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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INTRODUCTORY COMMENTS

This is the fourth 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 North Carolina's (State) progress to meet requirements including those required by July 1, 2017 and those required to be met by July 1, 2021[1].

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).

There are six threshold compliance requirements in this Settlement Agreement. The State's progress to improve its services and housing systems and meet the Settlement Agreement (SA) requirements for adults with serious mental illness has been uneven. There has been major progress in Supported Employment, mixed progress in Supported Housing, In-reach, Transition Planning, and Quality Assurance and Performance Improvement and minimal progress in Pre-Admission Screening and Diversion and Services.

Resources to meet requirements have been appropriated and a number of improvements have been made in use of new and existing resources. Changes in how and what resources are allocated are still needed to meet requirements. There are key initiatives still in start-up phase but are promising. Gains in all areas have been offset by these resource allocation issues, gaps in service availability, unresolved housing availability and access problems, ineffective practices, unresolved or undetected problems and slow follow through on major initiatives. There is still a lack of clarity and alignment of goals and incomplete identification and implementation of performance requirements.

The NC Department of Health and Human Services (DHHS) staff have been helpful with requests for information and questions about compliance efforts. In particular Kathy Nichols has stepped in as the Interim DHHS Special Advisor on *Olmstead* and provided steady, strong

[1] On November 1, 2017, Judge James C. Dever III entered a Consent Order granting a Joint Motion filed by the parties to modify Settlement Agreement timelines for Supported Employment and Supported Housing to end on July 1, 2021. To the extent possible, this Annual Report references the specific changes in Supported Housing and Supported Employment requirements that changed as a result of this Joint Motion and Order.

leadership. The Local Management Entity/Managed Care Organizations (LME/MCOs) Chief Executive Officers (CEOs) and their staff have given their time, provided insight, answered endless questions, and responded to requests in a thorough and timely manner. The University of North Carolina (UNC) Center Institute for Best Practices (NC Institute) staff have been very helpful. UNC staff have provided information and made it possible for the Reviewer and her team to observe Fidelity reviews, hold focus groups, and observe training.

The Disability Rights Network (DRNC), National Alliance for the Mentally Ill (NAMI) NC, Association of Retarded Citizens (ARC), NC Coalition to End Homelessness, NC Housing Coalition, and NC Justice Center have taken a special interest in this Settlement Agreement and how it can contribute to North Carolina making progress serving adults with serious mental illness.

As stated in the FY 2015 and FY 2016 Annual Reports, a community based services and housing system will only become effective with a robust set of structural pre-conditions in place, continuous improvements, and strong support for change from leaders, stakeholders, and staff at all levels. Improvements require a directional shift from a system with services being provided within institutional structures to a community system with inpatient care included as an integral part of the system.

A strong community based system requires sustained planning as well as changes and improvements in policy and practice. Shifts in the configuration of the system while improvements are being implemented may impede progress and should be made carefully with minimal disruption. A strong community based system includes an array of adequately funded services and housing appropriate to individual need and choice. It requires a clear vision and cohesive leadership by state, regional, and local organizations and stakeholders. Incorporating compliance requirements into any future plans for system design and performance can be advantageous and help improve individual outcomes.

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 the new services that are made available are older treatment models already shown not to be 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, rely repeatedly on inpatient care, become homeless, are exploited, or are incarcerated. With careful consideration, these problems can be avoided.

METHODOLOGY

The methodology for compiling this report is essentially the same as used in FY 2015 and FY 2016 Annual reports, with several noteworthy additions described below. 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.

Five experts and one organization have been retained by the Independent Reviewer. Elizabeth Jones and Katherine Burson have both been on the individual services review team since 2015. Patti Holland joined the individual services review team, as did Damie Jackson-Diop who, in addition to conducting individual reviews, facilitates focus groups and provider meetings. Ms. Holland is the former Deputy Assistant Commissioner for Mental Health and Substance Abuse Services in the Department of Human Services in New Jersey (NJ DHS), former Assistant Professor in the Department of Psychiatric Rehabilitation, School of Health Related Professions, University of Medicine and Dentistry of New Jersey, and a long time psychiatric rehabilitation services provider in New Jersey, Massachusetts, and Pennsylvania. She was responsible for services development and implementation of the New Jersey Olmstead Plan while at the NJ DHS.

Ms. Jackson-Diop has fifteen years of local, state, and national experience as a coach, facilitator, technical expert in workplace supports, and research advisor. In addition to her consulting work, she has been employed as an Americans with Disabilities (ADA)/504 Coordinator, Youth Transition Program Director, and technical advisor for individuals with disabilities. She is a certified RENEW Empowerment Coach and Facilitator.

The Human Services Research Institute (HSRI) in Cambridge, Massachusetts, has been retained to conduct an evaluation of client level data to determine the patterns of service use including the type, intensity, and frequency of services for the Transitions to Community Living Initiative (TCLI) target population. HSRI has provided expert consultation to national, state, and local organizations setting policy, serving and/or financing services for individuals with disabilities. For individuals with behavioral health disabilities, HSRI has worked on projects to analyze health care system utilization and costs, including conducting cost simulation models for planning behavioral health systems conducting behavioral health services research and development of evidence-based practices.

Meetings were held with LME/MCO executive staff in all seven catchment areas. Meetings were held with key staff of the Central Regional and Cherry Hospitals[2] during site visits to the hospitals. Meetings were also held with key statewide stakeholder groups and coalitions, including the Disability Rights North Carolina (DRNC), 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

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

ACT Technical Assistance Center.

Frequent meetings were held with DHHS staff and included 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 Individual Placement and Supports-Supported Employment (IPS-SE) Fidelity Review and one of her experts observed one IPS-SE Fidelity Review and one Assertive Community Treatment (ACT) Fidelity Review.

Seven stakeholder focus groups were held in each catchment area. The LME/MCOs made the invitations, enabling the Reviewer to assess who the LME/MCO thought were key stakeholders for this group. Nineteen (19) individuals representing fifteen (15) different organizations and stakeholder groups attended the Trillium stakeholder focus group; the other stakeholder groups varied in size from six (6) to eleven (11) attendees.

The stakeholders ranged from consumer and family advocates, TCLI participants, the LME/MCO Consumer and Family Advisory Committee (CFAC) members, local NAMI Board members, County Department of Social Services (DSS) Adult Services Supervisors, staff and Guardians, Public Housing Authority staff, landlords, homeless advocates and Projects for Assistance in transition from Homelessness (PATH) providers, Council of Government staff, United Way staff, a representative payee, community and hospital healthcare providers, and local community planning agency staff.

The stakeholders, to varying degrees, were familiar with TCLI but they asked questions of both the facilitator and the LME/MCOs to better understand the program. The lack of affordable and emergency housing, stigma, and case management and supports being too time limited, siloed and poorly coordinated were referenced. Several individuals spoke about individuals being “abandoned” and one person asked “what happens at the end of the settlement and still nothing in place to support the individuals.”

The need for the LME/MCOs and community organizations to strengthen their relationships to leverage resources and develop partnerships emerged as common theme and as a strategy for preventing individuals from unnecessarily entering institutional settings. CFAC members consistently spoke of their “voice” being heard by LME/MCOs.

IPS and ACT provider interviews and/or focus groups were held in each catchment area. A Division of Vocational Rehabilitation focus group was held in the Trillium area. Meetings were held with LME/MCO contacts and network management staff and with LME/MCO senior staff either in exit or entrance meetings or interviews. The review included analyzing information, including TCLI Monthly and Annual Reports, Fidelity Review summaries and contract documents, manuals, and review documents to measure progress toward meeting

Settlement Agreement requirements.

Individual recipient reviews (individual reviews) were conducted in all of the LME/MCO catchment areas. 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) 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.

A proportional random sampling method was used to ensure the review reflects the target population accurately across three LME/MCO 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 2017 as follows:

(1) In-reach Review: The Reviewer submitted a **Brief Report on In-reach** process to answer specific questions requested by the US Department of Justice (DOJ) Attorneys. The Reviewer submitted a written Report of this review (**Attachment B.)** to the Parties on May 19, 2017. Information from that review is summarized in the Discharge and Transition Process **Section III.(E)** section of this Report.

(2) SPH Chart Review: Referenced in the **Brief In-reach Report** were findings from a chart review at two SPHs, Cherry Hospital and Central Regional Hospital. The review was a randomized review of individuals discharged in September 2016. The focus of the review was on discharge planning. The Annual Review also includes findings from a chart review at Broughton State Psychiatric Hospital conducted after the In-reach review.

(3) IPS-SE Review: Katherine Burson, the Reviewer's IPS-SE Expert, submitted a Report in FY 2017 to the Reviewer summarizing her findings and recommendations on IPS-SE, which is referenced in the Supported Employment **Section III.(D)** of this Report.

(4) Crisis Services Review: A review was conducted to determine sufficiency of mobile crisis services as required in the Settlement Agreement. On site interviews were conducted in the Alliance, Vaya, and Cardinal catchment areas.

(5) ACT Services Review: A review of the 2015-2017 ACT Teams Fidelity scores was conducted to determine the sub-scores on the Tool for Measurement of Assertive Community Treatment (TMACT).

(6) Review of information in the Alliance and Eastpointe catchment areas regarding fifty-one (51) individuals with Housing Slots considered "Hard to House" because they had had a housing slot for longer than two hundred (200) days but had not moved into supported housing.

In addition to the aforementioned reviews, a series of structured interviews was held between the DHHS Division of Vocational Rehabilitation (DVR), LME/MCO staff, IPS-SE providers, other DHHS staff, and Katherine Burson, the Reviewer's IPS-SE Expert.

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, in providing community-based housing and in 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. Action steps and sufficiency of these Plans to meet Settlement Requirements are referenced where directly relevant to the findings set forth in this Report.

INDIVIDUAL REVIEW FINDINGS

This Report assesses the State's compliance with each of the Settlement's substantive provisions as of July 1, 2017. The narrative portion of this Report addresses 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 each is attached as **Attachment A**. This Report includes a section for broad recommendations although recommendations are also included with each provision.

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 State is required in the **S.A. § III (A) Substantive Provisions** of the Settlement Agreement "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.

As stated in last year's Report, the above paragraph is 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 that are not being met. Likewise, if services

and supports are available but are not "adequate and appropriate" or measures are not effective, the State is not be fully complying with the provision. When a finding in this Report is based on one of these two qualifiers, this will be identified. If a requirement is trending in the wrong direction, it will be noted. Likewise if there is progress toward meeting a specific requirement but that progress is not sufficient for a finding of compliance, this too will be noted.

Individual Reviews: 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 Reviews: In FY 2015, thirty-five (35) individual reviews were conducted. In FY 2016, one hundred and six (106) individual reviews were conducted. In FY 2017 one hundred and twenty (117) individuals were randomly selected and reviewed as part of the Individual Assessment Review. The total number of Individual Reviews conducted by this Reviewer and her team over two and half years is two hundred and fifty-eight (258). This does not include individuals reviewed as part of the FY 2017 In-reach review and the FY 2017 SPH chart review. In FY 2017, the reviews for three (3) individuals were limited because the assigned LME/MCO did not have any information on the individual. Other reviews were limited because the individual was incarcerated, deceased, family guardians refused access, or the individual was 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 117. Where review data was collected on a smaller sample, it is noted in this Report.

As referenced in **Figure 1**, in FY 2017, sixty-three (63) or 54% of individuals in the sample were men and fifty-four (54) or 46 % were women. The average age of the individuals reviewed was fifty-one (51); however, sixty (60/60%) percent of the individuals were over age fifty. Sixty-eight (68) individuals in the cohort were age fifty-one (51) or older; twenty-one (21) were between fifty-one and sixty (51-60) and eighteen (18) were over age seventy (70). Fifteen (15) were under the age of thirty (30), seventeen (17) between age thirty-one and forty (31-40), and fourteen (14) between the age forty-one and fifty (41-50).

Figure 1: Demographic, Living Settings, Guardian FY15-FY17 Sample Differences

Categories	FY 2015	FY2016	FY 2017
Average Age	54	49	51
Female	37%	43%	54%
Male	63%	57%	46%
Living in a SH Unit. with TCLI Housing Slot	37%	45 (43%)	33(28%)
Living in an ACH	28%	29(28%)	35 (30%)
Hospitalized in a SPH	11%	9 (9%)	16(14%)
Living in other locations (or missing)	24%	29(27%)	33 (28%)
Has a Guardian	70%	37%	30%

Of the information available on one hundred and fourteen (114) individuals, thirty-three (33) individuals were living in their own home with a housing slot, thirty-five (35) were living in ACHs, sixteen (16) were hospitalized in a state psychiatric hospital, and thirty-three (33) were living in other locations or were missing at the time of the review. While some information about these locations was sparse or unknown, it appeared likely that approximately half of the individuals were living in family homes or their own home. At least three (3) were confirmed to have moved to a skilled nursing home. One (1) individual was reported to be a resident of a long term substance abuse treatment facility and two (2) were incarcerated. One (1) individual was living in his car. Two (2) individuals were deceased before the review was scheduled.

Seven (7) individuals had mobility issues, with most requiring wheelchairs all or part of the time. Analysis indicates sixty percent (60%) of the individuals living in supported housing had at least one chronic health condition. This is a smaller percentage of chronic medical conditions than that of individuals living in ACHs as reported in the **Brief Report on In-reach.** Eighty percent (80%) of individuals living in ACH had at least two (2) chronic health conditions. This has implications for meeting services requirements and will be discussed as part of that review section. Of the five (5) individuals who had been living in motels or shelters before the review, one (1) was reportedly re-hospitalized and four (4) moved into their own home.

The conditions and upkeep of the ACHs visited was mixed. The homes ranged from being clean and well maintained to others in being in poor physical condition or crowded because of the building design. Visits were not conducted for the purpose of inspecting ACHs, so the extent of the problems was not assessed. There appeared to be problems in the building structure, maintenance, housekeeping and/or upkeep. Several older single family care homes had not been modernized.

Twenty (20) of the rental units where individuals were living were found to be well maintained. There was considerable in variation of clutter in the unit, how clean it was, how it was furnished, and whether or not the individual had decorated and personalized their unit. Some individuals had few personal belongings. Interestingly, this variation seemed in part to staff helping an individual move in and fix up their apartment. At least three individuals reported they did not cook and others reported cooking two or three basic meals.

Two individuals reviewed this year were living in units with bed bugs; one had already gone through the required bed bug eradication process but the bed bugs returned. The other was in a very rough neighborhood but the individual was afraid to move for fear of losing his deposit. He also had a criminal background and was worried he would be homeless as a result of losing his unit. Private units tend to be less well maintained than units in Low Income

Housing Tax Credit[3](LIHTC) properties. Individuals who accept less well maintained units do so because they have been turned down from nicer units and neighborhoods because their background checks reveal credit problems or criminal records or because they can't find more suitable housing. Nonetheless housing tenure is greater in private units.

Nearly all of the individuals living in a supported housing unit reported feeling isolated or lonely. Some individuals described their isolation as meaning they could not see family, friends or get to an AA meeting as often as they like. Others report being completely cut off from family or their former social contacts. For some, this was because they were estranged, for others it meant they had had to move a great distance from their family when admitted to an ACH and the same to find suitable housing. For some it was simply because their housing was in a very isolated location. Six (6) individuals (or staff working with them) reported gang violence or crime in their neighborhoods. Staff also reported individuals were living in unsafe neighborhoods but were not commenting on it for fear of losing their housing. Individuals could describe their feelings of loss when describing their previous role functions, such as being a good worker, a parent, a sister or a person, and sometimes they could talk about how they hoped people would see them again.

REVIEW OF SETTLEMENT AGREEMENT REQUIREMENTS

I. COMMUNITY-BASED SUPPORTED HOUSING SLOTS

The State is obligated to meet the requirements of the **Section III. (B)[1-8]** to make available, accessible affordable housing that meet criteria consistent with *Olmstead* requirements for integration.

In **Section III. (B)(1)** the State is required to **develop and implement measures to provide individuals with access to community based housing.**

(B)(2) identifies **priority categories** based on where individuals are living for Housing Slots.

(B)(3) is the provision for **1,624 Housing Slots** to be filled by July 1, 2017**.**

(B)(4) refers to **developing rules to establish processes and procedures for determining eligibility for Housing Slots.**

(B)(5) refers to **the 2,000 slots that must be available and filled for individuals living in ACHs.** This requirement must be met by July 1, 2021, thus is not reviewed this year.

[3] Low Income Housing Tax Credit (LIHTC) units are units in multi-family rental units that have either been constructed or rehabilitated with multiple sources of financing including Low Income Housing Tax Credits. In North Carolina, a portion of these units are set aside (targeted) for individuals with disabilities.

(**B)(6)** states **the State may utilize ongoing programs for housing assistance to fulfill obligations under this Agreement so long as the ongoing programs meet** criteria in **III.(B)(7)[a-g].**

III. (B)(7) refers specifically to housing slots being provided for individuals to live in settings that **meet following criteria: Housing must (1) be permanent with Tenancy Rights; (2) include tenancy support services that enable residents to attain and maintain integrated, affordable housing. Tenancy support services offered to people living in supported housing that are flexible and are available as needed and desired, but not mandated as a condition of tenancy; (3) enable individuals to have interaction with individuals who do not have disabilities to the fullest extent possible; and (4) not limit access to community activities at time, frequencies, and persons of their choosing.**

Included in the criteria is a requirement that housing "slots" pertains to scattered site requirements, unit location affording individuals' choice in daily life activities, such as eating, bathing, sleeping, visiting, and other typical daily activities. Single-occupancy housing is to be given priority.

(B)(8) refers to housing where housing slots cannot be used.

(B)(9) Individuals will be free to choose other appropriate and available housing options after being fully informed of all options available. This requirement includes language defining what "fully informed" means and which services an individual is entitled to if a housing slot is not available.

Overview: This review will focus on availability of, access to, and accessibility of housing that will to a large extent determine the State's ability to meet its supported housing obligations in this Settlement Agreement.

Availability refers to the availability of safe, decent affordable housing. A distinction should always be made as to what units are listed as available, but already filled and only available on turnover, versus those that are vacant or in some cases have a waiting list such as many found on rental property websites. There is also a difference between units being vacant for a short time but being continuously filled on turnover and units vacant for a longer period of time indicating there may be other problems such as location or conditions.

Turnover rates should always be factored into availability. The market may influence availability so when looking at turnover, if it is low, it probably means the market is tight. Likewise, if units are listed as available upon completion of being rehabilitated, individuals living in those units can return first before anyone new can move in. These factors are extremely important in accessing the availability of new Low Income Tax Credit (LIHTC) multi-family rental project awards or examining a LIHTC portfolio. However, with all the

facts, availability can be projected into the future based on production schedules, funding awards, and turnover history.

Meeting the housing obligations requires the availability of housing, timely access and a constant stream of rental units, access to units when newly available or on turnover, and inclusion of features specific to the needs of the priority populations. 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.

Access is also influenced by discrimination and stigma which may not manifest itself in outright rejection based on disability. Rather, individuals may be denied housing because of their criminal record, regardless of the type and history of their arrest and/or conviction, credit, even though Community Living Assistance (CLA) funds can remediate credit problems or other issues. Often, property managers tell a person the unit is no longer available, dodge requests, don't respond, or refuse reasonable accommodation requests. Complaints based on disability make up the largest number of housing discrimination complaints filed with federal, state, and local fair housing enforcement organizations; individuals with mental disabilities comprise forty percent (40%) of the complaints based on disability[4].

Challenges to access to amenities and services cannot be understated. Often surveys under report challenges. A recent review of NC HFA information regarding access to amenities and transportation at existing LIHTC properties referenced bus service being available within two blocks of a LIHTC property. The survey did not review actual bus schedules nor the type of property, whether elderly or family units. Elderly complexes generally have buses; family properties where most individuals in the target population live do not have bus service.

Larger cities, Charlotte and Raleigh in particular, have hub routes, meaning you travel to the center of town and then catch another bus to go to any other part of town. Two individuals interviewed in FY 2017 in Charlotte had to ride one and a half hours each way to see their service provider. The report references 30% of units having grocery stores within five blocks, but as evidenced by the on-site reviews this past year, many housing complexes are built on hills and have steep inclines. Many individuals have physical or medical limitations which makes walking two blocks with groceries difficult. Many locations are on busy roads with no sidewalks. The HFA review was not conducted with the over six hundred units in private properties where individuals live. A much better way to assess accessibility issues is by personal interview and/or feedback from transition or housing specialists.

4 *Study of Housing Discrimination on the Basis of Mental Disabilities: Results of Pilot Testing".* The HUD Office of Policy Development and Research Fair Housing, Washington D.C. (2017).

The housing barriers listed in the assessment greatly underestimate the actual barriers reported by at least 50% across all the barriers listed; an even greater percentage of individuals have challenges with access to transportation. The Reviewers' estimates are based on over 250 reviews and other data sources. TAC also indicated the estimates provided to them did not represent the true number of individuals with housing barriers.

Accessibility refers to the rental unit being located on an accessible bus route and that can be designed, constructed, altered, or adapted can be approached, entered, and used by individuals with physical handicaps. There are mandatory requirements for accessible housing but they may vary widely and are found in state, local, and model building codes, in agency regulations. Accessible units are typically more available in LIHTC properties, HUD 811 and 202 buildings/complexes but can also be found in private complexes.

The FY 2015 and FY 2016 Reports contained an analysis of issues that impact the State's success with filling Housing Slots at the request of the State. This year's Report will contain a less detailed description of each of these but will contain specific references to key issues for comparison across the three years as related to this compliance review.

There are positive trends that suggest the State may be able to come into compliance with Supported Housing Slot requirements in FY 2021. Much will depend on increasing availability, creating a ready pool of housing and reducing turnover once an individual has moved into housing. The LME/MCOs with assistance of Regional Coordinators have increased referrals, reduced the number of individuals in transition status, and built stronger relationships with property owners, developers, and landlords. The DHHS recently hired a Housing Director whose experience and leadership is already proving to be quite valuable. There are steps the State can take now that would increase the likelihood compliance can be achieved. These will be referenced as recommendations in this Section.

Section III.(B)(1) Develop and implement measures to provide individuals with access to community based housing. The State has relied on access to two types of arrangements for affordable rental housing. One type is private multi-family (and some limited single family) rental housing available on the open market that can be made affordable with rental subsidies. The second type is the Low Income Housing Tax Credit Program (LIHTC) which is a multi-family affordable rental program.

In FY 2017, the State continued to increase access through increasing the number of rental agreements with private landlords and made better utilization of LIHTC units that were either vacant, available on turnover, or new to the market. These are the most practical arrangements to pursue but both require establishing strong local relationships with landlords, property managers, affordable housing organizations, and city and county planners, as well as reinforcement of Fair Housing requirements. These arrangements may

take years of planning and require streamlined, effective housing search, referral, eligibility determination, and leasing. Individuals with psychiatric disabilities face multiple challenges when seeking housing in the rental market that require a long time to get through the maze of requirements, find suitable housing, and get a lease.

For consistency with earlier reviews, five actions to develop and implement measures were reviewed this year: 1) progress on a credible assessment and actionable State Strategic Housing Action Plan; 2) a plan for allocation of available Community Living Housing Fund resources; 3) the transition of the Rental Subsidy Administration program to the LME/MCOs; 4) implementation of the Targeted Unit Transition Program (TUTP), other resources for bridge housing, and other steps to improve access to permanent housing; 5) implementation of the State's Supported Housing Corrective Action Plan.

1) State Strategic Housing Action Plan: In April, 2015, this Reviewer recommended the State develop a Strategic Supported Housing Plan. DHHS funded the NC HFA to contract for assistance to develop the plan. The planning process did not start until June 2016 and has not been completed. The NC HFA contracted with the Technical Assistance Collaborative to assist with developing the plan. The decision was made well into the planning process that TAC should develop an assessment with recommendations but not a plan. Likewise the initial instructions for what to include in the assessment changed during the process which delayed the Plan's completion. The TAC Assessment and Recommendations Report was released in July 2017. The NC HFA issued an Interim Permanent Supported Housing Action Plan on August 1, 2017.

The TAC assessment included a policy discussion, a Gaps Analysis, a Services Capacity and Resource Assessment, and seven Strategic Policy Recommendations. TAC held consumer focus groups, collected data and information, and interviewed key stakeholders and meeting with State staff on multiple occasions. TAC recommended roles and responsibilities be clarified and reinforced at the state, regional, and local levels to ensure a sustainable infrastructure at all levels. TAC recommended increasing the "pipeline of new permanent supportive housing opportunities and maximizing existing PSH opportunities with a focus on six high value, high demand counties".

The NC HFA indicated in their Interim Permanent Supported Housing Action Plan that a final PSH Action Plan will be completed by February 2018, nearly three years after the Reviewer requested this be done. The Interim Plan listed six goals for calendar year 2017. The first goal listed eleven strategies and targets for increasing access to LIHTC Targeted Units. The targets to fill LIHTC units were quite low as written and will not likely enable the State to meet its housing requirements by June 2021. Targets in Goal 1, Strategy 5 and 6, have already been met and the Goal for Strategy 7 will be met in September 2016. There were also strategies to complete a change from Quadel, a private rental subsidy administrator, to the LME/MCOs

to manage the program. This shift is well underway and in its final implementation stage.

There was discussion after the Interim Plan was completed that the LME/MCOs should update their own housing plans. These plans are vital but should reflect LME/MCO responsibilities based on goals and action steps established by the State in its housing plan and in collaboration with the LME/MCOs. Meanwhile it is critical that LME/MCOs continue to, or if not already doing so, participate in local affordable housing plan efforts. These local planning efforts are where priorities are set for housing, particularly in urban centers.

The HFA's Interim Plan included one strategy to ensure the Key Rental Assistance Program is sustained that was referenced as being necessary to sustain access to rental resources for the TCLI target population and other individuals with disabilities. There was a strategy to engage with local Public Housing Authorities and/or HUD to support an *Olmstead* related preference for Section 8 tenant or project based housing vouchers. This preference opportunity is likely no longer available. Special Purpose Vouchers are vouchers administered by Public Housing Authorities or other eligible organizations for special purposes. These types of vouchers are mostly already allocated to qualified organizations and are in use. Many of the Special Purpose Vouchers, some of which are designated for non-elderly disabled individuals, can be accessed on turnover. A number of these vouchers have not been filled initially and/or on turnover by individuals eligible for their use, either because the voucher administrator did not get referrals or attempt to get referrals of eligible individuals. The opportunity to use these vouchers should be explored now.

There was a strategy to improve NCHousingSearch, an online rental listing service. One of the expected outcomes is to increase the number of listings using this service as accepting Transitions to Community Living subsidy by 5%. This is a very low target for some areas of the state and probably sufficient for others. The key issue to success of the rental subsidy program is for LME/MCOs to have the resources and support for housing search and landlord engagement in addition to the current plans for NCHousingSearch. The LME/MCOs should work with the DHHS and with NCHousingSearch to set specific targets for new listings in their area.

Goal 1 also includes strategies for updating the guidance to all NC HFA owners and property managers on their Tenant Selection Plan. The Legal Aid of NC/Fair Housing Project is being asked to continue to provide training on basic fair housing and reasonable accommodations. It was also recommended a baseline be established to measure denials of housing applications due to "better written reasonable accommodations requests." This Goal also includes a strategy for the NC HFA to investigate complaints of owners and landlords who may not be meeting TSP requirements. It may be useful for the NC Legal Aid/ Fair Housing Project staff, the DHHS, NC HFA, housing advocates, and LME/MCOs to examine the findings of the recently released *Study of Rental Housing Discrimination on the Basis of Mental*

Disabilities: Final Report referenced above.

Goal 2 was for the State to meet all the requirements of the SAMHSA Permanent Supported Housing evidence based practices. The State meets almost all of these requirements now. The timeline for meeting expected outcomes for Goal 2 Strategies is "ongoing." Goal 3, Strategies 1-4, are related to housing development. There have been numerous discussions for the past year but with no agreed upon proposals between the State agencies on how to go forward with these strategies. In the past, NC HFA has rejected or not followed through on any federal housing opportunities as referenced in Strategy 5. The DHHS has sought opportunities made available through SAMHSA and CMS.

DHHS was already advancing a Medicaid strategy to meet Goal 4. Goal 5 is focused on creating the PSH Action Plan. The DHHS may be pursuing this plan for the fall of 2017. Goal 6 Strategies are implementation tasks. One strategy is to implement the Community Living Integration Verification System (CLIVe) and the Transitions to Community Living Database. The timeline for the CLIVe implementation project is referenced as "throughout 2017". The second strategy is to replace the transitions database systems with a new workflow system. This infrastructure system enhancement is needed and is being implemented now.

In summary, the Interim Plan is of limited benefit. It is a mix of strategies and implementation tasks, most of which have been discussed for some time and are already underway. Some strategies have timelines and detailed expected outcomes. Some of the timelines listed in the plan have passed and targets, where listed, are low and have been or will be exceeded this month. There is one important compliance issue which the NC HFA can pursue, notably ensuring the Tenant Selection Plan requirements are added and being followed.

Since this Annual Report was completed in draft and the HFA Interim Plan was limited in its usefulness, the DHHS indicated they will take the lead to complete the requested Housing Strategic Plan and that the requirement for LME/MCOs to finish their Plans has been suspended until the State's Plan is complete.

2) Allocation of available Community Living Housing Fund resources: By legislative mandate[5] funds obligated for TCLI housing slot subsidies that are unspent at the end of the fiscal year when they are appropriated are transferred from the DHHS budget to the NC HFA budget in the subsequent year's appropriations process. In FY 2014, $2.89 million of the TCLI funds for Housing Slots was unspent and transferred to the HFA to be deposited in the Community Living Housing Fund. In FY 2015, $5.5 million was transferred and in FY 2016 $9.2 was transferred. There have been minimal expenditures and the funds available according to the State is approximately $16.6 million. The HFA, in consultation with DHHS, is responsible for

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

administering the Community Living Housing Fund. The budget language provides direction for priority for its use for individuals with SMI. It gives DHHS responsibility for identifying priority areas with the greatest need and can be used to recruit property owners who are willing to rent targeted units to individuals with disabilities.

It was recommended in the FY 2015 Annual Report, that "the HFA and DHHS develop criteria for leveraging those funds in communities where affordable housing availability is limited, in neighborhoods with properties that are accessible and with accommodations for the target population and demands for housing are the high, as part of a comprehensive housing strategy." In FY 2016, the Reviewer recommended the proposed Strategic Housing Plan be completed in October 2016 and include priorities and criteria for the use of these funds consistent with legislative language and with the highest and best use for the TCLI target population. In June, 2017, the Reviewer again reiterated a need for allocating these funds and met with LME/MCOs and DHHS representatives to discuss options. At that time it was clear several LME/MCOs had already begun working with local developers on potential projects. The Reviewer recommended Community Living Housing Fund awards be made to projects on a rolling basis to take advantage of potential projects and access to local funding. It was also recommended this process be transparent with requirements for a tenant selection process and long term use restrictions to assure the SMI population (identified in the Statute) would be the sole beneficiaries of these funds.

The 2016 Annual Report referenced that NC HFA funded a bond proposal for $2.8 million with Community Living Housing Funds. This award was made without full transparency. The DHHS and the LME/MCO were not involved analysis of the project including conducting due diligence on the proposal (for purposes of determining if the use of funds was targeted to housing for TCLI recipients), including determining if the type (and size) of units were suitable for individuals in the TCLI target population and developing a tenant selection plan prior to the funding award that would establish access requirements for the Target Population would have access. To date, there is no written agreement between the owner/developer, DHHS and the LME/MCO. Without clarity on unit and set aside requirements, a tenant selection plan and the opportunity for a due diligence review, funds could have been allocated for units that cannot be used to help the State meet its SA requirements for supported housing. This is an alarming disregard for a collaborative process that builds trust for future endeavors and meets the NC statutory guidance language requirements for use of these funds.

In June 2017, the DHHS shared a draft with the Reviewer of a proposal with features and requirements that would meet the above recommendations and statutory language requirements. This draft included provisions that have been used successfully in other jurisdictions including being able to right size the requirements with requests. These features

and requirements target units through new referral, tenant selection, and tenancy management responsibilities and relationships.

The success in other jurisdictions is also related to the engagement of local developers and organizations responsible for filling units and helping individuals sustain their housing. If the benefits of such an arrangement are to be realized in North Carolina, it would be because of the engagement between the LME/MCO, local housing organizations and owners/ developers. This approach gives the LME/MCOs the much needed opportunity to leverage local resources for long term permanent targeted units essential to the State meeting its obligations in the Settlement Agreement. Most importantly it provides for LME/MCO-property manager agreements that will in turn lessen the problem of tenants being denied units or tenants achieving long term sustainability.

As this Report was being finalized, the NC HFA and the DHHS agreed on the method and requirements for allocation of the Community Living Housing Funds and an announcement was made about the availability of these funds. Hopefully this agreement can help the State meet its obligations under the Settlement Agreement and Statutory language. The test will be the degree this process will provide for a binding tenant selection process, provide access to funds in a timely manner and provide accessible, affordable housing resources to enable the State to meet its requirements in the SA **Section IIII. (B).**

3) Transition of the Rental Subsidy Administration program to the LME/MCOs: One major challenge and achievement for the State this past year has been the shift from contracting with Quadel, a private firm that specialized in rental subsidy administration, to the LME/MCOs for Subsidy Administration. Quadel was originally contracted to be the TCLI housing "slots" subsidy administrator for subsidies for non LIHTC private rental units and to provide tenancy support services. By all accounts contracting with Quadel for tenancy supports services did not work as the firm was ill-suited for this responsibility. The LME/MCOs are more suited for this responsibility. The LME/MCOs began contracting with local service providers for TSM services in 2016.

DHHS and the NC HFA also determined the subsidy administration tasks could be done by the LME/MCOs, several of whom have an excellent track record managing HUD Shelter Plus care subsidies. The agencies decided this shift could also reduce duplication and provided the LME/MCOs a better opportunity to work directly with property managers, landlords, and owners. These changes were viewed as being beneficial in gaining access to more rental units and improving housing tenure. This process was phased in during early 2017 and will be completed by the end of the calendar year. The NC HFA reviews information submitted by the LME/MCOs on owner qualifications, quality inspections, and payment requests. The NC HFA maintains a data base of these transactions and qualifications. There have been some expected start up challenges with this change but none out of the ordinary.

Software and support for adaptable verification and payment systems are readily available in the marketplace. NC HFA created an in-house system that accomplishes the necessary verification, documentation, and approvals for payments. However, the LME/MCOs have the principal responsibility to find housing, get inspections done, determine tenant eligibility, execute the housing assistance payment documentation, get leases signed, and submit all the necessary documentation. The LME/MCOs pay the rental assistance portion of the rent and are then reimbursed by the NC HFA. The process does not include waiting list management and tenant matching functionality, which the LME/MCOs do themselves.

Arguably the greatest challenges to supported housing rental subsidy programs are landlord recruitment, verifying eligibility, and assuring a timely match of individuals to a unit they can lease. LME/MCOs need better tools for carrying out these functions, which could reduce time spent for each placement enabling staff to work with more individuals and help individuals move more quickly. There have been references to adding this function but to date the LME/MCOs have not been given the opportunity to pursue these changes.

4) Implementation of the TUTP, project based units and other resources for bridge housing that can improve access to permanent housing.

The State and four (4) LME/MCOs began pursuing interim housing arrangements through the TUTP program in FY 2016. This program provides the opportunity for individuals to move into short term housing arrangements prior to or after discharge from ACHs and SPHs. Transition staff work intensively with individuals when housing arrangements are being worked out. This is

Figure 2: Targeted Unit Transition Program

LME/MCO	Completed TUTP	Moved into SH during TUTP	Moved into SH Post TUTP	Moved into a Targeted Unit	Moved into a Private Unit
Alliance	5	5	0	3	2
Cardinal	22	18	0	5	13
Partners	5	5	0	3	2
Vaya	29	25	1	8	17
Total	45	37	0	10	27

beneficial when hospital discharge or ACH exits occur more quickly than housing arrangements can be solidified. Securing permanent housing arrangements and benefits will always be the goal for TUTP, but formal and informal supports could be added to the transition plan and be beneficial to an individual who is often in a "waiting mode" while in TUTP. Use and success of this program is illustrated in **Figure 2** above. Going forward, the State will need to make more arrangements for individuals being diverted from ACH and exiting ACHs or being discharged from SPHs. Options could include, single family dwellings used for crisis respite or bridge housing or small project master leasing options. These don't qualify as permanent supported housing for purposes of this SA and there may be some licensing requirements. However, the benefits outweigh the challenges for creating these opportunities as steps to permanent housing.

Master leasing means the LME/MCO would hold the lease with the owner, not the tenant. In this arrangement the tenant would be a sub-lessee. This does not meet the Settlement Agreement requirement in **Section III.(C)(7)[a]** but provides an important gateway to individuals gaining a lease in their own name. The DHHS could establish criteria for its use, limiting the time frame and providing a gateway for an individual to get their own lease. This provides an opportunity for an individual to get a unit with Tenancy Rights when other means are not possible. Owners and Property Managers though should not be permitted to violate Fair Housing requirements using the master lease as the only means for individuals to get access to housing.

5) Implementation of the State's Supported Housing Corrective Action Plan**:** In the State's Corrective Action Plan submitted on June 3, 2016, the DHHS took the lead in developing a focused, strategic approach to increasing availability of supported housing. 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 corrected the earlier statements by the NC HFA that there will be sufficient accessible housing available 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.

There has been very little progress on these action steps since the June 3, 2016 Corrective Action Plan was submitted. Some are no longer appropriate or possible, such as one goal to get $4 million into the Governor's budget in FY 2016 for master leasing. Some steps have been taken, such as adding a Business Analyst to the TCLI staff.

Diversion changes will be implemented in FY 2018 but will require "bridge" housing such as TUTP and master leasing, to achieve desired results. The Community Living Housing Fund allocation process was stalled during FY 2017. Given recent stalemates with the Housing Action Plan it seems the only option is for DHHS to develop a single Strategic Action Plan that expands upon and replaces earlier requested Corrective Plans.

*Findings[6] relevant to the State coming into compliance with **Section III. (B).***

1. The State has not developed the Supported Housing Strategic Plan requested by the Reviewer in April, 2015 with steps to move toward compliance in **Section III. (B)(1)**. The State contracted with the Technical Assistance Collaborative (TAC) in June 2016 to develop such a plan. The State changed course with TAC in late 2016 delaying the plan but did receive a comprehensive assessment and recommendations in July 2017. The TAC

[6] Findings will be listed in each section of this Report relevant to the State coming into compliance or being in compliance with the Section and Sub-section referenced in the narrative description for the Sub-section above each findings section.

assessment can serve as a resource for a strategic plan. DHHS has indicated it will produce such a strategic action plan as quickly as possible.

2. The State has made uneven progress on implementing its Corrective Action Plan for Supported Housing. The plan is out of date and does not appear to be a useful guide or tool at this point.
3. The NC HFA issued an Interim Plan in early August 2017. This plan has some useful short term goals but overall it is not an effective tool for bringing the State into compliance with **Section III.(B).** Many proposed outcomes have been accomplished. The steps proposed by the NC HFA in the plan are mostly for implementation tasks not strategic action steps.
4. The State just made an announcement for allocation funds in the Community Living Housing Fund but awards have not been made. Any further delays in making awards and assuring timely allocation of these funds may impede the State coming into compliance with **Section III.(B)(a)** by FY 2021.
5. The Rental Subsidy Administration program is in the final stages of being transferred to LME/MCO management.
6. The NC HFA is working toward upgrading their data management system.
7. The LME/MCOs have primary responsibility for "housing search". This is an important function that must be a constant activity aimed at increasing available not just a tool to look up availability of housing already known to the NC HFA. It is not yet defined as such nor is sufficient attention to and mechanism for each LME/MCO to increase and maintain a "ready pool" of housing.
8. The LME/MCOs have informal relationships with landlords and property managers but do not have a "ready pool" of housing with property managers and landlords agreeing to make potential vacancies known and agreeing to fill units based on immediate demand.
9. The State has worked with SocialServe to update and expand NCHousingSearch but the goals being proposed for expansion appear too low for some areas of the state based on the needs of a particular county or catchment area.
10. LIHTC Tenant Selection Plans need updating with more emphasis on investigation and enforcement. Given data on denials and potential for discriminatory practices, this is being given high priority by the NC HFA.
11. The LME/MCOs, with DHHS support, are effectively utilizing TUTP and LME/MCOs are proposing other bridge housing options to increase access to permanent housing slots.
12. The State is proposing using Master Leasing. This should not be done to absolve the

owner of Fair Housing obligations but rather to give opportunities to individuals with background issues to sub-lease an apartment with the goal to lease their apartment with full tenancy rights. If an individual can secure permanent housing through a Master Lease until they can secure a lease in their own name, this could help the State come into compliance with **Section III. (B).**

Recommendations

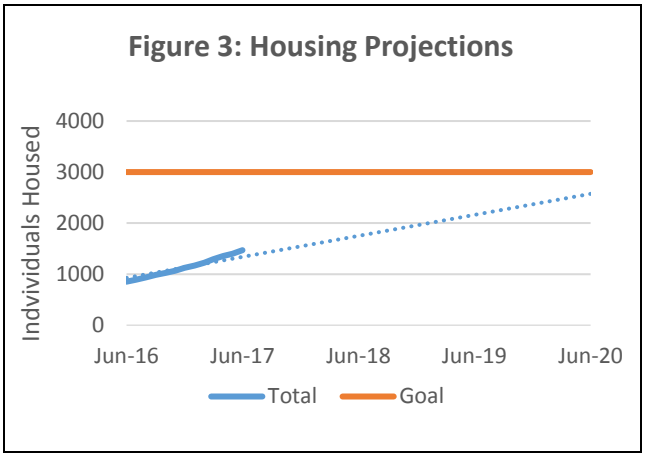
1. Complete the requested Supported Housing Strategic Plan as soon as possible. Tailor LME/MCO housing plan requirements on this Plan. Make changes to the June 2016 Corrective Action Plan that are consistent with the Settlement Agreement and fold those into the requested strategic plan.
2. DHHS and the LME/MCOs, define their respective roles and responsibilities for "housing search". Define targets, needed resources and staff requirements for this task.
3. Each LME/MCO develop a "ready pool" of housing as described above.
4. NC HFA continue efforts underway to update guidance, review, investigate complaints, and enforce compliance with LIHTC Tenant Selection Plans.
5. Expand NCHousingSearch listings. The DHHS, Social Serve and LME/MCOs set overall targets and catchment targets for expansion of listings.
6. Allocate the Community Living Housing Fund resources in a timely manner. Ensure the funds are allocated in a transparent fashion. Assure the allocation is for developing units in high need areas that maximize benefits to individuals with SMI/SPMI who are risk of entry into ACHs but also to projects that can place units in service as soon as possible. Make funds available in a manner to assure the funds being transferred to this Fund are available to TCLI recipients within the timeframe of this Settlement Agreement. Assure the LME/MCOs are involved at every step to better leverage funds and facilitate individuals' access to permanent supported housing.
7. Expand TUTP and make other bridge housing options available that increase access to permanent housing slots for individuals transitioning out of and being diverted from institutions, primarily ACHs but also SPHs.

Section III.(B)(2) Priority for the receipt of Housing Slots will be given to individuals in five (5) categories based on where individuals are living for Housing Slots. There is evidence to suggest the State is giving priority to individuals in Category 2 and Category 3 of the target Population. There are very few Category Priority 4 referrals of individuals hospitalized in SPHs. In FY 2017 only two percent of hospital discharges (2%) were discharged directly into Supported Housing.

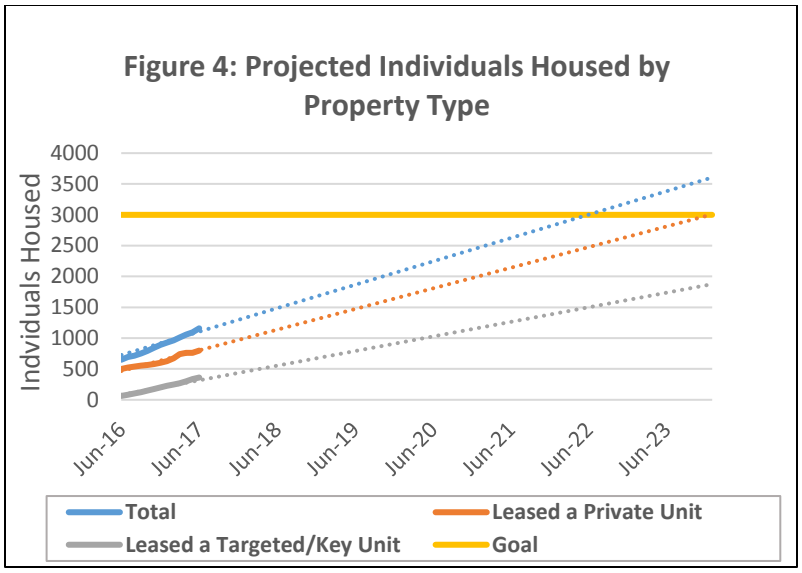
Hospital discharge records were reviewed in all three (3) State Psychiatric Hospitals and fourteen (14) individuals hospitalized in SPHs were reviewed during FY 2017. The reports from the chart review in two of the three hospitals were included in the Brief Report on In-reach submitted on May 19, 2017. There were no appreciable differences at Broughton Hospital in the information on discharge planning and discharge arrangements from the earlier report.

The State modified its definition of unstable housing in FY 2017 to bring it in line with the current types of unstable housing where individuals being discharged from SPHs are likely to move. This will likely expand the number of individuals referred for Supported Housing Slots but it also serves as a diversion from future institutionalization and is much more reflective of the needs of individuals being discharged from SPHs.

Section III.(B)(3) is the provision for **1,624 Housing Slots** to be filled **by July 1, 2017.** The State filled fourteen hundred and seventy (1,470) units by July 1, FY 2017 and eleven hundred and fifty nine (1159) individuals were residing in Supported Housing on that date, as noted in **Figures 3 and 4.** Nine hundred and fifty-three (953) individuals moved into private units with a TCLI subsidy. Four hundred and eighty three (483) moved into LIHTC units.



Of those numbers, eighty-four percent (84%) of individuals living in private units have retained those units over time. Only seventy-five percent (75%) of individuals moving into LIHTC units have retained their unit over the same time period. This higher percentage is surprising given the number of individuals still denied access to LIHTC units because of their history.



Individual Reviews demonstrate individuals at higher risk of losing their housing are living in LIHTC units. Further analysis will be conducted to determine the extent to which age or other factors result in a higher number of individuals leaving the LIHTC units. The State reported in April 2017 that two thousand nine hundred and fifty-five (2,955) LIHTC Targeted units filled and and that three hundred and sixty one (361) were filled with individuals in the TCLI target population, an increase of approximately 43% over an eight month period. However, over the same period there was a 75% increase in the number of individuals with other disabilities who were housed in the Targeted Program. This is not to say individuals with other disabilities should not have access to these units. It underscores the challenges the target population has in getting access to housing and the challenge the State faces meeting its obligation in the SA. What is also important is the number of Targeted Units that are not yet filled at all or not filled with individuals with disabilities as required in the statute.

The NC HFA reports five thousand seven hundred and eleven (5,711) LIHTC Targeted Units were committed on July 1, 2017, including new units available (placed in service) in FY2017[7]. This means a significant number units are either not available or not filled at a time the State is trying to meet its obligation in the Settlement Agreement for Supported Housing. Location is one issue for why units have not been filled but location alone cannot account for State's inability to assure individuals with disabilities including individuals in the SA target population cannot gain access to these dedicated resources.

Five hundred and ten (510) individuals in the TCLI Priority Populations applied for a Targeted Unit in FY 2017; this is a dramatic increase (340%) from the one hundred and fifty (150) applicants for Targeted Units in FY 2016. Three hundred and sixty one (361) individuals or seventy-one percent (71%) of those referred were successful in accessing a LIHTC Target Unit and are still residing in these permanent units. This is a significant gain over the forty-seven (47) individuals or thirty-one percent (31%) who were successful in accessing and retaining

[7] There were minor differences in the numbers reported by DHHS and the NC HFA for housing units available and filled in FY 2017.

their unit in FY 2016. The improvement was the result of the LME/MCOs making more referrals. They were aided by Regional Coordinators[8] who notify them of vacancies and by the NCHFA making "voluntary[9]" units available. The average number of referrals per individual made by each LME/MCO to achieve this change increased from 1.63 to 2.25, with Vaya, Cardinal, and the Alliance all referring over that average number. The percentage of the total number of referrals (not people) that were accepted was only thirty-one percent (31%); this number was up from nineteen percent (19%) in FY 2016.

Fifty-two (52) individuals who were referred either remained or were admitted to facilities. This data reveals there was essentially no change in the rate of denial or number of individuals who stopped looking for units, found other units, or remained or moved to facilities over the past three years.

The number and percentage of family units awarded in the last LIHTC round for the counties where individuals in the TCLI program most want to move remain essentially the same as the year before.

Seventy nine (79) individuals have returned to Adult Care Homes from Supported Housing since the FY 2013 and seventy-eight (78) individuals have died since moving into Supported Housing. Another one hundred and fifty-five individuals have left housing for other reasons (primarily medical or psychiatric hospital treatment, gone to jail, moved in with family or friends, drug/alcohol treatment, moved to skilled nursing care). Given the age and severity of medical conditions a high number of exits to higher levels of care or death is to be expected. Nonetheless, further analysis and recommendations for increasing tenure as referenced in other sections of this report is important especially the reasons for individuals returning to ACHs.

Findings

1. Eleven hundred and fifty-nine (1,159) individuals were living in Supported Housing on June 30, 2017. The State did not the meet the FY 2017 SA requirement to have sixteen hundred and twenty-four (1,624) units filled in FY 2017. However the State made significant gains in filling slots in FY 2017 over the number of slots filled in previous years.
2. There were significant improvements in both the number of private units and LIHTC units filled in FY 2017.

[8] Regional Housing Coordinators are funded by DHHS to assist individuals with disabilities gain access to Targeted/Key LIHTC units. The TCLI budget partially covers the cost of these Coordinators.

[9] Voluntary in this context means LIHTCs owners agreed to make more units available than they are required to make available based on their agreement with the NC HFA. Owners of properties other than LIHTC properties also have made "project based" units available.

3. The number of referrals to LIHTCs was much higher than the previous three years. The rate of denials was down somewhat but the number of referrals by individuals seeking a unit was higher.
4. Private units were filled at a faster pace than were LIHTC units.
5. The rate of denials was much higher in the Vaya and Alliance catchment area. While no inference can be identified with existing information, it may be related to Buncombe and Wake Counties having very competitive rental markets.
6. The rate of filling units is greater than the rate of separations (Death, return to ACHs, evictions, independent housing, hospital admissions, other). Nearly 50% of all separations from housing units is because of death or an individual returning to an ACH.

Recommendations for increasing the number of individuals accessing and retaining housing are found in **Section III.(B)(1-2)(6-7)** above**.**

Section III.(B)(4) refers to developing rules to establish processes and procedures for determining eligibility for Housing Slots consistent with this Agreement. The State has modified its definition of unstable housing at the request of the Reviewer. This was done following reviews conducted of individuals discharged from SPHs into types of unstable housing not included in the original definition. Unstable housing appears to be a significant factor, either as a cause or result, in repeat admissions, homelessness, substance use, and involvement with the criminal justice system. Findings and recommendations regarding the requirement to establish policies and procedures are included in **Section III. B. (2)** above.

Section III.(B)(5) refers to the 2,000 slots that must be available for individuals living in ACHs. This requirement must be met by the Agreement's conclusion, and thus is not reviewed this year. The State is closely monitoring the ratio of housing slots filled by Priority group, by each LME/MCO and percentage of units being filled by individuals exiting ACHs is approximately 60%.

Section III.(B)(6) states **the State may utilize ongoing programs for housing assistance to fulfill obligations under this Agreement as long as the ongoing programs meet criteria in III.(B)(7)[a-g].** The State has utilized Targeted and Key units but has not taken advantage of any other types of suitable scattered site housing programs or financing that could be available. As reported previously, in 2015, the NC HFA relinquished $13 million in HUD funded 811 PRA subsidies awarded to North Carolina for scattered site Permanent Supported Housing. The State also failed to make a timely required request for a HUD Housing Preference for this target population for the Section 8 Housing Choice Voucher program in 2016. In FY 2017, the State failed to request Community Development (CDBG) or Social Services Block Grant (SSSBG) funds that could have been used for rental repair and

rental programs for people with disabilities (including individuals in the SA priority population) in the aftermath of Hurricane Matthew. This happened after the United States Department of Housing and Urban Development (HUD) Secretary's designee recommended the State take this action. As stated earlier, the State has not taken advantage of HUD Special Purpose turnover Vouchers for the TCLI population.

The State has failed to act in a timely manner to infuse Community Living Housing Fund resources into projects that have already or could leverage other funds, including but not limited to CDBG, local housing trust funds and Housing Opportunity Home Investment Partnership (HOME) funds, and other funds available to for-profit and non-profit housing organizations who are purchasing, rehabilitating, and developing affordable housing. As referenced above, three LME/MCOs have worked diligently to develop proposals with local partners that would leverage other resources. These opportunities have been or will be lost soon, just as other opportunities have been lost with inaction or, as in the case of 811 PRA, the State refusing to go forward with a proposal that was already awarded to the State. The Settlement Agreement does not require the State to utilize or leverage other funds although the DHHS and the NC HFA are required in State statute to utilize the Community Living Housing Fund for the TCLI target population.

1. The State has not taken advantage of any ongoing (or new) (federal) programs for housing assistance to fulfill obligations under this Agreement.
2. Arrangements for using other programs could have been made since the Settlement Agreement was signed. Several opportunities including the 811 PRA, PHA preferences, special funds for individuals with disabilities in the aftermath of Hurricane Matthew are now closed to the State.
3. One opportunity to expand housing resources exists now, the Community Living Housing Fund. These funds, if utilized effectively, can help leverage other federal, state, local, and privately raised funds for capital or rental assistance. It is improbable that, unless the DHHS and NC HFA provide the LME/MCOs the opportunity to propose new projects be solicited on a rolling basis immediately, the Community Living Housing Fund resources will not be available to fulfill obligations under this Agreement.

Recommendations

1. The State make timely decisions on awarding Community Living Housing Funds based on the DHHS proposal and LME/MCOs unique needs.
2. DHHS. NC HFA and LME/MCOs continue to identify promising opportunities and, where possible, take advantage of them.

Section III.(B)(7) specifically refers to housing slots being provided for individuals to live in

settings that meet specific criteria as follows:

Section III.(B)(7)[a] Housing Slots must be in permanent housing with Tenancy Rights. The State has consistently followed this requirement.

Section III.(B)(7)[b] requires the State to provide tenancy support services that enable residents to attain and maintain integrated, affordable housing. Tenancy support is flexible and available as needed and desired, but not mandated as a condition of tenancy. Tenancy Support is a housing requirement but is also a service and will be referenced again as part of the services array. As such, the State took action in FY 2016 to re-vamp and strengthen Tenancy Support services. This service is now defined as Tenancy Services Management (TSM). A number of the providers selected to provide this new service are delivering services at the intensity and frequency that match individual needs and requests. They are providing assistance with move-in, sustaining tenancy, and daily living skills. Some teams are providing assistance with community integration. However, not all teams are providing services at the frequency and intensity needed. Nor are interventions focused and practiced at the level needed. This is a new service so both LME/MCOs and providers have much to learn.

ACT teams are required to provide tenancy support[10] and their performance is also mixed, but for different reasons. The time devoted by ACT to providing this support appears to be quite limited for most teams. Tenancy support as now defined was not originally considered a core function by ACT teams although Supportive Housing was added to the TMACT Fidelity Requirements. Thus some providers consider these services "added-on" rather than part of their other responsibilities. The average number of individuals served by each ACT team who are also recipients of TCLI housing slots is seven (7). This may also account for the limited attention given this function. Both the State and the UNC Institute, responsible for fidelity reviews, are aware of this issue and have already begun to focus attention on improving ACT teams' awareness and support for tenancy support.

Section III.(B)(7)[c-d] Housing is located where individuals are enabled to have interaction with individuals without disabilities to the fullest extent possible. Housing slots are provided so as not to limit an Individual's ability to access community activities at times, frequencies, and with persons of their choosing. Meeting this requirement continues to be a challenge, primarily because of locations of available housing and transportation. This impacts the State's ability to come into compliance with housing (slots) as well as these services requirements. This year's reviews identified that individuals would be more engaged in community activities with more assistance with transportation. In some situations, such as

[10] ACT is a bundled service and includes tenancy support. An individual is not eligible for a separate tenancy support service while receiving ACT.

attending church, individuals could get transportation from persons who are not staff. Some individuals need help, though, making those arrangements. One individual mentioned he cannot get to AA meetings easily because the bus service ends in his neighborhood at 6 p.m. He said he can sometimes get rides but this is not always an option. Likewise, several individuals mentioned wanting to attend church. Church members will typically give people rides but if an individual doesn't have an opportunity to get to church often enough to meet church members then it is difficult to make that happen. One woman has to travel an hour a half on two buses to attend a support group.

Section III.(B)(7)[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. Since this provision has not been used Compliance is not measured.

Section III.(B)(7)[f] Individuals are afforded choice in their daily life activities, such as eating, bathing, sleeping, visiting, and other typical daily activities. In FY 2017, the pattern of individuals having limited assistance with typical daily activities continues to be the same as reported in earlier reports with two exceptions. TSM staff are much more involved in individuals' daily lives. The State took a major step forward, allowing presumptive eligibility for PCS services in their homes enabling individuals needing assistance with eating, bathing, dressing, toileting and/or mobility to receive those services. There were some challenges getting this program off the ground, including poor communication with In-reach and Transitional staff and inappropriate response from the DHHS contractor's authorizing staff. However, there were only two (2) individuals in this year's review receiving PCS services so a review of its impact is difficult to discern at this time. Given the level of need for this service, it is assumed impact can be assessed with future reviews.

There is a much greater variance in assistance with daily activities for individuals being served by ACT teams. Very few connections to community providers providing individualized health and wellness services and natural supports were reported in the FY 2017 Individual Reviews and choices in typical daily activities still appear limited. As more TSM provider staff and teams are added, hopefully more attention can be made to offering these choices. TSM is a service but also required in **Section III.(B)(3)** as part of the Supported Housing requirement. The availability of the service is evaluated as a Supported Housing requirement but sufficiency of the service as it relates to Services requirements in **Section III. (B)** is also evaluated for compliance.

Likewise, Occupational Therapy services and consultation are not offered nor are often available. Occupational Therapists are uniquely qualified to assess an individual's skills for necessary independent, interdependent, and productive living. They can identify cognition deficits and role challenges. Roles where individuals may have challenges including being a neighbor, tenant, family member, worker or student. They can assist individuals identify important and valued

activities and identify challenges in living environments. In a consultative role they can assist staff to identify and assist individuals with these issues. The State is more aware today of the need to services and consultation to facilitate its ability to comply with the SA.

Findings

1. The State is in compliance with **Section III.(B)(7)[a] and [e].** The State has not yet met **Section III.(B)(7)[b] [d], and [f]** requirements.
2. The State has met the tenancy support requirement as written in this section but will continue to be reviewed as the program expands to ensure the supports are not yet as flexible and available as needed and desired. ACT teams have been provided training and education on tenancy support, but their performance to date on providing this support is mixed. This issue is raised again in the Services and Transition sections of this report.
3. There is a SA requirement for a person-centered plan to be developed by a qualified provider for ensuring all elements of and components of the plan are arranged for recipient in a coordinated manner in **Section III.(C)(8).** It was sometimes not clear who was the lead provider developing such a plan and role the TSM had in developing such a plan.
4. The State has assessed the problems with housing locations that are limiting access to community activities, at times, frequencies, and with persons the individual chooses. Access remains a significant barrier. The access barriers are often related to staff attention to remedies for transportation. The distance and access issues related to where units are located would necessitate more availability to housing with better access to services and community amenities and better transportation options.
5. Using location bus and community amenities as the sole markers for access for accessible and available housing the target population as required in the SA overlooks key issues such as terrain, individual's mobility issue, bus schedules, and distances to required services.
6. ACT team tenancy support performance in assisting with affording choice, assisting individuals with typical daily activities, and arranging for allowable supports is mixed.

Recommendations

1. DHHS and LME/MCO TCLI staff work collaboratively to develop performance standards and requirements for tenancy support staff and their supervisors (TSM) and ACT teams on tenancy support.
2. The DHHS and LME/MCOs work closely to develop a review protocol, coaching, and additional training for tenancy support for both the ACT teams and TSM staff. Request

the UNC Institute assist as needed with these tasks.

3. The LME/MCOs ensure other service providers, especially but limited to IPS-SE providers, LME/MCO Care Coordination and Network Management staff, SPH staff, and guardians are aware of **Section III. (B)(7)** requirements and especially how TSM staff can work closely with other providers, so service provision is seamless without gaps and duplication. This is vital for catchment areas where Critical Time Intervention (CTI), a model for transition activities essential to transfer of care including benefits, provider assignment and other activities associated with individuals moving into the community.
4. Build access to activities of daily living and typical daily activities into Discharge and Transition process requirements, person centered planning, and service provider requirements.
5. Expand availability of Occupational Therapy consultation and services for individuals with psychiatric disabilities in accordance with best practice Occupational Therapy standards.
6. Expand transportation options, shared rides, transport services, apartment complex staff rides, and other options. Explore options with church members, senior centers, and local organizations.
7. Re-assess housing location issues and develop better criteria for assessing location and access when developing housing options and considering individual placement options.

Section III. (B)(8) refers to housing where housing slots cannot be used. The State is only utilizing housing where slots are allowed to be used.

Section III. (B)(9) Individuals will be free to choose other appropriate and available housing options after being fully informed of all options available. LME/MCO TCLI staff are encouraged to review the adequacy of the education and information they provide to individuals and stakeholders (families, SPHs, general hospitals, guardians and providers, and other referring entities) about supported housing options and benefits and the array of services and supports. Responses from stakeholder groups during FY 2017 revealed this information is still not widely or fully known and understood. Informing both individuals and stakeholders regarding options and benefits, may help individuals better understand the program and stakeholders to be more supportive of the program. This requirement is being met but information provided and communication with stakeholders could be improved.

Compliance Summary

Meeting the Supported Housing requirements in the SA remains a challenge for the State. There are challenges both in meeting numerical targets and in developing "effective measures" to achieve targets. This year the LME/MCOs, with support from the Regional Housing Coordinators, the State increased filled units by forty-four percent (44%) or five

hundred and nine (509) individuals. The State is now giving more attention to challenges in assisting individuals to retain their housing. The State is examining reasons why individuals do not retain housing. This issue will be further analyzed and addressed in FY 2018.

The availability of housing in locations that don't present barriers to access to community resources and to a choice of daily activities is still a significant barrier as is available transportation. Loneliness and isolation are serious issues, as described in other sections of this Report and may impact the State's compliance with the SA's numeric requirements for individuals being counted who are "living in housing".

The State has successfully made the shifted of Rental Subsidy Administration to the LME/MCOs. The State's strengths are in meeting SA tenancy requirements and creating a tenancy support service (TSM). The State has received a *Comprehensive Assessment with Recommendations to Comply with the Olmstead Settlement* from the Technical Assistance Collaborative. It is a useful tool.

However, the State has been unable to complete a Strategic Housing Plan and was delayed in releasing a plan for allocation of the Community Living Housing Fund resources making timely use of those resources more challenging. These delays have undermined the State's credibility, which is vital to LME/MCO collaboration with developers. More importantly, it threatens long term compliance and it is a drain on time and resources. The DHHS indicates it will complete a Strategic Action Plan for Supported Housing as soon as possible. The DHHS has also agreed to make modifications to their Corrective Action Plan so the two plans dovetail for more consistency and better communication to the field.

II. COMMUNITY BASED SERVICES

Community-Based Services requirements in the Settlement Agreement ("S.A.") § III.(C) obligates the State to meet requirements for all services including obligations for funding services. It also includes detailed requirements for two specific services, Assertive Community Treatment (ACT) and Crisis Services.

Section III.(C)(1) requires that **"[t]he State provide access to the array and intensity of services and supports necessary to enable individuals with Serious Mental Illness (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."**

Section III.(C)(2) refers to services **individuals with SMI in or at risk of entry to adult care homes are eligible to receive if the individual does not receive a housing slot. Services provided to an**

individual who does not receive a housing slot and are not eligible for Medicaid (as referenced above) **shall be subject to availability of funds and in accordance with State laws and regulations regarding those services.**

In **Section III. (C)(3) services and supports "shall be (a) evidenced based; (b) flexible and individualized to meet the needs of each individual; (c) help individuals to increase their ability to recognize and deal with situations that may otherwise result in crises; (d) increase and strengthen individuals' networks of community and natural supports, as well as use of these supports for crisis prevention and intervention."**

In **Section III.(C)(4)** the State is to **"rely on the following community mental health services to satisfy the Agreement's requirements: Assertive Community Treatment ("ACT") teams, Community Support Teams ("CST"), case management services, peer support ("PS") services, psychosocial rehabilitation services, and any other services as set forth in Sections III.(C)(1) and (2) of the Agreement."**

In **Section III.(C)(5)** the State is required to operate ACT with fidelity to one of two ACT models. The State selected and is required to operate to fidelity with 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."**

In **Section III.(C)(6),** the State is responsible for a **person-centered plan** being **developed for each individual, which will be implemented by a qualified professional who is clinically responsible for ensuring that all elements of the plan are arranged for the recipient in a coordinated manner.** Plans are to include **psychiatric advance directives/or crisis plans so that such measures can be incorporated into the response to any behavioral health crisis.**

In **Section III.(C)(7)**, the State contracts with LME/MCOs for local management and services provision and in turn the LME/MCOs contract with service providers. As part of this arrangement, the LME/MCOs provide access to services as prepaid inpatient health plans ("PIHPs") for Medicaid beneficiaries[11]. **The State will monitor services and service gaps and, through contracts with PIHPS and/or LMEs, ensur[ing] the number and quality of community mental 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 LME/MCOs accountable for providing access to community-based mental health services[12]. The State remains ultimately responsible for fulfilling its obligations under the S.A.**

In **III. (C)(8)** each **LME/MCO is to provide publicity, material, and training about the crisis hotline, services, and the availability of Information consistent with federal requirements**[13].

[11] in accordance with 42 C.F.R. Part 438.
[12] in accordance with 42 C.F.R. part 438.
[13] in accordance with 42 C.F.R.§ 438.10

This information is also to be provided to all behavioral health providers, including hospitals and community providers, police departments, homeless shelters, and department of corrections facilities.

In **III.(C)(9)** the State is required to expand ACT teams to **43 teams serving 4,307 individuals at any one time by July 1, 2017. Individuals receiving ACT services will receive services by employment specialists on their ACT teams.**

There are three (3) Crisis Services requirements in **III.(C)(10).**

In III.(C)(10)[a] The State shall require that each LME/MCO 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-day-per week crisis telephone lines.

In 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.

In III.(C)(10)[c] crisis services shall be provided in the least restrictive settings (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.

Overview: As depicted in **Figure 5**, fifty two (52) of the one hundred and seventeen (117) individuals reviewed were receiving services at the time of their review. Seven (7) individuals, who had been living in the community, were selected for the review but were missing at the time of the review[14]. Another three (3) individuals were not reviewed because they had refused all services after moving in with relatives upon exiting an ACH or SPH; one (1) individual was refusing services and refused an interview but is living successfully in Supported Housing. All had gone through a PASSR review. Two (2) individuals were not followed by the LME/MCO after a PASSR because they were referred to a group home by the SPH and one (1) individual who received a PASSSR was convicted of a crime and was incarcerated before being seen by the LME/MCO.

Eighteen (18) individuals were reportedly receiving ACT services at the time their names were drawn for the review, (10) of whom were living in Supported Housing. Of those who were or had received ACT services, three (3) individuals were living with family, two (2) were recently terminated by or in the process of being terminated by their ACT provider and three (3) were missing. Thirty-three (33) other individuals were living in Supported Housing and receiving other

[14] Only one (1) individual was refusing services at the time of their review but still living in Supported Housing; two (2) were recently terminated by ACT and being re-assigned but listed on chart as receiving ACT.

services; two (2) were living in Supported Housing but refusing services. Three (3) individuals were receiving these other services but not living in Supported Housing. Four (4) individuals who had been assigned to a services provider were missing at the time of the review.

Figure 5: Services Type by Individuals Known to have Received Community Based Services

Services Provided for Each individual[15]	# of Individuals
Assertive Community Treatment	18
TSM, CST, PS and Medication Management	1
TSM, CST and Medication Management	7
TSM, PS and Medication Management	5
TSM and Medication Management	13
TSM, Medication Management, PS and Personal Care or Home Health	2
TSM, Medication Management, Individual supports, Counseling	1
TSM, PS, CST and Partial Hospitalization	1
TSM, PS, Medication Management and CTI	1
TSM only	1
PSR and Medication Management	1
Peer Support Only	1
Outpatient VA	1
Refusing Services but living in SH	2
Others who had received services other than ACT were missing	3
Total	59

LME/MCO TCLI staff often provide direct services beyond the responsibilities of TCLI In-reach staff and Transition Coordinators. They provide services that fall more under the scope of responsibilities of a service provider. This may be in part because of their commitment to seeing that individuals get the support they need if the services provider is not responsive. This is helpful at the time but leaves the service providers with the impression that TCLI staff have responsibilities for interventions that are service provider responsibilities. This is partly a result of the TCLI program being new with service providers still building capacity learning new roles and sometimes the result of having duplicative responsibilities.

There is also a reported problem with providers not being authorized (by the LME/MCO) sufficient units commensurate to individual need and the scope of services being narrowly defined as evidenced in PCPs. Regardless of the reason, it appears there is both a drop off of needed follow through and services being less intensive and not provided as frequently as needed after the TCLI staff begin to pull back their transitional support. It is not clear if this is a problem related to providers not making a convincing case for units and services needed or if the

[15] Service Arrangements may vary over time. Glossary: TSM: Tenancy Services Management; CST: Community Support Team; CTI: Critical Time Intervention; PS: Peer Support.

LME/MCOs are just not authorizing services based on their pre-determined risk factors or other criteria for services authorization. Regardless this may be a contributing factor to individuals returning to ACHs. More analysis is being planned to determine if this is a factor.

Community based services, by their nature, are required to be recovery-focused and community-based because individuals are returning to the community or being diverted from institutions and learning to live in the community. Provider and TCLI staff still need to learn new skills as well as to work in teams and across teams with staff from different disciplines and from different life and professional experiences. A good argument could be made for staff meeting competency-based requirements at the time they are hired and trained which could improve the likelihood the State can meet its SA compliance requirements for Community Based mental Services. This applies to TCLI and service provider staff. LME/MCO network development/operations and care coordination (management) staff should apply practices and guidelines specific to this target population. This population is not referenced in the DMA-LME/MCO as a "high-risk special needs population" even though it clearly fits the description of a high risk population with unique needs.

The DHHS DMH and DMA staff are responsible for services policy, development of services requirements and developing a services array, contracting with LME/MCO staff, and monitoring service requirements. The State TCLI staff work closely with the DMH and DMA staff as it pertains to the DHHS meeting SA requirements. As referenced in the Introduction to this Report, HSRI will assist the Reviewer with input from DHHS and the LME/MCOs to analyze claims data for individuals in the TCLI data base to better determine the service utilization patterns and the extent to which specific services are being utilized.

The DMH contracts with the UNC Institute for Best Practices for ACT and IPS-SE fidelity reviews and for providing technical assistance to DHHS, LME-MCOs, and service providers on a range of treatment and recovery approaches and practices including, but not limited to, Integrated Dual Disorder Treatment (IDDT), tenancy supports, and motivational interviewing. They routinely cover all aspects and requirements of ACT and IPS-SE service delivery at both the introductory and advanced practice levels. The Institute staff capacity was increased in 2016. Based on this services review, staff training remains a critical issue and the State and the UNC Institute should review needs and determine what additional training and technical support is necessary to bring the sufficiency of services into compliance with the SA. The Institute staff are also good resources for assessing potential access issues and determining how best to address them.

Community-Based Mental Health Services. **III.(C)(1-4) and (6)**: The State is required to provide access to an array of services and supports that are referenced in these requirements, with the needed intensity and frequency to enable individuals with SMI in or at risk of entry in adult care homes to successfully transition to and live in a community-based setting. Access refers to individuals getting services that are most appropriate to their need in a timely manner. Choice is

generally referred to as individuals having a choice of service providers in a particular geographic area and is relevant because a lack of choice may prevent individuals from receiving a beneficial service and/or one they would choose. Array refers to the types and levels of services provided by the State. The Settlement Agreement requires the state to "rely on" specific services but also requires the State to rely on "other services" as set forth in the Medicaid State Plan, the Medicaid 1915(b)/(c) waiver, and the state-funded services array in **Section III.(C)(4).** The SA does not name the "other" services specifically.

The services being provided, often referred to as the services approach, must be done in a manner to reinforce and help increase and strengthen individuals' networks of community and natural supports as well as help individuals use these supports for crisis prevention and intervention. Natural supports are generally defined as people around you that you can count on for help and organizations or groups that are instrumental in your life. Natural supports are considered personal, social, and influential, and are often thought of as adding to the quality and security of life. They have considerable impact on an individual's recovery. The difference between services and natural supports is often referenced as doing "with" rather than doing "for" a person. Natural supports include but are not limited to family, friends, co-workers, clubs, churches, and support groups. The SA requires each individual is required to have a person-centered plan that meets specific requirements and includes a crisis plan.

Findings

1. Requirements for **III.(C)(1-4 and 6)** are not yet being met. Progress across the myriad of services requirements is uneven. The State's Corrective Action Plan for Services submitted in June 2016 was not sufficient to help the State achieve compliance with the SA. The DHHS has indicated they agree that developing a Corrective Action Plan based on this year's findings and their own assessments would be the most prudent next step to developing and meeting the SA's services requirements.

2. As referenced in the Supported Housing section above, access to tenancy support, referred to as Tenancy Services Management (TSM) in **Figure 5,** is now provided with more flexibility and services are generally more available. Initially tenancy support was provided mostly on a set schedule that did not take into account the inherent challenges an individual faces in pre-tenancy, move-in and sustainability of housing. This created communication and coordination lapses. Tenancy support is also provided by ACT as a part of ACT's "bundled service." The State and LME/MCOs are still building the TSM capacity but there was a discernable improvement in the provision of this service over previous reviews. The service was initially provided by Quadel as part of their contract with the NC HFA. The State improved the service requirements and funds are now allocated to the LME/MCOs for contracts with service providers. The State made this change a priority in FY 2016 and FY 2017 and continues to give priority to building capacity and improving performance.

3. Individuals' access to services referenced in the Settlement Agreement was inconsistent. Services referenced include including Community Support Teams (CST), case management, psychosocial rehabilitation (PSR), Peer Support and "other" services necessary for individuals to transition from ACHs and SPHs or be diverted from ACHs and live in the community. As referenced in **Figure 5** above, thirty-one percent (31%) of individuals in the program (not receiving ACT services) were only receiving TSM and Medication Management. This percentage is low and compared with service needs identified in the FY 2017 individual reviews. This percentage will continue to be weighed against need identified in individual reviews.

4. The State has not provided guidance to LME/MCOs on expectations and responsibilities for access to and availability of services listed, including "other services" in **Section III.(C)(4)** of the Settlement Agreement.

5. In early FY 2017, the DHHS initiated a policy to allow presumptive eligibility for Personal Care Services (PCS) for individuals prior to their exiting ACHs. There were some difficulties getting presumptive eligibility approvals at the outset of this change but no problems have been reported more recently. It will be important in FY 2018 to determine if arrangements for this service are being offered and made as needed.

6. Case management is not an offered service. Both CST and Tenancy Support (TSM) include some elements of case management. Neither cover all the interventions essential for individuals to attain and maintain integrated, affordable housing based on individual reviews and TCLI staff assessments of the needs of individuals they serve.

7. Peer Support is a vitally important support service. There is strong evidence for its effectiveness in providing tenancy support, assisting individuals to meet their recovery and community integration goals. In-reach is provided almost exclusively by certified Peer Specialists. Peer Support is listed as a service the State is to rely on to satisfy the requirements of the SA. Peer Support is a Medicaid optional (b)(3)service[16] and also optional as a DMH funded service. A Peer Specialist is a required ACT team member and a "Peer Mentor" is required as part of IPS-SE. Other services could include Peer Specialists.

   On two occasions, when a reviewer mentioned that a referral to Peer Support might be a good idea, LME/MCO staff agreed. In both situations the Reviewer pointed out that the individual they were interviewing was isolated and lonely with few friends or contacts. Feeling lonely and being isolated are risk factors for deteriorating health and mental health problems.

8. Three (3) individuals were listed as being authorized for PSR but only one (1) attended the program. Psycho-social rehabilitation programs are site-based day programs defined and

[16] Medicaid funded (b)(3) services are considered optional Medicaid services and not defined in the Medicaid State plan, can only be provided by a qualified provider and offered and reimbursed by LME/MCOs using a definition approved by the DMA.

reimbursed by Medicaid and by the DMH for individuals with severe and persistent mental illness who have moderate to severe functional deficits. The program's focus is to promote independent and community living skills. The programs offer a range of work, education, skill, social and interpersonal experiences, both group and individual based.

9. Supported Employment[17] (IPS-SE) is covered under a separate section in the Settlement Agreement but it is also a part of the service array. Expanding access to and availability of IPS-SE is a work in progress.

10. Psychiatric services were consistently available across all the catchment areas.

11. Individual Supports is a covered service in the State's Medicaid Plan. One (1) individual in the random sample was receiving that service at the time of the review. Individual Support Services are defined as "hands-on" individualized assistance with everyday activities that are required by a member with severe and persistent mental illness in order to live independently in the community.

12. Critical Time Intervention (CTI)[18] was funded on a "pilot" basis by the State in 2015 and 2016 for individuals making transitions from institutions to community based care. Only one individual was receiving this service at the time of this review. The individual receiving the services was making a good adjustment to community living post hospitalization. He did seem to be confused with which staff was helping him with which issue. This confusion was also an issue for several other individuals who were receiving services from multiple providers. It is important to consider the communication, boundary, continuity, and coordination of care issues that arise from individuals being served by multiple providers.

13. Services are required to be evidence-based, recovery-focused, and community-based. Services are required to be flexible and individualized to meet the needs of each individual. There was little evidence that specialty services and approaches, especially specialized therapies, are being used. Specialty services and approaches needed include: age-specific evidenced-based services for young adults who have experienced maltreatment, abuse and/or have lived with instability; cognitive behavioral therapy including cognitive restructuring and other stress reduction therapies; grief counseling; trauma informed approaches including Eye Movement Desensitization and Reprocessing (EMDR); and other in-home care. Relapse (psychiatric, substance use and medical) is common and to be expected and prevention and interventions for relapse are needed. Consultation and expert assistance in psychosocial development, environmental stressors, neurophysiology and occupational therapies, Wellness Recovery Action Planning (WRAP) and other wellness approaches, and

[17] The State selected the Individual Placement and Support model of Supportive Employment (IPS-SE) as the fidelity model for Supported Employment. Requirements for IPS-SE are listed in **Section 3D.** (pg. 46) of the Settlement Agreement.

[18] CTI is a time limited short-term intervention for individuals with disabilities adjusting to a "critical time" of transition in their lives.

other supports would be helpful. In particular, occupational therapy consultation and services is quite limited but needed.

14. The failure to utilize specialty services and therapies could be the result of an insufficient number of qualified professionals to deliver the services. It could also be a lack of TCLI, Care Coordination, or service providers' understanding of what services could be beneficial for individuals in their care. It could also be a disregard of individuals' needs by above referenced staff or a combination of these factors. Where there are a limited number of qualified providers for specialized services, consultation with qualified experts and trainers could be useful. It is advised staff providing CST, ACT, PS, and TSM be offered opportunities to increase their knowledge and skills, within their scope of practice and under supervision, to utilize specialized interventions. Opportunities could include training, both on line and through courses or workshops in their local area or through coaching and mentoring.

15. LME/MCO staff working with individuals with SMI who are in or at risk of entry to ACHs or being discharged from SPHs need to be aware of the array of available services and of the needs of the Target Population so as to identify the services each individual needs, assure appropriate authorization standards are in place, and to assure services are offered and authorized.

16. THE DHHS and LME/MCOs began taking more steps to introduce new interventions and to provide more information on the benefits of services with a broader number of service providers and LME/MCOs before the end of the FY 2017 fiscal year.

17. Only nine (9) individuals in the review sample reported being engaged with community and natural supports. While not always made clear by the individual or known to the staff, it appeared that most of the nine individuals made connections based on their previous connections or being encouraged by Peer Support and TCLI staff. A third of the individuals in the review sample directly referenced feeling lonely while others talked about being isolated. At least three (3) individuals (and staff) indicated their only support network was staff and one (1) individual reportedly calls staff every day. A lack of transportation or the location of their home are impediments to seeing family, making social contacts, or considering work.

18. There is not yet evidence that all the "elements and components of Personal Centered Plans are arranged for the recipient in a coordinated manner." The development of a single plan with involvement of all community services providers does not appear to be required and promoted. Findings from a review of ACT PCPs are listed in #23 below.

19. The State is not consistently meeting the requirement of **Section III.(C)(3)** to increase the individual's ability to recognize and deal with situations that may otherwise result in crises and to include a crisis plan or psychiatric advanced directive in a person-centered plan is not met consistently. From record reviews and discussions with individuals reviewed, it appears

that it is TCLI staff routinely manage crises before and after an individual moves into housing including assisting individuals to recognize and deal with their crises. This appears to happen because TCLI staff feel responsibility for successful transitions. During Individual Review visits, TCLI staff who had been working with an individual during the required transition period, were sometimes taken back by finding individuals in crisis. This raises the question of who has responsibility for crisis prevention, intervention, and stabilization.

During the transition period, it is understandable for the TCLI Transition Coordinator to be involved in crisis management but following this period, it is the lead service provider's responsibility to do this. TSM staff do not have this responsibility and must rely on other crisis providers. TSM are often engaged in trying to manage a crisis, regardless of their responsibilities. However, they have not been provided specific training on crisis management responsibilities unless this was a part of a responsibility in earlier employment.

Interviews revealed that at least eight (8) individuals in the sample who had moved to the community were improving their ability to recognize and deal with situations that might otherwise result in crisis with help from a combination of their providers and TCLI staff.

Two (2) individuals in the sample were in a psychiatric crisis at the time of their review. Staff were not engaged in the situations nor was there information that suggested they had helped the individuals avoid the crises. One (1) individual was terminated from services while in crisis and nearly evicted. Fortunately the LME/MCO stepped in to re-engage with him and the LME/MCO and eviction was avoided. Two (2) individuals had experienced a health crisis and were hospitalized and one (1) other individual was experiencing a health crisis that was being well managed.

One (1) individual had been discharged from Cherry Psychiatric Hospital shortly before the review and went missing two days after being discharged, leaving her two small children with her mother. Her whereabouts or any attempted intervention was unknown at the time of the review as the review was coincidentally occurring immediately after she disappeared. In another situation, a provider was negligent in handling a crisis. In that situation the TCLI staff recognized the lack of provider follow through and immediately stepped in and resolved the situation. In this situation the LME/MCO had failed to follow through with making sure the woman had a provider. She is apparently no longer receiving services.

Five (5) individuals were experiencing or had recently experienced tenancy related crises. Tenancy related in this context refers to either the landlord/property manager or the tenant having difficulty meeting terms of the lease. Three of these situations were created by the tenant and in two of these situations the tenant was rectifying the problem but another tenant created a problem that was unresolved at the time of the review. The fourth issue, one created by the landlord, was resolved at the insistence of the tenant. Four (4) individuals

were actively using drugs and/or alcohol but only one (1) seemed to be in danger of losing their unit in the near future. This was in part due to the fact that the individuals were living in high crime neighborhoods where they could get a lease because of their past histories. One of the four was being served by a highly skilled ACT provider and one who had just moved was getting good support from both the TCLI Transition Coordinator and ACT team. Regardless of the precipitating event or change in an individual's medical or psychiatric condition, the failure to manage individuals' crises often leads to an individual losing their housing or being incarcerated, re-hospitalized, or institutionalized. For three (3) individuals, their team had assisted them to avoid eviction. They were also receiving services tailored to their substance use issues. It appeared the team was following the IDDT model closely.

20. The State is not meeting the SA requirement in **Section III. (C)(3)** to provide access to services that increase and strengthen individuals' networks of community and natural supports, as well as their use of these supports for crisis prevention and intervention.

Recommendations

1. The DHHS and LME/MCOs work collaboratively to develop guidance to LME/MCOs and providers for services access and service requirements. Include in this guidance are recommendations for specialty services and interventions.
2. DHHS and the LME/MCOs provide and/or arrange for technical assistance where needed to increase provider capacity to provide specialty services and interventions.
3. Information from the Reviewer's and DHHS data analysis be utilized to identify trends, patterns of use, intensity, and frequency of services. This data should be used to inform services guidance, expectations, and technical assistance needs.
4. A review of guidance for Person Centered Planning be conducted with emphasis on individualized supports tied back to the individual's plan profile statements. The State request the LME/MCOs conduct audits of PCPs for consistency with the SA requirements.
5. LME/MCOs work collaboratively with individuals with lived experience and service providers to develop goals and strategies for strengthening natural supports and reducing isolation and loneliness. DHHS support the LME/MCOs to meet these goals.
6. Peer support services be expanded to assist individuals in meeting their recovery, tenancy, and community integration goals.
7. Based on positive reports regarding CTI in North Carolina and the body of evidence for CTI, the DHHS and LME/MCOs should consider infusing CTI principles into discharge planning for Transition Coordinators, Tenancy Support, and ACT providers.
8. The DHHS complete and submit a Medicaid State Plan Amendment for a service that combines and makes more robust the elements of community support and tenancy support

into a single service. As the program expands, this will be an important step to strengthening services and meeting SA service requirements.

Section III.(C)(5) and (9) Assertive Community Treatment

Findings

1. The State has met the SA requirement to expand ACT teams to 43 teams serving 4,307 individuals at any one time by July 1, 2017.

2. Eighteen (18) individuals, reviewed during the individual reviews, were receiving ACT services. Six (6) of these individuals appeared to be receiving adequate services. Four (4) individuals spoke about wanting to work or return to school but were not receiving services by employment specialists on their ACT teams. On the positive side, two (2) individuals reported the Peer Support Specialist on the team and employment specialist were heavily involved in providing support and help in finding employment. One (1) individual was attending Narcotics Anonymous (NA) and two (2) individuals were attending Illness Management and Recovery (IMR) groups and having IDDT informed sessions with team members.

3. According to information regarding the number and location of ACT providers, the availability of ACT appeared satisfactory although ACT recipients in a few counties did not have a choice of providers. Choice is important for two reasons. One, an individual may have had positive or negative experiences with a particular ACT provider. Two, it is difficult to control for staff to client ratios and team size in a county with only one provider. One team was reported to be the only team serving three counties and approximately one hundred and fifty (150) individuals. This is a higher number than TMACT[19] (Tool for Measurement of Assertive Community Treatment) criterion for caseload size. This becomes a factor in maintain fidelity to the model and should be addressed by the LME/MCO in their contract with the provider.

4. As a bundled service, ACT includes employment services and the TMACT includes a criterion for ACT teams to include a vocational specialist providing services consistent with supported employment. With only one employment specialist on a team it may be difficult for individuals to get attention for employment assistance.

5. The average number of individuals served by ACT teams who are in the TCLI program is seven (7). The number of individuals on an ACT caseload is typically seventy (70) to one-hundred (100) individuals at any given time except in some rural areas where caseloads may be lower. This means that service and housing assistance needed by individuals in TCLI may be overlooked.

[19]The TMACT is the standardized tool used to rate service provider fidelity to ACT.

6. Individuals receiving ACT services are often not being seen frequently, not receiving sufficient vocational, housing, or crisis support, and not receiving any assistance with developing natural supports. For example, one ACT team would not visit an individual, in the review sample, because she lived in a rough neighborhood; one individual in the sample was told to look in want ads for a job as the only vocational intervention offered; another individual had a significant trauma history but received no specific help for that issue; one individual who had limited visitation with her children was not getting support or therapy for what was a traumatic experience for her. On all nine (9) occasions when issues were identified, the LME/MCO and/or provider was unaware of the issues until the Reviewer made the home visit. On three occasions the provider did not recognize there was an issue with how services were being provided. Two ACT teams seemed hostile toward assisting individuals they described as being the problem or not following through. Transportation was referenced by nearly all ACT recipients as an issue, yet staff seem resigned to transportation as an unsolvable problem.

7. Three (3) individuals receiving ACT services spoke about being lonely and two (2) of those individuals spoke about returning to an ACH because they were lonely, although neither had returned to an ACH at the time of the review. Location is sometimes a contributing factor but in these three situations it was not. One individual's social network is his ACT team and his Transitional Coordinator. He has no other social life. Staff from two ACT teams went out of their way to criticize the individuals they were serving, in one case while the individual was present. They are routinely void of references to strengthening an individual's networks of community and natural supports and, where referenced, typically it is a task for the individual. Individuals frequently referenced a lack of transportation or the location of their home as impediments to seeing family, making social contacts, or considering work. Approximately a third of the individuals directly referenced feeling lonely while others talked about being isolated. At least three individuals (and staff), indicated their only support network was staff and one individual reportedly calls staff every day.

8. ACT is considered a very intensive service provided to individuals with a very high risk of re-hospitalization, arrest, homelessness, repeated use of emergency rooms, or self-destructive behavior. ACT services were terminated for two (2) individuals in the review sample and the process was underway for two (2) others. The LME/MCO was stepping in to arrange services for three (3) of the individuals. It was reported these terminations were being initiated because the individual no longer needed this level of service. One individual was about to be evicted when the LME/MCO stepped in, got him referred to another provider, and stopped the eviction. In two other situations it appeared there were conflicts between team members and the individual being served. The problems referenced above have implications for the State meeting its SA requirements in **Section III.(C).** The LME/MCO has oversight

responsibility for this service and as such can conduct reviews and establish performance requirements to mitigate these performance issues.

9. For most individuals receiving ACT, their Person Centered Plans (PCPs) appeared nearly identical, rather than flexible and individualized to meet the needs of each individual. A review of twelve (12) PCPs was conducted in four catchment areas. None of the PCPs reviewed listed an individual being seen more than twice a week and five (5) PCPs referenced the number of monthly contacts as one (1) plus weekly medication drops. For one ACT provider, the visits were listed as one (1) in home visit and one (1) office visit weekly for three different individuals reviewed. These findings suggest the ACT teams are using the minimally allowable visits per week as customary rather than providing intervention as needed and required.

10. Authorization periods were reported to be as short as 90 days although most authorization periods were reported to be longer. The justification process for re-authorization, while essential, takes time away from service delivery and re-enforces a perception that ACT is a short-term intervention.

11. Providers and some LME/MCO staff referenced some individuals were going to be "stepped down" from ACT to a service such as CST that is provided but with less frequency and intensity. Typically LME/MCOs use established criteria for stepdown. It is not clear that successful tenancy and progress towards recovery for individuals living in supported housing are included in a meaningful way in criteria used by LME/MCOs to make stepdown decisions. These observations are not meant to second guess specific clinical decisions, but rather to point to a trend with ACT service delivery. This will be analyzed again in FY 2018.

12. ACT providers are meeting fidelity requirements as required in **Section III.(C)(5).** While it is important to consider the full range of ACT requirements when measuring fidelity, it is also instructive to examine the ACT sub scales to see if there are indicators of strengths and weaknesses. There is not an exact correlation, but there is a perceptible relationship between the needs of this target population and the sub scales where teams are falling short in their performance and fidelity.

    Most ACT teams have high Operations and Core Team sub scale scores. These are primarily related to the presence of required staff to consumer ratios, program size, recruitment, schedules and team composition. Performance was more mixed but generally acceptable on sub sections related to responsibilities, availability, and role of specialists, and to conducting Person Centered Planning. Scores were generally lower on Frequency and Intensity of services, Engagement and Psycho-education with Natural Supports, Interventions Targeting a Broad Range of Life Domains, Full Responsibility for Vocational Services, Frequency of Contact with Natural Supports, and Strengths Informing the Treatment Plan.

There was a slight improvement in ACT team performance between their first and second ACT review, which indicates the performance is gradually trending in the right direction; however, there is no evidence that all teams are performing at an acceptable level in the areas where scores fell off, as listed above.

Section III. (C)(7)(8) LME/MCO State Services Accountability and Monitoring Requirements and LME/MCO Information Dissemination Responsibilities

Findings

1. The DHHS DMH and DMA contracts with LME/MCOs require the LME/MCOs assess community need, gaps in services and to develop strategic plans to address gaps. The DHHS uses this analysis to assess need and plan for filling the identified gaps. The Gaps Analysis requirements do not include specific reference to the sufficiency of the number and quality of community mental health services providers to enable successful transition of individuals with SMI, who are in or at risk of entry into adult care homes, to supported housing, and for their long term success as tenants in supported housing as required in **Section III.(C)(7).** Nor are there quality or performance indicators spelled out in contracts or guidance documents. There are performance indicators in fidelity reviews but they do not account for the necessary performance requirements to meet transition and tenancy requirements in the SA.
2. The LME/MCOs provide publicity, materials, and training as required in **Section III.(C)(8).** There are a limited number of brochures, fact sheets, or other materials describing "Transition Year Stability Resources" as referenced in this requirement. Responses by individuals attending Stakeholder Focus Groups suggest that ongoing publicity, information dissemination, and training is needed, especially if goals for community integration are to be realized.

Recommendations

1. The DHHS expand requirements and give additional guidance to the LME/MCOs to meet the **III.(C)(7) requirements.** This requirement can be met by analyzing gaps in the availability of services as referenced in III.(C)(4) as needed for individuals in or at risk of entry into an ACH to successfully transition to supported housing and remain housed.
2. The State is meeting the requirements of **Section III.(C)(8).** Publicity, materials, and training are provided, although the need to renew these efforts continuously is evident.

Section III.(C)(10) Crisis Services

Findings

1. The State has initiated a statewide Crisis Solutions Initiative and in accordance with **Section III.(C)(10)[a]** required each LME/MCO to develop a crisis system plan. The LME/MCOs have developed these plans and this requirement has been met.

2. The Plans could be supplemented with other important crisis system components. For example, Crisis Respite[20] is a valuable service for individuals receiving services and supports TCLI and other individuals with SMI/SPMI who are at risk of adult care home or other institution admission. It is not referenced in the DHHS Crisis Services description and the SA requirements.
3. The State sets standards in contracts and monitors gaps through the Provider Capacity, Community Needs Assessment, and Gaps Analyses ("Gaps Analyses").
4. The State is not meeting the requirements for **Section III.(C)(10)[b-c].** The State has set standards for mobile crisis, including but not limited to establishing response times. The standards do not have requirements for acceptable response times. This is especially evident in catchment areas that are expanding into different counties and catchment areas that are experiencing population growth and traffic congestion, making response time requirements more difficult to achieve.
5. Mobile crisis providers interviewed have implemented effective mobile crisis response systems. They continue to expand their presence in their communities. They have little contact with TCLI recipients and have not seen Crisis Plans for TCLI recipients, or other individuals. There do not appear to be "alert" systems, which can be used to give valuable information to a mobile crisis team that a particular individual is in a pre-crisis mode and may need help from mobile crisis. Often valuable information about how to de-escalate a potential crisis is provider through an alert system.
6. The current response standard also does not take into account the **Section III.(C)(10)[c]** requirement that "crisis services be provided….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….". Mobile crisis providers are unaware of the PCP Crisis Plans and do not have access to them and TSM staff or Transition Coordinators do not have crisis intervention or stabilization in their job descriptions.
7. The feedback in the individual reviews for the past three years reflect little contact between individuals living in the community in the TCLI program and mobile or other crisis services. The upcoming analysis of paid claims data should reveal more definitive information regarding the use of crisis services for further review of the SA requirements for Crisis Services. TCLI Transition Coordinators and TSM staff provide crisis intervention and prevention; however, they do this outside the scope of their responsibilities.

[20] Crisis respite includes short-term care provided to a person outside an urgent care center, emergency room, or clinic. It can be provided as an in home or out of home service. In some communities the service is provided by trained peers and in other locations by a combination of trained peers and professional staff.

Recommendations

1. The State's mobile crisis standards establish acceptable standards for mobile crisis.
2. The LME/MCOs, TCLI staff, TSM and CST services providers and Mobile Crisis identify "alert systems."
3. Transition Coordinators and TSM staff be provided training in crisis intervention and establish a working agreement with mobile crisis to provide back-up when individuals in Supported Housing are at risk for a crisis or the situation has escalated to a crisis level.

Compliance Summary

This review revealed the State has yet to meet all the requirements in the Settlement Agreement related to access to the array and intensity of services necessary for individuals to live in community settings and the characteristics of those services, **Section III.(C)(1)–(9).**

Results from the review of these requirements was mixed. Overall, services must be improved and more consistently provided for the State to meet the requirements in the Settlement Agreement. Services specifically referenced in the Settlement Agreement, including ACT, Tenancy Support (TSM), CST, PSR, and Peer Support, are sometimes provided but not always at an acceptable level. This is both a capacity issue but also a problem with identifying individual needs and providing, developing, and implementing adequate PCPs. Case management as a distinct service is not offered in the State but aspects of case management are included in TCLI Transitional Tenancy Support, ACT, and Community Support.

The reviews revealed examples of exemplary Person Centered Planning and individualized, age appropriate, flexible recovery based services. There were also instances of immediate assistance to help individuals avoid crises. Both stakeholders and individuals reviewed were knowledgeable about services gaps and lack of transportation. However, stakeholder focus group attendees tended to know less about TCLI. Many individuals are isolated, lonely, and have lost or lack connections to their community and families. The Crisis services system is being developed but mobile crisis standards are insufficient.

Meeting the terms of the Settlement Agreement and sustaining service improvements to fulfill obligations with the Americans with Disabilities Act is a challenging endeavor. It takes time, a sustained effort, a willingness to change practice, an understanding of what approaches and services are needed, and a consistent delivery of effective services. To best explain what changes are needed for achieving and sustaining services compliance is to compare it to the description of the "change process." Change is described as "first order" or "second order." First order change deals with the existing structure, doing more or less of something. Second order change is creating a new way of seeing things completely. Both types of change apply for how services

need to be improved across the State. There is evidence that change is underway but more needs to be done.

III. SUPPORTED EMPLOYMENT

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 individuals 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 1,624 individuals by July 1, 2017.**

In FY 2017, the review of **Section III. (D)(1-3)**. of the Settlement Agreement included interviews with individuals as part of the randomized individual interview process, IPS providers, stakeholders, DHHS (Division of Vocational Rehabilitation [DVR], Division of Medical Assistance [DMA], Division of Social Services [DSS], Division of State Operated Healthcare Facilities (DSOHF) and Division of Mental Health [DMH]), LME/MCO and local DVR staff, and UNC IPS-SE trainers. The review included observing a fidelity review, collecting and analyzing data regarding number and location of IPS-SE teams and their fidelity review findings and a review of service utilization, contracting and performance requirements and outcomes.

In December 2016, Katherine Burson[21] conducted a focused IPS-SE review. Her findings and recommendations were reported in February 2017. The review included a review of data and other information, stakeholder meetings with DVR field office and State staff and with IPS-SE providers and LME/MCO staff. She also interviewed individuals who were either on In-reach status, transitioning to the community or had already moved to the community.

Since IPS-SE is a new service in the state, findings are based on four broad recommendations that have been made in each Annual Report beginning with the FY 2015 Annual Report. These recommendations are relevant to compliance. To measure progress and for consistency, findings continue to be tied to these recommendations. The State's Corrective Action Plan for Supported Employment submitted in June 2016 had goals and actions steps consistent with previous Annual Reports recommendations and progress on that Plan will be noted as well. References will also be made to five additional questions that are incorporated into the interview questions analysis based on the FY 2017 analysis. These include: 1.) what progress has been made to strengthen

[21] Katherine Burson is a former 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).

provider capacity and address infrastructure challenges?; 2.) what are the leverage points to increase understanding of and support for IPS-SE?; 3.) to what degree are the TCLI Target Populations being enrolled in IPS-SE and what barriers still exist to their being enrolled?; 4.) what is the understanding of and support for IPS-SE within DHHS, with DVR field offices, LME/MCOs, especially with Care Coordinators and contracts and network management staff, service providers, individuals receiving services, families and Guardians; and 5.) what progress has the State made on meeting goals on its June 3, 2016 Corrective Action Plan goals for IPS-SE.

The four recommendations are as follows:

1. Clarify State (DMH, DVR and DMA), LME/MCO and Service provider roles and responsibilities and expectations and tie them to LME/MCO and provider expectations to contracts; establish performance measures between the DMA/DMH with LME/MCOs and between the LME/MCOs and service providers and within the DVR system; conduct quality monitoring and strengthen collaborative engagement and training.

DHHS is holding information sessions statewide for LME/MCO staff regarding the benefits of IPS-SE (and other services). The UNC Institute for Best Practices IPS-SE trainers have been actively engaging LME/MCO and DVR staff and providers to help strengthen collaborative engagement and overall performance. UNC recently held an IPS Symposium to broaden awareness of and identify the benefits, including cost benefits and outcomes of IPS.

It was apparent from all the FY 17 IPS-SE focus groups (with State leaders, LME/MCO staff, providers and VR counselors), individual reviews and ACT team interviews that confusion on roles and responsibilities is a barrier to successful implementation of IPS-SE across the state. During a focus group with service provider leadership and another focus group with providers and VR counselors, frustration was palpable and the need for clarification was exceedingly evident. The IPS-SE providers have the benefit of understanding the importance of roles, responsibilities and expectations which helps them establish the service. This leads to frustration though when mental health service providers, DVR, referring agencies and LME/MCO staff do not reciprocate in their roles to support individuals to be referred to IPS-SE and getting the supports they need.

It would also be beneficial for DSOHF and SPH staff, local DSS Adult Services staff, Guardians, families and individuals receiving services to get relevant information, including the benefits and potential outcomes, about IPS-SE. The DHHS and UNC's Institute information sessions are a starting point but this step alone will not result in IPS-SE providers getting referrals and support for their services. The State and UNC IPS-SE Institute staff have been hosting regional SE Collaboratives, information and technical support groups) with providers and DVR for several years. LME/MCO staff (including TCLI staff) have not been regular attendees. These collaboratives could yield a greater benefit with broader participation.

It also appears that LME/MCO staff, including TCLI staff and referring organizations have a limited and sequential view of community integration, of which employment is a subset. A typical sequence appears to be: In-reach, engage to move, enroll in services, and move into housing with little or no attention to community inclusion. This progression occurs in this same sequence regardless of whether the individual has indicated a desire for employment prior to or while living in an Adult care Home or hospitalized at an SPH. The exception appears to be individuals who initiate and seek employment on their own. The IPS model of Supported Employment has shown increasingly positive employment outcomes[22]. The model demonstrates many individuals with a serious mental illness who otherwise would not have the social capital to engage in mainstream integrated competitive employment, meet their recovery goals and live successfully in the community.

IPS-SE providers are required to meet IPS-SE Fidelity. Fidelity reviews measure the degree to which an IPS-SE provider is implementing the evidence-based practice in a manner demonstrated to obtain the best employment, community integration and recovery outcomes. Fidelity scores are separated in five levels. The first, a score of 73 or below is not considered supported employment. A score of 74 – 99 is considered Fair implementation; 100 – 114 is considered Good implementation; and 115 – 125 is considered Exemplary implementation. IPS-SE fidelity review staff reported thirty-three (33) teams have reached Fair implementation or better. Of these 33 steams with reported scores, one (1) this year reached Exemplary implementation, six (6) have reached Good implementation and twenty-six (26) were in the Fair fidelity range. Five new (5) teams are preparing for their baseline review.

One essential part of the evidence-based supported employment intervention is Integration of vocational and clinical interventions. The Fidelity instrument defines this to mean: 1) employment specialists are to be part of mental health treatment teams from which at least 90% of the employment specialist's caseload is comprised; 2) employment specialists actively participate in weekly mental health treatment meetings that discuss individuals and their employment goals with shared decision making, between the individual served and the team members and with documentation of mental health treatment and employment services in a single chart; and 3) engagement and outreach are shared responsibility of the mental health professional and the employment specialist.

Analysis of state reported fidelity data reveals weak scores of 1 and 2 out of 5 for items related to clinical and vocational staff integration. This appears to be largely the result of contracts and fee structures not supporting clinical and vocational integration. This is particularly true when an IPS-SE team is part of an organization (or site) that previous to their providing IPS-SE services,

[22] Bond, Gary, The Employment Center, Rockville Institute, Westat: *Evidence for the Effectiveness of Individual Placement and Support Model of Supported Employment.* (2017)

were Community Rehabilitation Programs (CRPs). CRPs were not being reimbursed for behavioral health clinical services resulting in behavioral health providers not being reimbursed, thus not always sufficiently engaged. It also results in CRP agencies not scoring as high on Fidelity reviews which may result in lower reimbursement potential.

Another factor is that clinical teams in behavioral health agencies sometimes do not encourage and support employment goals with concrete action steps. There are many entrees for this support ranging from engaging individuals regarding how they spend their time each day, to establishing daily habits and routines to get to work prepared and on time, to managing symptoms and interpersonal and task demands at work, and so forth. Historically this type of support and integration has not regularly been part of the mental health clinical team culture. This type of culture shift can happen with leadership, attention to incentives, reimbursement requirements and placing mental health services performance measures in contracts.

The state has established two performance measures on their performance dashboard, published monthly: 1) the total number of new individuals served by a fidelity SE provider and 2) the total number of individuals in the priority population served by a fidelity provider. These are solid and relevant performance measures.

One LME/MCO met their performance target for the year exceeding their target for four months. Two LME/MCOs met their performance target in three (3) different months and one (1) in two (2) different months. LME/MCOs typically met their performance target when new teams in their catchment area met fidelity for the first time. Individuals on their caseloads can then be counted for compliance purposes. And, there are no indicators of key processes that help discern how to increase these numbers. Neither are there measures to evaluate whether the business model is working for meeting compliance requirements and sustainability, nor are there universally agreed upon employment outcome measures.

The 2017 requirements for services needs and gaps analysis[23] only referenced an LME/MCO having the choice of two Medicaid funded IPS-SE providers and one non Medicaid funded IPS-SE service provider in their catchment area. This might have been appropriate for small catchment areas. It is no longer a good measure of choice of providers when catchment areas are so large that driving time from one end to the other is over four hours.

Data regarding the employment outcomes as of December 1, 2016 reveals that twenty-four percent (24%) of those enrolled in SE obtained jobs (510 /2137 individuals enrolled). Thirty-eight

[23] 2017 Community Mental Health Substance Abuse and Developmental Disabilities Needs and Gaps Analysis Requirements for North Carolina LME/MCOs. The due date for submission of the LME/MCO submission of the gaps Analysis was June 30, 2017. The DHHS review of this information was not available for this report.

percent (38%) of those enrolled were "in or at risk of ACH[24]" (809/2137 total enrollees). Twenty-three percent (23%) of the "in or at risk of ACH" using a broad definition of "in or at risk obtained jobs". Thirty-eight percent (38%) of the 1,328 enrollees who were not considered "in or at risk of ACH" had obtained jobs. A lower percentage of the "in or at risk" population have obtained jobs to date. There is not sufficient information that definitively determine if this is an IPS-SE provider performance issue and/or individuals "in or at risk" having more challenges to becoming employed. However it is important for the State and LME/MCOs to collect and analyze this data.

In the FY 2017 random review, five (5) individuals out of the forty-nine (49) reviewed who were living in the community at the time of the review had been referred to IPS-SE. Of the nineteen (19) individuals receiving ACT services, five (5) were provided or had been provided any of the core vocational or supported employment services.

It is recommended the DHHS Divisions (Medicaid, VR, DMH) and UNC Institute staff review where there are gaps and challenges to IPS-SE being implemented, especially for the "in or at risk" population. Ideally this would be included in the required LME/MCO services Needs and Gaps Analysis to illustrate that IPS-SE is an important, core service. Such a review is important to inform the State's IPS-SE Corrective Action Plan. It could provide information to incorporate into LME/MCO and provider contract requirements and performance measures. All parties can then track the same outcomes and collaborate on performance improvement.

To help shift the culture of the system of care toward employment, it will be helpful to establish the following or similar data points:

- # of non-IPS enrollees[25] participating in employment engagement activities;
- # of "in or at risk of" IPS enrollees identified from Service Providers surveying their caseloads
- # of "in or at risk of" IPS referred to IPS-SE from Transition Specialists and service providers when they begin to engage an individual and develop a service plan (PCP);
- # of individuals currently receiving ACT who meet the target population definition;
- # ACT recipients with an employment related goal as part of their treatment plan (could be engagement around employment, i.e. pre-IPS-like intervention;
- # of ACT recipients who are getting supported employment (IPS) services; (If ACT teams meet applicable IPS-SE fidelity requirements, this would indicate how many individuals in the priority population have access to IPS.); and

[24] The Settlement Agreement references individuals in the target population as being "in or at risk of" Adult Care Home placement so this phrase is used throughout this section to define the target population for Supported Employment.
[25] Enrollees refers to individuals who have been referred and getting IPS-SE services. It is a fidelity requirement that no one referred to IPS-SE is denied IPS-SE services.

- # of ACT recipients working in integrated, competitive employment.

Recommendations:

1. Develop materials to clarify roles, responsibilities, and expectations for MH Team, DVR Counselor, IPS-SE Training staff, as was done for IPS Team members, MCO-LMEs and state MHA. In corporate all roles and responsibilities documents into a single document.
2. Ensure DVR, LME/MCO and providers involved with IPS are trained and understand the specifics of roles and responsibilities across all the organizations and designated staff understand the specifics of the role they themselves are expected to fulfill.
3. Specify supported employment as a service for eligible persons regardless of TCLI status in the LME-MCO contracts.
4. Include employment and IPS-SE performance indicators in the *North Carolina LME/MCO Performance Measurement and Reporting Guide.*
5. Start planning next steps for infrastructure development a year in advance to prepare LME/MCOs, VR Counselors, and IPS Providers and ensure inclusion of critical performance measures in contracts, service definitions and guidelines, performance measures, quality monitoring, training, performance appraisals, competency requirements, policies, procedures, protocols, etc. This will hasten implementation and facilitate meeting the Settlement Agreement targets and long term stability of the service.
6. Review goals, activities and expected outcomes from the State's Corrective Action Plan for IPS-SE and modify or update these as needed.

Recommended points of leverage/rapid implementation facilitators

- Routinely schedule Executive Team Division level leadership discussions on progress and barriers that require attention from leadership and support needed to ensure success.
- Routinely schedule and require integrated cross-system collaborative solution-focused stakeholder meetings (IPS-SE providers, LME/MCO TCLI and other key staff including network management staff), focused on specific infrastructure challenges/needs.
- Flow charts and Role and Responsibility documents
- Contracts, service definitions and guidelines, performance measures, quality monitoring, training, job descriptions and performance appraisals, competency requirements, policies, procedures, protocols, etc.

Develop and implement sustainable IPS business models.

Building a sustainable model requires attention to organizational design, workforce needs and demands and matching payments and payment structure to service requirements through work

flow analyses. It is important to conduct break-even analyses on regular intervals. Likewise it is important to adopt quality improvement processes to better understand unintended consequences and thereafter adapt contract expectations and regulations where necessary.

DMHDDSA, DMA and DVR have taken initial steps to help guide the implementation of sustainable IPS business models. But guidance alone is not sufficient. IPS-SE is a relatively new service model and not yet universally valued as core mental health service and resource. Because the service is so new and is a valuable service for the broader population of individuals in the behavioral health service system, a business case needs to be made for why the State and LME-MCOs want to make IPS-SE widely available and sustainable. Making this case has broader applicability than the case being made for the State to come into compliance with the Settlement Agreement. Conversely, a stronger business case will make it more likely the State will meet its Settlement Agreement requirements for Supported Employment. Making the service a requirement in this Settlement Agreement and including referrals as a performance indicator is not the same as making the business case.

Currently, IPS-SE services are not incented over other employment models or other less-recovery oriented mental health services even as the research indicates more positive outcomes and a good return on investment. ACT gained support two decades ago after a solid business case was made for the service. A cost benefit analysis could help build this case.

The DVR has an important role to play in increasing the number of individuals in the target population who get IPS-SE services and become competitively employed and coming into compliance with **Section III.(D)** of the Settlement Agreement. As referenced previously, it is important for the DHHS Division of Vocational Rehabilitation to make changes in Community Rehabilitation Program (CRP) contracting requirements and internal processes including automatically referring individuals with serious and persistent mental illness to IPS-SE providers.

DVR staff have provided training to their field offices to encourage collaboration with service providers and LME/MCOs and contracting with IPS-SE service providers. The results are mixed. Of the four (4) agencies represented at the Trillium SE focus group, one (1) still had not applied for a VR contract. In December 2016, at a state leadership meeting, it was reported that there were now six (6) VR contracts in place with IPS teams that were not previously under contract with DVR as Community Rehabilitation Provider[26] (CRP), a number had applied but contracts were not signed and three (3) agencies had yet to apply.

There are some champions in the DVR field offices but other staff appear not to consider this initiative part of their job. Over half of the IPS-SE teams surveyed for fidelity this year indicated

[26] In North Carolina, Community Rehabilitation Providers (CRP), provided services to individuals with disabilities prior to the initiation of the Settlement Agreement and typically already had contracts with the DVR.

they did not have contracts with DVR. In the coming year, the Independent Reviewer will review DVR staff job descriptions and performance requirements to determine if increasing or changing job expectations could be of some benefit to increase joint collaboration which in turn will help the State come into compliance with **Section III. (D).**

During five IPS-SE stakeholder meetings and interviews with service providers, held by the Independent Reviewer throughout the state in FY 2017, there were numerous references to:

- challenges with the IPS-SE provider payment requirements and structures;
- unrealistic demands, primarily but not solely related to service planning and paperwork and other requirements, given staffing requirements in IPS;
- the costs associated with standing up small teams with high fixed costs and staff turnover and for the larger providers trying to manage their budgets when there are differences in contracting and authorization practices across LME/MCOs;
- there was a universal concern with how to begin working with individual residing in an ACH before knowing where they may move, especially if they move to a different catchment area.

Participants in one stakeholder group indicated they got TCLI referrals when the TCLI program started over four years ago but since then only receiving a few referrals a year. This is consistent with findings from individual reviews and an analysis of DHHS data. Participants in the groups repeatedly spoke about the challenges of managing across three to four different fund sources with different requirements. The same was true for service providers with multiple LME/MCO contracts. One person even said that if DVR and the LME/MCO are in the room together they are having different conversations and don't even know it.

A number of concerns raised in stakeholder groups and interviews were mentioned frequently enough across the state to indicate these are not just the concerns of one provider or providers in one catchment area. Several of these issues are being or have been addressed by the State and by some LME/MCOs. Many of these problems appear to be related to communication breakdowns. For example, communications to providers may not have been clear, providers may not have attended meetings where the communication was transmitted or the communication

has yet filtered out to everyone involved in LME/MCOs or IPS-SE teams. The concerns most frequently raised include difficulty determining the following:

- whether or not the same IPS interventions can be provided to an individual regardless of funding stream – service definitions for Medicaid B3[27] funds and state funds are different;

[27] B3 refers to the (b)(3) Medicaid Waiver authority granted by the Centers for Medicaid and Medicare Services (CMS) to states to use cost savings to provide additional services to Medicaid beneficiaries

- how to provide IPS when there is a lack of clarity on which funding stream is available to a given individual;
- whether or not persons need to meet both the VR definition of supported employment and target population to receive IPS-SE services,
- whether an individual who received ACT could also be a VR customer;
- programs only being able to enroll individuals who meet the "in or at risk of" ACH criteria because they are out of other sources of funding yet the provider is not receiving referrals for individuals "in or at risk of";
- whether or not TCLI and VR funding can both be used for an individual;

Concerns raised also included:

- getting enough referrals to make a program fiscally viable;
- how to remain fiscally viable when more individuals on a team's caseload become employed;
- how to manage individualized contracting that pays providers different rates for different services and a lack of transparency around rates;
- LME/MCO authorizations for the initial, intermediate and long term phases of IPS-SE not mirroring required timeframes for tasks to be conducted during those phases; there were reports that some individuals in the intermediate phase got bumped down to long term phase even though they got a job and then both the rate and authorized hours drop;
- getting authorizations for job development services after an employee loses a job following hospitalization; and
- contracting with more than one LME/MCO and having to provide the service differently depending on the LME-MCO; LME/MCOs may structure their service requirements and reimbursement differently for each funding source.

Recommendations:

1. Update the Corrective Action Plan with a goal(s) and action steps to develop sustainable business models based on a review of best practices, recommendations from this and previous reports and input from service providers with action steps for the State, LME/MCOs and service providers.
2. Review the goal(s) and action steps on a regular basis at the State and LME/MCO-local DVR office level.
3. As part of this task, produce a document for use by LME/MCOs, DVR field offices and Providers that includes service definitions, sequencing, and reimbursement guidelines into a single document with case examples for illustration.
4. Add the following (or similar) performance measures to LME/MCOs and service providers, as applicable, to assess the success of the funding model:
    - number (and percentage of total) IPS-SE and ACT providers with VR-service provider contracts;

- number of LME/MCOs engaged with DVR and providers that have developed effective funding models utilizing milestone payments;
- adding funding for and provider requirements where necessary for IPS-SE providers and mental health service providers to be reimbursed for required tasks such as treatment team meetings;
- number of LME/MCOs using milestone payments;
- number of providers accessing DMH, Medicaid and VR funding. (With criteria for what it means to successfully access bother types by the number of providers who are successfully sequencing all available funding streams.)
- number of individuals for whom IPS services are paid by more than one funding stream; and
- average amount recouped (by all funding streams) by provider per individual served.

Recommended points of leverage/rapid implementation facilitators:

- DHHS and the LME-MCOs take opportunities to recognize the importance of increasing the target population's access to IPS.
- State agencies lead, model, and create structures to facilitate integration across the systems.
- The state's Corrective Action Plan convey effective funding and reimbursement policies will be vetted with LME/MCOs, IPS-SE teams and IPS-SE experts as needed.
- Contract amounts and types of funding aligned with business models.
- LME-MCOs have a business plan for IPS-SE and require each of its IPS-SE provider to submit a business plan with actions/ resources needed to meet targets. These documents are foundational for evaluating the viability and success of proposed and funding models.

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

Developing and implementing an Action Plan to fill the IPS pipeline is crucial to meeting compliance but is also a complex undertaking. The State made substantial progress on filling the pipeline in the past year. In March 2016 the State added $800,000 to LME-MCOs for ten (10) new teams and eight (8) expanded teams[28]. The impact of that funding was seen in the FY 2017 with an increased number of teams meeting fidelity and individuals getting IPS-SE.

The discretion on which agencies would get additional funding was left with the LME/MCO. The State hoped these funds would be used by LME/MCOs to add seven (7) new teams and add expansion funds for seven (7) teams[29]. This goal was met.

[28] 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.
[29] the FY 2018 TCLI budget allocations were not finalized for this expansion at the time this report was issued.

The DHHS issued the FY 2017 (annual) non UCR allocation letter[30] on December 9, 2016. This allocation, although late being issued, is beginning to yield results. Five (5) teams have successfully met Fidelity requirements in the last six months and five (5) more are preparing for their baseline Fidelity review. Two teams combined in FY 2017 to spread administrative costs and maximize performance. While funding certainly helps, these increases also occurred at the same time newly funded UNC Institute trainers who are also fidelity reviewers were added. Both contributed to these improvements.

The State's guidelines allow the LME/MCOs flexible use of funds to "support increasing the number of individuals that are part of the priority population receiving IPS-SE services from a team that has met fidelity" with an expectation of a minimum a twenty-five (25%) increase from their December 2016 reported data. From February 1, 2017 through July 1, 2017, there was an increase of twenty percent (20%) for teams meeting fidelity and a sixteen percent (16%) increase for individuals who met the "in or at risk" of definition. This percent increase will be tracked again at the one year mark.

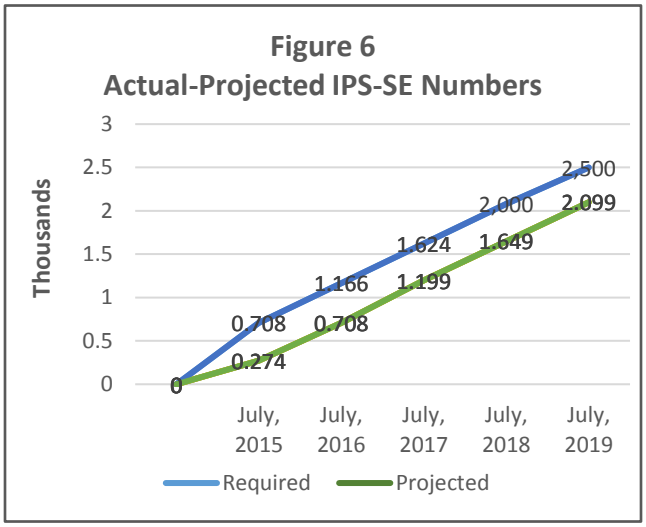
This allocation could be used to incentivize the Usual, Customary and Reasonable (UCR) rate by a set percentage point for individuals in the target population; develop and implement milestone payments; expand a team to allow it to serve greater numbers, and cover some start-up costs for new teams. In this fiscal year (2018), the allocation letter is expected to go out earlier. The 2017 and 2018 allocation plans developed by each LME-MCO should be analyzed by the State to determine the viability of the business models using the following questions:

- Can the plans be reasonably expected to increase the number of individuals in the Target Population receiving IPS-SE?
- Does the cost model for serving the "at risk of ACH" population cover the cost of the service; regardless of client mix?
- Does the cost model for serving the "in or at risk of ACH" population cover the cost of the service?
- Are the SE enrollment numbers for both the "in ACH" and "at-risk ACH" priority populations increasing and if yes, are they increasing at the same rate?
- How does mental health service utilization change when individuals are employed?

The caseloads of many employment specialists on IPS-SE teams are not filled. Research indicates 60 – 70% of individuals with mental illness want to work. Caseloads not being filled is likely a reflection of a culture that does not embrace or understand the value of employment. Teams operating under-capacity is a major contributor to IPS-SE providers having difficulty establishing

[30] "Non UCR" refers to non-recurring state (non-Medicaid) funds or for B3 (Medicaid) funded services.

a viable business model. An exemplary fidelity caseload is 20 individuals per employment specialist. Many teams find a need to extend this to 25 due to demand and business model factors. However, of the 4 agencies that participated in the Trillium SE focus group, 1 carried an average caseload of 15, another 15 – 20 and another 14. Only one of the agencies reported an average caseload of 20 and they reported that they had to chase referrals to keep the caseloads near 20.



On July 1, 2017, the State was serving 1,119 individuals, defined as "in or at risk" of Adult Care Home placement, 465 fewer than required by this date. To meet the final Settlement Agreement obligations, the State will need to serve an additional 1,301 individuals by July 1, 2021. At the present rate individuals access this service, the State is on track to meet its required obligation on July 1, 2021 (**Figure 6**).

If this service is given more visibility, greater clarity and additional resources and support, the State may meet Settlement Agreement requirements for IPS-SE by the required date and lay a solid foundation for sustainability of this valuable service.

Recommendations:

1. Continue to conduct broad and targeted cross system workforce education and the robust evidence supporting IPS-SE effectiveness.
2. Map out the TCLI Workflow from the first contact with a member of the TCLI priority population through transition and independent community living. At each point in the workflow, identify opportunities to engage individuals about employment. Identify forms or structures that need to be modified to cue staff at each point to engage around employment. All forms (e.g., PASRR packets, assessments, PCPs [treatment plans] and updates) should have required fields that address employment.
3. Hold all staff at each point of contact responsible for increasing the enrollment numbers (i.e., LME/ MCO In-reach, Transitional Coordinators and Care Coordinators, SPH treatment teams, DVR counselors, MH treatment teams, ACT and CSP) and LME/MCO, IPS-SE and ACT staff responsible for increasing employment outcomes.

Recommended points of leverage/rapid implementation facilitators:

- DMH Allocation guidance
- Promotion materials and public support from State and LME/MCO leadership
- Service definitions and practice guidelines
- Policies, procedures, protocols and forms
- Performance measures, including dashboard measures, reporting and quality monitoring (DMH and DMA contracts)
- Roles and Responsibilities fact sheets and other documents
- Performance appraisals, job descriptions
- Technical Assistance (UNC Institute, DVR and DMH staff)

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

Impressions and findings:

The final recommendation is to build IPS capacity in locations where it is most needed because of the number of referrals in a particular area and/or in areas where there are not a choice of providers. Capacity building is about ensuring that IPS programs reach fidelity and ensuring IPS-SE is available where and when needed. In this case, capacity building includes ensuring the Target Population can easily access fidelity IPS services.

The FY 2017 the TCLI Services Non-UCR Allocation letter (to LME/MCOs) issued on December 9, 2016 allowed for flexible use of funds to "support increasing the number of individuals that are part of the priority population receiving IPS-SE services from a team that has met fidelity". The allocation instructions allowed LME/MCOs to fund teams for expansion, assist teams with lower caseloads and to add staff were teams are needed, especially in counties with high demand. (See discussion under *3. Develop and Implement an Action Plan Action Plan to fill the IPS Pipeline, pgs. 9-10*.)

Even with expansion in FY 2017, LME/MCOs have thirty-five (35) IPS-SE contracts with teams that meet fidelity to provide IPS-SE services in eighty-six (86) counties. This is an improvement over FY 2016 when contracts only covered seventy-three (73) counties. However, even with contracts, IPS-SE service providers do not yet have capacity to serve individuals in thirty-two (32) of the 86 counties. Only twenty-five (25) counties have more than one IPS-SE provider.

The system rewards providers meeting fidelity a higher reimbursement rate. IPS-SE is new and requires sufficient start-up funds for providers to enter this program. During this start-up period, state funding is essential for new teams to meet fidelity, for growth of small teams and for expanding coverage.

Providers also need a sufficient number of Priority Population referrals or they are forced to seek referrals of other eligible participants who don't meet the Settlement Priority Population eligibility requirements. 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 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 twenty of the individuals interviewed or reported on living in the community were interested or 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 earlier reports, 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. DMH, DVR and LME/MCOs have supported expansion of Certified benefits counselors who could provide accurate information and dispels dis-beliefs about employment impact on benefits.

The last issue related to building needed capacity is for ACT teams to provide comparable IPS-SE services to those provided by IPS-SE teams. CMS and state regulations, consider ACT a “bundled service”. This means that the team is paid a rate covering costs of all necessary behavioral health services. Individuals receiving ACT cannot access IPS-SE services provided by IPS-SE teams because it would be considered double-billing. Individuals served by ACT can access some DVR services as long as they are not services required by ACT regulations. However LME/MCOs can establish contract performance standards for ACT teams to provide IPS services. The Settlement Agreement allows the State to propose an evidence base model supported employment model. The State chose IPS-SE.

The Independent Reviewer made a recommendation in FY 2016 that the parties allow individuals in the target population whose ACT teams deliver employment services that meet applicable IPS-SE fidelity standards to “count” toward Section III.(D)(3)’s numeric requirements for supported employment Services. This was proposed for three reasons. One, it is estimated that approximately 30% of individuals in the target population is receiving ACT services. Unless comparable fidelity and performance is measured, it is not known if individuals are receiving effective employment related services. Two, using the theory that what gets measured gets done, a more rigorous review and measurement would act as an incentive for ACT teams to provide effective supported employment. Three, 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.

ACT data for teams who have gone through fidelity reviews since 2014, revealed that very few

ACT teams could meet the comparable IPS-SE standards. Individual review and ACT stakeholder discussions confirmed these findings. ACT Employment Specialists time did not always appear to be devoted to employment related tasks or to individuals in are in the "in or at risk" population group. Since the review of the data and the reviews were completed, the State and the UNC Institute Fidelity review and TA teams have focused more attention on this issue. Because of this attention, it is recommended the issue of allowing ACT teams with highly fidelity to IPS related items be re-visited in FY 2018.

Each LME/MCO should be expected to identify needs and gaps within their catchment area and how they plan to fill the identified gaps. Projecting need in high volume counties and in counties where there is no coverage is especially important. As referenced above, the DHHS could incorporate requirements in the Gaps Analysis and/or DMH and DMA contract requirements.

The PASRR form lists psychiatric services the individual is recommended to receive. This list of available services does not include IPS-SE. It would be helpful when the State shifts to its new Pre-Admission Screening and Diversion system (see section of Report in **Section III.F.)** in 2018, to include IPS-SE as a potential service. Employment information is gathered in the PASSR history questions, but there is not a cue on the form to link this with needed access to evidence-based employment supports.

Building capacity where it's most needed can also refer to making certain staff completing TCLI Transition Plans (PCPs) and SPH discharge plans include inquiries for interest in supported employment. For this to occur in a meaningful way, staff will need to be knowledgeable of opportunities, the no reject requirement for IPS-SE an understanding of benefits. As stated above, there is a lack of evidence suggesting that a broad range of staff see facilitating integrated community participation, including employment, as an essential part of their role and responsibility. Thus, the culture of care does not embody community participation and employment as essential recovery, health, and wellness intervention and outcome.

Recommendations

1. Require reporting on how many individuals receiving ACT are getting jobs.
2. Continue to conduct broad and targeted cross system workforce education about IPS and the robust evidence supporting its effectiveness.
3. Through Gaps Analysis and contract requirements, require the LME/MCOs to identify gaps, number of providers based on having all counties covered with at least one provider, choice of providers and higher number of teams in high volume counties based on county size, caseload sizes and plans for eliminating gaps.
4. Map out the TCLI Workflow from the first contact with a member of the TCLI Target Population through transition and independent community living. What opportunities are

there at each point in the workflow to engage individuals around employment? What forms or structures need to be modified to cue staff at each point to engage around employment? All forms (e.g., PASRR packets, Comprehensive Clinical Assessment, Person centered Plans (PCPs), other treatment plans and updates) can have required fields that address employment.

5. Hold all points of contact (i.e., In-reach, LME-MCO, DVR counselors, IPS provider agency intake, MH Treatment teams including but not limited to ACT and CST, Peer Support, SPH treatment teams) responsible for increasing the enrollment numbers and employment outcomes.

Review recommendations from this and previous report at least monthly to identify and begin work on next step. This will hasten implementation and facilitate meeting settlement targets.

Recommended points of leverage/rapid implementation facilitators

- All points where individual plans are formulated or discussed (Pre-Screening and Diversion, discharge planning, regular PCP reviews, etc.)
- Service definitions and practice guidelines
- Fidelity reviews
- Technical assistance (UNC Institute and DMH staff)
- Data mapping
- IPS-SE and ACT Collaboratives
- Performance measures, reporting and quality monitoring[31]
- Roles and Responsibilities in fact sheets and other documents[32]
- Performance appraisals, job descriptions
- DMA and DMH Contracts with LME/MCOs and LME/MCO contracts with providers, including ACT and CST.

Compliance Summary

The State has not yet met requirements in **Section III.** (**D)(1).** Measures are being developed and implemented that are encouraging. The State struggled initially to put a viable plan in place to implement this requirement. A Corrective Action Plan was developed in June 2016 and the State was successful in meeting its 2016 Corrective Action goals. Those goals were essential but will

[31] In DMA and DMH Contracts with LME/MCOs and LME/MCO contracts with providers, including ACT and CST; DVR requirements.

[32] Ibid

need to be modified with higher and broader targets if the State is to come into compliance with this measure by July 1, 2021. There are still concrete action steps, including those identified as recommendations in this Report that could be taken. Points of leverage and rapid implementation facilitators that if used could also enhance the State's performance.

The State continues to be in full compliance with **Section III. (D)(2).**

The State has not yet met requirements for **Section III. (D)(3)** but achieved a forty-one percent (41%) increase in FY 2017. Forty hundred and ninety one (491) individuals "in or at rick of" ACH placement were enrolled in IPS-SE with teams meeting Fidelity requirements**.** There is a need for the State (DHHS Divisions), LME-MCOs and local DVR offices to clarify roles and responsibility to build capacity and support providers to develop a viable business model and fill the pipeline to meet requirements with **Section III.** (**D)(1) and (D)(3).** There is always pressure to increase the numbers of individuals served more quickly. But focusing on numbers alone undermines the potential for the program's success. Perhaps the greatest challenge is the lingering lack of recognition of the value of this service and skepticism that individuals in the "in or at risk" of ACH placement can work and recover.

IV. TRANSITION AND DISCHARGE PLANNING

The **Discharge and Transition Section III.(E)(1-14)** section of the Settlement Agreement covers a wide range of required tasks and action steps that begin with In-Reach and extend through Discharge and Transition Planning processes. In-reach staff, Transition Care Coordinators, the DMA, DMH, DSS and DHSOF leadership, SPH treatment teams, Tenancy Service Management (TSM) teams, LME/MCO SPH Liaisons and Care Coordinators, Guardians, state level TCLI staff, and community mental health service providers all have a role and most have responsibilities in the In-reach, Discharge, and Transition planning process. Each of these requirements is discussed individually or as a set of connecting functions. Findings and recommendations are referenced in each section and the compliance summary.

Section 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, including the option of transitioning to supported housing, its benefits, the array of services and supports available to those in supported housing, and the rental subsidy and other assistance they will receive while in supported housing. For individuals with a history of re-admissions and crises, the factors that led to re-admission shall be identified and addressed. Procedures have been implemented, but the State is still falling short of informing individuals accurately and fully about community options and addressing factors that led to a re-admission. This is partly related to In-reach staff not always being informed of community options, as community and natural supports are narrowly defined and/or not considered options

at the time of referral. It is also related to a general focus on addressing re-admission factors. Recommendations are referenced in other sections below.

Section III.(E)(2) In-reach: The State has increased funding for In-reach staff for each of the LME/MCOs. There are eighty-six (86) funded full time equivalent In-reach positions. There has been some turnover in the past year but the vacancy rate for these positions is low across most LME/MCOs. In-reach challenges and performance were extensively covered in the **Brief Report on In-reach[33].** Following the completion of that Report, additional reviews were conducted in the Eastpointe, Sandhills, and Alliance catchment areas. Findings from the more recent reviews were consistent with the findings in the **Brief Report** and are summarized below.

Reviews were conducted of twelve (12) individuals on ACH In-reach and Transition status after the **Brief Report**. Of the 12, two (2) had moved to their own apartment after their names were pulled but before the review began, four (4) were living with family or were moving around, one (1) was missing, and five (5) were interviewed in ACHs where they were living at the time. The average age of individuals still residing in adult care homes was sixty (60).

Challenges to In-reach

One woman, age 56, was first referred to an LME/MCO in 2014 after being assessed for admission through the PASSR process. She is now living in her third (3rd) ACH since 2013. The first two homes closed. The LME/ MCO could not locate her after the 2nd home closed but the LME/MCO got a new PASSR for her so reconnected with her in February 2017. She was in transition status when seen by the Reviewer's team in April 2017. She is using a walker and wheelchair now as she is recovering from a broken leg. She wants to live in a senior apartment in a nearby community and is interested in doing volunteer work and returning to her church.

Based on available information, eight (8) of the 12 individuals had two or more chronic health conditions. Asthma and diabetes were the most frequently reported conditions. Two (2) were amputees, one (1) had a gangrenous foot, and two (2) were living with breathing machines. Two (2) individuals had moved to the community but returned to an ACH before the review. Three (3) individuals self-reported substance use disorders. One (1) individual moved back to the ACH, afraid that if he remained in the community he would start drinking and using drugs again. He also said he did not believe the LME/MCO wanted to help him move again. One (1) woman moved back to an ACH after having difficulty getting up and down to her second floor apartment with her breathing apparatus. It is likely that most of the individuals seen in ACHs during this review period will not move to the community. This is due to four factors: age, medical conditions, lack of support through assertive engagement and personalized care, and individual preference.

[33] Brief In-reach Report submitted on May 19, 2017

In-reach planning has been provided for five thousand and ninety four (5,094) individuals since 2013. There was an increase of seven hundred and sixty-five (765) or 15% in FY 2017. Meeting In-reach goals is challenging in part due to the engagement process but also because of other factors. Individuals often move from adult care home to adult care home; closures are not uncommon and this often leads to abrupt moves. Sometimes a forwarding address is not made available or is incorrect. Guardians often don't give permission for the individual to be seen by the LME/MCO. Individuals, especially older individuals with medical conditions, may have complications leading to a move to skilled nursing care or to hospitalization. Families and staff discourage individuals from talking to In-reach staff.

LME/MCOs readily admit they were overwhelmed and fell behind trying to meet the quarterly site visit schedule initially. They have been implementing systems to improve response time and to find individuals they may have lost touch with before.

LME/MCOs send letters to individuals (or their guardians) who have repeatedly said no to In-reach. The State and LME/MCOs continue to work on reducing the numbers of individuals on the In-reach list who do not meet the SMI/SPMI population definition, have a primary diagnosis of IDD or dementia, are psychiatrically or medically unstable, have moved out of state, or are deceased. This effort is ongoing. The names pulled for the most recent individual reviews reveal that individuals in these categories are still on the In-reach list.

The State, with LME/MCO input, is revising In-reach and Transition tools. This is a very positive step. The State and the LME/MCOs should also assess the need and, as warranted, expand the array of services and provide consultation on clinical and rehabilitative interventions.

LME/MCOs and providers (when they are engaged in In-reach) are required to facilitate individuals' visits to community settings and to offer opportunities for individuals to meet with other individuals with disabilities who are living, working, and receiving services in the community, with their families and with community providers. This required step has not been taken except on a limited basis. The State and LME/MCO staff are discussing potential steps that can be taken to meet this requirement.

Findings and Recommendations

The State has not yet met the **Section III.(E)(2) In-reach** requirements. Specific findings in the most recent reviews were consistent with the **Brief** Report on In-reach submitted on May 19, 2017. The State continues to make progress on meeting In-reach timelines and improving the accuracy of the In-reach list. Recommendations remain the same as those made in the **Brief Report on In-reach**.

Section III.(E)(3-12) Each individual with SMI, in or later admitted to an adult care home, or State psychiatric hospital operated by the DHHS with Effective Discharge Planning, must be

provided with a Written Discharge Plan. Discharge Planning is to be conducted by transition teams that include persons knowledgeable about resources, supports, and opportunities available in the community, including community mental health professionals. Underlying the entire transition and discharge planning process is the required goal that planning is to assist the individual's growth, wellbeing, and independence, based on the individual's strengths, needs, goals, and preferences, in the most integrated setting in all domains of the individual's life (including community living, activities, employment, education, recreation, healthcare, and relationships).

These requirements reference professionals and their required subject matter expertise, teams with linguistic and cultural competence, and peer specialists when available. These requirements refer to three types of transition teams at the State and local level, including one specific to SPH planning and discharge and requirements for each type of team. These requirements describe in detail requirements for discharge planning, timeframes, process, goals, and desired outcomes. III.(E)(3-8) and (9-12) are reviewed together because LME/MCOs provide these tasks and functions seamlessly. Reporting on the progress and recommendations of these requirements separately would create unnecessary redundancies in the Report.

Transition and Discharge Plans/Planning

There is clear evidence from the Individual Reviews and State reports that written discharge plans with goals, as referenced in the Settlement Agreement, are completed with individuals in the TCLI Transition Phase. Individuals are being given the opportunity to participate as fully as possible in their treatment and discharge planning except when guardians refuse to discuss discharge planning. Guardians have the authority to do so but there is evidence they often do this without full knowledge of options that might help improve an individual's health and well-being.

Staff skills in developing "effective" plans for individuals to move to a more integrated community setting are improving. This comes with experience, better information, opportunities to improve competencies, and a willingness to embrace recovery. There is evidence that discharge planning for individuals who would qualify for TCLI does not begin at admission at the SPHs. It does begin more regularly for individuals just moving into an ACH.

Individuals are being assisted with benefits acquisition, assuring individuals can get a lease for an apartment they want, making pharmacy arrangements, setting up doctors' appointments, and making move-in arrangements. The individual's goals and needs are largely identified, although if the individual identifies employment, it is often deferred. As reported in the IPS-SE section above, there is a view among some staff that an individual should move and experience a period of stability before pursuing IPS-SE or employment. This does not always appear to be the individual's view of what is important to them. IPS-SE is an effective service for individuals

regardless of their living situation changing or their functional level. CTI is a helpful intervention and TMS staff are viewed by individuals as being helpful. Some individuals, though, seem confused about which staff are helping them with the various arrangements and benefits. A staff member at Sandhills showed the Reviewer's team a good example of a consolidated PCP for four different agencies providing services. This type of planning builds collaboration and reduces confusion and gaps or duplication.

Transition teams are only partially knowledgeable about resources, services, and opportunities in the community. Team members do not always have the subject matter expertise relevant to accessing needed community mental health care, including other types of care essential for a safe and successful transition to community living. These provisions are vital to successful transitions and to individuals being willing to move to supported housing. Often individuals living in ACHs or hospital at SPHs lack social capital. They may not have been able to live successfully in the community because the "types of care essential for a safe and successful transition" were not available to them previously. Likewise, inpatient hospital staff, guardians, and family members may not be agreeable to supported housing. If the range, types, and intensity of services are available, and transition teams cannot articulate knowledge of and provide reassurance services will be available, many individuals will not move.

Two other factors influence these decisions. One, transition teams sometimes hesitate to give assurances. They do not feel confident that the services and supports needed are available and/or will be provided at a level, frequency, and intensity needed. Plans are also limited in identifying "natural" supports and goals an individual may have for social, recreational, religious, or education pursuits. Individuals often reference how they will miss their friends living in ACHs but arrangements for get togethers with friends aren't referenced. The State and LME/MCOs may want to consider pursuing natural supports as a requirement of the CTI program.

Plans reviewed over the past two years reveal that while referrals to providers are being made during the transition process, linkage to services is still uneven, sometimes delayed, or not begun at all until discharge planning is completed. The approach and process for completing the necessary transition paperwork, specifically the In-Reach/ Transitions to Community Living Tool, is being re-vamped which should improve transition planning.

TCLI staff frequently comment on the difficulty with transition planning when an individual is living in an ACH that closes, especially if it is a "sudden closure." The sooner an LME/MCO TCLI staff member can be apprised of a potential closure, the better equipped they will be to assist an individual in their plan to move to the community.

Team and Staff Requirements

SPH Planning: The State is fortunate to have very committed Division of State Operated Healthcare Facilities (DSOHF) staff assisting with building these partnerships. In FY 2016, there

were signs the SPH staff and LME/MCOs were beginning to eliminate barriers for the LME/MCOs to work "in concert with the facility lead." There is some evidence that relationships are improving and the type of collaboration necessary for discharge planning is beginning to occur but protocols are not yet in place for effective discharge planning with direct referrals to Supported Housing (or TUTP, see reference in Housing Section of this report) or for the process to meet the requirements of this Agreement. At one point in FY 2017, one of the SPH's staff directly discouraged TCLI staff from attending individual treatment team meetings. That request was rescinded but it speaks to the lack of cohesion in the State's SPH discharge planning process.

The following chart (**Figure 7**) includes the numbers and the increase of individuals moving into supported housing from SPHs by LME/MCO over the past year. This is an improvement over earlier years. Only twenty-four (24), less than two (2%) percent of the sixteen hundred and ninety eight (1698) individuals discharged from SPH discharges in FY 2017, moved directly into supported housing. There is no record of the number of individuals who moved into unstable housing.

Figure 7: Category 4 Referrals to Supported Housing

	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya	Total
FY 2013-16	24	9	14	18	13	15	4	97
FY 2017	33	17	10	17	10	8	5	100
Total	57	26	24	35	23	23	9	197

There was substantial evidence from the reviews that individuals are being admitted and discharged to SPHs and general hospitals coming from and returning to unstable housing. In the last round of individual reviews, five individuals were identified as recently moving into unstable housing following hospital (SPH or community hospital under contract to a LME/MCO) discharge. One of the identified individuals returned to a trailer with no electricity or running water and two to well-known high crime neighborhoods. One individual reviewed previously was living in a run-down motel at the time of his first review. His name was pulled again and he was back in the SPH. The same was true for another individual living in an apartment complex in a high crime area. The State has strengthened its definition of "unstable housing," which presents an opportunity for transition teams and hospital staff to identify more clearly and earlier when an individual is planning to move to unstable housing and offer supported housing. This is also a challenge as teams will need to identify the potential for an individual returning to unstable housing and intervene appropriately. Likewise, it will be important for LME/MCOs will need to identify individuals being admitted to SPHs who are "high risk" for repeat admissions.

Findings

1. Discharge plans often identify needs in only a few domains. Thus goals and actions only partially address needs and preferences. Discharge planning does not begin at admission in

either the SPHs or ACHs. SPH admission information is available daily to LME/MCOs but TCLI staff are not informed of admissions at SPHs until after the LME/MCO Liaison or SPH staff contact them. The ACH Pre-Screening Admission PASSR sometimes does not reach LME/MCOs for several days or longer after admission.

2. The SPH discharge plan and the LME/MCO Person Centered Plan are sometimes done cooperatively but remain separate functions. There are separate requirements for each. However, there is opportunity for and clear reasons to develop the two processes into one combined process. To keep them as separate is counter to effective discharge planning. The SPH is making discharge plans with specific community living option and services options that would be more appropriately done in collaboration with the LME/MCO. The same is true with the PASSR 2nd Level Screen, Community Integration Plan initiated by the Screener and the LME/MCO PCP.

3. There is a variation among staff on transition teams as to the extent of their knowledge about all the resources, supports, and opportunities available to individuals in the community. Likewise, they do not always consider all resources, supports, and opportunities. This a particular problem as referenced in #1 above when these processes are carried out separately. There are some excellent transition teams and excellent plans but not all teams perform consistently well.

4. The required goal for discharge planning to assist the individual's growth, wellbeing, and independence, based on the individual's strengths, needs, goals, and preferences in the most integrated setting in all domains of the individual's life is not being met. Most individuals are given the opportunity to participate in their treatment and discharge planning. At times, it appears SPH teams make decisions before or without including the input of the participant. This generally occurs when staff do not fully understand that giving the individual an opportunity to voice their preferences is vital to recovery.

5. The State, with LME/MCO input, is developing new, improved transition planning processes, tools, and forms. This is an encouraging step. The State will be implementing these changes in FY 2018.

6. Professionals with subject matter expertise as required in the Settlement Agreement are not always made available for planning.

7. Teams include individuals with linguistic and cultural competence or have staff available to assist teams.

8. Matching providers with specific expertise appropriate to assist individuals with specific needs, exiting ACHs and SPHs, is not always done purposefully. In some locations, providers are not always available.

9. TMS teams are building capacity and skills to assist with discharge and transition planning. The TMS services are critical but the teams do not provide the full array of services an individual typically needs to exit an institution or ACH.
10. There is not a "high-user" plan in place to identify and intervene with individuals whose lives are chaotic and service use is sporadic and unplanned. This is typically evidenced by individuals seen frequently in emergency rooms, recurrently admitted to community hospitals, SPHs and ACHs, being discharged into unstable housing, abandoning housing, being arrested, being evicted, and/or falling in and out of homelessness. Not every individual's patterns are the same but typically include some combination of the above.
11. Individuals who were admitted to SPH who were homeless or living in unstable housing are often discharged to a homeless shelter or unstable housing.
12. The SPHs and the LME/MCO In-reach and Transition Coordinators and LME/MCO Liaisons do not yet "work in concert" to the degree necessary for effective discharge planning.

Recommendations

1. Re-vamp the SPH discharge planning process and the ACH Pre-admission Screening processes. For SPH discharges, modify the notification, treatment, and discharge planning processes through a crosswalk of current processes with Settlement Agreement requirements.
2. Further develop and implement the transition planning process changes already in progress.
3. For both SPH and ACH transition planning, identify and remediate possible barriers, establish new protocols, and establish staff roles and responsibilities.
4. Develop performance and outcome indicators to meet the Settlement Agreement requirement for "working in concert" and measure each LME/MCO and each SPH's performance in meeting those requirements.
5. Conduct an analysis of individual goals, needs, and preferences, across all the domains identified in the Settlement Agreement. Identify outcomes that promote an individual's growth, well-being, and independence as part of this analysis.
6. Where needed, make changes in community service and resource arrangements, as well as availability of subject matter experts in assessing behavioral health and health care arrangements. Give special attention to preference for IPS-SE services and analysis of natural support opportunities and preferences.
7. Incorporate a responsibility into the job descriptions for In-reach Specialists (or Peer Specialists working within the SPH) to assist an individual in identifying their goals, needs, and preferences, and to participate with the individual, upon their request, in SPH discharge

planning discussions and meetings.

8. As part of the analysis, develop new protocols for identifying individuals at "high risk" for re-admission including, but not limited to, repeat crisis events and admissions, criminal justice system involvement, history of unstable housing and homelessness as part of the pattern of repeat admissions or termination of services (by providers or by the individual), and failure to maintain housing (either eviction or abandonment).
9. Analyze service use data as it becomes available and establish protocol for collecting and analyzing service use and "high risk" data. Incorporate this information into requirements for Gaps Analysis requirements, including TCLI specific requirements where necessary to identify gaps in meeting the Settlement Agreement requirements.
10. Match referrals for services and "bridge" housing or other treatment with provider expertise and interest.
11. Develop a plan for identifying "high users" that includes the State, LME/MCOs, and SPHs taking steps to execute discharge and transition plans for individuals who are identified at "high-risk" for re-admissions or crises. It also includes identifying providers with skills and experience intervening successfully to reduce or eliminate these patterns of use and monitoring the effectiveness of such a plan.

III.(E)(9-12) DHHS is required to create a transition team at the State level to assist local transition teams in meeting their requirements, identifying, addressing and overcoming barriers preventing individuals from transitioning to an integrated setting. The DHHS team is required to ensure that transition teams (both State hospital facility staff and leadership of the LME/MCOs) are adequately trained. The State team will oversee the transition teams to ensure individuals have community opportunities. 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. If an individual decides to remain in an ACH or SPH, the team shall identify barriers to placement and steps to address the barriers and document attempts to address barriers. The State shall document these attempts and ensure the decision is an informed one. The State will re-assess individuals with SPMI who remain in ACHs or SPHs for discharge into an integrated setting on a quarterly basis, or more frequently upon request; the State will update written discharge plans as needed based on new information and/or developments.

The State TCLI staff meet bi-monthly with TCLI Coordinators and other LME/MCO staff. LME/MCO Liaisons and TCLI staff including In-Reach and Transition Coordinators, SPH and SOHF and DMH staff meet quarterly. There is typically an information exchange in the meetings; barriers are generally discussed and new or revised policies are presented and/or reviewed. The State staff

attending the meetings have expertise in how to resolve problems that arise during discharge planning and implementation of discharge plans. Discharge planning is frequently but not always an agenda item of those meetings. Attendance is typically excellent at these meetings.

Section III.(E)(10) requires the "DHHS transition team" ensure transition teams (both State hospital facility staff and leadership and LME/MCO transition coordinators) be adequately trained. Training has occurred but given information gleaned from attending meetings and from individual reviews, it appears that protocols for effective discharge planning are not in effect and that new protocols and performance requirements for both facility staff and LME/MCOs and providers are necessary to meet all the requirements in **Section III.(E)(1-12).** The SOHF staff do intervene in some instances where barriers are identified but the entire process needs to be further reviewed to determine what additional responsibilities the local and State level teams need to assume to meet these requirements

It was recommended in FY 2016 that transition teams set quarterly goals including goals to reduce barriers and to increase numbers of individuals discharged to TCLI housing slots or to the community with TCLI supports. This recommendation is repeated this year. It was also recommended that transition teams include DSS staff when needed and appropriate and that TCLI staff meet with community hospital discharge planners on a more frequent basis as needed for effective transition of responsibilities. Hospital discharge decisions are the responsibility of the treating psychiatrist and treatment team. Likewise, TCLI staff and Liaisons should have the responsibility to assist the individual with housing decisions, including responsibility for arranging group home placements, with permission of a guardian, where applicable, or where there are legal status restrictions or pending criminal charges. Each LME/MCO will need a ready pool of housing to increase the direct referral to supported housing and will need to increase availability of the TUTP.

In-reach staff meet with Individuals in ACHs at least quarterly[34] although their needs and barriers to placement are not always well documented or quantified to determine if there are systemic barriers to their placement. Two problems that are being addressed are Medicaid County of Origin and problems with PCS not being made immediately available at discharge. The State should document problems that are being identified, what steps are being taken to address them, and what progress and/or success is being made with each barrier. The State is required to assess whether or not individuals who decide to stay in ACHs are making informed decisions. This is being done by LME/MCOs.

Findings

1. The State has initiated two types of transition team meetings. The first, a bi-monthly State-

[34] Individuals who decline In-reach may get letters quarterly.

LME/MCO TCLI Coordinators meeting that focuses on a wide range of issues including transition planning. There is not an established agenda item for identifying barriers that local teams may be having with identifying and ameliorating barriers to discharge as required by the Settlement Agreement. These meetings are productive but not all barriers and key issues are addressed in a timely fashion. Training occurs as required in the Settlement Agreement but the frequency and effectiveness of the training are not assessed. The State has the opportunity to do that this year as it implements new transition requirements.

2. The quarterly TCLI-SOPF-SPH meetings cover a number of issues regarding progress and barriers with SPH referrals. However, the agenda items do not address in detail difficulties and agreements on discharge plans. The Settlement Agreement requires a much more focused approach to addressing and remediating barriers. Each SPH is working with at least three (3) MCOs. It may be more productive to conduct a quarterly meeting and more frequent meetings with each LME/MCO separately to remediate specific problems.
3. The LME/MCOs have responsibility to identify barriers to placement for individuals choosing to remain in an ACH or SPH (although discharge from a SPH is not always by individual choice). Documentation of this decision as an informed decision is the responsibility of the LME/MCO; however, it is not always clearly documented nor is there always documentation of what attempts are being made to address the barriers to placement (if barriers, not choice, are the reason an individual chooses to remain in an ACH).
4. These barriers, though, are typically verbalized by staff during interviews and meetings, although it is not always clear what steps are being taken to remove the barriers. Guardian decisions are often cited as the barrier. Often Guardians make this decision without the benefit of LME/MCO staff having the opportunity to fully assess an individual's needs and make recommendations on how these needs can be addressed in a more integrated community setting with services and supports.

Recommendations

1. DHHS evaluate the effectiveness of the State's approach and consistency with the Settlement Agreement requirements for **Section III.(E)(9-12).** Since the introduction of new transition tools and processes is planned soon, this evaluation could be informed from feedback from the introduction of these processes. The State should consider utilizing work groups and holding conference calls with TCLI staff to improve the flow of information and work through barriers and changes.
2. The State evaluate the requirements for documentation of barriers and remediation of barriers at the individual, LME/MCO, SPH, and State levels. Determine what changes need to be made to meet the requirements of the Settlement Agreement for **Section III.(E) (9-12).**

Section III.(E)(13)[a-b and c] refer to time frames and requirements for In-Reach, Discharge and Transition Processes. Transitions do not occur on average within ninety (90) days of assignment to a transition team. DHHS's policy is that transition begins the day the DHHS issues a housing slot and continues until the day an individual moves into housing. The current average days for transition is now one hundred and fifty-six (156) days, an increase from one hundred and thirty-three (133) days in FY 2016. Every year the average length of time from issuance to a slot to move in for all the individuals on the list in a particular catchment area grows longer, even if the overall performance improves. This is because some individuals have had a slot dating back several years. For example, an individual may get a slot then have surgery or a medical procedure and not be able to move or have to move from Adult Care Home to Adult care home without any opportunity to look for a place to live. Other individuals may be turned down repeatedly by landlords and then move somewhere else but retain their slot.

When viewed by the percentages of individuals who move in a given fiscal year, a clearer picture of current performance emerges as depicted in **Figure 8** below. In FY 2013 and FY 2014, the percentages of individuals transitioning was higher with fewer individuals transitioning during that start-up period. When viewing the number of individuals who transitioned within 90 days in FY 2017 compared to the previous two years, the pattern is not as clear, with two LME/MCOs showing fewer individuals transitioning in 90 days, two (2) having essentially the same number of individuals transitioning and three (3) having a higher percentage transitioning within the 90 day period. Interestingly, only one (1) LME/MCO shows a linear trend over the three years. The State's dashboard captures these percentages and the percentage of In-reach contacts during the month the individual agreed to transition as well as the number of individuals who agreed during the month to transition and did not receive a housing slot number the same month.

Figure 8: Percentage of Individuals Transitioned within 90 days

LME/MCO	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17
Alliance	100%	66%	27%	28%	24%
Cardinal	100%	70%	35%	30%	45%
Eastpointe	100%	93%	81%	56%	76%
Partners	100%	75%	73%	43%	57%
Sandhills	100%	69%	39%	46%	57%
Trillium	100%	71%	54%	28%	61%
Vaya	100%	57%	28%	20%	44%

There does not appear to be a correlation between contacts and number of individuals getting into housing. Another view of the transition periods is a breakdown of the timeframes individuals have had a housing slot as depicted in **Figure 9** below:

Figure 9: Average Days Individuals on Transition Status (April 2017)

LME-MCO	0-90 days	90-180 days	180-365 days	365-730 days	730+ days	Total
Alliance	35	36	49	17	6	143
Cardinal	138	145	65	19	5	372
Eastpointe	95	20	10	2	1	128
Partners	94	57	40	2	1	194
Sandhills	77	51	19	7	8	162
Trillium	88	45	30	21	6	190
Vaya	56	66	30	10	3	165
Total	583	420	243	78	30	1354

To further analyze the issues related to unusually long transition periods, the Reviewer requested the Alliance and Eastpointe MCOs provide information on individuals who have been on the transition status for longer than two hundred (200) days.

There were forty-three (43) individuals on the Alliance Behavioral Health Care list. Several appeared on the list as not moving, missing, or no longer engaged for multiple reasons. Of individuals on the list:

- nineteen (19) had been involved in the criminal justice system making it difficult for them to get property managers to agree to rent a unit to them;
- fourteen (14) had been in and out of psychiatric and general hospitals since getting a housing slot; included in this group was an individual with Stage 4 cancer and one with brittle diabetes;
- six (6) moved and were no longer interested in TCLI but names were still on the list;
- eight (8) had guardians who did not agree with a move;
- seven (7) had substance use or alcohol related problems;
- four (4) were ready to move after earlier delays;
- four (4) had disappeared;
- two (2) had dementia and moving was no longer an option but they still had a housing slot; and
- one (1) had a traumatic brain injury (gunshot).

There were eight (8) individuals on the Eastpointe list. Of the individuals on the list all were on the list for different reasons including:

- one (1) simply “fell through the cracks” and was not contacted by staff;
- one (1) has a traumatic brain injury and is unlikely to move;
- one (1) had surgery which caused a delay;
- one (1) lived in flooded area and placement delayed;
- one (1) discharged from Cherry hospital before housing arrangements could be finalized;
- one (1) discharged by Cherry to area where he doesn’t want to live and arrangements to move not finalized;

- one(1) selected housing that was still in construction but can move when it is finished; and
- one (1) has been at Cherry for one hundred and twenty-five (125) days and only will agree to live in Goldsboro where housing is scarce.

The State continues to meet requirements for **Section III.(E)[a-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. This variance and the inability of transitions to occur in a timely manner is reason for some concern at this point of implementation of the Agreement.

For some individuals on this list, the option to transition is no longer possible. DHHS would need to have a very specific limited set of criteria for names to be removed from the list. This is coupled with the State 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 are likewise urged to add performance measures regarding transition tasks to provider contracts.

Making housing more easily and quickly available and streamlining the transition processes are recommended actions. One strategy proven successful for individuals to “bridge” into a supported housing permanently is the Targeted Unit Transition Program (TUTP). It has been a helpful resource for individuals who want to move into permanent housing but whose housing search is not complete. Individuals who expressed interest in moving to supported housing have used the program when their ACH closed but permanent housing arrangements had not been made yet. Four LME/MCOs have started using the TUTP. Cardinal and Vaya have used the Program fifty-one (51) times. Eighty-four percent (84%) of individuals leaving the transition program moved into permanent supported housing and then are included in the Supported Housing for purposes of meeting **Section III.(B)(3)** of the Settlement Agreement. Partners and the Alliance have used the program on a more limited basis. One hundred percent (100%) of the ten (10) individuals from those two catchment areas who have used the program moved into permanent supported housing.

There are times when an individual is in declining health and would benefit from personal care services and specialty health care, especially specialty care for chronic diseases upon exiting an ACH or SPH or in risk of either. Wellness coaching, home health, and wrap around and specialty TSM, CST and ACT are critical as referenced in the Services section and may also be needed upon discharge or in lieu of admission. Where the individuals get those services should not always be

the deciding factor unless their level of need or dementia dictates it. Level of need is distinguishable so that when an individual qualifies for nursing home or assisted living those services should be available and even then there may be times where an individual, their family, or their guardian chooses hospice or has the means for 24 hour in-home services.

Findings

1. The State does not yet meet the requirement for transition into Supported Housing within 90 days. There are positive signs with activities that the State may meet this requirement by July 1, 2021.
2. The State has made some progress but it is uneven across LME/MCO catchment areas. The above charts illustrate those differences.
3. There are individuals who have had housing slots for over 200 days who have serious obstacles to being housed permanently. More assertive engagement, better care coordination, and follow-up may have prevented some of the individuals from being on the list over 90 days. Yet others have medical conditions, have guardians who steadfastly refuse to allow the individual to move, or are waiting for housing to become available.

Recommendations

1. The State review this information and if necessary collect information from other LME/MCOs on reasons for individuals having a slot and not moving to housing within 90 days. Establish criteria for LME/MCOs to return slots. The criteria should be limited to the same or comparable reasons an individual is taken off the In-reach list.
2. The LME/MCOs have an obligation to assist an individual to secure permanent housing that meets the Settlement Agreement requirements. This obligation extends to individuals often deemed “difficult to house.” It is recommended that each LME/MCO maintain a list of everyone who has had a housing slot for more than ninety (90) days and review that list weekly in a team meeting or conference call. Every individual should be reviewed regardless of their situation.
3. Transition staff should report actions taken the previous week and planned for the coming week to assist an individual to get housing. Staff should identify barriers that they need assistance remediating and/or consultation they need to assist an individual to get housed. If an individual is living in an unstable situation, the TUTP may an alternative. Service providers play a key role in assisting an individual to be housed and should be asked to participate in the meetings and calls.
4. Review barriers and recommendations for improvement in each State-LME/MCO scheduled meeting. Identify the person(s) responsible for implementing the recommendations. The responsible party/parties report on progress of any steps taken as a result of these

discussions in subsequent meetings.

5. Expand TUTP and identify other potential bridge resources.
6. Each LME/MCO develop the housing ready pool as discussed in the Supported Housing section of this Report.
7. The State continue to report on the 90 day transition period placement performance on the Dashboard. The State report on this performance in the monthly report as shown on Figure 9 above.

Section III.(E)(13)[d][i-iv] Required procedures must be followed when an ACH has received notice that it is at risk of a determination that it is an IMD. The Reviewer was not notified of any home being found at risk of being an IMD in FY 2017.

Section III.(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. LME/MCO staff continue to report that ACH staff either interfere or discourage individuals from moving. LME/MCO staff indicate that there is a wide range of response from ACH staff when they try to visit individuals on In-reach status and when individuals indicate they want to move to the community. On one hand, ACH staff are very supportive and helpful in other homes where this does not occur. This was clearly evident when the Reviewer's team visited ACHs. LME/MCOs report hearing discouraging remarks and individuals saying that they don't want to move after saying they do want to move. Staff report individuals say "no" after saying "yes" coming more from individuals in homes where staff are more discouraging than in homes where staff are more supportive. Staff have stated the more success they have helping individuals move, the greater the problems encountered.

LME/MCO staff continue to voice concern about retaliation towards residents when they report incidents to DSS and DHSR. While this may have occurred, and still may, the LME/MCOs must report it in accordance with DHHS (DMA and DMHDDSA) contracts and each local DSS and DHSR must investigate. On a recent complaint made by a LME/MCO staff person, DHSR did not interview the complainant but found the complaint to not be substantiated. On a second complaint, LME/MCO staff found an individual getting ready to move being denied information regarding medications and information regarding her health care providers. This individual's psychiatrist was reportedly told to terminate her case which would not have been necessary given where she was moving. The LME/MCO scrambled to try to get the information needed to make sure the individual could move. They did not get a call back from the local DSS to follow-up until eight days after making this urgent complaint.

Findings and Recommendations

The State is not yet in compliance **Section III.(E)(14)** The DHSR and DSS agencies have enormous responsibilities and staff are pulled in many directions, which sometimes makes their response time and the sufficiency of their response uneven. It is recommended that the State be clear on expected response times and clearer on response to LME/MCOs (and their providers) when they register complaints. Violations will occur. It is not possible to expect, given the changes contemplated with this Agreement that all ACH staff will be supported of individuals moving to the community. Nor are individuals always treated with respect and dignity by all staff all the time while living in the ACHs.

The expectation for this agreement is that the LME/MCOs follow the complaint requirements each time they witness or have evidence of a violation of the **ACH Bill of Rights** requirements contained **in Chapter 131D of the NC General Statutes and 42 C.F.R. § 438.100**, and that DSS agencies and DHHS staff promptly and fully respond to those complaints and take action if warranted. It is imperative the LME/MCO complainant be contacted.

Compliance Summary

Slow but meaningful progress is being made on developing and implementing effective **In-Reach and Transition Planning.** The State is not yet in compliance on twenty-four (24) of twenty-nine (29) of these provisions. The State is not yet meeting the transition timeframe requirement. The major barriers to the State meeting these requirements include the organizations and staff (listed in the introduction of this section) working more collaboratively toward the same goals, the lack of a ready pool of housing (see Housing Section), the need to eliminate or reduce duplicative and unnecessary processes, and timelier, effective discharge planning (SPHs). The **Brief Report on In-reach** identified areas for improvement and those were augmented with additional information in this Report. The TUTP program success is a breakthrough achievement and should be expanded. The State's development of new transition planning documents and plans for improving the processes are promising. Reducing barriers, adding more focus to developing staff skills and knowledge, and meeting community integration requirements are key to the State In-Reach and Transition Plan requirements.

V. PRE-ADMISSION SCREENING AND DIVERSION

III.(F)(1-3): In (F)(1) The State will refine 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. The state shall connect any individual with SMI with an appropriate LME/MCO for prompt determination for mental health services. In III. (F)(2) Once an individual is screened the LME/MCO will work with the person to 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 provision in Section III (E) of this Agreement. I**n 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 concerns and objections to placement in an integrated setting, and will monitor individuals choosing to reside in ACHs, offering In-reach and transition planning services.**

Below is a description of the challenges facing the State in meeting these requirements and a review of each requirement. The State is required to use the Pre-Admission Screening and Resident Review[35] (PASRR) process to screen individuals with serious mental illness who are referred to ACHs. This is a process designed for ensuring individuals are correctly screened for adult care home and intermediate and skilled nursing home admission. PASSR does not include a support process with immediate and effective options for diversion necessary to avoid relying solely on even brief institutional care and for community re-integration. Both of which are typically less effective and more expensive unless an individual requires treatment and short term rehabilitation following an acute exacerbation of an illness, has an accident, or has surgery. Individuals can be eligible for ACH admission and still be able to live safely and successfully in the community. The two, ACH placement and community living with support, are not mutually exclusive.

The current PASSR sequence places the diversion decision options at the end of the process, so often the LME/MCOs are not aware the PASSR process is underway. The sequence begins with an automated referral followed by an independent review conducted by a qualified professional to determine if the individual qualifies for an Adult Care Home or Skilled Nursing Facility Thus the LME/MCOs are not in a position to present diversion options until after ACH placement decisions are made. This is counter to responsibilities given the LME/MCOs as PIHPs (Pre-paid Inpatient Health Plans). All Medicaid funded mental health services are managed and authorized through the PIHPs. As such, they could screen individuals, make diversion arrangements available, and make the necessary arrangements for a PASSR to be conducted in reverse order as being conducted currently.

Data and reporting flaws were identified in FY 2013 and FY 2014 data. As a result of these identified flaws and lack of diversion generally, the first Reviewer reported the State was not in compliance with the Pre-Screening and Diversion provisions of the Settlement Agreement.

[35]Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not in appropriately placed in nursing homes for long term care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for serious mental illness (SMI) and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings.

In FY 2015 the State TCLI staff reported that to remedy the problems they would use 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 PASSR information was leading to reporting errors and impacting the LME/MCO's diversion response capability. A significant number of individuals were 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 in FY 2015 while changes were being made to the process. 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. The State was very hopeful the new process would reduce problems.

A thorough review of the State's performance in trying to meet the Settlement Agreement Pre-Admission Screening and Diversion provisions was conducted in FY 2016. This review included forty (40) reviews of 1st level screens, 2nd level reviews and CIPs, interviews with LME/MCO staff, guardians, ACH staff, contractors, and State staff, and visits to six individuals who were not diverted.

III. (F)(1): Screening Process: The State recognizes issues with the current process based on their own review and the reviewer's 2016 **Brief Report on Pre-Admission Screening and Diversion** and the **FY 2016 Annual Report**. The purpose of a strong diversion program is to ensure individuals have informed choices and the option of being connected to services and housing before they reach the Level II screening verification point. When they reach that point, diversion is less likely to occur. This provides assurance the State can manage its behavioral health and health care system to avoid unnecessary institutionalization for individuals with SMI and SPMI. Second Level PASSR reviews must be conducted by an independent reviewer. This type of review can be so disconnected from the service system that it becomes a de facto ACH admissions processing measure that results in individuals becoming quickly disengaged from services altogether.

One other hurdle to overcome is counting individuals as being diverted who weren't actually pre-screened and/or diverted from ACHs. They may not have been admitted to ACHs but they weren't always informed of their choices nor diverted into community care. There is a difference between "diverted from" and "not being admitted to" an ACH. While unintended, the current reported diversion numbers make it appear the State is diverting a larger number of individuals than are actually being diverted.

In FY 2017, eleven (11) individuals counted as diverted by the State were reviewed as part of the annual review. Below is a listing of where the individuals were placed or residing at the time of their referral and their disposition:

- Three (3) individuals were listed as diverted who were hospitalized at an SPH. Two (2) of the 3 were referred to an LME/MCO for In-reach by SPH staff. One (1) individual was discharged by the SPH to a group home at the request of her Legal Representative (LRP) but was then convicted of a crime and is now in prison; one (1) individual was referred to and received In-reach and transition services and moved into supported housing; and one (1) individual was discharged by the SPH to a boarding home.
- One (1) individual was living in an ACH when her PASSR was completed and a referral was made to the LME/MCO for In-reach. She was visited and she said she did not want to move to the community. The LME/MCO followed up with three letters. She was listed as having a serious mental illness but was not being treated for mental illness. She had multiple health problems and moved back and forth between the skilled nursing wing and adult care wing of the facility where she lived.
- Two (2) individuals were discharged from a private hospital to private residences after a PASSR was completed but neither agreed to In-reach and as a result neither individual was seen by the LME/MCO. One individual had an extensive psychiatric history and was slated to enter an ACH but change her mind and moved in with family and declined services.
- The second individual's hospital admission was precipitated by heavy drinking, hypothermia, and frostbite. This was his second admission in three months and his medical team did not believe he would be safe living alone. He declined all services and indicated he was not going to discontinue drinking. This individual did not have a diagnosis of mental illness per the hospital physician where he was treated when the PASSR was done nor did the PASSR Level II reviewer indicate he had a mental illness. Nonetheless his PASSR was sent to a LME/MCO TCLI program. He was never seen; no reason was given.
- One (1) individual was hospitalized at a general hospital and was referred for a PASSR by the inpatient unit staff. He reportedly had a severe traumatic injury resulting from an industrial accident, was a victim of abuse, and had a history of suicide attempts. He had a history of multiple hospitalizations, multiple strokes, and other health issues, and had made several suicide attempts. He was homeless at the time of his admission, had a long history of substance use and serving time in prison on a drug possession charge. He reportedly requested to move to a group home although the inpatient team was seeking ACH placement. He subsequently moved to a group home and the TCLI staff said they were told by the State he would not meet TCLI criteria because of that placement.
- One (1) individual was referred for admission to an ACH via a PASSR by staff at a general hospital where he had been hospitalized for medical (acute exacerbation of COPD) and

psychiatric reasons. Hospital staff did not feel like the individual could care for himself. The hospital did not make a referral for services, though, and instead got the PASSR done. The hospital was in a different catchment area than where he lived. The LME/MCO got the PASSR but not until a week after he was discharged. The address on the PASSR was his brother's address, not the address where he had been living, and was not in the catchment area of the LME/MCO that got the PASSR. The LME/MCO made five attempts to contact him but were unsuccessful. In all likelihood he did not agree to an ACH placement. However, there was no discharge planning between the hospital and the LME/MCO covering the county where he was going to live. Two months prior to this admission the individual had spent eleven (11) days in an alcohol and drug abuse and treatment center after being committed there. He was referred for treatment after that discharge to a provider in the catchment area where he lived in a trailer, not to the LME/MCO. The trailer had no electricity or water at the time of his last admission. His substance use history is very extensive.

- One (1) individual moved into a Supported Housing following a referral to In-reach. He had been referred following a PASSR review which was conducted after he moved to the ACH rather than before he moved to an ACH.
- Two (2) individuals out of the eleven were referred by community organizations as being "at risk of" ACH placement. One was referred by a homeless organization after living on the streets for six months. She had been hospitalized prior to being homeless. She was approved for a housing slot and had moved into an apartment when seen for this review. She had lived in her apartment for about a month, had not cooked there, taken a shower, or slept in her bed but was remaining housed.
- The second individual had also been hospitalized at a general hospital but referred upon release to a boarding home. She was also referred to an ACT team but fired the team and called the LME/MCO for services. Given her history, she was approved for a housing slot and moved into a mobile home.

In summary three (3) individuals out of 11 were diverted. This is consistent with findings from earlier reviews. It appears that the number of individuals actually actively diverted is approximately 30% of the number of diversions reported.

One (1) individual moved into an ACH. Four (4) individuals who were hospitalized in private hospitals returned to private residences, three (3) of the four (4) with no services (at their insistence) and one (1) with a referral to the LME/MCO, who could not find the individual. One (1) individual moved to a boarding home and one moved (1) to a group at his request, neither with any LME/MCO involvement. One (1) individual moved from one wing of an ACH to a skilled nursing unit in the same home. It was clear in several instances the LME/MCO

did not make an attempt to assertively engage two individuals but one other individual was referred to the wrong LME/MCO and the SPH discharge process is largely managed by the SPH, making it more difficult for effective discharge practices. TCLI staff are not given any role in group home discharges from SPH. This is a missed opportunity as discussed in the earlier **Brief Report on In-reach**.

Eighteen hundred and three (1803) PASSR screenings were processed in FY 2017. Of that number, it was reported that one hundred and thirty nine (179) individuals diverted and that seven hundred and forty-five (745) were not diverted. Eight hundred and seventy nine (879) were identified as screenings "In Process." This seems high for such a short term process but it is lower than the one thousand and forty-four (1044) PASRRs "In-Process" in FY 2016. There are some regional differences in the number of PASRRs processed, with Partners, Trillium, and Eastpointe catchment areas having a disproportionately higher percentage based on their per capita population as depicted below (**Figure 10**).

Figure 10: PASRRs Screened (by catchment area)

LME/MCO	FY 2016	FY 2017	Annual % Change	% of Total Screened	% of per capita pop.
Alliance	259	204	- 11%	11%	18%
Cardinal	475	482	2%	27%	30%
Eastpointe	237	199	- 16%	11%	8%
Partners	223	248	+ 11%	14%	9%
Sandhills	183	143	- 22%	8%	11%
Vaya	274	222	- 19%	12%	11%
Trillium	200	305	+ 53%	17%	13%
Total	1851	1803	----	100%	100%

These differences are minor and likely reflect the use of PASRR as a placement tool by community hospitals, DSS staff, and or guardians.

The State will implement a new Pre-Screening and Diversion process in calendar year 2018. The plan is for referrals (Level I Screens) to be made to LME/MCOs. The LME/MCO will conduct a brief immediate assessment and assist the individual (and their guardian) to make an informed decision regarding community living options or to have a Level II Screen conducted by an Independent Screener for ACH placement. It is possible the Independent Screener does not find the individual eligible for ACH placement or the individual chooses a community option even after the Level II review is conducted. The LME/MCO, being already informed this process is underway, maintains contact with the individual and can assist the individual to make other living arrangements including Supported Housing if eligible.

Under either scenario, the LME/MCO is responsible for working with the individual to implement a community integration plan. Today these plans are done separately from other plans being developed with an individual. This change should enable the LME/MCO to use one plan reducing potential inconsistencies and redundancies. For individuals hospitalized at a SPH, the plan is for this to be the responsibility of the LME/MCO.

The State faces two challenges to successfully complete this overhaul. One is to fully inform and work with referring organizations who are making Level I referrals. There is a large number of organizations to train and work with after training to assure this new referral process is successful. The second challenge is for LME/MCOs to screen quickly and effectively and to have access to a ready pool of permanent housing, TUTP options, and other resources for diversions as needed.

As a PIHP, the LME/MCOs have responsibility for any new referrals so this process falls under their scope of responsibilities. The LME/MCOs already get PASSR referrals but after, not before, the process. They spend an inordinate amount of time locating individuals and beginning the In-reach process. But getting referrals on the front end requires a response that is more time sensitive and challenging. They need to be preparing for this change now to effectively respond to this new request. Reference is made to the need for more "bridge" housing and a ready pool of housing resources in this Report. This is essential and it will take time for those resources to be developed.

Section III. (F)(2) Once screened, the LME/MCO will work with the individual to develop and implement a community integration plan consistent with discharge planning provisions in Section III.(E). Review of CIPs reveals that they are written as part of the 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. The process as designed is not conducive for diversion planning. 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. It is recommended the process be managed by the LME/MCOs who have staff with skills in assertive engagement and person-centered planning for this target population and staff who are knowledgeable about community resources. 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.

Section III. (F)(3) When an individual, after being fully informed of the available alternatives to entry into an adult care home, chooses to transition to an adult care home, the State will document the steps taken and show that the decision is an informed one. The State is required to implement individualized strategies to address concerns and objections to placement and to monitor individuals and provide In-reach and transition planning.

Findings and Recommendations

The State is not yet meeting the requirements for **Section III.(F)(1-3) Pre-Admission Screening and Diversion.** Recommendations for meeting these requirements are the same as made in FY 2016. The State is on track to implement new Pre-Screening protocols in calendar year 2018. Since diversion is not possible for most individuals being referred now, this presents a new challenge for the LME/MCOs. The State plans this change to take place in early 2018. The type of rapid response needed to effectively divert individuals who choose to live in the community after being referred to an ACH requires extensive preparation. LME/MCOs need to be preparing for this change as soon as possible. A more complete assessment can be made after this change is underway.

Compliance Summary

The State does not yet meet **Section III.(F) Pre-Admission Screening and Diversion** requirements. In summary, the PASSR is used to conduct the federally required screening for ACH eligibility and placement. The 2nd level PASSR review is conducted by an independent screener. But the process is not sufficient for, nor instrumental in, creating diversion opportunities. The individual being screened is not fully informed of available alternatives before the ACH decision is made. The connection to the LME/MCO is typically done after the ACH decision is made or, in the case of SPH discharge, made without the full and effective participation of the LME/MCO. The PASSR screening still occurs, although less frequently, after an individual has moved into the ACH.

Recommendations for coming into compliance with these requirements were made in the FY 2016 Annual Review. Interim steps and long term changes were recommended. This year's review identified the same issues so these recommendations have not changed substantially. One challenge became more evident this year. The In-reach review revealed more challenges with SPH discharge processes, which underscores the need to revamp those processes for diversion and transition planning.

The State is committed to revamping **Pre-Admission Screening and Diversion** to remain in compliance with PASSR requirements, but to also come into SA compliance with these requirements, and is on schedule to complete and implement this re-design. The process to shift away from the current PASSR will be lengthy and many organizations will need to be brought into the planning process well ahead of time and trained once a new approach is in place. There are two additional recommendations for this change. One is for the State to develop a detailed plan with dedicated responsibilities and resources to facilitate this change. The second is to stage the change using available resources for diversion beyond those available now. If the State's plan and proposed changes are effective, the State can come into compliance with these provisions by FY 2021.

VI. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Quality Assurance and Performance Improvement includes requirements for the State to develop and implement a quality assurance and performance improvement system to ensure that community-based placements are developed in accordance with this Agreement. There are six major requirements. These pertain to oversight, development of systems and tools, including a dashboard for decision support, monitoring protocols, data collection and use of data, the development of a Quality Assurance System, completion of Quality of Life Surveys and implementation of the External Quality Review ("EQR"). It includes requirements for the State to publish an annual report.

The State has faced challenges with data collection but has made progress on development of a dashboard for decision support and use of the EQR to monitor LME/MCO policies and procedures overall specific to TCLI.

The timing of the required release of this Annual Report and the State's being able to release their Annual Report does not coincide so that this review includes a review of the State's most recent Annual Report. However information from the FY 2016 Sate's Annual Report is referenced below. The State has provided the Reviewer with a "draft" FY 2017 Annual Report so their newest draft was compared to information submitted in FY 2016.

Section III.(G)(1) requires **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 and 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 Acting Senior Advisor has identified responsibilities and is tracking progress across all the SA requirements. Challenges have been identified in earlier reports. This year the most significant challenges include:

1) the need to clarify roles and responsibilities, determining "flow through" and task analysis where policies and actions of one group may impact the performance of another entity. This includes performance measures needing to be identified for each DHHS Division, local DVR offices, the SPHs and the NC HFA as well as the LME/MCOs. In turn the LME/MCOs identify performance requirements for providers. It is important these measures be consistent across

LME/MCO, partly because providers work across LME/MCOs and consistency is important for contracts for a service with statewide standards.

2) the repetition (and sometimes unnecessary differences) in documentation requirements and plans starting with the PASRR, In Reach, Transition, Discharge Planning through provision of Community Based Services and the same with housing documents (assessments, PCPs, discharge plans and community plans, etc.).

3) the need to hold required reporters accountable through contract obligations so data can be reported and verified more quickly.

4) the re-examination of requirements for Gaps Analysis to assure adequate standards and strategies for eliminating gaps and meeting SA obligations.

5) Corrective Action Plans are updated to better align with SA requirements. Performance expectations be included for each action item.

As reported last year, a pre-requisite for accomplishing this task is the development of 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. Progress is being made to improve the quality of the data in the Transitions data base and operating platform which will enable the State to better analyze data. Verification of IPS-SE data is an example of where more work needs to be done to assure integrity of the data.

Quality Assurance and Performance Improvement should reinforce effective transformational (changes associated with changing a system), transactional (organizational performance toward meeting compliance or a goal) and decision-making processes. Quality Assurance is focused on compliance and Performance Improvement is a proactive process focused on continuous improvement. When these processes are separated, they tend to become duplicative and staff begin to see these interactions, transitions and decisions as being separate. This leads to under estimating the value of clear, joint cross-party responsibilities (i.e., hospitals and providers, State and LME/MCOs, State agencies, etc.) 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. This Report identifies a number of challenges with breakdowns when two entities are required to work together.

Findings

1. The State must develop and implement a Quality Assurance and Performance Improvement monitoring system to "ensure" that community-based placements are developed in accordance with this Agreement is yet fully in place. To be in full compliance with **Section**

III.G(1), the State must identify accountability requirements and hold itself (DHHS Divisions, the SPHs and the NC HFA) and the LME/MCOs accountable for all the specific requirements in the Settlement Agreement.

2. There are Quality Assurance and Performance requirements in place for items, **Section 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.

Recommendations

1. Ensure roles and responsibilities are clear and accountability measures are attached to all relevant entities, as referenced above. Examine any accountability measures to avoid unintended consequences.
2. Determine the areas where the State is not delegating responsibilities to the LME/MCOs to meet the Settlement requirements. Request the LME/MCOs establish policies and add contracting requirements with providers as necessary. As referenced in the Community Based Services section of this Report, identify IPS-SE and ACT roles and responsibilities and performance expectations. Complete this analysis before completing FY 2018 DMH and DMA contract modifications.

III.(G)(2) A Transition Oversight Committee is required to monitor monthly progress of the implementation of this Agreement, and will be chaired by the DHHS Secretary's designee. The DMA, DMHDDSA, DSOHCF, State Hospital Team Lead, State Hospital CEOs, Money Follows the person, PIHP (LME/MCOs to report on progress being made. LME/MCOs are responsible for reporting on discharge-related measures including but not limited to: housing vacancies, discharge planning and transition, referral processes and subsequent admissions, time between application for services and discharge designation and actual admission date to community-based settings.

Finding

The State does not adhere to this requirement but some required members of this required group, meet as a leadership team. Minutes of the meetings of this group, how frequently they meet and their agendas and reviews are not reported. The Settlement Agreement does not require the NC HFA, the Division of Aging and Adult Services and Division of Vocational Rehabilitation Services to be a member but DHHS includes them in regular leadership meetings and they are vital members of the Team. The required reporting does not occur in the manner

prescribed by this Requirement. It would be helpful if this Committee reviewed monthly reports on items specified in this requirement and made recommendations to the Special Advisor, the DHHS Division Directors, the NC HFA Executive Director and the Deputy Secretary for Health for further consideration.

Recommendation

Establish the Transition Oversight Committee in accordance with the SA requirement **Section III.(G)(2).** Publish minutes from these meetings including recommendations for the DHHS and NC HFA. Include additional members as referenced above.

Section III.(G)(3)[a-g][i-vii] includes Steps the State is taking related to Quality Assurance and Performance Improvements.

Findings

The State has taken steps to develop and implement a majority of the requirements listed under **Section III.(G)(3).** The State is taking steps to develop and phase-in protocols, instruments/tools and enhancements for on-gong monitoring and evaluation but not yet meeting **Section III. (G)(3)[a].** However additional steps are necessary. Monthly reports generate about 60% of the required information and some other informational is available. Institutional tracking is occurring as required in **Section III. (G)(3)[b]**. The standard report to monitor institutional patients (SPHs) length of stay, readmissions and community tenure as required in **Section III. (G)(3)[c]** is not yet in place. A system for discharge planning for individuals exiting SPHs will require a much greater investment of time, level of joint planning and a level cooperation than exists now between the DSOHF, the SPHS and the LME/MCOs. The benefits though would far outweigh any commitment of time and resources to this process and would enable the State to meet the requirement for priority for housing slots for individuals in Category 4.

The State is reporting housing slot tenure. Collecting information on community tenure will be difficult to verify for individuals who don't have housing slots. However, it is 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 **Section III.(G)(3)** not referenced specifically in this Report or 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 included as reporting requirements and performance expectations for these items for the LME/MCOs and LME/MCOs with providers.

The DHHS has introduced a “Super Measure” for LME/MCOs to fill a specified number of housing slots during the year and added this measure to the LME/MCO contract. There is a financial

penalty attached to this measure beginning in January 2018 for LME/MCOs who do not meet their "filling slots" requirement. Super measures can be useful but only if and when applied to entities who have full control of all the variables associated with performance on any measure. Likewise it is prudent to determine if meeting one measure may lead to other problems meeting other requirements. For example, the requirement for filling units may be met but without a concomitant requirement for individuals sustaining their tenancy being factored in. It may be more appropriate to measure net gains overtime.

In FY2016, the Croze Report[36] identified core documents that should have contained key expectations but were insufficient for adequate accountability to meet terms of the Settlement Agreement. This problem decreases the State's ability to discharge its Settlement Agreement obligations that are delegated to the LME/MCOS. The FY 2017 DMH contract reflected a number of changes based on these findings. The DMA contract did not reflect significant change and as a result this contract is less effective as a tool for meeting the SA requirements.

State staff have recommended using TOPPS data for review purposes. This data is helpful but it too is not sufficiently aligned with the Settlement requirements for use as performance monitoring and quality assurance tool. Analyzing reports and findings, such as the ACT and IPS-SE Fidelity reports, the TAC Housing Assessment, SPH discharge placements and claims data (to be analyzed in FY 2018) can be helpful to identifying relevant process, performance and outcome measures.

The State is required to develop and implement a centralized housing data system to inform discharge planning **Section III.(G)(3)[e].** The State is developing a centralized 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 diversion and ACH/SPH discharge planning requires daily input and updating (real time) availability of housing. This can only be possible if the input of housing availability becomes a LME/MCO resource that also includes functionality for housing information (based on LME/MCO housing search) with real time need based on individual info being uploaded and used by LME/MCO staff who are the primary users of this information. It's more of a waiting list matching system than housing search system. A centralized system does not typically have this functionality nor does Socialserve's current module suffice for this purpose. Statewide data requirements and decision tools are important but applications that LME/MCOs can use for their housing search and ready pool/waiting list management (as needed) are not yet available.

[36] Colette Croze, an Expert in Medicaid, managed care and behavioral health systems development and compliance reviewed and analyzed State contracts and related documents and issued a report to the Reviewer on the DMA and DMH contracts with the LME/MCOs to determine the extent to which these contracts included the Settlement Agreement responsibilities delegated to the LME/MCOs.

The LME/MCOs will begin their role in Pre-Screening (for ACH admissions) getting 'real time" daily information on SPH admissions and community hospital admissions in FY 2018. Connecting this information to housing data can be useful to the LME/MCO which is another reason to give the LME/MCO the tools to inform and match individuals to housing.

The State is publishing a monthly dashboard for monitoring selected metrics toward compliance with the SA and to inform decision making. The State has made substantial progress in increasing the validity of information included on the dashboard and making it more useful. Refreshing items on the dashboard is important to assure the items being measured are the most current and salient to SA compliance and sustainability. For example, the State should include housing tenure on the dashboard consistent with the requirements of the modified Settlement Agreement.

Recommendations

1. Continue to make use of and refine the TCLI Dashboard. Evaluate each requirement on a regular basis for its relevance to critical compliance issues.
2. Develop an institutional tracking system as part of an overhaul to SPH discharge planning in a manner that can lead to performance improvement in discharge planning.
3. Develop a housing data system that matches discharges and diversions with housing availability. Establish a system that provides each LME/MCO with tools for combining real time housing search and housing match.
4. Match reporting requirements with data collection points to ensure data is systematically being collected and transmitted to decision makers and end users to meet the Quality Assurance and Performance Improvement requirements in the SA.

Section III.(G)(4) Quality Assurance System: This section requires the State to regularly collect, aggregate, and analyze information, both for successful placements and for 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. A formal listing of major barriers and progress on overcoming challenges should be reported and reviewed with internal and external stakeholders semi-annually. This is done informally now. Singular efforts don't equate to a systems approach with feedback loops with decision makers working collaboratively to assure the right things are being done the right way. There is a difference between doing a job right and doing the right job. The State still falls short of having a quality assurance system focused on doing the right job.

4. The Transition Oversight Committee review this information and report and make recommendations on a semi-annual basis.

Section III.(G)(5) Quality of Life Surveys: The State is required to report Initial, Follow-up and 24 Month Follow-Up surveys. The State reports the rate of completion of these surveys and a Dashboard measure has been added referencing LME/MCO compliance with this requirement. The State set targets for completion for each LME/MCO. Those targets are different for each LME/MCO based on past completion rates and for FY 2018 the target average across the LME/MCOs is 58%. This is an important exercise but surveys of this type are known to overstate satisfaction. Focus groups, personal interviews and feedback loops are also key to measuring quality of life.

Findings

1. Surveys are being submitted and the rate of completion is identified for each LME/MCO on the DHHS TCLI dashboard.
2. Most surveys are not being completed in the required timeframe.

Recommendation

1. Continue monitoring completions on the TCLI Monthly dashboard.

Section III.(G)(6)[a-j] External Quality Review (EQR): The LME/MCOs have been audited by the Carolinas Center for Medical Excellence (CCME) consistent with C.F.R. 438.58 requirements for EQR. Review summaries are published in the Annual Report. The State's FY 2017 "draft" Annual Report identified EQR findings for TCLI policies and procedures, documentation and record reviews, lack of inclusion of the TCLI population as a Special Needs Population, and quality of life surveys. This is an important step to making the EQR a relevant review process for TCLI. Due to scheduling conflicts in FY 2017, the Reviewer was unable to attend any EQR reviews but will be attending two reviews in the fall of 2017 to better determine the value of these reviews and adherence to Settlement Agreement requirements. The only finding associated with this requirement is that EQRs now review specific TCLI policies and documentation. Recommendations may be made following further analysis of the EQR process in FY 2018.

Section 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 numerous examples throughout this Report of opportunities for using data for decision making, allocating resources and improving processes and performance across all of the SA threshold requirements. The State publishes monthly reports based on data collected by the DHHS and LME/MCOs. The State has improved its verification processes particularly in reporting IPS-SE but in other areas as well. The LME/MCO dashboard is useful and appears to be widely viewed and used for decision making.

Findings

1. The State has the capacity to aggregate and analyze data for some requirements, particularly requirements for information already gathered in the Transitions data base including PASSRs/admissions, In-reach, Discharge and Transition Planning, Housing Slots filled, and separations. The State also collects most of the Performance and Quality Assurance data, Incident Reports, Fidelity information, SE services, and SPH data from other sources.

2. TCLI reports are generated monthly and have been updated periodically to identify performance trends.

3. There are still questions regarding verification and validity of the data. This is partly related to volume and continuous efforts to improve data quality. A great deal of effort has gone into "cleaning up" the Transitions data base. One continuous problem is to secure verification that an individual is not eligible (or no longer eligible) for TCLI. This verification (on the state's FL2 form[37]) requires cooperation from treating physicians and ACH home owners. Requests for this verification are often delayed or ignored.

4. Service use data is not available for reporting, assessing performance and decision making.

Recommendations

1. A number of recommendations have already been identified under other categories.

2. One key issue not cited earlier is the continuous need to clean-up the Transitions data base. The DHHS should take steps to require FL2 forms be updated in a timely manner as requested. This should include establishing requirements for LME/MCOs to make these requests and requirements for timely response from ACH owners and their contract physicians.

Section III.(G)(8)[a-b] Reporting. The State is required to publish an Annual Report identifying the number of people served by type of service and for each type of setting as described in this agreement. The Report should detail the quality of services and supports using data, quality assurance and performance improvement, the contracting process, the EQRs and outcome data as described in the SA.

Findings

1. The State publishes an Annual Report. The best time for the State to publish this report is after the end of their fiscal year since some data is collected on a fiscal year basis. This results in a delay on reporting the sufficiency of the State's report in this Annual Report. The FY 2016

[37] This is a one-page medical form that lists the physician's recommended level of care as well as medical diagnosis, care needs and medications.

Report has been published and a draft FY 2017 Annual Report is in process. The draft report has been available for review.

2. The Annual Report does not report on specific measures including repeat emergency room visits and repeat inpatient admissions referenced above. However, the State is beginning to examine the potential to report on services utilization data beginning in FY 2018.

Recommendation

1. Re-examine the SA requirements for the Annual Report and begin the process for collecting and analyzing this data as early as possible in FY 2018 in order to add required information to meet this requirement in the next Annual Report.

Compliance Summary

The State's Quality Assurance and Performance Improvement monitoring system is not yet developed in such a manner to meet Settlement Agreement requirements. Areas that need attention include reporting on all data collection requirements in the SA, aligning responsibilities, requirements and performance, creating sufficient feedback loops, eliminating unintended consequences resulting from measuring performance in one area that may create negative consequences in other areas.

The State's Corrective Action Plans for Supported Housing, Supported Employment and Services require updating with more attention being given to establishing relevant and timely action steps, more clarity on responsibilities and more substantive performance requirements. The Supported Employment Corrective Plan has more relevant useful action steps and will require fewer, but nonetheless important, modifications. Likewise, establishing applicable performance requirements for DHHS Division leadership and staff, SPHs, local DVR offices and for the NC HFA is critical. In recent months, DHHS leadership has signaled an interest in using data analytics and developing a system wide QA plan. This should be done along with establishing the required Transition Oversight Committee. Hopefully this will come to fruition in FY 2018.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

The State continues to make progress in meeting the Settlement Agreement requirements but progress is somewhat uneven**.** Substantial changes are being made but many more are required. There have been leadership changes in the Department, both in the TCLI program and in the Secretary's office. These changes have not slowed progress, and in some respects have enhanced progress. There is a need for consistent support across the leadership of a number of DHHS Divisions. This is difficult to achieve when meeting these requirements also requires significant change in current operations. The LME/MCOs' TCLI teams have also experienced leadership changes but the impact of these changes is not yet fully known. Nonetheless the LME/MCOs have

taken major steps to improve their Supported Housing Programs and implement TSM. The DHHS and their UNC TA team are working with LME/MCOs to strengthen ACT, TSM and Supported Employment (IPS-SE) capacity.

Supported Housing, Supported Employment and Services Corrective Action Plans need to be updated, improved and re-submitted for review. Some LME/MCOs are beginning to take a broader view of what they need to do to meet their obligations.

Barriers need to be overcome and continuous improvements made in five key areas. One is for the DHHS, DMH, DSOHF, DMA and DAAS in particular, to make needed changes in Pre-admission Screening, Diversion, Discharge and Transition Planning through creating a better pathway for pre-admission screening and diversion, shortening transition periods and increasing referrals of individuals hospitalized in SPHs. The second is making improvements in the availability, array, frequency, intensity and quality of services. The TCLI target population is not a single homogenous group where one size of services fits all. Improving services requires a better understanding of needs, more individualized person centered supports and services, use of effective resources and use of data for decision making.

The third is to reduce barriers for individuals living in ACHs or hospitalized in SPHs to be referred to and get access to housing, needed services and supported employment. Fourth is for the State and LME/MCOs to overcome barriers to Supported Housing development, access and availability of housing. This can only be achieved if the State is clearer on its direction for Supported Housing and provides better and timelier guidance and access to resources. DHHS appears poised to make that happen but this is way overdue. This clarity and direction is essential to LME/MCOs, who have responsibility for filling housing slots.

Finally and perhaps most importantly is the need for all the organizations and stakeholders in the State's "system of care" to step up support and help for individuals who want to move and have moved to the community in meeting their recovery goals. It's one thing to voice the need to give attention to the social determinants of health. It's important to speak about these determinants; but it requires action. Many individuals have voiced feelings of being isolated, lonely and unsure if they have the strengths to live successfully in the community. Life is not just a service, although services and supports are essential. It's also community, faith, friends, acquaintances and family. It's a safe and decent home, a job and/or activities that an individual finds rewarding and fulfilling. A colleague recently said it succinctly, its health, home and hope, the greatest of these is hope.