occasions individuals were interviewed who were discouraged by Guardians from moving to a community before any discussions could proceed with what arrangements for services could be made to address their concerns. The Guardians did not feel such a move was in the best interest of the individual because they had either failed in their placement before and unable to live more independently.

The second category states the obvious: access to Supported housing is limited by immediate availability, a good match and the Guardian refusing to allow the individual to meet with the LME/MCO to establish a relationship to move forward with Supported housing. When need, especially immediate need, does not match up with availability for individuals being referred through the PASSR process individuals do not have choice of housing. It is important to have a ready pool of units or some temporary housing to make pre-screening and diversion to be effective.

Smoky, Partners, Cardinal and Eastpointe LMEs/MCOs have started "Targeted Unit Transition Pilots" with support from DHHS and the HFA. The pilots are testing out the viability of using temporary housing while individuals search more a permanent place to live. The stays are meant to be short term, up to 60 days with a one month extension if necessary. To provide context, four individuals were interviewed in Charlotte in June, 2016 who had participated in the pilot. Three had been referred to the LME/MCO via a PASSR after becoming homeless and one referred because she was living in a group home that had been infested with bed bugs. All four had payees and ACTT services. They had spent an average of forty nine (49) days in a hotel with the longest being eighty seven days (87) and the shortest fourteen (14) days. Three (3) moved into targeted units and one (1) moved to a private residence. None of the four would have successfully transitioned to supportive housing without this program or a "ready and available" housing unit at the time they were screened through the PASSR process.

The DHHS is interested in expanding this approach and adding a master leasing program to help individuals who can't get leases in their own name to get into supportive housing more quickly. Master leasing is a program where a third party holds a lease for one or more individuals who cannot hold a lease in their own name as a result of prior issues. The third party typically pays the subsidy portion of the lease on the tenant's behalf. The tenant remains obligated to meet tenancy requirements. Cardinal has also solicited the support of experienced homeless outreach staff to assist with housing search. This is positive move and has demonstrated results in communities around the country. The Alliance is pursuing this option although ironically struggling to find an affordable housing organization willing to participate with them.

The third issue is the "denial and discouragement" problem individuals in the Priority Populations face as referenced above with the LIHTC program. This problem is illustrated by the number of individuals who report being discouraged and stop looking **(Figure 2).** It is a constant concern of the TCLI staff across the state as they try to

convince individuals to apply for housing knowing they are facing discrimination and discouragement. It puts a damper on the process and slows down the time from housing slot approval to an individual actually securing housing. The NC Justice Center, Disability Rights North Carolina and others encouraged the HFA to take action with owners The HFA and DHHS have focused attention on assuring LME/MCOs have information on how and when to make Reasonable Accommodation requests. LME/MCOs report this assistance has been helpful.

A recent survey of the use of Reasonable Accommodation for this past fiscal year[16], reveals LME/MCOs and providers have assisted forty-four (44) individuals to make Reasonable Accommodation requests. Twenty (20) of the 44 were accepted, seventeen (17) denied and seven (7) pending at the time of the survey. The requests were made more often by Trillium, Alliance and Cardinal. Given the State's increased focus on furthering fair housing, it is likely requests will increase. The percent of acceptance and denial is consistent with these types of requests nationally.

Priority for Receipt of Housing Slots (Section III B. (2)(a-e) The State's data reveals individuals in in Category 5 of the Priority Population comprise 56% of the Priority Population who have moved into Supported Housing arrangements through June 30, 2016. This is a much higher percentage than the percentage of individuals in each of the other four priority groups[17]as illustrated in **Figure 3**.

Figure 3:
Totals of Individuals in Housing by Population Category, June 30, 2016

Cat. 1: Individuals with SMI residing in an ACH determined by the State to be an IMD	94/11%
Category 2: Individuals with SPMI residing in an ACH licensed for at least 50 beds and in which 25% or more of the resident population has a mental illness	142/17%
Category 3: Individuals with SPMI residing in an ACH licensed for between 20 and 49 beds and in which 40% or more of the resident population has a mental illness	38/4%
Category 4: Individuals with SPMI who are or will be discharged from a State psychiatric hospital and who are homeless or have unstable housing	97/11%
Category 5: Individuals being considered for admission to an ACH and determined through preadmission screening to have SMI	482/57%

SPH referrals increased from 50 to 97 in FY 2016, a 51% increase. Hospital discharge data reflects that typically only two (2) to four (4) individuals are discharged monthly directly into Supported Housing which is only approximately 2-3% of all discharge

[16] comparison data for previous years is not available

[17] These ratios are in part influenced by the number of homes in each of these categories.

destinations. If this number trended up to twenty to thirty percent (20-30%) of the total discharges, the number of individuals being discharged to Supported Housing could increase to between thirty (30) and fifty (50) individuals per month or four hundred (400) to six hundred (600) per year.

The State reports a higher number individuals were contacted by In-Reach staff while hospitalized at a SPH, get housing slots and or move into Supported housing after they are discharged. Often individuals also have to move someplace temporarily because they cannot find housing of their choice, have not gotten through the approval process or some other issue related to their being making the move. This issue will be discussed further in the Community Services section of this Report.

Central to the State's taking effective measures to meet its Supported Housing compliance requirements is maintaining a low turnover rate. Maintaining a low turnover rate is a indicator of an individual's stability in the most integrated setting. It is also cost effective resulting in lower overall costs of care (even serving individuals who are homeless has been found to be more expensive than supported housing) and it is highly correlated to an individual's increased self esteem, independence and satisfaction.

To gauge performance it is important to examine turnover at three levels. First, the total number of individuals who leave housing by a standard categories (i.e., including eviction, death, placement in a higher level of care either permanently or temporality for long term care, rehabilitation, other medical, psychiatric or substance use treatment, moving to live with family, friends on their own without a housing slot or in the case of this SA returning to ACHs). Positive leavers include those who leave by choice either to live somewhere else or to get some type of out-of-home treatment. Negative leavers leave either because they are evicted, avoiding eviction or desert their unit. Death is not considered either a positive or negative leaver. Given the average age and presence of chronic health conditions and lifestyle death will be one of the leading causes of turnover.

Forty (42) individuals or five percent (5%) of the total who moved into housing have died since moving into Supported Housing. This percentage is consistent with the number of deaths of individuals in this age cohort with severe psychiatric disabling conditions and is consistent with data reported in other state supported housing programs. Fifty six individuals (56) moved to an ACH or AFL, twenty nine (29) moved to live with family and thirty-five (35) moved into their own home (with no Housing Slot) or

left the state. It is likely some individuals may have moved before being evicted since eviction will have an impact on where they can rent again. Of the remaining twenty two individuals (22), six (6) moved to a mental health group home, one (1) was admitted to a psychiatric hospital, seven (7) to a state psychiatric hospital, one (1) moved to a skilled nursing facility, (6) were incarcerated, nine (9) were admitted to a substance use treatment facility or Oxford House; and (4) were admitted to a medical hospital (4) or an Assisted Living Facility (1).

Filling the exact number of slots as required in this Agreement or in any housing program requires refilling a substantial number of Housing Slots that are vacated over the course of eight years. The State filled eight hundred and fifty-three (853) Housing Slots using TCLI and Key funds for rental subsidies before turnover. According to the June 2016 TCLI monthly report, six hundred and fifty (650) individuals have retained their rental unit. This means that to have met the 2016 Housing filled unit obligation, five hundred and sixteen (516) additional initial slots would need to have been filled by June 20, 2016.

The percentage of individuals remaining in their housing at the one year mark is 81% and that percentage has remained the same in FY 2016 as FY 2015 and the percentage of individuals who have remain in their housing at the two year mark increased slightly from just over sixty eight percent (68.4%) to seventy one percent (71%) over the past year. It is recommended the State continue to analyze turnover and require the LME/MCOs to do the same.

Every year the number of slots to be refilled increases and at the current turnover rate the State would have to fill at a minimum three thousand and nine hundred (3,900) slots by June 2020 for 3,000 slots to actually be filled on that date. In FY 2017, nine hundred and seventy four (974) and in FY 2018 three hundred and fifty eight (358) additional slots or one thousand three hundred and thirty two (1332) slots need to be filled if there were no turnover slots that need to be filled. Based on the performance to date and an algorithm developed to calculate the number of units to be refilled the number of individuals who need to be placed is actually one thousand six hundred and seventy six (1676) by July 1, 2018. The number of slots to be filled can be reduced to closer to 1,332 if turnover is reduced.

It is difficult to project the number of individuals who may eventually be re-housed and the numbers fluctuate as often individuals indicate they may re-consider only to change their mind. However data from other states suggests that over time this number may grow to 30-40% of those who could return, meaning they are not deceased, in hospice,

skilled nursing or otherwise not eligible.

The State has begun to analyze turnover with a calculation for the number of individuals who could be re-housed. This is an important calculation. The greater number of individuals re-housed is a positive message to individuals who may be ambivalent or run into problems and to staff to keep working with individuals who have lost housing. Of the two hundred and three individuals who have exited housing since the program began it appears that as many as many as one hundred and fifty three (153) individuals could return to Supported housing. Based on analysis of this data it appears that thirty five (35) individuals have either left the state or moved into independent housing or may not qualify for Supported housing in the future. Individuals not included in the potentially re-housed group including those who are deceased, moved to hospice or to Skilled Nursing Facilities and even this last group may return depending on the trajectory of their disabling condition.

It is recommended the LME/MCOs be given their per capita share of slots allocated for the year[18] as a performance target and that the total number of slots to be filled by June 30, 2020 also be published even if slots have to initially be allocated consistent with budget language. Providing information on performance targets for each year through FY 2020 is important to provide now given the level of planning necessary for meeting SA requirements.

The State gives LME/MCOs different targets, dividing the slots evenly slots and by formula. This formula is helpful if the per capita populations of the catchment areas are the same or similar. If the State gives the LME/MCOs which have less population, a higher or virtually the same per capita target than LME/MCOs with a greater population, the State cannot expect to meet their housing obligation over time. The LME/MCOs with a much lower per capita population cannot make up the difference if the larger LME/MCOs simply meet their goals. **(Figure 4).**

There are percentage differences in the number of slots filled across catchment areas based on the State's per capita population. Center-Point Human Services[19], Eastpointe, Partners Behavioral Health Management (Partners), and Trillium Health Resources (Trillium) have filled slots that bring them within 10 percentage points of their

[18] # of Medicaid covered lives is another way to factor required LME/MCO performance but in NC covered lives tracks per capita closely. There are individuals in the program not eligible for Medicaid so per capita is used for this recommendation.

[19] CenterPoint became part of the Cardinal Innovations LME/MCO on July 1, 2016.

proportion of the per capita population in slots filled through FY 2016. Sandhills and Smoky are within 84% and 66% of their proportion. Cardinal is at 59% and the Alliance[20] at 37%.

Figure 4:
Housing Slots Filled Based on State Targets for FY 2016
Based on Per Capita Percentage Required to Date[21]

LME/MCOs	Alliance	Cardinal	CenterPoint	Eastpointe	Partners	Sandhills	Smoky	Trillium
FY16 State Target	84	96	60	84	84	72	72	84
FY16 State Target % Filled	32%	78%	45%	33%	81%	50%	47%	46%
Total Filled in FY16	27	75	27	28	68	38	34	39
Total Filled FY13-16	77	166	70	87	103	108	100	142
% Per Capita Filled (FY13-16)	37%	59%	100%	93%	98%	84%	66%	93%
Per Capita FY13-16[22]	210	280	70	93	105	128	128	152

Likewise Housing search data also depicts a difference in numbers of individuals searching for units that may account for some of the difference. Creating greater access in metropolitan counties especially in light of fewer rental vacancies, escalating rents, fewer LIHTC units per capita and more competition for private units will require the State and LME/MCOs to consider strategic opportunities and a closer look at internal processes, targets and housing plan strategies.

The recent Point-in-Time analysis **(Figure 5)** of the number of individuals in active housing search over a two month period (mid April-mid-June, 2016) illustrated that Partners had fifty-five (55) individuals in active housing search during this period and that overall the LME/MCOS were assisting two hundred and twenty-one (221) individuals in active housing search. This illustrates that there are nearly two and a half times as many individuals looking for housing than actually are approved and move into housing monthly. The Point-in-Time data confirm DHHS data that on average number of days from Housing Slot issuance to placement is one hundred and thirty-three (133) days.

The Point-in-Time and DHHS data and the Individual reviews all point to difficulty finding

[20] Alliance has slightly lower percentage of Medicaid covered lives than their percentage of the statewide population and Eastpointe has a slightly higher percentage of Medicaid covered lives their per capita percentage population.

[21] figures based on DHHS July 2016 dashboard, FY 2016 TCLI monthly report, FY16 SA Compliance requirement and NC 2014 census.

[22] Number of slots required, per capita, to meet the FY16 compliance requirement.

housing and individuals being denied as major barriers to individuals moving into housing. This issue will be discussed further under the Transition section of the Report as other factors appear to create this length of time. However it is undeniable, a lack of available, affordable housing is a significant barrier. A relatively high percentage of individuals are turned down for criminal or credit problems, some give up looking and others go to live with family or other circumstances intervene and they stop looking.

Figure 5: Housing Point-in-Time Analysis

LME/MCO	# in Active Search[23]	% of total searching[24]	% of per capita pop.[25]	Individuals C/C[26]	% C/C still looking[27]
Alliance	37	17%	18%	11	30%
Cardinal	21	10%	24%	6	29%
Eastpointe	14	6%	8%	2	14%
Partners	55	25%	9%	3	5%
Sandhills	26	12%	11%	5	19%
Smoky	41	19%	11%	10	24%
Trillium	27	12%	13%	2	7%
CenterPoint[28]	NA	NA	6%	NA	NA
Total	221	100%	100%	39	19%

As stated above and found in FY 2015, both staff of Cardinal and Alliance report more challenges with finding suitable housing in their most affluent counties. In Alliance's case their percentage of individuals in housing search closely mirrors their per capita population.

There is a wide range of number of individuals in active search compared to per capita catchment population equivalencies. These findings do not appear to be a good predictor of LME/MCO performance. Rather is more related to the state's disparities in availability of affordable housing units. It would be prudent though for the LME/MCOs to analyze their challenges and performance based on these metrics and other factors.

The State added TCLI funding to increase the number of Regional Housing Coordinators

[23] in active Search from mid April through mid June, 2016

[24] % of total # of individuals statewide searching during the review time period

[25] percentage of the state's per capita population living in the catchment area

[26] C/C: individuals with a criminal background (arrest or conviction) or credit problem, denied at least once and actively seeking housing at the time the review was completed

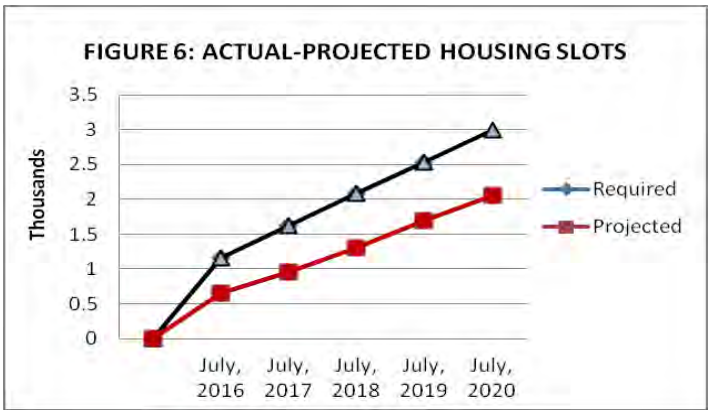
[27] % C/C: percentage of individuals in active search in the catchment area with a criminal or credit background issue still looking for housing

[28] CenterPoint was not asked to participate during their merger transition process but their % of population was included.

in FY 2015 and increase TCLI staffing in FY 2016 which will be discussed in the Discharge and Transition section of this Report. The impact of adding TCLI staff will not be reflected in slots filled immediately nor will it compensate for other factors that may impede housing access and availability. However Partners, which is having increased success in filling units reports that with additional staff they have re-arranged workloads to enable staff to focus on a smaller geographic area and manage their time more productively. Eastpointe referenced the help of their new Regional Housing Coordinator who knows their territory as helpful. It is recommended DHHS staff, especially the Regional Housing Coordinators, Socialserve and LME/MCOs work closely on housing search and with the HFA on continuing to expand the availability of Targeted Units and all the groups work in partnership to engage local housing organizations.

The State's trend line for filling 3,000 slots by June 2020 improved slightly in FY 2016. Three hundred and thirty four (334) individuals moved into supported housing (with a allocated housing slot), an increase in the number of individuals from two hundred and forty three (243) individuals moving into supported housing the prior year. The percentage of individuals retaining housing at one and two years has remained virtually the same as previously reported. The percentage of individuals returning to ACHs has remained virtually the same from the previous year and all other reasons for leaving Supported Housing have remained consistent since these reports were generated.

The State projected higher numbers of slots will be re-filled. If the State's numbers were used, the State would still not meeting its targets in 2020 and somewhere between four hundred (400) and five hundred (500) slots would be left unused at that the time Agreement is set to expire depending on current projections. The State is taking proactive measures for individuals to re-use their slots but that will still not result in 3,000 slots in use at the time the Agreement is set to expire.



Based on FY 2016 data, 66% of the required Housing Slots will be filled on June 30, 2020 **(Figure 6).** This is an improvement over the 2015 projection of 54%. DHHS has proposed corrective action plan for increasing filled slots.

Priority for Individuals described in Section III. B.(2)(a-b) and (c) and Section III. B.(5)
The State is not required to fill a specific number of slots as described in III B. (2)(a),(b) and (c) in FY 2016 but will be required to fill two thousand (2,000) slots with individuals in those categories by July 1, 2020. The State filled two hundred and seventy four (274)[29] slots with individuals from those three categories by June 30, 2016. This represents thirty two percent (32%) of the total slots filled down from forty percent (40%) filled in these categories at the end of FY 2015. If the State were meeting its overall housing slot requirements in FY 2016, the number filled for these three categories would be 770.

The State is urging LME/MCOs to fill more slots with individuals in those three categories. There are significant barriers to LMO/MCOs meeting this target. One is the split focus required between Diversion and In-reach to engage individuals in transition planning and moving to Supported Housing. Another is the focus required to assist individuals being discharged from SPHs, many of whom will either be sent to an ACH or being re-hospitalized because of a lack of stable housing.

The LME/MCOs report individuals are being discouraged by ACHs and sometimes by Guardians and families from leave ACHs. This was confirmed directly by participants and Guardians during Individual review interviews. The transition processes are also laborious and require TCLI staff to employ successful motivational skills. These barriers will need significantly mitigation for the State to meet this requirement by June 30, 2020. The DHHS has provided training to DSS staff, including Guardians and staff working with Guardians, on the State's obligations and DSS obligations in this SA. The State is examining options to streamline transition processes.

Housing Assistance Using Ongoing Programs (Section III. B (6). This requirement is a statement that ongoing programs can be utilized for the State to fulfill its obligations to this Agreement so long as the programs meet criteria in III. B(7)(a)-(g). Since affordable housing is not easily obtainable or accessible, it is important the State use all available existing programs especially but not limited to the LIHTC program. The Priority Populations are as entitled to affordable housing programs to the extent that non disabled people are entitled based on their income. They may also be entitled to housing in categorical programs such as McKinney resources and veterans housing resources if they meet criteria for one of these programs.

[29] data on the number of individuals who retained their housing (or been re-housed) from those categories is not included

The TCLI rental subsidy program continues to rely heavily on the private rental market with only seventy three (73) individuals getting a LIHTC unit. This represents twenty-four (24%) of the total of the units filled in FY 2016 an increase from twelve percent (12%) the previous year. Partners reports an increase in access to LIHTC units in May and June and Trillium reports fourteen (14) individuals have recently applied for targeted units. As reflected in the Reviewer's FY 2015 Report, the NCHFA turned down HUD 811 PRA funds awarded in FY 2013 which could have yielded up to 500 PRA rental subsidies for individuals with disabilities in North Carolina. The NCHFA did not apply for 811 PRA subsidies in FY 2014. There is no indication when additional subsidies will be available again.

The State and LME/MCOs have reached out to Public Housing Authorities with mixed success although none of the States' PHAs have yet sought the required permission for a Tenant Selection Preference for the target population with the HUD Office of Fair Housing and Equal Opportunity (FHEO). The HUD Secretary's Special Advisor Jennifer Ho made herself available to assist with the process. This step, taken by Georgia has resulted in 193 individuals in their *Olmstead* target population getting a Section 8 HCV since 2013. Their preference was recently renewed by HUD. As cited earlier, the State did not accept Section 811 PRA funds (FY 2012 solicitation) or apply in FY 2014 to add rental assistance for individuals with disabilities now in place in six other states with a Remedial Agreement, each included a priority for individuals with psychiatric disabilities.

Recently the HFA added two staff, Community Integration Liaisons, to serve as the primary liaisons between the HFA and DHHS. According to their job descriptions, they may also represent the agency to the General Assembly and Governor's office. The first duty listed in their job description is as follows: "engage(s) with all levels of staff at MCOs/LMEs across the state to monitor client caseloads eligible under the state's *Olmstead* Agreement and ensures progress is made in housing clients at a rate to ensure success with the 2020 objective; identifies obstacles and challenges to client placements throughout the system". They also have a duty to problem solve with all partners working collaboratively to provide successful placements of clients in community living arrangements, in particular to troubleshoot with project owners, management companies, and Supported service providers to overcome barriers to successful tenancy.

These two duties violate the Settlement Agreement terms and other legal requirements as written. Their duties conflict with duties explicitly stated for other organizations in the Settlement Agreement. The duties call into question the HFA's understanding of confidentiality and individual rights. These descriptions were finalized without

consultation with DHHS nor did the State request a change be made in the Settlement Agreement to accommodate a shift in responsibilities. The staff, likely unaware of the inappropriateness of these duties, approached LME/MCOs with no notification causing confusion all the while LME/MCOs were working toward building their own capacity with Socialserve, the Regional Housing Coordinators and DHHS to create more housing opportunities.

There is one duty in their description that seems appropriate for the HFA staff and already being undertaken by the HFA, Socialserve and the Regional Housing Coordinators as well as the LME/MCOs: "work to create new housing opportunities for clients with disabilities expanding creative partnerships with nonprofit and for profit entities including PHAs, DCDs, CAAs and members of the Apartment Association of NC, designs new linkages to federal, state or local rent subsidy programs." The HFA explains their role as a "control" tower to remove obstacles helping lift up the LME/MCOs.

A control tower team in an airport actually helps with air traffic flow not with air traffic disputes or with adding more air space or runways essential for adding capacity. Control tower functions, if that analogy fits at all, are the responsibility of the LME/MCOs and they ask for help when owners and property manager/landlords appear to not meet their legal or lease obligations. Likewise spending time "monitoring caseloads", "ensuring progress with placements" and "identifying challenges to placements" is highly inappropriate. Negotiating with owner/property managers and removing barriers with property managers and owners when requested is important.

It is advisable for the DHHS and the HFA to immediately sort out responsibilities assuring the widest and best use of staff to carry out these duties. Adding Socialserve and the LME/MCOs and other stakeholders to those discussions could be worthwhile but only after the principal organizations have agreement. It is important to recognize the valuable contributions being made by the Regional Housing Coordinators to improving performance in the Supported housing program especially their support to LME/MCOs. Their work is repeatedly cited as critical by LME/MCOs and participants. Hopefully their role will be fully utilized going forward.

One point not referenced in the job description nor responded to otherwise is the seeming lack of a strong HFA compliance focus with their owners who have Regulatory Agreements with the HFA. These descriptions do not acknowledge the need for action to ensure compliance and for a formal grievance policy across the agencies and with LME/MCOs and owners that recognizes the limits of exchanging confidential information

that is highly detrimental to participants and recognizes owners and tenant's rights and responsibilities. It would also be helpful if their role with the work being undertaken by the HFA toward furthering fair housing were clarified.

The HFA with encouragement and technical support of the NC Justice Center and others has taken a more assertive position on Fair Housing providing training and a strong policy of affirmatively furthering fair housing within its housing programs. The agency issued a memorandum to Owners and Managers of Affordable Rental Housing with an NCHFA Regulatory Agreement in February 2016 indicating that it had been brought to their attention LIHTC developments may have screening policies that are 'so restrictive they deny access to an important housing option to many persons within the Olmstead settlement class".[30] The HFA cited six tools the HFA is using to cover owner's potential costs and to recognize that credit checks when credit issues are covered by the Key program seem unnecessary. These items actually extend assistance to owners for people with disabilities and are payments for agreeing to a tenant who by law should be rented to without such a bounty.

The HFA issued a *Model Policy for Screening Applicants with Criminal Records* and provided sixteen trainings on Fair Housing, eight for landlords and property managers and eight for TCLI staff. This was issued in advance of the HUD General Counsel issuing formal *Guidance on "Application of Fair Housing Act Standards to the Use of Criminal Records by Providers of Housing and Real Estate-Related Transaction and the Fair Housing Act"* and before the HUD Secretary issued the Final Rule on Affirming Furthering Fair Housing (AFFH) on July 8, 2016[31].

The HFA issued a *Tenant Selection Plan Policy for Properties Monitored by the HFA* in June 2016. The HFA has requested Owners review their current tenant Selection Plans for conformance with the new policy and provide a tenant Selection Plan that conforms to the new policy by October 31, 2016. These steps and very strong risk mitigation strategies already in place are very important steps.

Melding the use of ongoing programs and new housing capacity is complicated. It requires a strategic approach, the best use, not redundant use of everyone's time. The DHHS and the HFA have more than enough staff to accomplish their housing goals; the new Corrective Action housing goals are a step in the right direction. DHHS has been seeking a Housing Director for over a year. Adding that position as the State's leader for

[30] cite letter

[31] HUD Guidance on Criminal Records (April 4, 2016) and Final Rule on AFFH on July

housing initiatives would help with this ongoing issue.

One additional issue of increasing importance is the utilization of funds obligated for TCLI housing slot subsidies that per legislative mandate is transferred from the DHHS budget to the HFA budget. In FY 2015, $2.97 million of the TCLI funds for Housing Slots was unspent and was transferred to the HFA to be deposited in the Community Living Housing Fund[32]. In FY in 2016, $5.5 million was transferred bringing the total to $8.47 million. These additional funds just recently transferred in the SFY17 budget and the Reviewer has requested the proposed Housing Plan to be completed in October 2016 include a plan, priorities and criteria for the use of these funds consistent with legislative language, highest and best use for the TCLI target population. Unless there is an increase in rate that housing slots are being filled this amount could be in the same range as FY 2016 in FY 2017.

The HFA, in consultation with DHHS, is responsible for administering the Community Living Housing Fund. The budget language provides direction for the target population and gives DHHS responsibility for identifying priority catchment areas; other criteria for how the funds are to be used. It was recommended in the FY 2015 Report the HFA and DHHS develop criteria for leveraging those funds as part of a comprehensive housing strategy.

The June 3, 2016 Corrective Action Plan comes closest to what would be considered formal recommendations. It is recommended the proposed Housing Plan provide concrete details for the June 3rd recommendations. The lack of a concrete strategic plan continues to undermine the State's long term ability to come into compliance with housing requirements. Presently the question of future of Subsidy Administration is also being sorted out between the HFA and DHHS with the LME/MCOs making inquiries and proposals given their proposed responsibilities. The final decision in this matter is not subject to a compliance review but this issue remaining unresolved over the extended period of time raises questions regarding the State's ability to take effective measures necessary to meet compliance requirements. Resolving these matters will enable the State to provide clarity for the LME/MCOs, tasked with major responsibilities and move forward toward meeting its compliance requirements.

The DHHS has been given responsibility and resources for funding administrative housing functions including allocating resources for the infrastructure and capacity building activities necessary for the State to meet its housing obligations. Resources

[32] North Carolina State Budget Act 143C: G.S. 122E-3.1.

have been allocated for tenant based rental assistance management, systems development, Regional Housing Coordinator salaries (5 FTEs), housing policy development, contract compliance and monitoring, housing search data system/ landlord outreach, tenancy support training and one FTE for HFA to meet its obligations under the Agreement. Hopefully the DHHS will assure outputs associated with these allocations will result in the State meeting its housing obligations.

Of the $8.47 million transferred to the HFA in the past two years, the HFA is in negotiation with an affordable housing developer who had a funding gap of approximately $1.7 million in a bond deal. The HFA is proposing providing funding to this developer and this is considered a "pilot" for gap financing in the future. The final amount and terms are not yet known. This type of arrangement is best made with due diligence on the amount requested and terms of an agreement for access to units in return for this investment. Typically this would be a set of units for a set number of years with payback requirements in the event of a sale or default. These terms would also have to be memorialized in a set aside agreement. This offer was made without plans and priorities for the future use of the Community Living Fund. This is concerning as is the lack of published criteria, transparency and analysis of the potential best uses of the Community Living Fund. Hopefully the DHHS and HFA will work closely together to develop criteria and carry with public review especially in light of fact this Fund will likely growing in future years.

B.7. Housing Settings Meet Criteria for Permanent Supported Housing with Tenancy Rights, are Scattered with Priority for Single Occupancy with Choice, Community Access, Recovery Focus and Integration Requirements (III. (7)(a-g)(i-ii).

(a.) **III.B.(7)(a)**. Housing Slots require permanent housing have Tenancy Rights. The State has consistently followed this requirement. During Individual Reviews, there were a number of instances where TCLI and Tenancy Support staff and participants spoke knowingly of Tenancy Rights and ways they had expressed their rights when necessary.

(b.) The State took action in FY 2016 to re-vamp and strengthen Tenancy Support services. Tenancy Support is essential to individuals living successfully in the community. On November 1, 2015, the State issued a Tenancy Support Team Bulletin re-defining TST services requirements and shifting responsibility for the delivery of these services from Quadel to service providers under contract to the LME/MCOs. The LME/MCOs were funded for two teams each beginning in January 2016. The State updated the Tenancy Support definition in June 2016, making a name change, from TST to Tenancy Management Services

(TSM), adding an option to use an Occupational Therapist for a Qualified Professional (QP) position and clarifying UM and entrance processes.

The State while announcing their intent months ago, is now taking preliminary steps to request a State Plan Amendment (SPA) for this service. Their goal is to make this request to CMS next summer. The CMS provided guidance in June 2015 on what interventions may be included in services for tenancy related services.

The State requested the UNC ACT Center for Excellence to provide technical assistance and training to ACT teams and other service providers on tenancy support. For ACT teams, it was to make them aware of their obligations to deliver these services within their current requirements. ACT teams will not require additional funding rather a greater focus on tenancy support. Ongoing technical assistance and training is necessary for new teams and existing ACT teams to make the necessary shift to providing these supports. Changes in LME/MCO provider contracts with performance requirements for tenancy support are essential to achieve desired outcomes.

This step was heralded by the LME/MCO staff and stakeholders. It provides a clear path forward for expansion of this service to a level needed to support individuals living in the community, especially those who do not qualify for ACT. If the service could be provided based on the level of an individual's need especially during pre-tenancy and at the time when someone moves, it could provide a level of stability greatly needed by individuals making a life change in where and how they live.

The Reviewer upon viewing the definition in November 2015, after it was published, made written recommendations regarding the service responsibilities and definition. To date there has been no response to these recommendations although the June definition includes a reference to the TSM being responsible for the PCP and Crisis Plan if an individual does not accept a mental health service.

Several questions remain with the service:
1) The service definition refers to TSM being responsible for the PCP and Crisis Plan if an individual does not accept a mental health clinical service. Individual Reviews reveal a mental health clinical service is not always offered. Medication management is the only service provided for many individuals and it is not sufficient for PCP and Crisis Plan management for individuals moving into supported housing.

2) The definition is not clear on what services are to be delivered prior to an individual

moving. It is especially confusing because it references identifying needed resources is considered only a part of the assessment with no reference to assisting individuals to access resources as an intervention. There is no reference to assertive outreach, assistance with decision making/problem solving and relapse prevention as part of the pre-tenancy tasks when engaging and establishing a relationship is essential (and best practice) in delivering recovery based services.

3.) There is no provision for this service being available for an individual exiting an ACH, SPH or being diverted from either, who meets one of the Priority Population categories if they move to a location where a housing slot is not required or for someone who no longer is using their slot but otherwise would benefit this service listed in this definition. In this year's Interview sample 29 individuals, 27% of the sample were living in another location. This omission goes to the question of the State being required to provide an adequate service array for the Priority Populations to be discussed under the Services section of this Report.

(c)(d.) Individuals are placed in units where interaction with other individuals with disabilities and housing slots being be provided so as not to limit an Individual's ability to access community activities at times, frequencies and with persons of their choosing. Both are goals for the State and LME/MCOs. Interestingly, two (2) individuals interviewed were emphatic they either wanted to be left alone or liked being more isolated. Both were making a good adjustment to community living. One has frequent contact although a challenging relationship with his family and has a car so he could get around but be alone when he wanted to be alone. The other man has a motorized wheelchair and can get around town but stated emphatically he did not like going to the senior center because "people talked too much". He also has daily PCS services so he does have interaction, and based on the conversation, is likely to have friends he does not talk about. But those are the exceptions, more often individuals talked about being isolated as a problem. One woman living outside of a small town indicated her desire to move into town to be closer to services and the TCLI staff concurred they were working towards helping make that happen. Feeling isolated doesn't always occur in rural communities.

On a recent visit in Charlotte, two individuals spoke about having to take a bus for over an hour, with one change in buses, to get across town for appointments at their ACT program office. They were visited infrequently in their home. Both had just moved into their apartment. One of the individuals tearfully spoke about feeling isolated.

One lady in the eastern part of the state talked about her neighbor taking her out to dinner once a week; several individuals spoke about going to church. Overall six (6) individuals

indicated they belonged to community organizations, mostly a senior center or a church. One gentleman reported going to lunch daily at a senior center. Eleven (11) people reported some type of recreation, mostly walking and nine (9) spoke about wanting to be engaged in volunteer activities or were beginning to volunteer. One woman spoke about volunteering with her daughter when she was allowed home visits with her daughter on weekends and was excited that she may regain custody of her daughter and could do this more often. A couple talked about enjoying karaoke nights at a local social club.

Overall social, health and wellness, volunteer activities and church events are still not the norm in most individual's lives. While location matters to some extent, opportunities for interaction generally have to offered, nurtured and supported. The State and stakeholders are encouraged to prioritize these opportunities.

(e.) All but 250 Housing Slots are to be "scattered" with agreement that the 250 units may be in disability neutral developments that have up to 16 units and no more than 20 % of the units occupied by individuals with a disability known to the State. The State has made one inquiry about using these funds for a small group living arrangement that at the time was available to the Priority Populations. It was a small attached rental unit arrangement with less than eight units with 1 or 2 bedrooms each which is ideal for individuals who are requesting to live with or near friends and/or have 24 hour care needs, especially an older population.

(f.) Individuals are afforded choice in their daily life activities, such as eating, bathing, sleeping, visiting and other typical daily activities. Very few connections to community ihealth and wellness services and natural supports were reported in the FY 2016 Individual Reviews and choices in typical daily activities still appear limited. As more TSM staff is added, hopefully more attention can be made to offering these choices. The State recently took a major step forward allowing presumptive eligibility for PCS services in their home enabling individuals needing assistance with: eating, bathing, dressing, toileting and/or mobility.

(g.) Priority is for single-occupancy housing. Almost all the housing units visited by this Reviewer and the second expert were single occupancy. The exceptions were one couple who met while living in the same adult home and married. They have being living in their rental unit for nearly three years. A second instance was a couple who met in and ACH. They have been living in their rental unit for a year. The third are two older women living together. One qualifies for TCLI, the other does not. While this roommate relationship is working well at the moment it is clear that if this relationship did not

work it would create issues for the TCLI participant who is older, has a significant hearing loss and is less capable of living on her own. While all three of these relationships could fray and the TCLI program staff and participants would have to work out other arrangements, they fall within the definition in the SA for roommate relationships. Likewise three individuals were living in single family homes and one in a mobile home, not multi-family rental units. In all three of these situations the single family homes were small rentals in locations requested by the participant and the young man with the trailer clearly preferred that arrangement.

B. (8). Housing Slots cannot be ACHs, Group Homes or other settings that must be licensed. They are not being used.

B (9). Only allowable types of housing can be used for Housing Slots. Individuals are free to choose other housing after being informed of their option for a housing slot.

II. COMMUNITY-BASED MENTAL HEALTH SERVICES

Compliance Summary

Services compliance requirements focus on the availability and access to services for the target population with specific emphasis on ACT and Crisis Services, the delegation of responsibilities to the LME/MCOs use of person centered planning. Compliance across services requirements is mixed. The State has taken steps to improve and expand tenancy support, improve the quality of services through training and technical assistance and now facilitating PCS eligibility. However the State has yet to develop an adequate level and array of services and supports and has not developed sufficient and adequate accountability of the LME/MCOs for functions delegated to LME/MCOs in the Agreement in order for the State to to be in compliance with three provisions, **C.(1-2) and C.(7)** in this Agreement.

III. C. (1) and C. (2) The State shall provide access to an array of services and supports 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 (for individuals regardless of whether or not they have a Housing Slot if they are enrolled in Medicaid eligible for Medicaid 1915(b)(c) waiver services and for the State funded service array and for individuals not receiving a Housing Slot access only to state funded services subject to the availability of funds.).

Section III. C. (4), refers to the State relying 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.

There were notable improvements in the access to services and supports this year. One, was a shift to LME/MCOs contracting for two TSM providers in each catchment area replacing Quadel as the statewide tenancy support service provider. Second, was funding to double In-Reach staff and to add funding for additional Transition Coordinators. There are now eighty-six (86) In-Reach Specialists and ninety seven (97) Transition Coordinator positions. At the end of the FY 2016, the DMA issued a bulletin giving LME/MCOs the ability to request an expedited Personal Care Service (PCS) assessment for individuals served through the Transition to Community Living Initiative (TCLI). Regardless of these additions and changes, services are still not yet sufficient for the state to meet the individualized needs of the target population. The State may want to consider using their Corrective Action plan to create a stronger, more comprehensive and clearer direction for creating an array of services, available to the target population.

There are variations in services and practices by type of service, authorization, intensity, availability and appropriateness of LME/MCO networks. Availability remains problematic in some areas of the state. The type and intensity of services an individual receives is dependent on where an individual lives (catchment, county or community), where housing is available, and intensity and appropriateness are subject to authorization and care coordination practice, contracting and provider performance, and Transition Coordinators being assertive in making service arrangements.

One barrier to access is the Medicaid "County of Origin"[33] requirement. This requirement is particularly burdensome since individuals often move from their county of residence to another county when admitted and/or discharged from ACHs; often their move is across catchment lines. Fewer individuals pulled for this sample were living or moving into a different county making comparisons across years more difficult. References to the impact of the "County of Origin" issues can be found throughout this report. DHHS is working to minimize this problem with single use agreements and staff assistance. Assessing this barrier will continue to be a compliance review focus.

Of the seventy-four (74) individuals interviewed living in the community or in the process of

[33] "County of Origin" refers to county of residence for Medicaid eligibility. The County of Origin is used to assign beneficiaries to LME/MCOs, as well as determine which county is responsible for providing the county share of State/County Special Assistance payments.

moving to the community, thirty nine (39) or 52% of the individuals were getting the supports (or intensity of the supports) needed at the time they were seen. This percentage is consistent with last year's findings and with the notable exception to create TSM services; there are no significant changes in service availability to report in FY 2016. Twenty three (23) individuals were receiving ACT, eighteen (18) were living in the community although one (1) of the 18 was missing, one (1) individual was living with his mother, three (3) were living in ACHs and two (2) were hospitalized at the time of the review.

Peer support was rarely mentioned and data suggests not widely available as a separate service. In-Reach peer staff often accompanied Reviewers on visits and were still involved in some situations after their In-reach responsibilities were concluded. With TSM getting re-organized mid-year, data was not collected on the adequacy of these services for this review. Peers are included on TSM teams. Data to determine high use patterns will be analyzed in FY 2017.

Interviews with State staff, LME/MCO staff and stakeholders, site visit observations and a review of contracts and other documents confirmed the services array is limited especially in some areas of the state. The limitations appear to be: (1) a lack of needed services, typically but not exclusively specialty case management with a clinical overlay where necessary, specialty services and health and wellness and peer supports, (2) a lack of understanding by the State and LME/MCOs (across divisions within the LME/MCOs) of what services are important to provide especially specialty services, health and wellness supports, peer support; 3) use of data for state level systems design purposes and LME/MCO decisions to contract for and titrate services and supports. Supervisors should play a major role in assisting staff to learn and use their skills and knowledge to assist individuals to engage in their recovery and participate in services. Attention will be given to their role, or lack thereof, in future reviews.

There were instances where individuals were living in more "service rich" areas of the state and not receiving necessary services but there are more rural pockets in the state where service providers are not available. The State and the LME/MCOs have an obligation to fill those gaps to the extent possible. The obstacles for individuals getting services they need in more 'service rich" areas of the state are related more to assuring individuals get access to level and quality of services they need.

A *very* preliminary review of Medicaid claims data received on July 26, 2016[34] verifies this

[34] this information was received after this Report was in progress; completed analysis and verification is not

view. Unfortunately this data can only be discussed in broad strokes in this Review. A full FY 2016 set of claims would not have been submitted to MCOs for payment and processed by this date. Nor will this information reflect the services provided to approximately 15% of the TCLI population not eligible for Medicaid. This information will be requested. Medical and long term care services data will also be requested. A complete Report including but not limited to patterns of use and differences among LME/MCOs will be submitted following analysis of this data. Nonetheless this preliminary information is consistent with the information gleaned from the Individual Reviews. The level and array of services is insufficient to meet TCLI participant needs.

Section III. C. (3)(a-d) refers to the services being evidenced based, recovery-focused and community based, flexible and helping individuals with crisis and use of natural supports. The State and LME/MCOs are making a strong effort to build these principles into every aspect of practice through training, fidelity reviews, supervision and contracts. From recent interviews there is not yet enough evidence that services are provided consistent with these principles and in accordance with best practices but this type of change takes time and is underway.

The primary Community-Based Mental Health Services, CST, Crisis, Peer Support, Individual Support and ACT, must be adequately supported and available across pre-tenancy, move-in and post tenancy (after move-in) phases of Supported Housing. To be effective these services are individualized and often knitted together. ACT is a stand-alone service encompassing a comprehensive range of service interventions. Tenancy support arrangements should be included as one of these interventions. TCLI and ACT roles and responsibilities are closely related so they should be cross walked to assure staff have a full understanding of roles and responsibilities and to assure there are not gaps during transitions. The same is true across TSM, other services such as CST with the TCLI roles. Provider service requirements would have to be fully incorporated in contracts, performance expectations and job descriptions for the State to have taken the necessary effective measures as required in this SA.

The level of engagement by ACT teams varied. Eighteen (18) individuals interviewed indicated they were visited at least once a week by their team; this should be the minimum not the routine. The primary focus of ACT teams appears to be “illness management”.

Individual review data highlighted in the Compliance Review section above and State data

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possible without additional time. In addition there is not full information included on claims submitted toward the end of the year.

reveal a very weak pattern of LME/MCOs holding providers accountable. Assisting individuals to be successful in their home, to make work and social connections in the community and get help with transportation is lacking. Individual reviews revealed that when adaptable equipment was needed it was made available (for twelve individuals) but specialty services were not frequently mentioned except for individuals who were in dialysis or recovering from injuries.

Sixty-two (62) individuals reported having an assigned medical practitioner and forty-six (46) individuals reported getting mental health treatment, typically medication administration. To the extent possible, ACT teams should be competent in serving individuals with dual disorders and other co-morbidities. Given the age and health conditions of the target population, primary and specialty healthcare and nursing and/or personal care is also needed; not just through making certain referrals are made which results in a parallel, not integrated system with healthcare providers but by incorporating joint treatment planning and practice.

CST (or an equivalent service that covers clinical case management and support functions) appears lacking in both availability and at the level needed for individuals in the target population to be successful in their transition and/or diversion to community living. ACT appears to be provided more during the post tenancy phase of service. Even then it appears the TCLI staff appear to be providing most of the housing related services interventions. TCLI staff appear to be carrying out most the service responsibilities typically required during the pre-tenancy and move-in phases of Supported Housing. It is not appear that ACT is utilized for diversion.

The TCLI Coordinators provide direct services filling in critical gaps not filled by service providers with because there are not clear requirements for services or poor performance and no accountability. While this happens with ACT, it is more prevalent with individuals receiving CST and other services. As funded and practiced today, CST and other services while helpful are not adequate substitutes for a more robust community service that combines a recovery oriented direct service case management/care coordination, illness management, crisis prevention and rehabilitation interventions and that also includes assistance to get and keep housing as part of a individual's recovery plan. The lack of ongoing case management for individuals who have been placed from adult care homes (ACH) or other restrictive settings to the community has been noted in the last two Reports. It is essential the State re-conceptualize its case management/care coordination function.

Creating TSM is a step in the right direction but it falls short of ensuring case management

functions will be carried out by TSM staff, it is not available for individuals who do not currently qualify for TSM but are in the TCLI target populations and can not be expanded without additional state funding or increased LME/MCOs allocations.

Section III.C. (7) & (8), also references LME/MCO responsibilities. **Section III. C. (7)** references both LME/MCO operations responsibilities and State monitoring responsibilities for 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. This Section references the State as responsible for holding the PIHP and/or LMEs accountable for providing access to community-based mental health services in accordance with 42 C.F.R. Part 438, but the State remains ultimately responsible for fulfilling its obligations under the Agreement. These responsibilities will be referenced below and again in the Report section on **Quality Assurance and Performance Improvement.**

The newly developed Division of Medical Assistance-MCO contract effective beginning July 1, 2015 describes U.S. Department of Justice requirements (Section 15 beginning on pg. 54 of that Contract) including the following: (15-1) Staff; (15-2) Care Coordination; (15-3) Person Centered Planning; (15-4) Internal Quality Assurance/ Performance Improvement Programs; (15-5) Clinical Reporting Responsibilities; (15-6) Assertive Community Treatment [ACT]; (15-7) Peer Support Services; (15-8) Supported Employment; (15-9) One Time Transitional Supports; (15-10) Diversion Processes; and (15-11) Communication. No further changes have been made.

The descriptions comport with requirements of the Settlement Agreement. However, these requirements are not spelled out in the sections of this contract where the overall responsibilities of the PIHP are spelled out. For example, Coordination of Care is referenced on pages 19-24 but the so called "DOJ Settlement Agreement" population Coordination of Care provisions are on page 55 and not inserted in the Coordination of Care section. This same pattern is followed in other sections. This makes it appear the "DOJ Settlement Agreement" population is separate and the target population is defined by a legal agreement instead by their special needs as other populations are referenced. This type of separation is what often leads to the subtle but powerful exclusion of the target population from the benefits the LME/MCOs provide other populations. Differences such as these send a message to LME/MCO staff, stakeholders and even some State staff.

A measure of effectiveness for meeting SA service obligations is the degree to which

individuals are encouraged and supported to be fully integrated into the community. While not a service per se, reducing stigma and helping individuals overcome their fear of a community acceptance is essential. Future reviews will include the results of additional data analysis to determine if there are differences in the quality and type of assistance individuals receive if they are part of the Settlement Agreement target population. The description (pg.55) appropriately references the DOJ Settlement Agreement population as a required "Special Healthcare Population".

The contract language also raises another flag. LME/MCOs are being asked to contract only with providers who are in fidelity to the TMACT model (Tool for Measurement of ACT) and providers who are in fidelity with the Individualized Placement and Support-Supported Employment (IPS-SE) model. These requirements were established to enable the State to be in compliance with the Settlement Agreement and current policy. The Settlement Agreement appropriately requires fidelity for ACT and IPS. Fidelity provides basic requirements from which to measure effectiveness, quality and availability for compliance purposes. However measuring fidelity is not instructive for assessing network capacity nor does it substitute for steps LME/MCOs need to take to expand their network to include providers who are trying to meet compliance requirements. Meeting fidelity does not substitute for State establishing requirements and the LME/MCOs adding incentives for SA related performance requirements in their contracts with providers.

The State is supporting IPS expansion to cover some costs and several LME/MCOs are covering some costs. Unlike private business or academic research, "bringing a product to market costs are not included" to support promising providers. Expansion of the IPS provider network is arguably one of the most perplexing Settlement Agreement provisions for the State. It requires the availability of agencies willing to make changes to the IPS-SE, their finding qualified staff to provide the service, be willing to go through the process to meet fidelity and patching together fund sources to make the program financially viable. This will be discussed again in the **Supported Employment** section of the Report.

Changes were made to the DMH contract issued in the spring of FY 2016. The Reviewer offered recommendations for those changes but the Croze report discussed on **page 73** raises additional questions regarding contract obligations. Beyond the contract language other issues persist. Network management oversight, network sufficiency, and provider requirements for pre-tenancy services need strengthening. There appears to be a direct correlation between the lack of services availability (including an array and intensity)

especially pre-tenancy services and supports with the high numbers of individuals entering adult homes and with the low numbers of individuals moving into the community (from ACHs and SPHs) as part of the TCLI program. It appears that neither staff, potential participants, guardians and family members feel the services available are adequate or there is a lack of awareness of what services are available. A review of LME/MCO contract obligations and new resources for managing Medicaid eligibility are discussed below.

The State is not taking full advantage of what services can be delivered as part of the State's Medicaid Plan nor are services available within each LME/MCO area that could be provided under the State's current Medicaid state Plan. Fortunately the Centers for Medicare and Medicaid Services issued a CMS Informational Bulletin[35] (CIB) addressing allowable housing related services and what and how they could be covered in June 2015 and a description in III. B. (7)(a) discusses these proposed changes in more detail.

This CIB was written to assist states in designing Medicaid benefits, and to clarify the circumstances under which Medicaid reimburses for certain housing-related activities, with the goal of promoting community integration for individuals with disabilities. The housing-related activities referenced in this CIB include a full range of flexible services and supports much needed for the individuals in this settlement Agreement's target population in the three phases, pre-tenancy, move-in and post tenancy sustaining services referenced in this Report. The CIB also describes the type of housing related collaborative activities needed for successful transition and long term support. State staff has signaled enthusiasm for the type of focused interventions included in the CIB which over time can be cost effective and lead to the type of successes needed for compliance with this Settlement Agreement. TSM is in part been developed based on information from the CIB. It is also recommended the State analyze their current ACT services description to add language reinforcing housing related activities.

Assertive Community Treatment (ACT) is more available than other services for individuals who do not qualify for ACT but have complex service needs, for individuals who have not consented to ACT, may not qualify for ACT and do not have complex needs but may have a range of needs. ACT still needs to be more available in a few areas of the state. Through contract arrangements with LME/MCOs the State is providing each individual receiving a Housing Slot under this Agreement with access to services for which that individual is eligible

[35] CMS Information Bulletin; *Coverage of Housing-Related Activities and Services for Individuals with Disabilities* (cib-06-26-2015).

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.

For **Section C. (3)(a-d)** record reviews and staff and individual interviews reflected that State staff and LME/MCO leadership are reinforcing services meeting these standards. The State is continuously providing training on best practices, person centered planning, tenancy supports, motivational interviewing/assertive engagement, IDDT, CPR (eCPR), trauma informed care and psychosocial rehabilitation in addition to tailored training and technical assistance offered to ACT and IPS providers.

Training is referenced because staff skills in the various best practices were noticeable during individual reviews as was person centered planning. The State and LME/MCOs can still improve especially on **C. (3)(d)** increasing and strengthening individuals' networks of community and natural supports as well as use of supports for crisis prevention and intervention.

Section III.C. (10)(a-c). Crisis Services states the State must require that the LME/MCOs develop a crisis service system that includes mobile crisis teams, walk-in crisis clinics, community hospital beds, and 24/7 crisis telephone lines. III.C. (10)(b) of the Settlement also specifies that the State will monitor crisis services and identify service gaps, and section III.C.(10)(c) specifies that crisis services will 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".

These requirements do not specify what crisis services should be available for the Priority Populations. Nonetheless the Priority Populations having access to crisis services falls under the "effectiveness" and service array criteria. The State would appear to be in compliance with **Section III.C.(10)(a) and III C.(10)(b)** because of the work on the Crisis Solutions Coalition, funding added for Behavioral Health Urgent Care and Facility Based Crisis Centers. The State is exploring and hopes to pilot Paramedicine Behavioral Health Crisis Response and has actively promoted Mental Health First Aid. These are reasonably mixed facility based and mobile crisis approaches although funding this year skews response towards facility based operations. In the coming year the availability of mobile crisis will be reviewed to determine if both facility based and mobile based operations are available in the same geographic area to the extent practically possible.

There is scant evidence the Priority Populations are being served in these programs. Other indicators from individual Reviews and data collected this year raises further questions. Only one individual out of those seen in the Individual Reviews indicated she had used crisis services. She went to crisis upon being arrested for shop lifting. There appear to be three explanations for such limited use of crisis programs. One is that TCLI staff appear to managing crisis situations and are giving particular attention to crisis prevention reducing the need for more formal crisis services. The second explanation is that the target population does not have the same level of crises that other segments of the SMI and SPMI have and third associated with that hypothesis is that crisis programs are often more utilized by individuals who are not engaged in treatment, community programs and supported housing. Further analysis is needed to verify these assumptions.

Preliminary FY 2016 Medicaid data results indicate that less than $1 million[36] was reimbursed for crisis services for individuals considered in one of the target population and other than thirty (30) individuals residing in ACHs and SPHs all other services were for individuals being diverted except one individual who had a TCLI housing slot. Most of these claims were unduplicated although with data only collected at the LME/MCO level, the level of duplication is unknown. The average cost per individual was lower than $1,000, and for thirteen individuals the cost was greater than $2,000. There was less than $1 million spent on facility based crisis services. There could be duplications across facility based and non facility based services. Only one individual was listed as having transitioned to the community as a part of TCLI. This individual was seen in the same catchment area as the individual seen in Crisis services so this may be the same person.

Based on interviews with individuals who had moved into Supported housing, the TCLI staff, Peer Support and Tenancy Support staff are actively engaged in crisis prevention and stabilization.

In the Partners area where one of the state funded Critical Time Intervention (CTI)[37] pilots is underway, staff was engaged with three individuals providing assistance to individuals in transition in addition to the TCL support they were already receiving. The assistance is remarkably similar to what is provided by In-Reach, TCLI staff and Tenancy Support. CTI practice is essentially the same as what TCLI staff provides. The literature supports this conclusion. The major difference is that TCLI staff is part of a managed care organization and CTI are typically part of a direct services operation. This is not to say CTI is not important as a time limited set of interventions. But it is important to correctly define it as just that ---a set

[36] these figures will be updated following a full analysis in the fall of FY2016.

[37] CTI is a time limited approach to mobilizing support to individuals during transitions from hospitals, jails, homelessness and other setting to community living.

of interventions. It can become one more hand off at the time it is important for individuals in the priority population to be able to establish an ongoing trusting relationship with an individual and team. One participant said during a home visit last spring, “please don't bring one more new person to see me". This information will be collected by completing the Medicaid paid claims analysis and more in-depth review. The Reviewer will issue a separate report by January 2017 on CTI and Crisis Services.

DHHS made crisis services a priority in 2013 and established a well funded, well organized Crisis Solutions Initiative (CSI) in November 2013 to (1) work in partnership with all the stakeholders in the crisis system and (2) find ways to replicate and sustain successful models by eliminating barriers and establishing policy and funding to support those models. The DHHS structured a FY14-15 project list with the assistance of the LME/MCOs.

By May of 2015, all LME/MCOs had 24/7 Access Centers that provide screening, triage, referral and customer services functions. Eighty three (83) counties reported some version of a walk-in crisis center and there are twenty two (22) facilities licensed as facility-Based Crisis Services Units. The State reports some variability in the role each unit plays locally. All the LME/MCOs support law enforcement Crisis Intervention Teams.

The State has identified key benchmarks and is collecting data to mark progress of various initiatives including reduction in emergency department admissions, wait times in emergency departments, and number of readmissions to emergency departments. Over $1.4 million in TCLI funding is being used to tailor and pilot Critical Time Intervention (CTI) for the target population. Four pilot sites have been selected and the initiative was launched in May 2015.

III. SUPPORTED EMPLOYMENT

Compliance Summary

The State made considerable progress implementing Supported Employment in SFY 2016. The State is partial compliance with **D.(1)** and by taking measures to ensure greater access for individuals exiting institutions and individuals receiving ACT getting access to IPS services and by further refining and improving the system's performance and capacity can come into compliance with this requirement. The State is in full compliance with **D.(2)** but remains in non-compliance with **D.(3).** Many of the instrumental activities necessary for **D.(3)** compliance are now being carried out by service providers, across the DHHS Divisions, at the LME-MCO and local DVR level. This non compliance finding is largely because the State simply cannot make progress quickly enough to come into compliance on **D. (3)** this year and the effort necessary to be in full compliance has not yet permeated through the entire

system. This comes after the State struggled for three years to put a viable plan in place and overcome many of the inherent challenges standing up this evidence based supported employment service.

In Section III. D.(1). the State is required to develop and implement measures to provide Supported Employment (SE) Services to individuals with SMI, who are in or at risk of entry to an adult care home, that meet their individualized needs. In Section III.D.(2), Supported Employment Services are required to 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. The State selected the Individualized Placement Services (IPS-SE) model. In Section III.D. (3), the State is required to provide Supported Employment Services to 1,166 individuals by July 1, 2016.

In FY 2015, the State was found in partial compliance with **III. D.(1)**, in compliance with **III. D.2.,** and in non compliance with **III. D.(3)**. The review identified three major issues and included recommendations for each issue: 1. Build stronger support for IPS-SE and ramp up schedule to add providers and teams (that meet fidelity); 2. Create more capacity with ACT for supported employment; and 3. Build capacity (and the Report included a list of capacity building items).

In November 2015 a further review of these issues was conducted with Katherine Burson[38]. The review included a review of data and other information and meetings with key supported employment stakeholders and State staff over a three-day period. Following this review, findings and a number of additional and more specific recommendations a number of which are described below were detailed and related to State staff. A second three-day review was conducted in late April 2016 to assess progress and make additional recommendations. These recommendations further informed this review. Consistent with last year's recommendations, the review conducted in the fall identified four key areas for improvement, all consistent with last year's recommendations:

1. Clarify the State's and the LME/MCO roles and responsibilities. This begins with providing stronger State leadership for IPS-SE; tie LME/MCO and provider expectations to contracts; promulgate the long awaited service definitions; establish performance measures; conduct quality monitoring and strengthen collaborative engagement and training.

[38] Katherine Burson is a highly respected state Rehabilitation Services Director whose state has made significant progress in implementing IPS- SE as a Supported Employment service and as a core mental health service. She is assisting the Reviewer to review SE compliance (SE Expert).

2. Develop and implement sustainable IPS-SE business models.

3. Develop and implement an Action Plan to fill the IPS-SE pipeline.

4. Develop and implement a targeted plan to build IPS-SE capacity where it is most needed.

The State's Corrective Action Plan for Supported Employment was strikingly consistent with those recommendations and included targets for cross systems capacity building, business model development, rate increases and services expansion with intensive technical assistance.

The Reviewer and Expert's review in April 2016 highlighted positive changes and continuing challenges. As stated in the introduction of this Report, the reviewer shadowed an IPS-SE fidelity review in Wilmington, met with UNC IPS-SE technical assistance staff, reviewed and verified data routinely and upon request with the DHHS staff. Four individuals who had been referred to SE were interviewed during the Individual Reviews.

The State has made measurable progress with clarifying roles, responsibilities and expectations, providing leadership, adding new language to LME/MCO contracts and streamlining VR processes. In November 2015, the DHHS released an LME/MCO Communication Bulletin (#1168) clarifying issues related to the use of four different fund sources for IPS-SE. The State followed up this advisory with multiple training events and more clarity for LME/MCOs and providers on budgeting using these four different types of funds. This is an extremely important and challenging task for providers given the lack of matching requirements, definitions and pre-requisites for using one set of funds versus another across the four fund sources.

In January 2016, the State reported making long awaited changes in the IPS-SE definition consistent with IPS-SE fidelity requirements and consistent with best practice. The definition removed specific IDD language, added critical elements of IPS-SE, established and updated provider, staffing, training and certification, fidelity and documentation requirements. The DMH also made a change in the state rate for teams that meet IPS-SE from $14.02 per quarter hour to $19.02 per quarter hour. Training was provided following these changes and the IPS-SE Service Definition training materials were quite comprehensive. Training on the Allocation letter was provided and meetings locally are being held to follow-up on this training. It will be important to assure specifics on integrating DVR funding are consistently part of these discussions.

Although progress has been made, developing a culture that emphasizes employment and recovery throughout the system, including LME/MCOs, service providers and advocates, remains a challenge. To create such a culture, all groups need to work closely together, committed to change.

Requirements for IPS-SE were added to LME/MCO contracts, yet specific expectations for network capacity is not included in either the DMHDDAS or the DMA contracts with LME/MCO. Clearer expectations for network capacity, provider responsibilities and guidelines and targets for serving individuals in or at risk of admission to an ACH would provide guidance and accountability. Adding participation in SE Collaboratives and training through both contract documents and program guidance is recommended. The *North Carolina LME-MCO Performance Measurement and Reporting Guide* (10-12-15) does not include any employment related performance measures.

One issue plaguing the program in FY 2015 was the inability to count the number of individuals who could be counted as recipients of IPS-SE services per **Section 3.D.(1)** of the Settlement Agreement. In September 2015, the State issued a TCLI Fidelity IPS-Supported Employment Participant ACH In/At Risk Checklist. In May 2016, a review was conducted to verify that the identification of IPS-SE recipients being served by providers meeting IPS-SE fidelity was accurate and that the State's capability to accurately count the number of individuals with SMI in or at risk of entry to an adult care home was sufficient. The At Risk checklist is well written and LMEs were provided instructions on the protocols for using, verifying and submitting the checklist data. The DMH receives the checklists, verifies the data before reporting it. The process appears to accurately capture the Priority Populations being provided IPS-SE services. Data is only reported on individuals receiving services once a team meets IPS-SE fidelity.

It appears one of the IPS-SE program's strengths is also one of its limitations. The earlier problem with accuracy in reporting was partly related to providers incorrectly reporting data. This was in part because many providers especially Community Rehabilitation Program (CRP) providers were not as familiar with the Priority Populations definitions and reporting information that included individuals not in the one of the priority populations; that was a limitation. A strength of the program is the expanded provider network. It includes CRP agencies with expertise and experience in supported employment widening the circle of organizations serving the target population. Continuing this approach will likely be necessary if the State to meet its compliance requirements in IPS-SE. There are two cautions though with expanding relying on CRP providers. Many were CRP providers prior to the State adopting the IPS-SE standards so provider staff have to shift their approach and often that

takes time and clear expectations on what is expected using a new approach. The second is that CRP providers often have to rely on relationships with mental health service providers for counseling and treatment. In the IPS-SE review shadowed in Wilmington, it was clear the contracted provider had not adopted a recovery approach to their practice. This issue has been referenced by providers and TA staff as an issue. The LME/MCOs will need to support CRP agencies (who don't have access to qualified services staff) to secure quality service provider contracts in order for the IPS-SE services to be effective.

DMHDDSA, DMA and DVR have taken steps to help guide the implementation of sustainable IPS business models. The State reports conducting one webinar on braided funding. When engaged in this level of a shift, continuous guidance is essential. It can be aided by making certain that state processes are complimentary and assisting the providers and LME/MCOs develop worksheets and manualized approaches to help providers work through their business models. Providing "points for leveraging" in contracts is vitally important. Discussions with providers suggest that more and regular technical assistance on development and implementation of sustainable business models is warranted for **3. D (1).** compliance. It is recommended the focus for technical assistance be not only with service providers but also with LME/MCO Network-contracts staff and that this type of assistance be provided together with and for DVR staff and LME/MCO and SE service provider staff.

It was recommended providers meeting IPS-SE requirements become VR contractors and for the state Division of Vocational Rehabilitation to make changes in CRP contracting requirements and internal processes including auto referring individuals with serious and persistent mental illness to IPS-SE providers. DVR immediately began working with their local offices and providing training. DVR's overall commitment and quick and effective response to these recommendations has been one of the more encouraging developments in both the overall State's compliance efforts as well as with the IPS-SE requirements. Many of the ideas for improving the collaboration among the agencies have come from DVR staff.

In FY 2016 LME/MCOs and DVR reported additional contracts are being negotiated. As a result, twelve (12) of the twenty-two (22) IPS-SE providers meeting fidelity have CPR contracts in place and one more contract is being finalized.

Developing and implementing an Action Plan to fill the IPS pipeline is crucial to meeting compliance but it is also a complex undertaking as it requires attention to the above recommendations. The State has made rapid progress on filling the pipeline in the past year. To successfully meet compliance requirements, the State will need to sustain their current momentum.

In March 2016 the State added $800,000 to LME-MCOs for ten (10) new teams and eight (8) expanded teams[39] in March 2016. The discretion on which agencies would get additional funding was left with the LME/MCO. The DHHS hopes to add seven (7) new teams and add expansion funds for seven (7) teams in FY 2017[40].

Even with this current and proposed expansion, providers who are willing to expand their IPS services, either new teams or expansion of current teams, must have sufficient "start-up" funding to cover the gap between their current budget and a budget that would cover expenses for staff who would have to be in place for the provider agency to meet IPS-SE requirements. In the past providers have waited as long as six (6) to nine (9) months to get scheduled for a fidelity review and were expected to have sufficient staff in place to meet fidelity yet were not provided adequate funding to hire staff. If a staff person resigns or takes another position within the agency, then the agency may have to start the hiring process again, further delaying the fidelity review. Unless the agency had sufficient cash reserves or other sources of funding to cover these costs, the agency could not meet fidelity requirements.

Nine (9) teams are awaiting their first review and four (4) of those teams' fidelity reviews have been scheduled meaning they are closer to being ready. With their very full review schedule through February, 2017, provided at the time this Report was written, it will be sometime before reviewers can be available to schedule additional new teams even if the teams were ready for a review. Its possible additional reviews could be scheduled but at the current rate of scheduling it appears unlikely and it is not recommended. In addition to the new reviews, twenty-one (21) second and third required reviews are also scheduled. If a team scores between sixty (60) and seventy-three (73) on its first review, it must be scheduled to go through a second review within one hundred and eighty (180) days and score a seventy-four (74) to meet fidelity. Presently there are twelve (12) reviewers. Of those, three (3) are shadowing and each review requires at least two (2) reviewers.

Review scoring and reporting is very time consuming and many of the reviewers, who are state staff or technical assistance staff, split their time between their SE administrative duties and providing technical assistance. This many agencies interested in expanding IPS-SE services is positive. To meet compliance requirements in the future, it will be important to focus on managing growth, helping agencies learn how to budget to deliver this service,

[39] Cardinal Innovations and the Alliance Behavioral Health Care were awarded two new teams each plus expansion funds for one team; the other six LME/MCOs were awarded one new team each plus an expanded team.

[40] The FY 2017 TCLI budget allocations were not finalized for this expansion at the time this report was issued.

recruiting qualified staff and managing turnover. Likewise contracting and managing the expanding network is an important step and challenge for LME/MCOs and for the DVR, DMA and DMHDDSA.

Even with this potential growth, participants in twenty-seven (27) counties are not listed as having access to IPS-SE services. Individuals in at least nine (9) counties will likely gain access to this service if service providers meet fidelity requirements in reviews already scheduled. It is also possible for teams to be asked by LME/MCOs to serve individuals in adjacent counties. For very practical reasons of resource limitations, this may not always be possible. Recruitment and retention is a challenge. Within the program, teams are limited in the number of individuals they can serve by the number of available qualified staff. Moreover, service providers must have sufficient earnings and/or reserves to add staff who are eligible to bill for services. The system inadvertently depresses earnings by requiring providers to meet fidelity to get a higher rate and a rate that can actually cover costs. IPS-SE is new and requires sufficient start up funds for providers to enter this program. The new State funding is essential for growth and sustainability.

Based on analysis of the individual reviews discussed earlier, there are few referrals of individuals in the first four Priority Populations. Only 32% of individuals served by teams that meet fidelity requirements are in one of the first four Priority Populations.

At least eight (8) of the twenty-two (22)[41] teams that have met fidelity, are currently serving at least 50 participants. Four (4) teams need additional staff before taking anymore referrals and seven (7) teams are serving fewer than thirty (30) participants, several of those are located in rural areas. The average number of individuals served by teams meeting Fidelity who are in the Priority Populations has increased from twenty-three (23) to thirty-four (34). While small teams in rural areas may struggle, it is important to assure teams with local business contacts are in place. For example, it is difficult to consider how effective a team located in Greenville could be in Murfreesboro or how a team in Asheville could be effective in West Jefferson or Sparta[42]. Of all the services required in this Settlement Agreement, SE is the one service where establishing a local presence is most essential for success.

Five (5) individuals out of 105 in this year's Individual Review were receiving IPS-SE or had been referred to IPS. Of those, none reported being competitively employed. Individuals who have moved into their own apartment or home could potentially be successful in

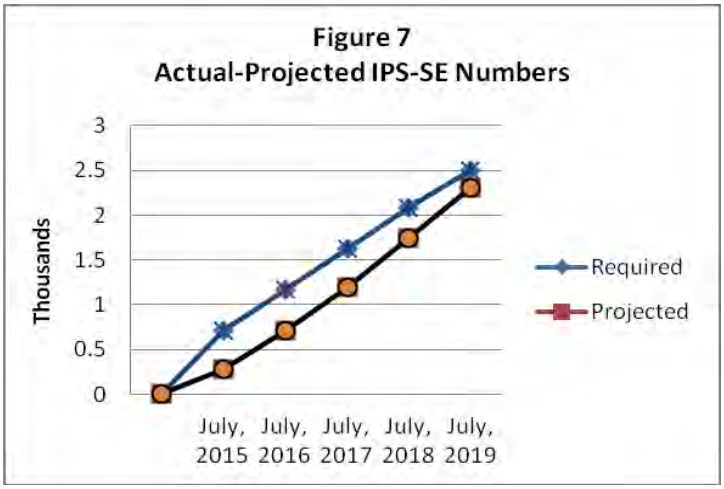
[41] Data on nineteen of these teams was available at the time the State submitted data for this Report but IPS-SE reviews have now been completed and scored with 22 teams meeting fidelity.

[42] These communities are only illustrations and not indicative of any issues in these counties.

gaining employment with IPS-SE given sufficient encouragement and support. Of the individuals who had moved to the community, it appears that as many as 70% of the individuals interviewed could go to work with encouragement, job adaptations and support. The primary reason individuals could not work is related to their medical conditions or age although a few individuals have cognitive impairments that may make competitive employment difficult. As referenced in the FY 2015 Report, a number of individuals who voice reluctance to go to work do so undoubtedly because of fear of failure, relapse, and loss of benefits or having lost interest in working again. Again with this year's Reviews, ACT Employment Specialists did not always appear to be engaged in employment related tasks with a substantial number of individuals served by their team. There were also several individuals still residing in ACHs and one individual visited in a SPH (who was already accepted into an IPS program) who expressed a desire to go to work.

The last issue related to the pipeline is the potential for ACT teams meeting comparable IPS-SE fidelity standards so to enable ACT recipients to receive acceptable IPS-SE services. The Settlement Agreement allows the State to propose an evidences base SE model. This recommendation is made for two reasons. One, a large number of individuals in the Priority Populations are receiving ACT services and would not have access to the most effective employment services without more rigorous requirements being placed on ACT teams. Two, the State is developing a comprehensive IPS-SE system and ACT providers and recipients could benefit from being more a part of this burgeoning system. Likewise, if requirements placed on teams were met and approved, individuals getting individual placement services while assigned to ACT could potentially be counted towards the State's Supported Employment numbers for compliance purposes.

In last year’s Report, steps were identified for the State to mirror standards by requiring the ACT team scoring at a high level on specific standards, ACT Team supervisors and other team members being oriented in and trained annually in IPS-SE, each ACT team enter into an agreement with a certified IPS-SE provider for purposes of case reviews and joint problem solving and team building functions and require a second certification and DHHS approval. This was recommended both in the FY 2015 report, by Katherine Burson and for inclusion in the Corrective Action Plan. On June 30, 2016 the State made a proposal to the Reviewer for requirements for ACT teams to meet Supported Employment fidelity requirements. The proposal does not fully address supervision and organizational requirements but could be modified and reviewed again.



The State will need to serve an additional 1,792 individual before June 30, 2019 to meet SE Settlement Agreement obligations. At the present rate and with the number of additional teams to be reviewed for fidelity in the next six months, the State will likely be at 92% of its required obligation on July 1, 2019 **(Figure 7).**

There is a likelihood the State with additional resources can reach the required number and build a solid foundation for sustainability and improvements in this valuable service.

The final recommendation and capacity building related issue is the building of IPS-SE capacity. Capacity building is about ensuring that IPS-SE programs reach fidelity, about assuring the services are effective beyond what is required for "baseline" fidelity and about ensuring IPS-SE is available where and when needed. In this case, capacity building includes ensuring the TCLI target population can easily access effective IPS-SE services. The State, TA staff, LME/MCOs and providers should work together to establish performance expectations beyond "baseline" fidelity requirements.

The DMHDDSA, DVR and DMA staff have worked collaboratively this year to create a stronger foundation for the program with rate changes, additional resources for providers, making roles more clear and revising the IPS-SE definition, exploring business model development and changes in DVR contracting. Training essential to promulgating these changes effectively was conducted as explained above. The State has made a significant step forward adding technical assistance resources for five new staff at the UNC Center of Excellence in Community Mental Health devoted to IPS-SE. State staff along with UNC staff have promoted the IPS-SE Collaboratives and DVR State staff have crisscrossed the state promoting a Community Rehabilitation Program (CRP) contracting model. Providers report the training is of high quality.

State and UNC staff appear to largely understand where targeting could be focused and with the key foundational issues now being addressed, targeting capacity can become a primary focus. Priorities for targeting the building of capacity include:

1. LME/MCOs expand IPS-SE to counties where there are not teams in operation that meet fidelity, using a data analytic approach to identify where more IPS-SE capacity is needed overall and for the Priority Populations.

2. The State and LME/MCOs reinforce their request for SE providers to seek CRP contracts.

3. The State contracts with LME/MCOs include modified IPS and provider requirements to fully reflect delegated SE Settlement requirements including threshold requirements for network capacity and numbers served.

4. LME/MCO leadership, Network Management and Contracts staff work more closely together and with TCLI staff to develop an understanding and take action to support the development of IPS-SE services and contracts to fulfill obligations delegated to them.

5. The State make changes to ACT requirements to assure individuals receiving ACT have access to effective employment services and ACT teams can meet equivalent IPS-SE fidelity.

6. UNC and the DHHS Divisions examine the IPS-SE fidelity scores by section to determine where there are strengths and weaknesses across the state and within LME/MCO catchment areas for further technical assistance and or changes in practice guidance and performance and contract requirements.

7. UNC and the DHHS Divisions building more TA capacity and tools for LME/MCOs and providers to expand and enhance business modeling, articulate contract requirements, develop Learning Collaboratives and add performance requirements beyond fidelity requirements.

8. The State and its stakeholders build a culture of confidence that supports individuals with SMI/SPMI going to work in jobs of their choice, building their skills and securing additional education where requested and necessary and creating accommodations where needed. This culture needs to extend to advocates, families, community leaders and employers

IV. DISCHARGE AND TRANSTION PROCESS

Compliance Summary

Slow, steady progress is being made on developing and implementing effective In-reach and Transition Planning. Nonetheless, the State is out of compliance with **E. (13)(c)**, the 90 day time frame for discharge planning after assignment to a transition team. It is essential to

assign a transition team, begin engagement and planning as early as possible, focus sufficient resources to transition steps and reduce barriers and redundancies in transition planning. The number of individuals who should be on in-reach status needs to be verified and updated so staff time can be spent constructively. Provider staff engagement occurs too late and providers taking more responsibility is essential. Strengthening compliance of In-Reach and Transition Planning will continue to be a challenge. New In-Reach and Transition staff, increased SH availability and a focus on joint planning and responsibilities will help.

III.E. (1-14). The Discharge and Transition section of the Settlement Agreement covers a wide range of tasks and action steps across the In-Reach, Discharge and Transition Planning functions. These tasks overlap with the Pre-Tenancy and Move-In tasks associated with Housing Slots and assigned to TSMs and to tasks provided by community mental health service providers discussed above. The State made progress in defining the Discharge and Transition obligations.

Last year's Report identified these tasks as transformative and transactional which by their nature would require significant refinement, improvement and to some degree consolidation for the State to be in full Compliance with this section of the Settlement Agreement. The State has provided additional funds for In-Reach and Transition Coordinators for each LME/MCO. By the end of the FY 2016, there were funds for eighty-six (86) funded In-Reach positions and ninety-seven (97) Transition Coordinator positions allocated to the LME/MCOs. The process of hiring new staff and re-calibrating staff assignments typically does not change the short term output. In another major development, a person will be hired at DHHS to serve as a TCLI liaison for County, DSS, LME/MCO and DAAS staff. This position will utilize NCFAST and NC Tracks systems to research case information inputting/updating data for TCLI participants. This will likely result in faster changes in Medicaid County of Origin and help resolve other issues that are required to update TCLI participant information reducing staff time and helping participants get quicker access to necessary benefits.

III.E. (1) The State is required to implement procedures for ensuring that individuals with SMI in or later admitted to an ACH or SPH will be accurately and fully informed about all community options. Procedures have been implemented, but the State is still falling short of individuals being accurately and fully informed about all community options. This issue raises effectiveness questions and will be more fully explored in **III.F. Pre-Screening and Diversion.** Nonetheless, information gathered from Individual Reviews and the State's data reveals that procedures are in place and being implemented.

III. E. (2)(3)(4)[a-e](5)(6)(7)[a-c](8)[a-d{i-ii.}e-f]) In-Reach and Effective Discharge Planning,

with a Written Discharge Plan. These items are reviewed together because LME/MCOs provide them as seamless duties although with separate staff assignments. The State is only in partial compliance on **Sections III.E. (2-3)**. but the State and LME/MCOs are continuously refining and improving these processes. One challenge in FY 2016 was orienting such a large group of new staff to the program and their duties. Towards the end of the fiscal year, it became apparent this orientation process was concluding and new staff were becoming full contributors to this work.

One of the overall strengths of the TCLI program is the work being carried out by LME/MCO staff assigned to these duties. During Individual Reviews, the Reviewers spend a great deal of time with In-Reach staff and Transition Coordinators while meeting individuals and reviewing their records Staff strengths, insight, tenacity and overall effectiveness were easily recognizable during these visits. They are challenged by others having low expectations for individuals they serve which is often manifested by indifference and/or negative feedback from ACHs, DSS staff, Guardians, families, providers and hospital staff who may be opposed to placement generally. Local agency staff and providers including hospital staff may be unaware of their obligations in this Agreement or more generally their obligations under Title II of the ADA and the *Olmstead* decision. It is not always easy for Guardians to clearly sort out the differences between these obligations and their fiduciary obligations as Guardians. The In-Reach workers and Transition Coordinators are learning overtime how best to navigate those challenges and to build relationships with ACH, hospital staff, DSS staff, Guardians, families and others.

As stated previously, these strengths also contribute to one of the program's weaknesses, the lack of service provider engagement. Transition Coordinators rarely end their role at ninety (90) days. This has been tremendously beneficial at the individual level as crises and chaos often envelop individuals moving into the community after long tenures in ACHs and SPHs. Individuals served in this program live on meager incomes, are often challenged by relapse, have challenges making decisions, have health crises, are faced with demands associated with benefit eligibility, are often isolated and exploited, have limited social and personal support and have severed or exploitive relationships with friends and families. Their issues are overwhelming but for many their will to succeed is strong and they rely on Transition Coordinators. Transition Coordinators are part of the community management system required of LME/MCOs; they are not service providers. The overall effectiveness of the service system is diminished if service providers play a passive role. The Transition Coordinators strength and commitment, cannot take the place of a strong service provider presence--both are necessary.

One example of the creativity and commitment of In-Reach staff was reflected in an incident

a Family Care operator screamed at a resident that he "wasn't right in the head" as well as making other negative comments. The In-Reach worker and the TCLI Supervisor, present during the visit, calmly removed themselves from the situation. The In-Reach worker re-calibrated his approach that led to his establishing a relationship with the individual away from the home. His ingenuity of knowing when to avoid confrontation he could not control but not allowing such vitriol from the owner interfere with the long term goal of the resident resulted in the individual making plans for moving to the community.

On **E.(2)** specifically, In-Reach staff appear generally knowledgeable about community supports but sometimes lack detailed information that would be helpful to answering questions or ease doubts of individuals they are interviewing. The State TCLI staff have been helpful to LME/MCOs and In-Reach and Transitions staff on these details. There are a large number of details and frequent turnover so experience and knowledge is still an issue. For some, attaining more skills in Motivational Interviewing and the Stages of Change model would be helpful. This varies as some In-Reach workers are particular skilled at Motivational Interviewing; their lived experience is invaluable.

The greatest challenges, though, with In-Reach are with the inaccuracies and duplications in the information on who is available for In-reach contact and meeting the requirements to continue In-reach when the individual has moved or does not qualify for the program. This latter point is detailed in **III. F. Brief Report on Pre-Admission Screening and Diversion (Attachment B).**

On the former point, the State and LME/MCOs have tried to better manage In-Reach especially follow-up with new strategies based on perceived interest and better information while retaining protocols consistent with Agreement requirements. For example, LME/MCOs are requesting housing slots quickly when an individual shows interest in moving to help the process be more realistic for the individual. It is helpful when In-Reach staff take individuals on short trips to neighborhoods. Adding visits model apartments or to visit persons who have already moved could also help.

Information gleaned from the Individual Reviews, DSS meetings and other conversations across the state suggest that individuals are not fully aware of changes being made. DSS staff, Guardians, providers, discharge planners and families don't yet have a common and complete understanding of the TCLI program.

The State is continuing to pursue information accuracy issues. The State believes and the Reviewer concurs there are duplications and errors in the number of individuals listed as

being on In-Reach status.

Current data reflects monthly ACH In-reach visits have exceeded four thousand three hundred and forty (4,340) a new high in June 2016 and an increase of 18% over June of 2015. Meeting In-Reach goals is challenging and staff are often faced with trying to reach out to everyone rather than spending more time with fewer people which could result in an increase in the number of individuals becoming more engaged and interested in moving to the community and/or being diverted from ACH placement if diversion appropriate.

There has been a somewhat even but steadily number of individuals receiving in-reach services while hospitalized in SPHs per month. The overall increase in those who started in-reach in SPHs in FY 2016 was one hundred and eighty nine (189) from two hundred and forty nine (249) to four hundred and thirty eight (438) or a 44% increase. The numbers remain quite low given the total of SPH discharges monthly. In May 2016, SPH discharges totaled one hundred and sixty eight (168); direct TCLI placement to a housing slot was four (4) which means that at the time of discharge only 2% of discharges were referred directly to a TCLI housing slot.

Fortunately in-reach contacts make it possible for TCLI placements to occur after discharge. In FY 2016 there was a 50% increase from fifty (50) to ninety seven (97) individuals who moved into SH who started in-reach in SPHs including twelve (12) in the month of June. If this rate were sustained, well over a hundred (100) individuals could access SH who started in-reach in SPHs annually. While priority for Supported Housing slots will remain with individuals living in ACHs, this would be a significant accomplish. It also supports the consensus in the field that it can lower re-admission rates and demonstrates the State's commitment to sustainable systems change.

Although data are not reported formally, the State confirms this occurs regularly especially with transition pilots. With more streamlined processes the number of direct TCLI discharges could increase substantially and could reduce the need for In-reach to ACHs, individuals moving to boarding homes and homeless shelters. Data also suggests stark differences in SPH in-reach by LME/MCO catchment area. There were no discernible differences across SPHs.

One problem currently out of the control of the LME/MCOs and to some extent the DHHS is the apparent constant movement of individuals from one ACH to another. This is often done by owners to avoid having one or more of their homes designated an IMD, for other business reasons such as ACH consolidations and closings or owners having unstated

agreements with other owners to move individuals who may be disruptive. To some degree individuals may chose to move to be closer to family, because they no longer like living in a particular home.

Further discussion and analysis will be conducted this coming year to quantify this issue and determine if there are steps that can be taken to mitigate this problem. The NC General Statute, Chapter 131D. voluntary closure process does little to help LME/MCOs with identifying where people move. As evidenced in a review of Cardinal's "Hub" role in a recent voluntary closure in Halifax County or the Alliance's "Hub" role with Country Home in Cumberland, many individuals moved before the Alliance team arrived even after the State's notice to the Alliance staff.

In-Reach and TCLI staff frequently comments on this issue and the extent to which this is disruptive to the In-Reach process while not quantified yet is well known. DSS staff have mentioned "buses rolling up" to move people from one home to another. While some of this information may be dated or even over stated, a number of people familiar with the process have made similar comments on the lengths to which private owners move individuals, denying choice at the time of a closure. Smoky and the Wilkes DSS went to extraordinary means to ensure choice was offered as a result of a recent licensure revocation at the Wilkes County Home and while no evidence can be corroborated to date that individuals were exploited or coerced, Smoky was able to offer choice to those eligible for TCLI and Smoky has information on where people moved so they could continue in-reach services. This will be addressed again in **III. F. (14)** but its bearing on In-reach cannot be understated.

III. E. (3) requires the State to provide individuals with SMI with an effective (written) discharge plan. There was evidence in the Individual Reviews and by State reports that written discharge plans with goals referenced in the Agreement are completed with individuals in the TCLI Transition Phase.

To date the Individual Reviews have been limited to review of individuals in the TCLI data base. Beginning in FY 2017, this review will be broadened to include individuals with SMI regardless of their TCLI status exiting SPHs[43].

Plans reviewed in FY 2016 revealed that while referrals to providers are being made linkage to services is uneven, sometimes delayed or not begun at time that would be most effective for discharge planning or individualized in all domains of an individual's life. This was

[43] Information on individuals exiting ACHs is limited to those identified through In Reach, including those not diverted but with a Level II screen who moved to an ACH.

reported earlier in the Compliance Findings and Community Services sections of this Report. The Reviewer has recommended that the PCP process be revamped with a focus more on engagement and planning and less on getting detailed information from individuals through multiple visits as required with the current process.

On multiple occasions, reviews revealed Transition Coordinators and In-Reach workers meet with individuals at least three times just to complete forms, primarily the In-Reach/ Transitions to Community Living Tool. This process requires a high and unrealistic attention span. It would be more helpful to consider in vivo discussions about interests and "perspective". Current review protocols did not include a question regarding the number of visits to complete the forms but will be added to this year's protocol. Filling out forms can never replace the value of well organized, intentional and informed PCP interviewing. When the focus is on getting all the required information into the required planning tool, the attention to relationship building becomes less of a focus at the time it is needed the most. This issued has been raised with State staff.

Section III.E.(4)(a-b) refer to discharge planning being conducted by transition teams that include persons knowledgeable about resources, services and opportunities in the community and professionals with subject matter expertise about accessing needed community mental health care including other types of care essential for a safe and successful transition to community living. TCLI teams appear very knowledgeable and eager to secure services and/or seek assistance but some are limited by the breadth and level of their experience and knowledge of what is needed for a successful transition. This is primarily a foundational issue that will likely improve over time and the type and level of support staff are provided.

III.E. (4)(c-d) refer to staff having the **linguistic and cultural competence** to serve the individual and having peer specialists available. Based on Individual Reviews, the State appears to be in compliance with these provisions. As LME/MCO catchment areas grow and become more culturally diverse, it will be important for LME/MCOs to consider the cultural make-up of their teams and supervisors.

III.E. (5) refers to the State psychiatric facility, the PIHP and/or LME transition coordinator working in concert with the facility lead. The State is fortunate to have very committed State Operated Healthcare Facilities staff assisting with building these partnerships. In the limited time spent with teams and in State psychiatric facilities it appears there is some movement in this direction although there is no indication transition teams setting specific goals to improve timeliness of discharge related tasks which is discussed in **III. E. (13)(a-c).**

Section III.E.6. refers to each individual being given the opportunity to participate as fully as possible in his or her treatment and discharge planning. There is sufficient evidence the State continues to be in full compliance with this provision.

Sections III.E. (7) (a.-d.) Discharge Planning. Progress is being made toward compliance with **Section. E. (7) (a-d)** as staff are increasing skills in developing "effective" plans for individuals to move to a more integrated community setting. This comes with time, willingness to embrace recovery and make a shift in staff skill sets. There was not definitive evidence during the Individual Review process that discharge planning begins at admission although LME/MCO Hospital Liaisons get information on admissions in a timely manner and communicate this information to TCLI staff on a regular basis. In FY 2017, a review of SPH records will be conducted to further assess **E. (7)(a-d).**

III.E. (9-12) requires the DHHS to create a transition team at the State level to assist local transition teams meet their requirements, identifying and addressing barriers and reporting quarterly or more frequently upon request to update transition plans as needed. The State TCLI staff meet routinely with TCLI Coordinators, In-Reach Specialists, SPH and SOHF facilities staff. Meetings occur at SPHs quarterly. Barriers are reviewed. Key issues such as County of Origin, availability of specialized services, availability of housing and challenges with planning processes are typically discussed. Collaboration among planning partners is raised although in the spirit of cooperation discretely discussed.

It is recommended Transition teams set quarterly goals including reducing and/or eliminating barriers to individuals being discharged to TCLI housing slots or to the community with TCLI supports. Transition teams should include DSS staff and meet with community hospital discharge planners on a scheduled basis. Planning for individuals considered at high risk for re-admission, relapse and disengaging in services and identification and availability of additional services including specialty services, medical and personal care services and peer support are either missing from plans and/or inadequately addressed as referenced in the Community Services section of this Report.

III.E.13. (a) (b) and (c) refer to time frames and requirements for In-Reach, Discharge and Transition Processes. The State is in compliance on **III. E. (a) and (b).** Meeting the requirement for **III. E. 13. (c)** is still unattainable in part because of the lack of available housing, denials, eligibility barriers and challenges with completing documentation and Plans. It is not uncommon for individuals to be ambivalent about moving and for others such as Guardians and family members to have differences of opinions on where and how the move should happen, if at all.

Transitions are taking on average 133 days from Housing Slot issuance. The SA requires this be 90 days. This means this average needs to be decreased by 33%. This would significantly reduce the period of uncertainty individuals have about moving. There is an iatrogenic effect of waiting a long time for discharge after getting a "housing slot" and planning for discharge. It is not uncommon for persons ready to leave the hospital to become anxious, even agitated and sometimes this leads to an adverse decision for the person being considered "not ready" for discharge.

The question of needing additional TCLI staff and In-Reach workers gets broached at times. With the FY 2016 increases in TCLI staffing, there is no indication additional staff would solve the effectiveness problems found in Transition Planning in this Review. Fundamental changes in processes, clear oversight, stronger performance management and changes in service provider availability and responsibilities are key issues today following four years of implementation and increased staffing.

DHHS is planning on making performance targets and making accomplishing applicable TCLI tasks a requirement in staff performance evaluations. On the theory of what is not assessed or measured won't be achieved, movement in this direction will likely yield results. The LME/MCOs are urged to do the same not just with TCLI staff but across a broader range of staff as discussed earlier and likewise urged to add performance measures to provider contracts.

Recently questions and allegations have arisen that In-Reach and TCLI staff are pushing people out the door when they are not ready. After conducting over 170 individual reviews across multiple types of reviews, there is no evidence this is occurring. Choice and the safety and the well being of individuals are universally respected. At times individuals ask to leave an ACH or express concern because of their fear of being struck by others, falling as a result of being accidentally hit by residents in wheelchairs, intentionally hit by residents or have difficulty getting along with a roommate who may be disruptive.

A number of individuals exiting ACHs and SPHs have chronic health conditions and would benefit from personal care services, home health and specialty health care. Steps are being taken to address this issue but its importance cannot be understated. Often Supported Housing is not considered an alternative because where an individual lives is confused with what an individual needs to live in their own home. The deciding factor should be based on an individual’s need for skilled nursing care or related to their dementia or other illnesses and disabilities which are dis-qualifiers for the TCLI program. Wellness coaching, home health and specialty CST and ACT, that are not available now, are also critical as referenced in the Community Services section.

III. E. 13 (d) (i-iv.) includes that required procedures be followed when ACHs have received notice that it is at risk of a determination that it is an IMD. This has only occurred twice during the entire Settlement period and only now as a result of IMD reviews starting to take place in 2015 after a four year break in reviews. One notice was rescinded after additional information was submitted by the ACH in question and before the LME could actually go to the home to intensify their In-reach. On the second situation when the ACH received notice the Reviewer met with Sandhills and visited the home. The owner was not present, working at the other home she owns that day. Based on that visit, Sandhills will be required to continue with In-Reach and Transition Planning. "At Risk" designations will always require the LME/MCOs to reach out to individuals quickly given the history of ACH owners moving individuals to avoid losing revenue.

For **III.E. (d)(iii.-iv.)** the State and LME/MCOs have followed requirements to track the location of individuals who moved out of an adult care home on or after the date they received an At Risk notice and to provide In Reach, Transition planning and services as required for individuals in Priority Group 2. Tracking individuals has been very challenging given individuals moving between ACHs. Nonetheless the State and the LME/MCOs continued with in-reach for individuals who became part of Priority Group in 2013 at the time the Agreement took effect.

I**II. E. 14. The State shall monitor ACHs for compliance with the ACH Bill of Rights requirements contained in Chapter 131D of the NC General Statutes and 42 C.F.R. § 438.100.** The review of this provision was limited to a review of the State and LME/MCOs meeting their responsibilities in Chapter 131D and 42 C.F.R. §. 438.100. On three occasions when the potential of imminent harm and/or exploitation was observed directly, incidents were reported consistent with requirements in 131D. Even when reported directly, the focus was first on the LME/MCO filing a complaint, reporting abuse and neglect or potential fraud and second, follow-up inquiries to see that the complaint was made, investigated and confirmed or refuted and that In-Reach and Transition Planning not disrupted or halted and individual choice not impeded. The review was not of the investigation per se which is outside the purview of this Agreement. On other occasions when the Reviewer learned second hand about an incident, the second step referenced above was taken to discern compliance with this provision. It appears DHHS has been required to deal with investigations recently that have consumed a great deal of staff time. Given the welfare, health and safety of ACH residents is in the balance, this time is necessary and likely ongoing.

As referenced previously LME/MCO staff voiced concern about retaliation towards residents if they reported incidents to DSS and DHSR. While this may have occurred and still may, the LME/MCOs must report it in accordance with their contracts with DHHS (DMA and

DMHDDSA) contracts. OAAS and DHSR are working closely with local DSS staff on these issues. DHSR is demonstrating leadership in investigating potential licensure violations. Recommendations for improvements in this provision include: 1) the LME/MCOs and County DSS Adult Services Units working more closely together on reporting and feedback; 2) the LMEs/MCOs report to DHHS any concerns they have about DSS follow-up but only after they have first reported to DSS and provided the DSS the opportunity to remedy the situation; and 3) DHHS ensuring DHSR has adequate capacity to follow-up on inquiries and complaints.

Information on the proposed Wilkes County Home revocation is a good example of a strong working relationship between DSS and the LME/MCO even though their responsibilities are different and sometimes seem at odds on assuring choice and protecting safety--these do not need to be mutually exclusive

While only partly related to this item, it is important to note that DSS Directors, Adult Services and Guardians are critical to the success of Agreement. The DHHS has provided six trainings for staff this past year. This is helpful for orientation and disseminating information. The Reviewer has met with five DSS Directors and their staff and attended one meeting of the Adult Foster Care Region 1 Association in July 2016. LME/MCO staff accompanied the Reviewer to two of these meetings. The meetings were held for the purposes of an exchange of information and identification of challenges. They were informative and it appears that this type of exchange on a regular basis between DSS staff and LME/MCOs would be more beneficial way to build collaboration and achieve progress than further training (unless new information needs to be conveyed). The Reviewer plans to continue local DSS meetings with LME/MCO staff.

V. PRE-ADMISSION SCREENING AND DIVERSION

Compliance Summary

The State is not in compliance with **III. F. (1)** and in partial compliance with **III. (2)-(3).** A number of the processes listed in the SA are in place but the processes are used primarily to gain access to ACHs without informed choice and the processes are not instrumental in creating diversion opportunities.

The information secured from the Review and State reports would indicate the Level I screen and Level II Review is not helpful to LME/MCOs in their establishing a relationship with an individual and beginning in-reach even after changes were made to the process in FY 2016. The State is committed to revamping this process again to come into compliance with these items and is the beginning stages of an eighteen month plan for completing and implementing this re-design. Recommendations for these changes

have been discussed and briefly outlined below. The process to shift away from the current PASSR will be lengthy and many organizations will need to be consulted with before and trained after a new approach is implemented.

The DHHS DMHDDSA will implement this new process over the next twelve to eighteen months and have extended their current contractor's (Earthmark) contract for eighteen months while these changes are being made. One challenge facing the DMHDDSA is having sufficient internal resources to carry through with tasks to complete this overhaul. Another challenge will be organizing and delegating resources to make this shift. The **Brief Report Pre-Admission Screening and Diversion Voluntary *Olmstead* Settlement Agreement (Attachment B)** was submitted to the State with a description, methodology and findings from this review.

3. F. (1-3) The State will define and implement tools and training to ensure that when any individual is being considered for admission to an adult home, they shall arrange for a determination, by an independent screener, of whether the individual has SMI and connect any individual with an appropriate LME/MCO. In F.2. once screened the LME/MCO will work with the person to implement a community integration plan. In F.3., if an eligible individual after being fully informed of their choices, chooses to transition into an ACH, it is the responsibility of the LME/MCO to show the decision is an informed one and set forth and implement individualized strategies to address objections and concerns and to monitor individuals residing in ACHs, offering In-reach and Transition Services.

The State continues to use a Pre-Admission Screening and Resident Review (PASRR) process to screen individuals with serious mental illness referred to ACHs for admission as instituted on January 1, 2013 in accordance with **III. F. (1)**. The State refined this process and extended a new contract to an organization to conduct independent screens in FY 2016 to assure individuals were screened in a timely manner to minimize multiple transitions.

DHHS has had a number of challenges meeting this requirement. Staff reported data base and reporting flaws that may have made 2013, 2014 and 2015 reporting inaccurate. In FY 2015 staff reported they would be using two indicators to track carefully the number of second level screens per month and the number and percentage of diversions. According to State and LME/MCO staff, the amount of missing and incorrect information was leading not just to reporting errors but it drastically affected the LME/MCO's diversion response capability. A significant number of

individuals are being admitted to ACHs or remaining in ACHs without being assessed as a result of misinformation and reporting issues. The Reviewer deferred a review of these provisions last year while changes were being made to the process. The State and LME/MCOs indicate improvements were made but without a pre and post evaluation of those improvements, a review of their effectiveness is not possible.

The first Reviewer reported the State was not in compliance with the Pre-Screening and Diversion provisions of the Settlement Agreement. Given their shift and progress with reporting, the State was determined to be in partial compliance on all these provisions in FY 2015.

In FY 2015 the State decided to contract with Earthmark to complete the Level II Comprehensive Clinical Assessment and screening process and initial CIPs. The State updated the CIP and Guidelines to meet the needs of the new Level II screening process for Earthmark. Training was conducted and the PASRR manual was revised to include the revised and updated CIP forms and guidelines. The State was very hopeful the new process would reduce problems.

A more thorough review of Pre-Screening and Diversion provisions was conducted in January 2016 providing the State and Earthmark contract six months to demonstrate needed change. The review was conducted in January through early March with forty (40) reviews of Level I screens, Level II reviews and CIPs, interviews with LME/MCO staff, Guardians, ACH staff, Earthmark contractors and State staff and visits to six individuals who were not diverted. These reviews were conducted in the Cardinal and Alliance catchment areas.

In addition to these findings, the DHHS TCLI monthly report depicts one thousand and forty four (1044) PASRRs "In-Process" for the year, one hundred and thirty nine (139) diverted, six hundred and sixty eight (668) not diverted equaling eight hundred and seven (807). There are some regional differences in the number of PASRRs processed with Eastpointe, Sandhills and Partners receiving a disproportionate percentage based on their population as depicted below **(Figure 8).** These differences are minor and likely reflect the use of PASRR as a placement tool by community hospitals, DSS staff and or Guardians. There are also differences reported in the number of individuals diverted per capita by LME/MCOs. Based on accuracy questions and widely divergent numbers of individuals in process, these are not reported on at this time. The State is continuing to assess these numbers for accuracy.

Figure 8: PASRRs Screened

LME/MCO	Total PASRRS Screened	% of Total Screened	LME/MCO % of per capita pop.
Alliance	259	14%	18%
Cardinal	383	20%	24%
CenterPoint	92	5%	6%
Eastpointe	237	13%	8%
Partners	223	12%	9%
Sandhills	183	10%	11%
Smoky	274	15%	11%
Trillium	200	11%	13%
Total	1851	100%	100%

A review of CIPs reveals the first section is written as part of a two part review for ACH admission but are not designed for and actively used for ACH diversion planning. The items in the CIP are cursory. During follow-up phone calls, Earthmark contractors did not elucidate having such knowledge and reported some inaccurate diagnostic information. The CIP planning as currently carried out is redundant and communicates the service system's interest is in facilitating ACH admission, not diversion to community living. While screening needs to be independent, it can be so disconnected to the service system that it becomes a de facto ACH admissions processing approach or results in individuals becoming quickly disengaged from services altogether.

The State also reports the totals do not reflect those that were sent to the LME/MCOs and in a diversion status or in process then withdrawn from the process due to the determination the individual was either moved out-of-state, was deceased, had a primary diagnosis of dementia, IDD or was not SMI/SPMI or not medically or psychiatrically stable. This year's more intensive review also revealed that LME/MCOs had difficulty finding some individuals as the addresses on the forms they received were old or incorrect or that individuals had already moved or been living in ACHs. It is very difficult for the LME/MCO to get a FL-2 form completed that reflects the current level of an individual's dementia or absence of a SMI/ SPMI disabling condition. At a recent meeting of DSS Adult Services staff, an inquiry was made for the possibility of getting more certified Level 1 screeners so more people could get screened more quickly and moved into ACHs.

As stated in the compliance summary, the State recognizes issues with the process and how it contributes fewer diversions. The larger point of diversion is that individuals have

informed choices and are being connected to services at or before they reach the screening verification point in the process.

There are interim steps the State can take now to potentially be in compliance before the revamped system is implemented. The State can ensure that no one moves to an ACH and screened after the fact (now generally screened by a staff member of the home). LME/MCOs can reach out to each DSS in their catchment area, their hospitals, especially those who are referring a significant number of individuals to ACHs, from their psychiatric unit(s) or medical units to establish closer working relationships for the purpose of making community placements, using the Targeted Unit Transitions Pilot or other resources. The State could also design and test out a new one step "CIP[44]/ expedited PCP" process tracking referrals in real time to help ensure placements are more timely.

For diversion to occur as a realistic first choice, the transition planning process would have to be extensively revamped to come in line with best practice. An individual review "preliminary" LME/MCO generated preliminary PCP could take the place of the CIP with redefined roles for service providers, LME/MCO Care Coordination staff, In-Reach and TCLI Transition Coordinators. This would enable the review to be used to expedite approval for TCLI housing slots and services. It will be essential for staff with skills in assertive engagement and person centered planning for this target population and knowledgeable with community resources to be engaged. There are several options for obtaining the independent verification of SMI.

The State and LME/MCOs will need to enhance and direct resources for providers to this effort rather than succumbing to only suggesting this be done by just adding LME/MCO staff without concomitant changes in provider responsibilities. Care coordinators who already have responsibilities for assisting with discharge arrangements and network management staff can be engaged. This will require changes in LME/MCO authorization practices, care management and changes in contract and performance expectations for service providers. With the interest already generated within the DHHS and the LME/MCOs, it appears the State will meet compliance requirements but not in the short term.

[44] The SA requires a CIP in 3. F. 1. but there is no prohibition from establishing a single plan

VI. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Compliance Summary

The State is not in compliance with **III. G.(1)** is in partial compliance with **III. G.(2-4 and 6-7)** and **G. (5 and 8)** deferred. A non compliance finding on **III. G (1)** is related to the lack of contractual obligations for housing administration and contracts with LME/MCO and between the LME?MCOs and providers to measure performance in delivering services and supports, including filling Housing Slots pursuant to this Agreement. In FY 2016, the DHHS began publishing a very useful dashboard for measuring performance and for LME/MCOs to use for decision support. The dashboard can be an important tool but not yet sufficient as a dashboard. Many protocols, data collection instruments and requirements are tracked and are helpful for decision support.

There are always cautions with collecting information for compliance as well as for decisions making, quality improvement and measuring performance and outcomes. One, there is always the danger of redundancies and collecting only information that is useful. Even with these cautions and with noted limitations, there are numerous examples of data being collected and informing decisions in Pre-Admission Screening, In-Reach, IPS-SE, Tenancy Support and housing access.

III.G. (1) is a requirement for the State to develop and implement a quality assurance and performance monitoring system. The State's task is to implement a system to ensure community-based placements and services are developed in accordance with this Agreement, services and supports individuals need for their health and safety and welfare are in place. There are eight requirements, one with, five sub-requirements and another with eight sub-requirements included as part of this requirement. This provision includes goals for a number of important items necessary for individuals to achieve greater independence, be more integrated, obtain and maintain stable housing, avoid harm and decrease institutionalization.

The State is still working to overcome a number of inherent barriers to develop a comprehensive quality assurance and performance improvement system that meets these requirements. The challenges include: 1) measuring performance including trying to measure performance while still building and changing the system; 2) reducing the repetitiveness of documentation and plans beginning with the PASRR, In-Reach, Transition, Discharge Planning and Community Based services and housing documents (assessments, plans, etc.) that consume time and energy; 3) holding required reporters accountable through contract obligations so data can be verified more quickly and reporting is completed

timely within requested due dates; and 4) collecting information collected through plans and documentation to meet multiple requirements and report performance.

The State began building infrastructure and processes to accomplish quality assurance and performance improvement early in this compliance period. As reported last year, a pre-requisite for accomplishing this task is developing uniform applications for data collection, tracking and monitoring and establishing standard reporting and developing protocols. The State has continued to refine its monthly and annual reports. Issues still exist with reporting and verification. The State has rectified some reporting and verification problems, IPS-SE reporting is an example.

To be in full compliance with **III. G. (1),** the State must "ensure" that community-based placements are developed in accordance with this Agreement**.** This is not yet fully possible because the State does not yet hold the LME/MCO's contractually accountable for all the specific requirements to ensure services are developed in accordance with provisions of this agreement and 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.

A recent review conducted by Colette Croze, and confirmed by a review of her report and referenced documents reveals that core documents that should have contained key expectations were insufficient for adequate accountability and as such decrease the State's ability to discharge its Settlement Agreement obligations necessary through the work of the LME/MCOS. Other documents reviewed for this Report create non binding expectations but they do not replace contractually binding requirements.

Of the twenty (20) indicators required in the Settlement only twelve (12) or 60% are reported. Likewise the number of DMA contractually required measures that are to be reported; only six (6) or 15% are reported. Of the key Settlement Agreement requirements that are to be contractually delegated, only two (2) of 15% are in the LME/MCO contracts.

There are Quality Assurance and Performance requirements in place for other items, **III. G. (2-8)** referenced below. But developing and implementing a quality assurance and performance system to ensure that community-based placements and services are developed in accordance with this Agreement takes time and requires that contracts and formal guidance be performance and outcome based so it can be reviewed and measured. This includes performance expectations be set in contracts for services, supports, In-Reach and Discharge and Transition Processes, Pre-Admission Screening and Diversion, housing development and support and training/technical assistance.

Quality assurance and performance reporting should reinforce effective transformational and transactional decision-making. When these processes are separated as they are now, they tend to become duplicative and staff begin to see these interactions, transitions and decisions as being separate. It leads to under estimating the value of clear, joint cross-party responsibilities to outcomes. Needed improvements are more often seen as being the responsibility of another party not being a joint responsibility. Behavioral health, other human service delivery systems and housing support systems are notable for how performance and reporting break down when two more systems are involved, especially when payment is tied to certain outputs and outcomes.

III.G.(2) A Transition Oversight Committee is required to monitor monthly progress of the Implementation of this group, chaired by the DHHS Secretary's designee. It is reported that some required members of this required group, meet as a leadership team. Minutes of the meetings of this group have not been reported. The Settlement Agreement does not require the NC HFA, the Division of Aging and Adult Services and Disability Services (VR) to be a member but DHHS includes them in regular leadership meetings and they are vital members of the Team. It is unclear to what extent SPH Executive Officers, MFP, LME/MCOs participate.

III.G. (3)(a)-(g)(i-vii) includes Steps taken related to Quality Assurance and Performance Improvements. The State has taken steps to develop and implement a majority of the requirements listed under **III.G. (3).** Still missing from their reporting is overall community tenure, not just reporting housing slot tenure. This may difficult to verify for individuals who don't have housing slots. It would be useful for comparison purposes and for reporting on effectiveness of services for individuals in TCLI not receiving Housing Slots. Likewise reporting on congregate day programming and patterns of repeat emergency room visits is missing. For these items and others listed **under III.G. (3)** not included on the dashboard (including institution length of stay, readmissions, census tracking, re-admissions, number of people employed, attending school or engaged including community life or maintenance of chosen living arrangement), it is not clear to what extent there are performance expectations for these items for LME/MCOs and LME/MCOs with providers.

The State is required to develop and implement a centralized housing data system to inform discharge planning **(III.G. (3)(e).** The State has centralized a housing data base and has been upgrading this data base for payment flow, referral workflow and streamlining functions overall. However, establishing a system to fully inform discharge planning relies on daily input and updating (real time) availability from a single source for each LME/MCO catchment

area. In part this is a housing search issue, though rather than just a data input and availability issue which will potentially improve with Socialserve.

III.G. (4) Quality Assurance System: This item requires information be regularly collected, aggregated and analyzed, both for successful placements and problems or barriers. The State is required to review this information on a semi-annual basis and develop and implement measures to overcome identified problems and barriers. The state has developed measures, collects data and reports on many provisions in a usually reliable monthly report. These are required to be reported in an Annual Report. The State's recent Corrective Action Plans listed challenges. A formal listing of major barriers and progress on overcoming challenges could be reported and reviewed with internal and external stakeholders semi-annually. This is done informally now. A good example of a barrier that was analyzed in FY 2016 was the landlord and property manager denial of participants' housing applications.

DHHS and HFA staff and stakeholders worked collaboratively to establish a more up to date HFA Fair Housing Policy and other materials, met with owners, provided training for landlords and for LME/MCO staff who work with participants and landlords and property managers. Other examples reported earlier are the recognition the PASRR process is not yet working well for diversion purposes and that In-Reach processes could be improved so that LME/MCO In-Reach staff could maximizes their time engaging individuals who are interested and could benefit from community placement.

III.G.(5) Quality of Life Surveys: The State is required to report Initial, Follow-up and 24 Month Follow-Up surveys. The State indicated these would be referenced in their TCLI Annual Report.

III. G. (6)(a-j) External Quality Review (EQR): The LME/MCOs have been audited by CCME the Carolinas Center for Medical Excellence (CCME) and Mercer consistent with C.F.R. 438.58 requirements for EQR. The Reviewer was able to shadow one review at Smoky in the fall of 2015. Review summaries are reportedly to be published in the Annual Report . When **III. G. (1) and III. G. (6)** are read together, it appears the EQR process is of limited value as part of the State's obligation under **III. G. (1)** the State and the LME/MCOs could be take advantage of this opportunity for TCLI beyond evaluating the basic adherence to processes for completing desk procedures. Overall the EQR could be a valuable tool for organizations meeting "PIHP" requirements and the State is encouraged to consider how the "PIHP" processes can enhance TCLI performance and overall compliance.

III. G. (7) Use of Data: refers to the State's capacity and actions to aggregate and analyze data collected by the State, LME/MCOs, and the EQR organization on the outcomes of this Agreement. There are a number of examples of how the State has taken action. One in particular is a shift in approach to In-reach contacts. The numbers being reported likely include duplications and individuals listed initially who have moved with no forwarding information. Over time, if corrected, this will enable In-Reach and Transition staff to focus more attention on building trust and confidence with individuals who may indicate being more ready to move. Other examples include the shifts being made at the LME/MCO level and State level to increase In-Reach for individuals in State Psychiatric Hospitals and the increase in PASRRs being processed. The State will need support from LME/MCOs for this to occur and State staff across multiple DHHS Divisions will be called upon to make these shifts.

G.8. (a) and (b) The State is requried to publish an Annual TCLI Report. The most recent Report was not published before this Report was written.

Summary of Findings and Recommendations

There are many recommendations listed in each Report section. Compliance Ratings are included **Attachment A.** with comments. The requirements of this Settlement Agreement are achievable with strong leadership, continued financial support and changes in practice, resource allocation and contractual commitments. Below are five major Findings and Recommendations for key threshold requirements:

(1) The State is making slow and still somewhat uneven progress across most threshold provisions in the Settlement Agreement. TCLI program funding requests have been honored by the Governor and Legislature and TCLI, DHS leadership and LME/MCO leadership is strong.

(2) The State remains out of compliance with one Supported Employment provision, the number of individuals in the Priority Populations being served by providers who meet IPS-SE fidelity. This report details the significant changes being made by the State to come into compliance with this provision. Though it will be challenging, the State needs to continue its current Plan and retain momentum. It now appears possible the State may come close or meet its compliance requirements by the end of June 2019. Much of this optimism is based on DHHS initiated changes. Going forward, LME/MCOs will play an ever increasing role in analyzing their needs, supporting and expanding their provider system. Continued expansion/start-up funding, attention to business development, provisions for ACT teams mirroring IPS fidelity, provider performance and building provider capacity will be monitored

closely as these appear to be issues most associated with potential success meeting the Supported Employment requirements.

(3) The State is no longer in danger of falling further behind in meeting the threshold provision for filling Housing Slots but is only making minimal progress. The State does not yet have a Plan to be in full compliance by June 2020. The State put forward a Corrective Action Plan in June 2016 that outlines a strategic course of action. The third-party vendor contracted to submit a draft Housing Plan for State consideration will be submitting their final plan, reviewed by State agencies and stakeholders, by October 28, 2016. While the State will be working with the vendor to make final revisions of the Plan prior to this date, it is not clear what priorities, actions and timeframe for actions, will be included in the Plan.

It is recommended this Plan be melded with the Corrective Action Plan submitted in June 2016 to frame a more detailed, actionable course that will yield resources necessary to meet this threshold requirement. In the meantime the impact of the Fair Housing focus and expansion of housing agreements and other actions should become more evident. The Plan and impact of this focus and agreements, will be reviewed by the end of the calendar year and submitted to the Parties in a six month housing review.

(4) There are significant gaps and limitations in the array, intensity and availability of community mental health services. The State is beginning to fill this gap with Tenancy Support Management services but adding a service to the Medicaid state Plan is projected to take at least a year and a half; state resources are being utilized now to pay for the service. Yet the current definition omits key interventions and does not cover individuals not living in a funded TCLI Housing Slot. Medicaid and state data analysis will be conducted in FY 2017 to pinpoint patterns of use and how these correlate with the perceived service needs of the Priority Populations. This will include an analysis of medical and health related services paid claims.

(5) LME/MCO infrastructure and leadership is essential and leadership. A recent analysis reveals the LME/MCO contracts show gaps in the State's delegation of Settlement Agreement requirements to the LME/MCOs. There are still required reporting elements missing from reports although the State has made good progress on developing the infrastructure for reporting performance improvement. The State published its first TCLI dashboard template in February 2016 and after feedback has refined and is publishing this dashboard monthly.

(6) Pre-Admission Screening and Diversion is largely screening for ACH eligibility and diversion is rarely achieved before ACH admission. The State is committed to re-vamping

the PASSR process which is projected to take up to next eighteen months. There are steps the State can take to address critical issues while changes are being made.

(7) Access to Community Mental Health Services, Supported Housing Slots and other resources remains is greater for individuals in the sub-target population being diverted from ACHs than for individuals residing in ACHs and much greater than for individuals exiting State Psychiatric Hospitals.

Full compliance and success of this program is predicated on staff and supporters recognizing this accomplishment requires transformative change. Most importantly, believing recovery is possible for individuals with disabilities and nurturing and instilling hope are by far the greatest contributions that can be made in this endeavor. With that belief and action, compliance can be achieved.

Respectfully Submitted,

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Martha B. Knisley
Independent Reviewer

Date: 10/ 1 /16

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 Supported 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	PC	These numbers are limited; the State is not keeping pace with FY 2020 III. B. (5) requirement for 2000 individuals to have access to SH
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	(low) PC	When combined with B.2.(a.) and (c.), does not keep pace with 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	(low) PC	When combined with B.2.(a.) and (b.), does not keep pace with 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	(low) PC	The state has yet to develop effective measures for all the individuals who may benefit from SH exiting SPHs to access SH directly upon discharge or within a short time frame.
5.	III.B.2.e.	Individuals diverted from entry into ACHs pursuant to the preadmission screening and diversion provisions of Section III. (F).	PC	The state has effectively made SH available to individuals at "risk of" inappropriate institutionalization but not routinely diverting individuals from ACH placement.
III.B.3.		The state will provide access to 3000 housing slots in accordance with the following schedule:		
The state did not meet the housing access requirements in 2013 and 2014; each year a new row will be added to the Report of the state's performance in meeting the SA Housing slots requirements.				
6.	III.B.3.a.	By July 1, 2016 the State will provide Housing slots to at least 1,166 persons	NC	The state has not met this obligation for two consecutive annual reporting periods.
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.	(low) PC	Rules and procedures are in place but the State has not taken sufficient steps for this process to result in timely move-in. It is recommended the state reduce steps and redundancies from an individual being identified as potentially eligible to "move-in".

Rating Taxonomy:
C: The State is in full compliance with this requirement
PC: The State is in partial compliance with this agreement trending toward full compliance with this agreement; LPC is "low" partial compliance which means the State is trending toward compliance but at a slower rate and at risk on non compliance and "HPC" means the State is carrying out instrumental activities and more effectively and often faster rate than PC
NC: The State is not in compliance with this item because steps taken are not effective, delayed or substantially below a specific requirement
D: Deferred, there is not enough information available to rate this item.
NR: Not rated

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	Fifty-six percent (56%) of the slots offered have been provided to individuals in Category 5; this item will be rated after June 30, 2020.
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 utilizes ongoing programs and given the lack of available private units, can likely only meet the terms of this agreement using 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 permanent housing with Tenancy Rights	C	No additional comments
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	(high) PC	Tenancy support services (TSM) were expanded in FY 2016, a new service definition created, training provided and additional funding allocated to the LME-MCOs to contract for this service. These changes took place in the last six months and based on a limited review, appear to be effective. Further review is needed.
12.	III.B.7.c.	They enable individuals with disabilities to interact with individuals without disabilities to the fullest extent possible	PC	TCLI staff has been cognizant of this requirement as part of their assistance to recipients in making housing choices which is often time consuming but essential.
13.	III.B.7.d.	They do not limit individuals' ability to access community activities at times, frequencies and with persons of their choosing	(low) PC	Housing availability is limited; which also results in some individuals having limited access to community activities.
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 DHHS staff has consistently applied 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	PC	Resources to assist individuals who may meet PCS criteria for self care and daily activities have recently been made available through presumptive eligibly for PCS; however, individuals who don't meet the PCS criteria threshold but may still need assistance should be provided assistance to have more integration opportunities.
16.	III.B.7.g. (i.) and (ii.)	The priority is for single-site housing. *does not include full text*	C	No additional comments

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	No additional comments
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	No additional comments
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	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, County of Origin problems slow down the process and interfere with access. There are not sufficient services available at the point where an individual could be diverted; nor does the current array (or use of current array) provide opportunity to live in community based settings. The State is building capacity through new TSM services and training and technical assistance.
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	The array of services, while not always available and at the intensity needed, are available through the 1915 (b)/(c) Waiver and state funding.
	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;	(low) PC	Reviews and data indicated there is still variability in the degree to which services are strengths based and recovery oriented to strengthening individual's networks of community and natural supports.

20		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.		
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.	PC	The State is relying heavily on ACT availability; there is some variation about the availability, accessibility 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. It appears service requirements in the SA may not be included as performance requirements in contracts. This will be further reviewed in FY 2017.
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.	PC	TMACT Fidelity is monitored regularly and ACT providers are encouraged to strengthen their services and participate in ACT Collaboratives and training. Information was only provided on 75 of the 81 teams listed in the information provided. 29 teams met fidelity on TMACTs completed in FY 2016 with an overall increase of 4 points on team scores. While some teams did not meet fidelity during their initial reviews, only 5 teams scored in the low provisional range and/on their second TMACT in FY 2016. The State can take steps to strengthen providers of other services to be more engaged in supporting TCLI participants which based on Individual Reviews is recommended to be given priority in FY 2017.
23.	III. C. 6.	A person-centered service plan shall be developed for each individual, which will be implemented by a qualified professional, clinically responsible for ensuring 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.	C	Individual plans are developed and appear to meet the SA requirements.

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 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.	NC	The PIHP (MCO) and DMH contracts identifying TCLI requirements are in place statewide. Only 15% of the TCLI requirements are reflected in these contracts. Partly as a result of need for more State guidance and requirements the LME/MCOs do not yet use utilization and advanced network management tools, leveraging, best practices and accountability measures to ensure services are delivered in a timely manner, with sufficient intensity and focus on arranging for services that match the needs individuals have to move to and live successfully in the community. Individual reviews, focus groups and interviews do not reflect sufficient attention to these issues.
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	PC	A materials review reveals the State is attempting to comply with this provision. This requirement is in the State-LME/MCO contract. Based on key informant interviews, individual reviews and meetings with stakeholders, information has not been provided in a manner to ensure service availability is understood at the level required to meet the SA requirements.

		State Plan that they are contractually required to provide. *The State will remain accountable for implementing and fulfilling the terms of this Agreement*		
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.*	(low) PC	The State is making progress on ACT implementation but work is still underway (and will be for some time) to assure the teams are effective and available to individuals in the target population cross the entire state.
The state met the requirements for the number of persons served by ACT in 2013 and 2014; 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, 2016, the State will increase the # of individuals served by ACT to 40 teams serving 4,307 individuals at any one time, using the TMACT model.	C	The number of teams operating at fidelity to TMACT exceeds the FY 2016 obligation.
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 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.	C	A crisis system is in place and additional funds are being added to increase capacity, especially facility based capacity; EMS and MH First Aid training are being made available.
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.	PC	The LME/MCO gaps analysis provides some analysis of where gaps exist but does not provide recommendations for filling those gaps. The SA does not require the State to identify a specific measure for the Priority Populations to have access to Crisis services; however the number of individuals assessed as needing an ACH may in part be associated with lack of adequate crisis prevention services. Stakeholders have reported this problem; further analysis is needed.
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	PC	Crisis services provided in the least restrictive setting consistent with crisis plan and in a manner that prevents unnecessary hospitalization, incarceration and institutionalization was only identified as being used by one individual in the

		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.		Individual Reviews; further analysis is needed.
	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.	PC	The State is making significant progress to develop and implement measures to build an adequate IPS-SE network but has not developed measures to effectively provide these services to individuals exiting ACHs and SPHs. To date IPS-SE services are available in 70% of the State's counties and all the major metropolitan areas of the State.
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.
33.	III.D.3.	By July 1, 2016 , the State will provide Supported Employment Services to a total of 1,166 individuals;	NC	The State is making significant progress to develop and implement IPS-SE; at the rate of progress will be in partial compliance in a short period of time and potentially in compliance by June 30, 2019.
	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	PC	The procedures for ensuring individuals will be accurately and fully informed in accordance with this requirement are in place. Compliance with procedures or even refinement of procedures will still need to be done.

		in supported housing, and the rental subsidy and other assistance they will receive while in supported housing.		
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.	PC	Funding for In-reach doubled in FY 2016 enabling LME/MCOs to make more frequent contacts a necessary. Staff is generally knowledgeable about community supports and in many situations has built trusting relationships with individuals. The State is making plans to reduce duplicative information in the data being reported or information that may be inaccurate as a result of individuals moving from one home to another.
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 to 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 (community living, activities, employment, relationships education, recreation and healthcare).	C	There was evidence of written discharge plans. There were no indications individuals 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 from SPHs to ACHs, shelters and boarding homes than TCLI Housing Slots. The Reviewer did not request information on individuals not in the TCLI data base. In FY 2017 reviews will include individuals hospitalized at SPHs with SMI to ensure they are included in the Review.

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;	PC	Transition teams, in general, have knowledge of more formal community resources but some 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 that individuals could benefit from as referrals to these services and supports are 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;	(low) PC	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	C	Peer specialists, typically as In-Reach Specialists are included in discharge planning
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	There are many details and communication challenges for the State to meet and sustain full compliance but there is ample evidence this continues to be a priority.
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	PC	Although information is limited it appears improvements could be made on when discharge planning begins.
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;	PC	Not all Staff and Guardians ascribe to this principle so in theory this is a 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	(low) PC	Improvements should be made in developing written plans that are going to be effective for individuals to live independently in an integrated

		integrated community setting;		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.	PC	This is the State's position but requires further attention to be consistently practiced.
47.	III.E.8	The discharge planning process will result in a written discharge plan that:	C	See E.7(c) comments above.
48.	III.E.8.a.	identifies the individual's strengths, preferences, needs, and desired outcomes;	C	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;	C	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;	PC	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;	(low) PC	Barriers are often documented but plans are sometimes limited; there are many exceptions where staff has 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.	(low) PC	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	PC	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	(low) PC	Many performance issues and obstacles still exist creating delays in transition and discharge planning; The State is out of compliance on 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.	PC	Same issue 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.	PC	Transition teams are operational but have not been effective in addressing timeliness issues and will not likely be fully effective without additional contractual agreement improvements and performance requirements.
57.	III.E.10.	The DHHS transition team will ensure that transition teams (State hospital facility staff and leadership and PIHP and/or LME Transition Coordinators) are adequately trained. It will oversee the transition teams to ensure that they effectively inform individuals of community opportunities. The training will include training on person-centered planning. The 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.	PC	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 assists 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 as needed.
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	PC	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.

		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).		
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	PC	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 are 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 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).	NC	Transition planning is completed within 133 days on average 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, issues and other eligibility delays, the transition planning process being made more cumbersome with transition tools usually taking three visits to complete, challenges with differing opinions on placement, participant in -decision. The State is making progress and has improvement plans in place to come into compliance with this requirement.
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	D	More information is needed to review this provision. Only one home has been found "at risk" (after appeal of the at risk finding). The Reviewer was notified as required by the Agreement as was

		applicable LME or PIHP and county Departments of Social Services of the at-risk determination.		the DSS. With only one at risk determination in the past four years, it is an insufficient number to rate this item.
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.	D	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.	C	Even though only one At Risk of IMD has been designated the LME/MCOs continue to try to track individuals who were living in an ACH consider at Risk of in earlier reviews.
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).	D	See III. E. (13)(i) 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	PC	The State has maintained a rigorous licensure review schedule including findings on the Residents Bill of Rights after a DSS or LME/MCO have reported potential violations of Chapter 131D of NC Statutes. The threshold standard for violation of the Residents' Bill of Rights was not always fully understood by LME/MCO staff during interviews. LME/MCOs have sometimes been reluctant to make complaints for fear of retaliation by the home with a resident. However, DHHS actions in recent months have reduced reluctance to report and

		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.		improved the understanding of reporting requirements. The DHHS is not routinely successful in assuring their licensure admission revocation and full licensure review revocation findings will be overturned by a State appointed Office of Administrative Hearing Officer. This is not to say the OAH is correct or not. That is a legal matter.
III. F.		**PRE-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. Steps are already being taken to re-vamp this process to bring the State into compliance hopefully by the end of FY 2017 or the first six months of FY 2018. Changes may 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. Meanwhile the State and LME/MCOs are working toward maximizing their current efforts to improve the existing system.
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.	PC	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 in the same manner as provisions in Section E. According to State and LME/MCO staff, this process has improved this year but there are frequent questions regarding the service eligibility determination accuracy or appropriateness.
70.	III.F.3	If the individual, after being fully informed of the available alternatives to entry into an adult care home, chooses		These steps are being taken being taken to offer in-reach and services. This requirement is being

		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.	PC	met to the extent In-Reach and Transition Planning is being partially met.
	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	PC	The staff listed on this page meet in various configurations. However 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.

		application for services to discharge destination; and actual admission date to community-based settings.		
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;	PC	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	SPH census is tracked routinely and numbers of individuals identified as meeting TCLI in ACHs is tracked.
75.	III.G.3.c.	Develop and implement standard report to monitor institutional patients length of stay, readmissions and community tenure;	PC	The State contracts include requirements for 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;	(high) PC	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 (3 items), and 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;	(low) PC	A housing system is functional but at the level specified in this SA to inform discharge planning and availability has not yet developed.
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 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:	(low) PC	Steps are being taken to develop and expand data monitoring capacity of the following categories; however, monitoring outcomes have not been reported in the areas listed below:
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	(low) PC	The Reviewer has been provided information from 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	PC	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.	PC	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.	PC	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 sue the TCLI database are being 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 should focus on identifying and reducing or eliminating barriers as a major focus.
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.	D	The Reviewer has not received copies of Quality of Life surveys during this FY for review. However the Dashboard reflects that approximately 40% of QOL are submitted in a timely fashion on a monthly basis.
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	D	(A final report of this information has not been submitted.)

		extensive review of PIHP and/or LME documentation and interviews with PIHP and/or LME staff. Interviews with stakeholders and confirmation of data will be initiated. The reviews will focus on monitoring services, reviewing grievances/appeals received; reviewing medical charts as needed, individual provider follow up. EQR will provide monitoring information related to:		
90.	III.G.6.a.	Marketing	D	See above
91.	III.G.6.b.	Program integrity	D	See above
92.	III.G.6.c.	Information to beneficiaries	D	See above
93.	III.G.6.d.	Grievances	D	See above
94.	III.G.6.e.	Timely access to services	D	See above
95.	III.G.6.f.	Primary care provider/specialist capacity	D	See above
96.	III.G.6.g.	Coordination/continuity of care	D	See above
97.	III.G.6.h.	Coverage/authorization	D	See above
98.	III.G.6.i.	Provider selection	D	See above
99.	III.G.6.j.	Quality of care	D	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.	D	(A final report of this information has not been submitted.)
	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.	D	The FY 2015 Annual Report was not published at the time this Report was written.
103.	III.G.8.b.	In the annual report, the State will detail the quality of services and supports provided by the State and community providers using data collected through the quality assurance and performance improvement system, the contracting process, the EQRs, and the outcome data described above.	D	The FY 2015 Annual Report was not published at the time this Report was written.

ATTACHMENT B: PRE-ADMISSION SCREENING AND DIVERSION

Brief Report
Pre-Admission Screening and Diversion
Voluntary *Olmstead* Settlement Agreement
U.S. v. North Carolina
(Case 5:12-cv-00557-F)

April 8, 2016

Introduction

This Report is a brief summary of the Independent Reviewer's 2016 review of the U.S. v. N.C. Voluntary *Olmstead* Settlement Agreement provisions regarding. Pre-Admission Screening and Diversion (III. Substantial Provisions, F. (1-3)[45]. This Report does not include an annual compliance rating but does provide information that will be used for making the annual compliance rating in the 2016 Annual Compliance Review.

The Pre-Admission Screening and Diversion requirements are as follows:

"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 (ACH), the State shall arrange for a determination, by an independent screener, of whether the individual has Serious Mental Illness (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.

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.

[45] Case 5:12-cv-00557-F Document 2-2 Filed 08/23/12. Page 17

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 and objections to placement in an integrated setting, and will monitor individuals choosing to reside in adult care homes and continue to provide in-reach and transition planning services.".

The Independent Reviewer selected two catchment areas, Cardinal Innovations and the Alliance Behavioral Healthcare as the catchment areas for this review. The Cardinal review was narrowed to individuals who were identified as being from Rowan, Cabarrus, Davidson and/or Stanley Counties who were referred to Cardinal following a PASRR Screen I and Level II Review in October 2015 and January 2016. The Alliance review was a in depth record review, staff interviews, one home visit and a call with Earthmark for individual who went through a Level I screen and Level II Review in late December 2015 and January 2016. It also included a random selection of record and chart reviews of four individuals who were also selected in the "random" Alliance review conducted in early March 2016 of individuals who had gone through the PASRR process in 2015.

The Cardinal review was conducted in February 2016 and included thirty two desk audits[46] and staff interviews. Five (5) participants of the 32 were selected for interviews. ACH and FCH home staff was interviewed when available during participant interviews. One Guardian attended the interview. For Alliance, the desk audit was conducted in February 2016 for individuals referred in January. Four individuals were selected for interviews for that period. Information for four additional individuals were reviewed as part of the Alliance Random Review conducted in March 2016. The total number of individuals reviewed, either with an interview and desk audit and staff interview or just desk audit, was 40 including six face to face interviews. The review also included phone calls following up on PASRR Level II reviews with Earthmark, DHHS staff and Level II Reviewers and follow-up meetings with Directors of County Departments of Social Services (DSS). The DSS interviews also covered the DSS role in ACH and Family Care Home (FCH) licensure; licensure is not being discussed in this brief Report.

[46] two additional individuals were not reviewed because they were incorrectly listed as being Cardinal catchment area consumers when they were not.

Findings

The average age of the review cohort was 52.4. At the time of referral, six (6) individuals were residing at FCHs, five (5) were residing at ACHs, three (3) with family and (1) at an Assisted Living Facility. Fifteen (15) individuals or 37% were hospitalized in a medical or psychiatric unit of a general hospital. Four (4) were hospitalized at a State psychiatric hospital, one (1) at a State operated Alcohol and Drug Treatment facility, one (1) in a local jail and two (2) in skilled nursing facilities. Two (2) individuals were not in the catchment area where the PASRR Level II information was sent so no information was available.

Of those with Level II reviews, seven (7) could not be located by the LME/MCOs after multiple attempts including one of the individuals selected for the Alliance review. Two (2) others initially were not located but were eventually found and two (2) have Guardians who refused to discuss the individual moving and provided limited information. There were questions regarding the diagnostic impression being primary or even a reliable SMI diagnosis for mental illness for 25% of the review cohort or ten (10) individuals. At least three (3) of the individuals had a developmental disability, one with autism, a second with severe and profound mental retardation and a third with a neuro cognitive disorder as a result of an accident at age 8. The third individual was also identified as having schizophrenia although not experiencing symptoms. Neither of the first two had a discernible mental illness although both were receiving medications to reduce anxiety. One (1) individual was suspected to have Alzheimer's and two (2) with dementia. Records indicate all of the above referenced individuals are being prescribed psychotropic medications used to treat psychiatric disorders. Three (3) individuals have a substance use disorder. One (1) individual had one depressive episode many years ago, takes no medication, has no current diagnosis but has serious medical issues.

Four individuals (4) were moving or had moved to Supported housing but only two as a result of a referral to the LME/MCO as a direct immediate result of a Level II Review[47]. Of the four, one individual (who the Reviewer met) was living at a FCH when she requested a PASRR Review being advised it might be way to move, a second found housing through the VA, and two others were getting help from the LME/MCO to move into Supported housing before the PASRR process was initiated. Of the remaining individuals, there is information that suggests eighteen (18) individuals (45%) may choose and be able to move to Supported housing with the right supports and encouragement. Their potential to move quickly into

[47] The number of individuals with Screens and Reviews who were being "diverted" is different than number being processed and depicted on the DHHS Monthly Report.

Supported housing is limited by the lengthy process to become eligible, meet pre-housing requirements and lack of suitable, available and accessible housing. Both LME/MCOs were continuing to work with all the individuals if they could find them, if other disabilities did not rule out their serving them (and in some cases even when it did) and they were agreeable to working with the LME/MCO. This does not include the two individuals Guardians refused to allow to be considered for which there was not adequate information for review. The Diversion numbers reflected in the TCLI Monthly reports are different than actual numbers of individuals being diverted from ACH admission and being served in Transition status with LME/MCOs. This is understandable given the current PASRR process.

The PASSR process is an efficient method for assuring individuals move quickly to adult care or family care homes or remain in the homes where they are already living[48]. Most Level II PASSR reviews occur within 1-5 workdays following the submission of a Level I screen. The overall average is 5.7 days; that average includes holidays and weekend days and including two outliers with 6-8 weeks between the Screen and the Level II review. Twenty one (21) individuals had a PASSR Level II Review conducted within two days of a PASRR Level I Screen, one (1) on the same day. There were outliers but no patterns were clear with outliers. Individuals whose Level I screens were conducted while they were living in an ACH or FCH remained in those homes with the exception of the one young woman who was seeking a way to move.

Conversely LME/MCO follow-up averages several days to several weeks depending on workload. Cardinal recently reorganized staff to assign two Transition staff to be responsible for managing and follow-up with PASRR referrals. This change was made in the late fall after it became clear they could not respond quickly enough to establish a relationship and make alternative plans for an individual to move into the community rather than to an ACH or FCH. They were also concerned that many individuals moved and they could not find them and while this has improved they are still challenged with finding individuals.

The LME/MCOs are often faced with providing In-reach for individuals who are not appropriate referrals for TCLI because of their medical or other disabling condition. When it is clear an individual has dementia or another condition, but not SMI the LME/MCO is tasked with securing the proper documentation for dis-continuing In-reach often after the fact. These processes can be lengthy and time consuming.

The Level I referral/screening process is used to screen individuals in not out of adult care

[48] 27% of individuals in this survey were already living in an ACH or FCH when the PASRR I was completed.

homes and the Level II screen is used to verify disability. The process is not used with the individual as a community planning tool. For general hospital discharges, planners who often have little or no relationship with LME/MCOs, the process fulfills the purpose of assuring a timely discharge. In turn discharge timeliness goals are met. There are few arrangements for individuals to move to bridge or permanent arrangements. It also helps discharge planners avoid discharging individuals to shelters or housing known to be unsafe or inadequate. State psychiatric hospital staff initiates the PASRR process separate from their referral to the LME/MCO or sometimes initiate both the PASRR and LME/MCO referral. State Psychiatric Hospitals referring directly to ACHS/FCHs through this type of practice is no longer used by states except for nursing home placement purposes.

The LME/MCOs are attempting to divert individuals after an individual has moved (or remains in the ACH or FCH) and they quickly shift to provide In-reach. This process is made even less effective as a result of their not getting accurate information and in some situations their scheduling process. A cursory review might label this an indicator of the LME/MCOS performance. Performance issues can not ruled out in all situations. However a more in-depth review reveals the inability to divert individuals is much more systemic and in part the result of long term reliance on ACHs and FCHs. ACHs and FCHs are the first choice for discharge from hospitals if an individual is not returning home or being referred to a nursing home, assisted living, another treatment facility or a group home rather than Supported housing. The current process rules out almost any opportunity for timely Supported housing placement.

During earlier site visits, the Reviewer met an individual chose to be admitted to an ACH simply so he could access Medicaid benefits. LME/MCO staff reported other incidences where this occurred. This means that individuals who may otherwise be eligible for TCLI or capable of living in the community cannot do so if they do not qualify for Medicaid when living in the community and cannot afford medications or may need personal care assistance. Yet they qualify for Medicaid while living in an ACH. The incidence of this problem is at this point unknown.

In summary, the current Department of Health and Human Services (DHHS) statewide Pre-Screening and Diversion approach is not effective for diversion. It does not enable staff to develop meaningful actionable Community Integration Plans nor does enable LME/MCO staff to assist individuals to access services and housing as contemplated in this Settlement Agreement. The requirement for assuring individuals give informed choice if they are moving to an Adult Care Home is inadequate and individuals are only being given limited opportunity to participate in the process. Individuals are not given time and sufficient or

meaningful information about alternatives and lastly alternatives would have to be available.

Recommendations:

1. Process: The Settlement Agreement terms provide considerable latitude to the State for Adult Care Home Pre-Admission Screening. The State is to "refine and implement tools and training" to ensure that when any individual is being considered for admission to an adult care home (ACH), the State shall arrange for a determination, by an independent screener, of whether the individual has SMI".

It is recommended the State shift the focus of what is now the PASRR Screen from admission screening to diversion. When community living is ruled out (often by the Guardian) and not the informed choice of the individual, ACH admission be considered among other options. While admission to a FCH is not subject to this Settlement Agreement provision, individuals frequently move among FCHs and ACH so admission to a FCH should also be considered as well. It is the State's responsibility to propose and implement needed changes. Below are general recommendations:

(1) Regardless of referring source, the first referral of an individual thought to have a either a serious mental illness or to have a serious and persistent mental illness in need of housing, treatment and other services be made to the LME/MCO in the referent's catchment area regardless of their level of need unless the individual is being referred for skilled nursing care. Skilled nursing care referrals should be handled separately using the PASRR process.

(2) The referral process be retitled to reflect that it is a community services and housing screening and diversion process.

(3) The LME/MCO (assume Care Coordination staff) receives a referral (screen) and conducts a phone interview with the referent.

(4) If the referral is appropriate, meaning SMI/SPMI not ruled out, the LME/MCO does a face to face interview with the individual (and their Guardian) and completes an assessment and CIP. (The assessment and CIP tools use the same language/format as used for TCLI planning purposes to reduce duplication).

(5) At that time the LME/MCO reviews options and gives the individual (and Guardian) choices. The LME/MCO completes the CIP with the individual and sends the completed

assessment and CIP to a designated Independent Screener (electronically). The Independent Screener verifies the disability and the Plan.

(6) If the individual is then moving to an ACH or FCH, the referent assists the individual with that plan and the LME/MCO is notified of the plan by the Independent Screener. If the individual qualifies for In-reach, the LME/MCO follows up with the individual in the manner as they do now. If the individual is moving to a rehabilitation facility or substance use facility, remaining in jail or moving home or with relatives the LME/MCO follow-up according to their procedures.

(7) In some situations, a more comprehensive diagnostic evaluation may be warranted at the time of the referral. While this may take more time initially, it is likely less time than LME/MCOS are spending now trying to generate the documentation with facility physicians after the fact.

(8) Admission to an ACH simply so the individual can access Medicaid benefits should never be the reason for admission if the individual is capable of living in the community but cannot afford medications or may need personal care assistance.

2. Education: A number of referrals are being made for individuals who do not appear to have a serious mental illness as their primary disabling condition. The DHHS should make arrangements for handling those ACH referrals separately. The DHHS should advise the LME/MCOs how to explain this to referents and the DHHS should provide information to hospitals, Guardians, ACHs, FCHs, service providers and other referring organizations of these changes. Based on this review and discussions with LME/MCOs, this may be as many as 25% of the individuals currently being referred. Further guidance and education for referral sources will be necessary in lowering the percentage of individuals referred to LME/MCOs rather through a more appropriate referral process. This change will take considerable time to plan and to implement.

3. General Hospital Referrals: Since nearly 40% of the referrals in this review were made by general hospitals and because general hospitals typically request placement be made within a few days, the LME/MCOs will need to work with hospitals as quickly and closely as possible after hospital admission to develop referral arrangements. Any opportunity the DHHS has to speak with general hospital administrators concerning the need for these referrals to be made timelier would be helpful. LME/MCOS have agreements with local hospitals regarding referrals. It does not appear these agreements have had an impact on appropriateness of referrals. It is possible this is because the TCLI referral process is so separated from the

routine discharge process and because the current TCLI progress is so drawn out. However hospital discharge planners appeared to have little knowledge of TCLI.

4. Screens conducted for individuals who have already moved to homes: It is not clear why this continues to occur at this point; however, it should be stopped for individuals who have a serious mental illness or serious and persistent mental illness. There are no other recommendations for this practice except that it should be stopped for any new referrals and discontinued for individuals who have been living in homes for a longer period of time.

5. DSS-LME/MCO working relationships: The County DSS staff has several roles in this process. Some DSS staff serve as Guardians, some but not all get requests for PASRRs, they get referrals or questions about the process and they have roles in licensing and complaints. They have relied on ACH and FCHs as safe places for individuals with disabilities to live in lieu of other options. They are part of local government and as such in many ways are human services "first responders". DSS Directors have voiced concerns about lack of safe community options. It appears the working relationships between local DSS staff and LME/MCOs regarding ACH referrals, diversion options and Guardianship generally could be improved. DSS have been provided training on the PASRR process and information about TCLI. However training is helpful for providing information not necessarily the best option for effecting change. Frequent contact, closer working relationships, joint planning are more effective methods for prompting systems change.

6. Diversion Options: Any changes to this process will necessitate changes in how quickly individuals can access Supported housing directly and through some type of bridge that is effective for short term use only. The number of individuals who could benefit and choose Supported housing could vary but conservatively it would be 20 to 30% of those with a primary diagnosis of SMI or SPMI being referred now. These individuals are likely going to otherwise fall into Category II and III[49] of the SA target population. With special attention to this group, the State could track the actual number of individuals "literally" diverted from ACHs as a result of any changes to this process.

Any changes to the current Pre-Screening and Diversion process identifying more individuals who choose and could benefit from Supported housing and other services would necessitate a change in how quickly an individual can access Supported housing and what bridge to Supported housing could be made available. It would also necessitate the need for more affordable, accessible housing and assurance services and resources would be available.

[49] According to DHHS there are no Category I Homes in North Carolina