FIRST REPORT OF THE INDEPENDENT REVIEWER ON PROGRESS TOWARD COMPLIANCE WITH THE SETTLEMENT AGREEMENT BETWEEN THE UNITED STATES AND THE STATE OF NORTH CAROLINA

May 1, 2013

Submitted by: Marylou Sudders

EXECUTIVE SUMMARY

The voluntary Settlement Agreement (Settlement) between the United States and the State of North Carolina (State) was agreed to by the parties on August 23, 2012. As a result, the State will willingly meet the requirements of the Americans with Disabilities Act, the Rehabilitation Act, and the Olmstead decision, which require that, to the extent that the State offers services to individuals with disabilities, such services shall be provided in the most integrated setting appropriate to meet their needs. Accordingly, the Parties concur that the goals of community integration and self-determination will be achieved for persons with serious mental illness (smi).

Specifically, 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 smi, who are in or at risk of entry to an adult care home.

The Settlement is structured in a manner that acknowledges that sustainable systems change requires time, attention and deliberative

action. The parties acknowledge that implementing and sustaining the structure, systems and services for individuals with smi will occur in important incremental phases. By July 1, 2020, the State of North Carolina will comply with 48 substantive provisions.

This report establishes the baseline for all further reports as agreed to by parties in the Settlement. Although the parties agreed to the provisions of the Settlement on August 23, 2012, including the selection of an Independent Reviewer, the formal agreement with the Independent Reviewer was not approved until December 7, 2012. This report is based upon information gathered within 120 days from December 7, 2012 through April 7, 2013.

Going forward, reports filed by the Independent Reviewer will occur on the dates specified in the Agreement.

It is important to state that implementation of this Settlement does not occur within a vacuum. North Carolina's public mental health system is in a period of significant flux. In November, 2012, a new Governor was elected; following his election, key executive branch appointments were announced, including the appointment of a new Secretary of the Department of Health and Human Services (DHHS), Aldona Z. Wos, MD. Transitions both in leadership and organizational structure have occurred and continue to date. In February 2013, A new Medicaid Director, Carol Steckel joined DHHS. At the time of the filing of this report, the Director of the Division of MH/DD/SAS, James Jarrard, continues in an acting capacity reporting to the Medicaid Director.

The State's organizational structure does not readily allow for coherent and consistent implementation of services and supports for individuals with smi. Responsibility is shared among numerous public agencies, both state and county, including but not limited to the Division of MH/DD/SAS, Division of Medical Assistance, Division of Aging and Adult Services, Division of Social Services, Division of Vocational Rehabilitation, Division of State Operated Health Care Facilities and the North Carolina Housing Financing Agency.

Compliance with the Settlement is predicated upon all of these sister agencies working in concert to meet the Settlement provisions.

At the service provision level, the public mental health system also is experiencing significant change. This system is structured in alignment with the state's Medicaid system. Since 2011, the State has been operating under a 1915 (b)/(c) Medicaid waiver. Over the past year, the State has restructured its local management entities (LMEs) into eleven managed care organizations (MCOs) with expected full implementation as of January 2013. MCO/LMEs have responsibility for managed care responsibilities including the utilization and oversight of certain community based mental health services for individuals with smi. The MCO/LMEs are variable in their preparedness for assuming managed care responsibilities. During this period of review, the State already has reassigned MCO responsibilities of one organization to another one. MCO/LMEs are critical to the success to the Settlement as they are the point of community accountability for individuals with smi.

Most recently, the State has announced its intent to restructure its Medicaid system to improve care, efficiency and outcomes. An RFI solicitation was issued in February 2013 for public comment; the State anticipates significant changes to occur in 2014.

The State is fortunate to have an informed group of stakeholders who are committed to the principles and goals of the Settlement and are concerned about and eager to participate in the State's implementation's efforts. Stakeholder engagement and involvement is key to successful implementation and sustainability of these system's changes.

In this early phase of implementation of the Settlement, the State has demonstrated good faith efforts to comply with the obligations due to be completed by July 1, 2020. Secretary Wos has clearly communicated the state's intention to comply with the provisions of the Settlement Agreement and has secured sufficient public dollars to begin implementation activities.

BASELINE

The duties of the Independent Review are to observe, review, report findings and make recommendations to the parties with respect to the implementation and compliance with the Agreement. The Agreement stipulates that the Reviewer will conduct a baseline evaluation of the State's compliance with the terms of the Agreement within 120 days after engagement. This initial baseline is to inform the parties and the Reviewer of the status of compliance.

Attached to this baseline report is a summary document that will be used for the first annual report to be issued after August 23, 2013.

Interim Measures. Since entering into the Agreement, the State has taken several key and deliberate steps towards establishing an infrastructure to implement major systems change. These early implementation activities are necessary to appropriately meet the needs of individuals with smi. Community integration and self-determination for individuals with smi are the two goals that must be achieved in order to achieve compliance with the Settlement.

Early activities include: developing an overall implementation work plan; creating a working infrastructure, including workgroups of internal and external members; identifying scope of work and performance requirements; and, outlining a calendar of activities and critical deadlines to be met. The ambitious timelines include communication and training requirements for each major substantive provision.

Agreement Coordinator. Immediately upon execution of the Agreement, the State initiated a search for an Agreement Coordinator and sought out the Independent Reviewer's assessment of a preferred candidate. In November, 2012, Jessica Keith Bradley started in this newly established role to oversee the implementation of the Settlement provisions as Special Advisor for the ADA. Ms. Bradley reported to Beth Melcher, Deputy Secretary, until Ms. Melcher's resignation from the Department in March,

2013; her current reporting lines are unclear due to continued DHHS restructuring.

Ms. Bradley brings the requisite experience, knowledge, and commitment to the principles of community integration and recovery to the implementation of this Agreement. She has hit the ground running.

Several of the DHHS staff embrace the goals established in the Settlement; commitment throughout the agency is necessary in order to achieve compliance.

Transition Oversight Committee. DHHS established a Transition Oversight Committee to oversee the implementation of this Agreement. It was chaired by the Deputy Secretary until her resignation in March, 2013; Ms. Bradley now chairs the Oversight Committee. Specific work groups/committees including both public employees and stakeholders are organized around substantive provisions including: housing; supported employment; assertive community treatment (ACT); diversion; in-reach; and, quality management.

Pre-Admission Screening (PASSR). On January 1, 2013, the State implemented a PASSR process for individuals being considered for admission to an adult care home. The State has made reasonable efforts to communicate the PASSR process to community, private and public hospitals, adult care homes, community providers and stakeholders. The State has arranged for trainings on the new process and posted relevant information on the DHHS website.

An interim rule (regulation) regarding PASRR went into effect on March 1st, with a final effective date anticipated on June 1, 2013. This provision will be in full compliance with the specific provision of the Agreement when the following three conditions are met: the rule is final and fully in effect; the State actively monitors the enforcement of the PASRR process; and the State ensures that the screeners are independent to the state psychiatric facilities and adult care home industry.

In the first two months that data has been gathered and reviewed, the PASSR process appears to be having the desired effect of screening individuals with smi referred for placement into an ACH. In the months of January and February, 2013, 557 individuals were screened; 200 individuals received a Level II screening; and 67 individuals with smi were placed into an ACH. A random sampling of individuals referred to and/or placed into ACH suggests that the transition team processes are in their early stages of operation.

Community Based Services. The State has committed to providing access to an array and intensity of services and supports necessary to enable individuals with smi in or at risk of entry in adult care homes to successfully transition and live in integrated, community based settings. These services must be evidence based, recovery focused and community based. In order to support individuals living in the community, the State will rely on the following community mental health services: assertive community treatment (ACT) teams; community support teams (CST), case management services, peer support services; psychosocial rehabilitation services; and crisis services.

The Settlement details specific provisions pertaining to ACT; housing; crisis services; and, supported employment. These services are discussed elsewhere in this report.

With regard to community support teams (CST), case management services, peer support services, psychosocial rehabilitation services and any other services, these services must be: evidence based, recovery focused and community based; be flexible and individualized to meet the needs of each individual; help individuals to increase their ability to recognize and deal with situations that may otherwise result in crises; and increase and strengthen the individuals' networks of community and natural supports.

At the time of the baseline report, there is no documentation to support that these services meet a state approved, evidence based standard across the system.

Person Centered Service Planning. Key to the provision of evidence based services is the development of a person-centered service plan. As described in the Settlement, a person-centered service plan is developed for each individual with smi, which will be implemented by a qualified professional who is clinically responsible for ensuring that all elements and components of the plan are arranged for the recipient in a coordinated manner.

The State provided two day transition planning training to LME/MCOs and State Psychiatric Facility staff, which included some person center service planning. More training is necessary specific to Person Centered Service Planning.

In-reach, Discharge and Transition Planning. The State has agreed to implement procedures to ensure that individuals with smi in or later admitted to an adult care home or state psychiatric hospital will receive accurate and full information about all community based options, including supported housing. Individuals must be fully informed and participate in the process.

The State will provide or arrange for frequent education efforts to individuals with smi in adult care homes and state psychiatric hospitals. These In-reach activities will provide information about the benefits of supported housing, facilitating visits to community settings; offering opportunities to meet with other individuals with smi who are living, working and receiving services in integrated settings. In order to be effective, In-reach work must be provided by individuals knowledgeable about the community, including supportive housing. In-reach is to be provided regularly to individuals residing in adult care homes on a regular basis.

The State also has agreed to provide for effective discharge planning, including a written plan, to individuals with smi who are admitted to an adult care home or state psychiatric hospitals. The goal of discharge planning is to assist the individual to achieve outcomes that promote individual growth, well-being and independence based upon their strengths, needs and preferences in the most integrated setting appropriate. In order to be in

compliance with the Settlement, discharge planning is to be conducted by transitions teams composed of individuals knowledgeable about community resources, professionals with subject matter expertise; persons with cultural competence; and peer specialists.

On February 18, 2013, the State commenced In-Reach activities through its LME/MCOs. Prior to implementation, every LME/MCO received state training on the role of Transition Coordinators, In-reach activities and discharge planning. Based on information provided by the State, during the months of February and March, 2013, 166 and 259 individuals have received In-Reach activities; and a total of 42 individuals received transition services. Given that it is unclear what the universe of individuals with smi is that should be receiving In-reach and/or transition activities, it is not possible to make any further statements at this time. An area of concern is that in a number of LME/MCOs, the responsibility for these critical functions is spread among several staff; hopefully, this is a transitional phase while active recruitment for permanent position(s) occurs. Assigning these critical duties among existing staff with ongoing job responsibilities is not a long term solution to meeting the obligations of the Settlement. Shared duties essentially mean that no one has the ultimate professional responsibility for these important activities.

An area of focus for the State needs to be the discharge planning by the public psychiatric hospitals and utilization of ACHs. A random sampling of individuals referred to ACHs are from these facilities; the State should focus attention on ensuring that LME/MCOs and public psychiatric hospitals are working together on person centered discharge planning, including appropriate community based housing options.

Going forward, the DHHS Transition Oversight Team should engage with local transition teams to identify barriers to placement and difficulties implementing discharge plans. The Team also needs to establish and document the steps taken to re-assess individuals with smi who remain in adult care homes or state psychiatric facilities for discharge to an integrated community setting on at least a quarterly basis.

Housing. The State has committed to a substantial investment and development of supported housing for individuals with smi. The housing must provide permanent housing with tenancy rights; and include tenancy support services to enable individuals to maintain affordable housing in integrated, non-congregated settings. The State has entered into contractual agreements with Quadel Consulting and SocialServ.com for the purpose of implementing a statewide system of supported housing and tenancy supports for individuals with smi.

Quadel Consulting has experience both in the State and in the provision of similar housing subsidy programs in other states. For 10 years, Quadel has had a partnership with North Carolina's Housing Financing Agency for the administration of the section 8 program. This contract is effective February 5, 2013.

On March 18, 2013, The State approved a contract with SocialServe.com, a program of Non-Profit Industries for an on line searchable system for enhanced housing locator services; call system; tenancy financial eligibility system; waiting list system ; and monthly reporting system on key indicators.

The State anticipates that these two contracts plus additional State/Regional Housing Coordinators will identify integrated housing options for individuals with smi. The complexity of the process, as detailed in a 39 page, Housing How To's training PowerPoint raises concerns regarding the ability of the State to transition individuals from restrictive levels of care and/or at risk of institutionalization in a timely manner.

The Settlement stipulates that by July 1st, the State will provide housing slots to a minimum of 100 and up to 300 individuals with smi.

At the time of the baseline report, the State estimated that it had 633 individuals with smi in existing units of state subsidized housing. This number has not been validated.

Assertive Community Treatment (ACT). The State has more than 100 providers that offer ACT; some have independently sought out

accreditation. The State must ensure that it has a system in place to develop, implement and support a sustainable ACT fidelity program statewide. In order to be in compliance with the Settlement, each ACT must operate to fidelity with one of two national standards: Dartmouth Assertive Community Treatment (DACT) or the Tool for Measurement of Assertive Community Treatment (TMACT).

On March 15th, 2013, the State entered into a contract with the University of North Carolina's Center for Excellence in Community Mental Health (CECMH) for the purpose of evaluating the current ACT programs, providing technical assistance and training, and screening ACT for fidelity compliance.

The Settlement stipulates that by July 1, 2013, all ACT teams will operate in accordance with a nationally recognized fidelity model and will increase the number of individuals served by ACT teams to 33 teams that meet fidelity serving 3225 individuals at any one time.

Given the State previously did not require adherence to a statewide fidelity standard and ongoing quality measurement process, for the purposes of the baseline report, the baseline is set at zero.

Supported Employment (SES). The State has committed to providing supported employment services to individuals with smi who are in or at risk of entry to an adult care home. SES is defined as services that assist an individual preparing for, identifying and maintaining integrated, competitive and paid employment. In order to be in compliance with the Settlement, SES must be provided with fidelity to an evidence based model, such as the Substance Abuse and Mental Health Services Administration (SAMHSA's) supported employment tool kit.

On March 15, 2013, the State entered into a contract with the North Carolina Association for Persons Supporting Employment (NCAPSE) for the establishment of a Technical Assistance Center (TAC) focused on employment first. On behalf of the State, TAC will create the infrastructure and capacity to provide integrated, evidence based employment services for individuals with smi.

SES is being implemented at a critical time in the State. Overall unemployment remains at record levels. The majority of providers offer minimum level of state required staff training, much of it not directed at employment service training or best practices in employment services for individuals with smi. The State's employment providers have faced increased general operating, transportation and health care costs concomitant with MCO reductions in employment services budgets.

The Settlement stipulates that by July 1, 2013, the state must provide SES to a total of 100 individuals.

The baseline report is set at zero.

Crisis Services. The State has an array of community based crisis services available to respond to the needs of individuals with smi and others. Managed by the LME/MCOs, community based crisis services include: twelve LME/MCO call centers; forty-eight mobile crisis teams; 26 facility based crisis programs; 78 walk in crisis (WIC) clinics; 6 START teams; twelve crisis respite beds; and crisis intervention team trained police officers in each LME/MCO area.

There is longstanding agreement that efforts must be made to: impact utilization of Hospital Emergency Departments; reduce hospital "boarding" and to appropriately link individuals with community based services and supports. DHHS has made twenty five specific recommendations to the Legislature to improve the crisis services for individuals with smi; key among them is to strengthen care coordination for individuals who are at risk of crisis and/or acute hospitalization.

Quality Management. The State will develop and implement a comprehensive quality assurance and performance improvement monitoring system to ensure that community based placements and services are developed. The goal is to ensure that all mental health and other services and supports funded by the State are of good quality and are sufficient to help individuals achieve increased independence, gain greater integration into the community, obtain and maintain stable housing, avoid

harm, and decrease the incidence of hospital contacts and institutionalization.

The State has agreed to: develop and phase in protocols, data collection instruments and data base enhances for ongoing monitoring and evaluation; develop and implement uniform application for institutional census tracking; develop and implement standard report to monitor institutional patients length of stay, readmissions and community tenure; develop and implement dashboard for daily decision report; develop and implement centralized housing data system to inform discharge planning; develop and utilize template for published, annual progress reports; and develop and utilize monitoring and evaluation protocols and data collection regarding certain personal outcome measures.

The State has also agreed to develop a quality assurance system, quality of life surveys and an external quality review program; and an annual report.

Claims data is used to determine utilization patterns for service provision. There does not appear to be a uniform state data collection system that collects individual based information across the many public agencies that a person with smi may receive services and/or benefits from. Specifically in response to the Settlement, the State has created a Transitions to Community Living Score Card. This rudimentary score card should be automated and disseminated widely.

Individual tracking information has begun to be collected as of January, 2013; the quality and completeness of the data are a work in progress. Not all LME/MCOs have submitted the information in a timely basis making it difficult for the State to review and take action as necessary. This information is not formatted in a manner to allow for summary management reports.

The quality management provisions require substantial investment by the State.

Communication. The State has made efforts to keep stakeholders informed and engaged in this process. Stakeholders have been invited to participate in various workgroups. Pertinent information has been posted on the DHHS website and disseminated. Communication and trainings must be ongoing and continuous.

SUMMARY

The State, through its DHHS, has demonstrated good faith efforts in the early stages of this Settlement Agreement. The State has provided sufficient funding essential to the initial development of the services. Several important milestones have been achieved, including the introduction of a screening process for individuals being referred for placement into an ACH, entering into contractual agreements for certain key provisions of the Settlement, and creating an internal infrastructure to sustain implementation activities.

There are significant challenges in the development of tenancy based housing services and supported employment, implementation of person centered service planning, and full operation of In-Reach and Transition Planning for individuals at risk of placement or currently placed in ACHs.

In this baseline report, the State has demonstrated its intention of complying with the provisions of the Settlement.

Settlement Agreement Reference	Provision	Rating	Comments
III.B.1	The State will develop and implement measures to provide individuals access to community based supported housing.		
III.B.2	Priority for the receipt of housing slots will be given to the following individuals:		
III.B.2.a	Individuals with smi who reside		
	in an adult care home determined by the state to be an IMD		
III. B.2.b	Individuals with smi who reside		
	in an adult care home licensed for at least 50 beds and in which 25% or more of the residents has a mental illness		
III.B.2.c	Individuals with smi who reside		
	in an adult care home licensed for between 20 and 49 beds and in which 40% or more of the residents has a mental illness		
III.B.2.d.	Individuals with smi who reside		
	who are or will be discharged from a state psychiatric hospital and who are homeless or have unstable housing		
III.B.2.e.	Individuals diverted from entry into adult care homes pursuant to the preadmission screening and diversion provisions of Section III(F).		
III.B.3	The state will provide access to 3000 housing slots in accordance with the following schedule		
III.B.3.a	By July 1, 2013, the State will provide Housing slots to at least 100 and up to 300 individuals		
III.B.4	The State shall develop rules to establish processes and procedures for determining eligibility for the Housing Slots consistent with this Agreement.		

Settlement Agreement Reference	Provision	Rating	Comments
III.B.5	The State will determine each year the proportionate allocation of slots, giving priority to individuals described in Section III(B)(2)(a)(b) and ©.		
III.B.7	Housing slots will be provided for individuals to live in settings that meet the following criteria		
III.B.7.a	They are permanent housing with tenancy rights		
III.B.7.b.	They include tenancy support services that enable residents to attain and maintain, integrated, affordable housing.		
III.B.7.c	They enable individuals with disabilities to interact with individuals without disabilities to the fullest extent possible		
III.B.7.d	They do not limit individuals' ability to access community activities at times, frequencies and with persons of their own		
III.B.7.e.	They are scattered site housing , where no more than 20% of the units in any development are occupied by individuals with a disability, except as set forth		
III.B.7.e.i	Up to 250 housing slots may be in disability- neutral developments, that have up to 16 units, where more than 20% of the units are occupied by individuals with a disability known to the state.		
III.B.7.g.i	If single occupancy housing is not available when a person is ready to transition to community based housing, he or she can choose to either live with a roommate or wait for single housing. He or she will receive the in-reach and discharge planning services and will remain eligible to receive a		

Settlement Agreement Reference	Provision	Rating	Comments
III.B.7.g.ii	Single family housing is not preferred; If an individual chooses to live in a single family house because no other housing is available, that individual will receive in reach services and will remain eligible to receive a		
III.B.8.	Housing slots cannot be used in adult care homes, family care homes, group homes, nursing facilities, boarding homes, assisted living residences supervised living settings or any setting required to be licensed.		
III.B.9.	Individuals will be free to choose other appropriate and available housing options, after being fully informed of all options available. Being fully informed means that an individuals has been provided information about the option of transitioning to supported housing, its benefits and the array of services and supports available. If an individual chooses a housing option that does not meet the criteria of Section III(B)(7), because a housing slot is not available, that individual will receive the in reach and discharge planning services and will remain eligible to receive a housing slot as soon as one is available.		

Settlement Agreement Reference	Provision	Rating	Comments
III.C.	The State shall provide access to the array and intensity of services and supports necessary to enable individuals with SMI in or at risk of entry in an adult care home to successfully transition to and live in community based settings. The State shall provide each individual receiving a housing slot with access to services for which that individual is eligible that are covered under the NC State Plan for Medical Assistance, CMS approved Medicaid 1915(b)(c) waiver, or the state funded service		
III.C.2	The State shall also provide individuals with SMI in or at risk of entry to adult care homes who do not receive a Housing Slot with access to services for which that individual is eligible that are covered under the NC State Plan for Medical Assistance, CMS approved Medicaid 1915 (b)(c) waiver, or the state funded array. Services provided with state funds to non Medicaid eligible individuals who do not receive a housing slot shall be subject to the availability of funds and in accordance with state laws and regulations regarding access to		
III.C.5	All ACT teams shall operate to fidelity to either the Dartmouth Assertive Community Treatment model or the Tool for Measurement of Assertive		

Settlement Agreement Reference	Provision	Rating	Comments
III.C.6	A person center service plan shall be developed for each individual, which will be implemented by a qualified person who is clinically responsible for ensuring that all elements and components of the plan are arranged for the recipient in a coordinated manner. Individual service plans will include psychiatric advance directives and/or crisis plans so that such measures can be incorporated into the response to		
III.C.7.	The State is in the process of implementing capitated prepaid inpatient health plans for Medicaid reimbursable mental health services. The state will monitor services and service gaps through contracts with the LME, will ensure that the number and quality of community mental health service providers is sufficient to allow for successful transition of individuals with SMI, who are in or at risk of entry to an adult care home, to supported housing, and for their long term stability and success as		
III.C.8	Each LME will provide publicity, materials and training about the crisis hotline services and the availability of information for individuals with limited English proficiency, as well as to all behavioral health providers, et al.		
	Peer supports, enhanced ACT, including employment support from employment specialists on ACT teams, etc. will be implemented in coordination with the current LME implementation		

Settlement Agreement Reference	Provision	Rating	Comments
III.C.9	By July 1, 2013, all individuals receiving ACT services will receive services from employment specialists on their ACT teams.		
III.C.9.a	By July 1, 2013, all ACT teams in the State will operate in accordance with a nationally recognized fidelity model and the State will increase the number of individuals served by ACT teams to 33 teams serving 3225		
III.C.10	The state shall require that each LME develop 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.		
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.		
III.C.10.c	Crisis services shall be provided in the least restrictive setting 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.		

Settlement Agreement Reference	Provision	Rating	Comments
III.D.1.	The State will develop and implement measures to provide supported employment services to individuals with SMI, who are in or at risk of entry to an adult care home. individuals access to community based supported housing.		
III.D.2	Supported employment services will be provided with fidelity to an evidence based supported employment model.		
III.D.3	By July 1, 2013, the state will provide supported employment services to a total of 100		
III.E	The State will implement procedures for ensuring that individuals with SMI in or later admitted to an adult care home or state psychiatric hospital will be accurately and fully informed about all community based options including the option of transitioning to supported housings, its benefits the array of services and supports, and the rental subsidy and other		

Settlement Agreement Reference	Provision	Rating	Comments
III.E.2	The state will provide or arrange for frequent education efforts targeted to individuals in adult care homes and state psychiatric hospitals. The state will target in reach to adult care homes that are determined to be IMDs. The in reach will include providing information about the benefits of supported housing, facilitating visits in such settings; and offering opportunities to meet with other individuals with disabilities who are living, working and receiving services. The in reach will be provided by individuals who are knowledgeable about community services and supports, including supported housing and will not be provided by operators of adult care homes. The state will provide in reach to adult care home residents on a regular basis,		
III.E.3	The state will provide each individual with SMI in or later admitted to an adult care home or state psychiatric hospital operated by DHHS with effective discharge planning and a written discharge plan		
III.E.4	Discharge planning will be conducted by transition teams that include:		
III.E.4.a	persons knowledgeable about resources, supports, services and opportunities available in the community;		

Settlement Agreement Reference	Provision	Rating	Comments
III.E.4.b	professionals with subject matter expertise about accessing needed community mental health care and for those with complex health care needs;		
III.E.4.c	persons who have the linguistic and cultural competence to serve the individual;		
III.E.4.d	peer specialists when available;		
III.E.4.e	with the consent of the individual, persons whose involvement is relevant to identifying the strengths, needs, preferences, capabilities and interests of the		
III.E.5	For individuals in state psychiatric facilities, the LME transition coordinator will work in concert with the facility team. The transition coordinator will serve as the lead contact with the individual leading up to transition from an adult care home or state psychiatric hospital, including during the transition team meetings and while administering		
III.E.6	Each individual shall be given the opportunity to participate as fully as possible in his/her treatment and discharge planning.		
III.E.7	Discharge planning begins at admission; is based on the principle that with sufficient services and supports, people with SMI can live in an integrated community setting; assists the individual in developing an effective written plan; is developed and implemented through a person-centered planning process in which the individual has a primary role and		

Settlement Agreement Reference	Provision	Rating	Comments
III.E.8	The discharge planning process will result in a written discharge plan that		
III.E.8.a	identifies the individual's strengths, preferences, needs and desired outcomes;		
III.E.8.b	identifies the specific supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes, regardless of whether those services and supports are currently available;		
III.E.8.c	includes a list of specific providers that can provide the identified supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes;		
III.E.8.d	documents any barriers preventing the individual from transitioning to a more integrated setting and sets forth a plan for addressing those barriers;		
III.E.8.d.i	such barriers shall not include the individual's disability or the severity of the disability.		
III.E.8.d.ii	For individuals with a history of readmission or crises, the factors that led to readmission or crises shall be identified and addressed.		
III.E.8.e	sets forth the date that transition can occur, as well as the timeframes for completion of all needed steps to effect the transition;		
III.E.8.f	prompts the development and implementation of needed actions to occur before, during and after the transition.		

Settlement Agreement Reference	Provision	Rating	Comments
III.E.9	DHHS will create a transition team to assist local transition teams in addressing and overcoming identified barriers preventing individuals from transitioning to an integrated		
III.E.10	The DHHS transition tam will ensure that transition teams (both state psychiatric hospitals and LME transition coordinators) are adequately trained. It will oversee the transition teams to ensure that they effectively inform individuals of community opportunities and will include training on person centered planning. The DHHS transition team will assist local transition teams in addressing identified barriers to discharge for individuals whose teams recommend that an individual remain in a state hospital or adult care home or recommend		
III.E.11	The transition team shall identify barriers to placement in a more integrated setting, describe steps to address the barriers and attempt to address the barriers, including housing. The state shall document the steps taken to ensure that the decision to remain in an adult care home or state psychiatric hospital is an informed one and will regularly educate the individual about the various community options open to the		

Settlement Agreement Reference	Provision	Rating	Comments
III.E.12	The state will reassess individuals with spmi who remain in adult care homes or state psychiatric hospitals for discharge to an integrated community setting on a quarterly basis or more frequently upon request. The state will update the written discharge plans as needed based on new information and/or developments.		
III.E.13a	Within 90 days of signing the agreement, the state will work with LMEs to develop requirements and materials for in reach and transition coordinators		
III.E.13.b	Within 180 days of signing the agreement, LMEs will begin to conduct ongoing in reach to residents in adult care homes and state psychiatric hospitals and residents will be assigned to a transition team.		
III.E.13.c	Transition and discharge planning for an individual will be completed with 90 days of assignment to a transition team. Discharge of an individual will occur within 90 days of assignment to a transition team provided that a housing slot is then available. If a housing slot is not available for an individual within 90 days of assignment to the transition team the transition team will maintain contact and work with the individual on an ongoing basis until the individual		

Settlement Agreement Reference	Provision	Rating	Comments
III.E.13.d.i	Within one business day after any adult care home is notified by the state that it is at risk of being determined to be an IMD, the state will also notify the Independent Reviewer, Disability Rights NC, and the applicable LME and county DSS.		
III.E.13.d.ii	The LME will connect individuals with SMI who wish to transition from the at risk adult care home to another appropriate living situation. The LME will also link individuals with SMI to appropriate mental health services. The LME will implement care coordination activities to address the needs of individuals who wish to transition from the at risk adult care home to		
III.E.13.d.iii	The state will use best efforts to track the location of individuals who move out of an adult car home on or after the date of the at risk notice. If the adult care home initiates a discharge and the destination is unknown or inappropriate as set forth in NC Session Law 2011-272, a discharge team will be convened.		

Settlement Agreement Reference	Provision	Rating	Comments
III.E.14	The State and/or LME shall monitor adult care homes for compliance with the Adult Care Home Residents Bill of Rights contained in Chapter 131D of the NC General Statutes and 42 CFR. 438.100. The State will ensure that each individual is free to exercise his or her rights and that the exercise of rights does not adversely affect the way the LME, providers or state agencies treat the enrollee.		
III.F.1.	Beginning January 1, 2013 the state will refine and implement tools and training to ensure that when any individual is being considered for admission to an adult care home, the state shall arrange for a determination by an independent screener of whether the individual has SMI. The state shall connect any individual with SMI to the appropriate LME for a prompt determination of eligibility for mental health		
III.F.2	Once an individual is determined to be eligible le for mental health services, the State and/or LME will work with the individual to develop and implement a community integration plan. The individual shall be given the opportunity o participate as fully as possible in this process.		

Settlement Agreement Reference	Provision	Rating	Comments
III.F.3	If the individual, after being informed of the available alternatives to entry into an adult care home, chooses t transition into an adult care home, the State will document the steps taken to show that the decision is an informed one. The state will set forth and implement individualized strategies to address concerns and objections to placement in an integrated setting and will monitor individuals choosing to reside in adult care homes and continue to provide in reach and transition		
III.G.1.	The state will develop and implement a quality assurance and performance improvement monitoring system to ensure that community based placements and services are developed in accordance with this agreement, and that the individuals who receive services or housing slots are provided with the services and supports they need for their health, safety and welfare. The goal will be that all mental health and other services and supports funded by the State are of good quality and are sufficient to help individuals achieve increased independence, gain greater integration into the community, obtain and maintain stable housing, avoid harms and decrease the incidence of hospital		

Settlement Agreement Reference	Provision	Rating	Comments
III.G.2	A DHHS Transition Oversight Committee will be created to monitor monthly progress of implementation of this Agreement and will be chaired by the DHHS Designee .LMEs will be responsible for reporting on discharge related measures, including but not limited to Housing vacancies; discharge planning and transition process; referral process and subsequent admissions; time between application for services to discharge destination; and actual admission date to community		
III.G.3	DHS agrees to take the following steps related to QAPI:		
III.G.3.a	Develop and phase in protocols, data collection instruments and database enhancements for ongoing monitoring and		
III.G.3.b	Develop and implement uniform application for institutional census tracking;		
III.G.3.c	implement standard report to monitor institutional patients length of stay readmissions and community tenure;		
III.G.3.d	develop and implement dashboard for daily decision support		
III.G.3.e	develop and implement centralized housing data system to inform discharge planning		
III.G.3.f	Develop and utilize template for published, annual progress		
III.G.3.g	Develop and utilize monitoring and evaluation protocols and data collection regarding personal outcomes measures, which include the following:		
III.G.3.g.i	number of incidents of h arm		

Settlement Agreement Reference	Provision	Rating	Comments
III.G.3.g.ii	number of repeat admissions to state hospitals, adult care homes, or inpatient psychiatric facility		
III.G.3.g.iii	use of crisis beds and community hospital admissions		
III.G.3.g.iv	repeat emergency room visits		
III.G.3.g.v	time spent in congregate day programming		
III.G.3.g.vi	number of people employed, attending school or engaged in community life		
III.G.3.g.vii	maintenance of a chosen living arrangement		
III.G.4	The state will regularly collect, aggregate and analyze data related to in reach and person centered discharge and community placement efforts, including but not limited to information related to both success and unsuccessful placements, as well as the problems or barriers to placing and/or keeping individuals in the most integrated setting. The state will review this information on a semi annual basis and develop and implement measures to overcome the problems and barriers identified.		
III.G.5	The state will implement three quality of life surveys to be completed by individuals with smi who are transitioning out of an adult care home or state psychiatric hospital. The surveys will be implemented (1) prior to transitioning out of the facility; (2) eleven months after transitioning out of the facility; and (3) 24 months after transitioning gout of the facility.		

Settlement Agreement Reference	Provision	Rating	Comments
III.G.6	The state shall complete an annual LME EQR process which an EQR organization, through a specific agreement with the state, will review LME policies and processes for the state's mental health service system. EQR will include extensive review of LME documentation and interviews with LME staff. Interviews with stakeholders and confirmation of data will also be initiated. The reviews will focus on monitoring services, reviewing grievances and appeals received, reviewing medical charts, and any individual provider follow up. EQR will provide monitoring information		
III.G.6.a	Marketing		
III.G.6.b	Program integrity		
III.G.6.c	Information to beneficiaries		
III.G.6.d	Grievances		
III.G.6.e	Timely access to services		
III.G.6.f	Primary care provider/specialist capacity		
III.G.6.g	Coordination/continuity of care		
III.G.6.h	Coverage/authorization		
III.G.6.i	Provider selection		
III.G.6.j	Quality of care		
III.G.7	Each year, the state will aggregate and analyze the data collected by the State, LMEs, and the EQR organizing on the outcomes of this agreement.		
III.G.8a	The state will publish on the DHHS website an annual report identifying the number of people served in each type of setting and service described in this		

Settlement Agreement Reference	Provision	Rating	Comments
III.G.8.b	The annual report will detail the quality of services and supports provided by the state and its community providers using data collected through the quality assurance and performance improvement system, the contracting process, the EQRs, and the o outcome data described above.		