

**FY 2020 FINAL ANNUAL REPORT OF THE INDEPENDENT REVIEWER**

**In the Matter Of**

**UNITED STATES OF AMERICA v. THE STATE OF NORTH CAROLINA**

**Case 5:12-cv-00557-D**

**Submitted By: Martha B. Knisley, Independent Reviewer**

**March 1, 2021**

## Table of Contents

<b>EXECUTIVE SUMMARY .....</b>	<b>3</b>
<b>INTRODUCTION .....</b>	<b>9</b>
<b>METHODOLOGY .....</b>	<b>10</b>
<b>INDIVIDUAL REVIEW FINDINGS .....</b>	<b>14</b>
<b>I. COMMUNITY-BASED SUPPORTED HOUSING SLOTS.....</b>	<b>19</b>
<b>II. COMMUNITY BASED MENTAL HEALTH SERVICES.....</b>	<b>37</b>
<b>III. SUPPORTED EMPLOYMENT .....</b>	<b>.55</b>
<b>IV. DISCHARGE AND TRANSITION PROCESS.....</b>	<b>70</b>
<b>V. PRE-ADMISSION SCREENING AND DIVERSION .....</b>	<b>93</b>
<b>VI. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT.....</b>	<b>101</b>
<b>ATTACHMENT A: STATE AND LME/MCO REVIEW FINDINGS.....</b>	<b>111</b>
<b>ATTACHMENT B: SPH DISCHARGE PLANNING FINDINGS .....</b>	<b>124</b>
<b>ATTACHMENT C: FY 2020 INTERIM REPORT.....</b>	<b>129</b>

## EXECUTIVE SUMMARY

This is the Executive Summary of the FY 2020 Final Annual Report<sup>1</sup> 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 Independent Reviewer submits an annual report each year of this Agreement. The report documents North Carolina's (the State's) progress in meeting July 1, 2020, requirements, and the State's overall progress in meeting all the Settlement Agreement (SA) obligations by July 1, 2021.

The State is on track to meet one of six major Settlement Agreement requirements, Pre-screening and Diversion, in FY 2021 and to meet two major milestones of the critical Supported Housing requirement: 1) three thousand (3,000) individuals living in supported housing slots before July 1, 2021; 2) individual have access to housing; and close to meeting a third requirement that individuals are provided housing with tenancy rights, housing locations that don't limit community activities and individuals have a choice of daily living activities. The State is not on track to meet the Supported Housing requirement for two thousand (2,000) individuals to move from an adult care home and occupy a supported housing slot. This requirement is one of the main sub-requirements in this Settlement Agreement and is at the heart of the alleged *Olmstead* violations leading to this Agreement.

Nonetheless, the State increased the number of individuals living in supported housing by three hundred and thirty-one (331) between March 1, 2020, and December 31, 2020. Many In-reach staff, Transition Coordinators, and service providers risked their own safety during this pandemic to ensure that if individuals wanted to move from institutions where they were living in extremely close contact with other people or living in unsafe community locations, they would find a way to assist them to move. They helped individuals remain safely isolated in their own home.

Based on current information, the State's current and immediate plans, and progress to date, the State is making substantial progress towards meeting up to four (4) of fourteen (14) Discharge and Transition Process requirements in FY 2021. The State cannot meet the Community-Based Mental Health Services, Supported Employment and Quality Assurance and Performance Improvement requirements by July 1, 2021.

This report will reference the program the State designed to comply with the obligations of the SA, as the Transitions to Community Living Initiative (TCLI). Individuals identified for TCLI are eligible for assistance with the Discharge and Transition Process including diversion from adult care homes (ACHs). Individuals may gain TCLI eligibility through a required pre-screening process, get access to and assistance with Supported Housing, Community-Based Mental Health Services, and Supported Employment. The Settlement Agreement requires

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<sup>1</sup> Annual reports are submitted for the State's fiscal year which begins on July 1 and ends on June 30 each year.

the State to develop and implement a Quality Assurance and Performance Improvement system to ensure that community-based placements and services are in accordance with this Agreement.

The worst health crisis in the United States in the past one hundred years stymied the State's efforts to meet all the FY 2020 requirements and has delayed progress to meet FY 2021 requirements. It has also interfered with the Independent Reviewer's planned field work to fully measure the State's progress toward compliance with all the 2012 Settlement Agreement requirements. Knowing that the review would take longer to complete, the Reviewer has submitted the Annual Report in two parts. The first was an Interim Report submitted to the Parties on November 15, 2020, which included information and findings for items assessed at the end of the FY 2020 fiscal year. This Final FY 2020 Annual Report includes findings that required the Reviewer to complete field work in the first four months of FY 2021 when it was determined safer to conduct reviews in the community. This extra time afforded the Reviewer the opportunity to complete the field work necessary to complete this Annual Review. Given that FY 2021 was the last scheduled year of the Settlement Agreement, this report also includes progress and findings for information reported to the Reviewer through the end of calendar year 2020. This enabled the Reviewer to project that the State will meet several important Settlement Agreement requirements by July 1, 2021.

This report includes information from one hundred and forty-eight (148) interviews, including forty-seven (47) interviews and desk reviews referenced in this report as the "fall 2020 review<sup>2</sup>." A desk review includes a review of records and transition timeframes, and an interview of service provider(s) and staff of the Local Management Entities/Managed Care Organizations (LME/MCOs). There were twenty-seven (27) joint interviews of state psychiatric hospital (SPH) and LME/MCOs staff.

Below are brief, specific findings in each of the six major Settlement Agreement requirements.

The state made progress meeting the **Section III. (B)(3) Community-Based Supported Housing** requirement for individuals occupying housing slots, falling short of its FY 2020 requirement to fill two thousand five hundred and fifty-four (2,554) by just four (4) slots, despite the challenging last four months of the reporting year because of the pandemic. The State made excellent progress in the first six months of FY 2021 enabling individuals to occupy housing slots and will meet the requirement for three thousand (3,000) individuals to be occupying housing slots by July 1, 2021.

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<sup>2</sup> This report includes a number of references to a fall 2020 review. The fall 2020 review includes first person interviews with individuals eligible for TCLI benefits, including supported housing, services and supports, LME/MCO staff, service providers, State staff including State Psychiatric Hospital staff and Guardians. The review also included a review of documents including but limited to clinical records and reports.

As referenced in the Interim Report, the NC Department of Health and Human Services (DHHS) has partnered closely over the last several years with the State's Housing Finance Agency (NC HFA) to improve the capacity of the State's supported housing system for adults with Serious Mental Illness (SMI) and Serious and Persistent Mental Illness (SPMI). This inter-agency collaboration has allowed the State to develop new affordable, accessible housing and make more housing options available, leverage multiple types of federal funds, and improve its decision-making tools and technical assistance. This collaboration has reduced the problem of housing availability, although it will always remain a challenge; affordable housing for individuals with low incomes and other barriers is a nationwide issue.

Availability is no longer the greatest barrier to the State meeting its housing obligations. Ensuring access to safe affordable housing with support for daily living activities is a greater challenge especially for individuals living in ACHs, those with health challenges and/or with criminal justice backgrounds, The DHHS and NC HFA have built the infrastructure, established processes and reduced barriers for individuals with those challenges. The LME/MCO Housing Specialists have built stronger relationships with landlords and property managers. These steps have enabled the State to make progress meeting **Section III. (B)(1)** but the State's performance implementing discharge and transition process requirements **Section III. (E)** are not yet effective for a significant number of individuals eligible for TCLI to gain access to supported housing in a timely manner if at all.

The State did not make progress, however, toward providing supported housing for two thousand (2,000) individuals exiting adult care homes to occupy supported housing slots, as required in **Section III. (B)(5)** of the SA to occur by July 1, 2021.

The State is continuing to make progress to provide pre-and post-tenancy support to ensure individuals have access to housing, with tenancy rights, and housing that affords individuals choice in daily activities, community activities of their choosing, and with access to non-disabled individuals as required in **Section III. (B)(7)**.

The fall 2020 review revealed the State's performance is far short of meeting requirements in **Section III. (C) Community-Based Mental Health Services** for providing access to the array, frequency, and intensity of individualized recovery-based services and supports necessary to enable individuals to transition to and live in community-based settings. These findings are based on reviews of sixty-five (65) individuals living in the community, either in supported housing or in other locations<sup>3</sup> in the Fall 2020 review and other documentation related to the provision of community based mental health services. The state achieved slightly higher scores on the requirement for staff to assist individuals to access natural supports and to utilize natural

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<sup>3</sup> Individuals living in the community but not living in supported housing may have been issued a housing slot but either chose not to use it or have left their supported housing unit and remain eligible for supported housing, services and supports.

supports to prevent crises, but the State's performance was still insufficient to meet these requirements.

The person-centered planning process scores were extremely low, with slightly more than forty percent (40%) of individuals having a person-centered plan that fully or even partially meets requirements. The process is often formulaic and repetitive and not individualized; sometimes the plans only included the instructions for filling out the form and not responses to the instructions. The Plans are often out of date and often new plans are the same as previous plans. Securing service authorizations appears to be the primary purpose for completing these plans. Likewise, the scores were in the same low range on the requirement that the individual get individualized services that are recovery-oriented and provided with the flexibility and intensity needed. Community-Based Mental Health Services requirements are the cornerstone requirements of this agreement and essential for individuals with a serious mental illness to live in the most integrated setting possible.

The State met the requirement to adopt an evidence-based supported employment model, Individual Placement and Support (IPS-SE) in 2013 as required **Section III. (D)(2)**. But the State is not meeting the requirements in **Section III. (D)(1) Supported Employment** to develop and implement measures to provide supported employment to individuals "in or at risk of entry into" adult care homes. The State needs to take further action to demonstrate that individuals in TCLI, who are interested in employment, get the opportunity and access to supported employment and are provided assistance with preparing for, identifying, and maintaining employment. The fall FY 2020 reviews revealed that of the thirty-eight (38) individuals indicating an interest in employment and/or education, only four (4) received support to pursue this interest. Not all providers utilize vocational rehabilitation funding, there is limited interaction between the individual's service provider and their IPS-SE team, and there is a limited number of supported employment providers that meet fidelity as required in the Settlement Agreement in some areas of the state. It is more understandable that this would be a challenge in rural areas, but the problems were also present in some urban areas.

The State took one major step in FY 2020 toward its **Section III.(D)(1)** obligation to increase the effectiveness of the IPS-SE program. This step was to test out a new financing and incentive model to increase TCLI referrals and to cover expenses for individual engagement and follow-along supports. This model contemplates a full partnership between LME/MCOs, service providers, and counselors from the Division of Vocational Rehabilitation (VR). The model is in a pilot phase with the Vaya LME/MCO, its provider agencies, and VR. The pilot program, referred to as NC CORE, began in January 2020 and was beginning to show good preliminary results when COVID delayed job searches and a number of service recipients disengaged. Managing this process requires the pilot's managers to have cross-systems data (VR, mental health, and

Medicaid) to track results and demonstrate the effectiveness of the model to assist individuals in TCLI to get and maintain employment.

The State was slow in completing a data-sharing agreement between three Department of Health and Human Services (DHHS) divisions responsible for financing and implementing IPS-SE and is still in the early phase of implementing this agreement. This agreement is vital for the State to measure the effectiveness of this model, which in turn is vital to determine what steps are necessary to meet the SA's Supported Employment requirements. The State has discussed expansion of this model, but planning is still in an early stage and, as evidenced by the NC CORE pilot, may require more time, given COVID and continued lack of referrals for individuals in the "in or at risk" and TCLI group.

It is also not clear that the State met the FY 2020 metric in **Section III. (D)(3)**, requiring it to provide **IPS-SE** services to two thousand one hundred and ninety-three (2,193) people in the target population, because nearly twenty percent (20%) of the two hundred and eighteen (218) individuals verified as eligible to receive the service were in the count as "provided" the service in FY 2020 through April 1, 2020. By October 1, 2020 that the number of individuals in that group receiving supported employment services dropped to forty percent (40) when there was no evidence from claims data indicating individuals received a service. Information from the fall 2020 review and follow-up analysis also revealed that the State needs to refine the verification process to accurately track the number of individuals provided Supported Employment Services who are "in or at risk of" adult care home placement. A review of this requirement will take place again prior to the end of FY 2021.

The **Section III. (E) Discharge and Transition Process** review covered the discharge and transition process for three groups of individuals: those admitted to and then discharged from state psychiatric hospitals, those exiting ACHs, and those diverted from admission to ACHs. The COVID outbreak led to restricted access to adult care homes, so the fall 2020 review included only five (5) ACH visits to interview six (6) individuals. The psychiatric hospitals were mostly successful in controlling the COVID outbreak, providing an opportunity to conduct twenty-three (23) joint interviews with state psychiatric staff and LME/MCOs in August and September and another three (3) in November. These were in addition to interviews conducted in psychiatric hospitals in June and July, reported on in the FY 2020 Interim Report. There was also an opportunity to review thirty-three (33) individuals diverted from ACHs, including individuals who had recently transitioned into the community, were living in supported housing or other community locations, or had returned to an ACH.

In-reach staff did not always make frequent contact with individuals who expressed interest in moving or provide them with accurate information. There was evidence that over time there were increasingly fewer issues brought to the State's Barriers Committee addressing transition barriers and of staff being unclear on their responsibilities to document, report, and mitigate

barriers. Some of these “follow-through” delays were related to COVID, as was a failure to facilitate community visits for individuals considering a move to supported housing. The review team reviewed the timelines of transitions that occurred before and after the onset of the COVID pandemic, along with other records and progress notes. These reviews revealed that patterns of infrequent contact with individuals on in-reach and not facilitating community visits occurred both before and after COVID restrictions took effect.

On a positive note, the State has continued to address discharge, in-reach, and transition process challenges, including developing a new jointly informed decision-making tool, remediating some critical barriers, and challenging LME/MCOs to report barriers as they arise. The state is creating action plans to address these critical issues, establish and monitor performance, and give attention to improving access requirements. The State is on track to meet four (4) of the fourteen (14) Discharge and Transition Process sub-requirements and if the State takes prompt action, the State can potentially meet the discharge and transition process requirements in the next twelve months.

The State failed to provide information on five (5) of eight (8) **Section III. (G) Quality Assurance and Performance Improvement** requirements. This includes information on steps the State is taking to develop and implement a quality assurance and performance improvement system. The State is now seeking assistance from an outside firm to develop a State QA/PI system to meet the Settlement Agreement requirements. The State continues to report information on their External Quality Review (Medicaid requirement) and has established a Transition Oversight Committee. The State requires LME/MCOs to conduct quality of life surveys, but the method used typically yields similar results regardless of the individual’s experience. The Settlement Agreement does not specify the type of survey to use, just the timing of the survey. However, other more useful methods are available and could provide better information that is more helpful to individuals and to staff.

Many dedicated individuals, state psychiatric hospital staff, and LME/MCO and service provider staff worked tirelessly this year to assist individuals to move to and continue to live in their own home even in light of the COVID pandemic. State staff made progress to implement selected requirements of this Agreement, that when implemented help individuals transition and live successfully in the community. But the fall FY 2020 review brought to mind the final phrase from the FY 2018 Reviewer’s Annual Report, still an all-too-common refrain:

*So many individuals voiced their 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 is also community, faith, friends, acquaintances, and family. It is a safe and decent home, a job and/or activities that an individual finds rewarding and fulfilling.*

## INTRODUCTION

This is the Final FY 2020 Annual Report<sup>4</sup> on the status of North Carolina's compliance meeting requirements with the provisions of the Voluntary Settlement Agreement (SA) in United States v. North Carolina (Case 5:12-cv-000557-D) signed on August 23, 2012. The final report documents North Carolina's (the State's) overall progress in meeting the Settlement Agreement (SA) obligations. The final FY 2020 Annual Report follows a FY 2020 Interim Annual Report submitted to the Parties on November 15, 2020. This report repeatedly references the title of the State's approach and programs designed to comply with the obligations of the SA, which is known as the Transitions to Community Living Initiative (TCLI). Individuals are determined eligible for TCLI based on three criteria: 1) they are living in an adult care home (ACH), at risk of moving into an adult care home, in or discharged from a state psychiatric hospital (SPH) or discharged from a SPH to unstable housing; 2) their diagnosis; and 3) their functional needs. Individuals found eligible can get access to in-reach, transition, diversion, supported housing, and supported employment.

The worst health crisis in the United States in the past one hundred years stymied some of the State's efforts to meet the FY 2020 requirements and interfered with the Independent Reviewer's planned field work to measure the State's progress toward compliance with all the Settlement Agreement requirements.

As noted in the Interim Report, Governor Cooper issued Executive Orders the second week in March, suspending visitations to Adult Care Homes (ACHs) and severely restricting travel, in person meetings, and other activities necessary for the State, its Local Management Entities/Managed Care Organizations (LME/MCOs), and housing organizations to expand services and make more supported housing available. This resulted in slowing down the work of housing specialists and community outreach workers. The State focused its attention and energy on this unprecedented crisis. The Independent Reviewer suspended all in-person community-based reviews, including halting planned field work scheduled from March 23 through June 5, 2020.

With encouragement of the Parties, the review process for the Interim Report included virtual reviews with State and local staff and data analysis. Fiscal year<sup>5</sup>-end data was available, but with adjustments in the analysis and projections to account for the fifteen-week disruption.

There were limits to the virtual review process due to the disruptive nature of the pandemic. Staff focused on shifting responsibilities to crisis management, providing new guidance, and changing regulations and reimbursement requirements for LME/MCOs and providers, and assisting community-based staff with getting needed resources. This was especially true with

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<sup>4</sup> The Settlement Agreement requirements extend through July 1, 2021.

<sup>5</sup> The State's fiscal year is July 1 through June 30 the following year. The Reviewer's Annual Report covers the same period of time.

providing resources for supported housing because it is a safer place for an individual to live in their home with social distancing than living in an institution, on the street, or in a shelter where precautions are more difficult to maintain. The State and LME/MCOs recognized this fact and took steps to assist individuals to live in the safe places when possible.

This FY 2020 Final Annual Report will reference the findings of the Interim Report but does not repeat background material and rationale for those findings. Instead, this final report focuses on findings from reviews conducted in the fall of 2020 and from information collected on trends that emerged in the first two quarters of FY 2021 where those trends and other factors made it possible to make FY 2021 projections.

The fall review included one hundred and forty-eight (148) interviews with target population members and/or separate interviews with LME/MCO, service providers, state psychiatric hospital staff, and in a few instances, other key informants and guardians. These were all accompanied with additional “desk” reviews of relevant progress and care coordination notes, person centered plans, clinical assessments, discharge summaries, timelines, and transition materials.

The most reliable method to determine the State’s performance in meeting many of the Settlement Agreement requirements, especially related to adequacy of housing and tenancy support, discharge, transition and diversion processes, community-based services, and supported employment, is an individual interview accompanied by interviews with staff and key informants, including guardians. This method provides qualitative and quantitative information regarding whether the individual can make their own choices and get individualized recovery-based services and supports with the frequency, duration, and intensity needed for success in the community.

## **METHODOLOGY**

Field work included interviews with individuals eligible for TCLI benefits followed by a desk review for each individual. A desk review includes a review of records and transition timeframes, an interview of service provider(s), and interviews of staff of the Local Management Entities/Managed Care Organizations (LME/MCOs) for each individual selected for a review. This process was supplemented with desk reviews for additional individuals and desk reviews of individuals identified as meeting TCLI requirements and hospitalized at (or recently discharged from) one of the three state psychiatric hospitals (SPHs). Figure 1 identifies the numbers of individuals by type of review:

**Figure 1: Numbers of Individuals Reviewed by Type of Case Reviews in the Fall 2020 Review**

Review Types	In-Person Interviews and Desk Reviews	2 <sup>nd</sup> Review
In-Person Interviews	47	0
Desk Review <sup>6</sup> for Individuals Interviewed	47	0
Desk Reviews Only	28	4 <sup>7</sup>
SPH Desk Reviews	23	3

In addition to the fall 2020 reviews, the team conducted a special review of three (3) individuals referred to TCLI after admission to Broughton State Hospital in November 2019 and twenty-three (23) other individuals admitted to Broughton in September and October 2019. The team conducted fourteen (14) SPH discharge reviews in June and July 2020 and reported on both reviews in the FY 2020 Interim Report. The review team was unable to conduct interviews with four (4) individuals selected for a review: the team made two unsuccessful attempts to locate one (1) individual; one (1) individual was living in a skilled nursing facility; one (1) individual refused an interview, and one (1) individual was in jail. The Review Team performed a desk review of three (3) of these four (4) individuals.

This report follows the same methodology used in the reports for the four previous years, with two exceptions. The first change was that many case reviews included in-person interviews, but the review team also performed many case reviews this year as “desk” reviews only. In-person interviews are essential to gauge any differences in the individual’s experience and needs, especially for frequency and intensity of services based on the individual’s requests and needs as documented in the individual’s record. First person interviews also provide the opportunity for the Reviewer and her team to see where the individual lives as well as obstacles the location presents to the individual’s access to community amenities, friends, family, and services. An individual’s space is revealing in determining the individual’s accessibility needs and needs for personal support. Simply said, in-person interviews are essential to determine if the State is meeting the Settlement Agreement (SA) Supported Housing, Discharge and Transition Process, Community-Based Mental Health Services, Supported Employment, and Diversion requirements.

However, there was limited opportunity to conduct interviews and travel was more challenging during COVID. The Reviewer chose to conduct in-person interviews during October and November when the COVID risk was lower than during the spring and summer

<sup>6</sup> Desk reviews included a combination of staff (LME/MCO, SPH and service providers) interviews and chart reviews.

<sup>7</sup> These second reviews were conducted to review additional information and/or conduct a follow-up interview following the first desk review.

and before the expected winter surge.

The second change from prior reviews is that, with considerable input from the parties, the Review Team developed standards to measure those SA requirements that do not contain numeric measures.

Developing standards allowed the Review Team to score the State's performance in meeting specific, non-numeric requirements. In each review, the Review Team scored up to forty-six (46) requirements or sub-requirements as one of the following: fully consistent with the requirement (yielding a score of 3), partially consistent with the requirement (scoring a 1), or not consistent with the requirement (a score of 0). If an individual was only receiving In-reach services or In-reach and Transition Services, the reviewer may have only scored items related to those services. Likewise, if an individual has been living in the community for a number of years and no longer receiving In-reach or Transition services, the reviewer only scored applicable supported housing, community-based mental health services, and supported employment items.

The questions reviewers asked often covered multiple sub-requirements especially questions in the Discharge and Transition Process section as those requirements tend to be overlapping in nature. Some of the numbers associated with individual reviews may be different than the numbers of the types of reviews listed above based on questions we were unable to get answers for at the time of the review.

The standards the Review Team developed with the parties provide specificity to the SA requirements for items that do not include numeric measures. For each of these standards, the Reviewer referenced verification methods; sources of information; criteria for meeting a requirement, partially meeting a requirement, or not meeting a requirement; and applicable scores for meeting a requirement. The Parties reviewed proposed standards, recommended changes, and based on changes, accepted the standards and the methods as valid for this review.

Each new member of the Review Team met inter-rater reliability requirements and had the benefit of a second Review Team member in thirty-five percent (35%) of the reviews. The Independent Reviewer case-judged each review. The review documents included descriptions for each finding for each of the requirements.

For requirements not scored or not including numeric measures, the team reviewed the State's policies and practices based on the measures, norms, or models in comparative evaluations and standard practices across multiple jurisdictions, as well as its demonstrated success in establishing and implementing programs that achieve outcomes consistent with those required in this Settlement Agreement.

With respect to the SA obligations containing numeric measures, the State collects data to

report progress in meeting those requirements. The Reviewer verifies that the State's collection processes yield valid information and reviews the accuracy of data and written materials through interviews and responses to interview questions on a routine basis. This year, the Reviewer could not verify that data collected and reported for the number of individuals provided Supported Employment **Section III. (D)(3)** was correct. There is an explanation of this problem in the Supported Employment section of this Annual Report along with a recommendation on steps to correct the problem.

The Review Team assessed the State's progress in meeting the provisions of the Settlement Agreement through monthly work sessions, data analysis, and review calls with State staff on Pre-Screening, Supported Housing, and Supported Employment, as well as frequent contact to clarify data and information from the more formal review calls. The Reviewer also assessed progress through discussions with providers and community stakeholders, LME/MCO reviews, SPH and LME/MCO interviews, and chart reviews for individuals recently discharged from SPHs. The calls with LME/MCOs included three (3) supported housing calls, five (5) supported employment calls, and two (2) pre-screening calls divided across the LME/MCOs.

In addition to the SPH reviews, the Reviewer and members of the team met with LME/MCO staff, including TCLI teams, network management, care coordination, utilization management, housing, and agency leadership. The reviews covered Pre-screening (2 LME/MCOs), Supported Housing (4 LME/MCOs), and Supported Employment (4 LME/MCOs). Provider staff participated in the Vaya Supported Employment interviews. The Reviewer interviewed DHHS and NC Housing Finance Agency (HFA) staff. Each team received a list of questions to either submit responses beforehand and/or be prepared to answer in the interview. Each questionnaire included questions to measure the State's progress, or lack thereof, and challenges meeting the recently developed standards for each of the requirements in the SA.

Elizabeth Jones, Damie Jackson-Diop, and Patti Holland continued to provide assistance with reviews and interviews. Charlyne Boyette, Dr. Beth Gouse, David Lynde, and Katherine Burson joined the team in FY 2020 to provide expert consultation in anticipation of a more comprehensive review in the Spring of 2020. Earlier reports referenced their experience, expertise, and professional affiliations and credentials.

Since five (5) of these individuals do not live in North Carolina, the Reviewer added four (4) in-state reviewers for the fall review. The Reviewer added Kim Maguire, formerly Consumer Affairs Coordinator for Partners Behavioral Health LIME/MCO. Kim has over twenty years' experience in housing and services development and in human services management in the Gastonia, NC, community. While working at Partners, Kim contributed to the development of TCLI across the state. The Reviewer also contracted with Peer Voice NC for the services of three (3) reviewers with lived experience. Contracting through Peer Voice provided the opportunity

to work with one organization and adjust times and reviewers as needed. Peer Voice NC is a statewide coalition of peer run organizations that have come together to build peer leadership and impact policies, practices, and systems for individuals with mental health and/or co-occurring substance use disorders. The US Department of Health and Human Services Substance Abuse Mental Health Services Administration (SAMHSA) designated Peer Voice as the North Carolina peer led coalition to build a unified, vocal, and influential statewide peer and “consumer” organization in North Carolina.

### INDIVIDUAL REVIEW FINDINGS

Individual reviews capture the three most important aspects of this Agreement. One, what is the individual’s experience of what they are receiving, or not receiving, in helping them live in the most integrated setting possible? Two, what support and assistance did the individual receive to get and keep housing and/or employment and other essential services and supports based on their expressed and apparent needs as determined from interviews and documentation? Three, did those experiences and support match the actions required in the Settlement Agreement? Individual reviews are the best source for capturing primary source data which is valuable to get firsthand rather than secondary that that is also valuable but must be interpreted. Answering these questions enables the Reviewer to assess whether the steps the State is taking to “develop and implement 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 individual needs,” as required by **Section III. (A)**, will enable the State to meet the Settlement Agreement’s requirements.

Individual interviews help assess events, precursors to potential problems, and challenges an individual is facing. Interviews and chart reviews provide a clear picture not always found in data in determining how well a team works together, across organizations when necessary; why a team, provider, LME/MCO, and the State are or are not making progress; and what needs to happen for the State to meet the Settlement Agreement’s requirements. Overall, the review team has conducted seven hundred and seventy-nine (779) individual reviews over the past five and a half years, as part of the Individual Review process. In past years, there were special reviews relating to critical performance issues.

As referenced in the Methodology section, names drawn for this review came from the State’s “Transitions to Community Living Database” of individuals who are eligible for services and housing as defined in the SA. One of the categories, individuals living in adult care homes, had fewer names pulled because visiting adult care homes during the COVID pandemic was so challenging. A follow-up review of this group will occur in the near future.

The Fall 2020 reviews revealed guardian resistance to allowing individuals in their care to consider receiving services in the most integrated setting appropriate to their needs. Two (2) family guardians and two (2) public guardians for individuals in this review sample have consistently refused over time to consider listening to any alternatives an individual may have to living in an adult care home. One (1) public guardian insisted on placing an individual in an unlicensed group residence.

The reviews exposed some of the challenges and opportunities that arise when target population members have guardians. Reviewers identified problems with fourteen percent (14%) of individuals with guardians although one individual’s brother posed as a guardian and prevented his brother from access to community living. Staff from one (1) LME/MCO failed to engage two (2) family guardians to explain the TCLI choices, allowing an SPH social worker—who was likely less knowledgeable about TCLI—to do that instead. One (1) public guardian refused to consider a supported housing placement for an individual although she arranged for him to move to an unlicensed congregate setting where he was required to pay nearly eighty percent (80%) of his income in rent and pay for his own meals. One (1) individual’s family member attempted, with support from adult care home staff, to stop a Review Team member’s interview with an individual. The Review Team member persisted and interviewed the individual. The family member is not the individual’s guardian. On the other hand, three (3) guardians appeared to appreciate the work of the LME/MCO TCLI teams, of supported housing, and of the services and supports individuals were receiving.

**Figure 2: Demographic, Living Settings, Guardian, FY15-FY20 Reviews**

Categories	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Average age <sup>8</sup>	54	49	55	60	47.2 <sup>9</sup>	45
Female	37%	43%	54%	52%	49%	31%
Male	63%	57%	46%	47%	51%	69%
Living in SH with TCLI Housing	37%	45 (43%)	33(28%)	18 (47%)	30(28%)	42(40%)
Living in an ACH	28%	29(28%)	35 (30%)	13 (34%)	16(15%)	12(11%) <sup>10</sup>
Hospitalized in an SPH	11%	9 (9%)	16(14%)	2(1%)	10(10%)	23(23%)
Living in another location <sup>11</sup>	24%	29(27%)	33 (28%)	4 (10%)	49(47%)	27(26%)
Has a guardian	70%	37%	30%	15%	30% <sup>12</sup>	22%

<sup>8</sup> The review team was unable to obtain the ages of six (6) individuals being pre-screened or unknown to the LME-MCO.

<sup>9</sup> In FY 19, there were reviews conducted on forty-nine (49) individuals being pre-screened before admission to an Adult Care Home (ACH) or in diversion status. This population is younger than individuals being discharged from ACHs. The pre-screening cohort average age was 44 and the average of individuals not going through pre-screening was 50.

<sup>10</sup> One individual temporarily moved to a Skilled Nursing Facility.

<sup>11</sup> There was no information available on where twelve (12) individuals were living who were in the pre-screening process at the time of the review in FY 2019. Eleven (11) or 41% of individuals not in or having gone through the new pre-screening process of individuals living in the community were not living in Supported Housing.

<sup>12</sup> There was information regarding guardianship on only ninety-seven (97) individuals.

As referenced in **Figure 2**, in FY 2020, seventy-two (72) or sixty nine percent (69%) of one hundred and five (105) individuals in the fall review sample were men and thirty-three (33) or thirty one percent (31%) were women. The average age of the individuals in the individual reviews was forty-five (45). Service needs may differ for individuals in different age cohorts, which has significance for what services the State needs to make available in the service array.

Age: The number of individuals under the age of forty (40) increased slightly, reducing the average to forty-five (45). This may be the result of reducing the sample size of individuals living in ACHs during the pandemic and increasing the sample of individuals in the SPH transition process (**Figure 3**).

**Figure 3: Age Distribution**

	21-30	31-40	41-50	51-60	61-70	Over 70	Total
<b>FY 2020</b>	18	22	22	27	11	5	105
<b>FY 2019</b>	19	10	24	20	20	5	98

Physical Disabilities and Chronic Health Conditions: Thirty-three (33) of the individuals in the ACH and community review sample, or forty eight percent (48%) of the sample for whom information was available, had at least one serious physical disability, chronic health condition, or deafness/ blindness, and as a result needed daily assistance, care management, specialty care, accessibility features or equipment, and/or a unit with easier physical access (location of the building or in the building). Thirty (30) individuals had two (2) or more chronic illnesses and/or physical disabilities and the number was as high as nine (9) conditions for one individual. There was insufficient information on nine (9) individuals to determine if they had significant health conditions or physical disabilities.

Eight (8) individuals had major physical disabilities requiring either a wheelchair, prosthesis, or other adaptive equipment and accessibility features. Two (2) individuals required specialized equipment, a ventricular assistive device (brain injury), and oxygen device for breathing. Three (3) individuals had cancer, two (2) individuals had cirrhosis of the liver, and one (1) individual had a rare disease, Hirschsprung, related to a birth defect. The most common chronic health conditions were diabetes, COPD, osteoarthritis, GERD, heart disease, and seizure disorders. Two (2) individuals had a significant hearing loss, and one (1) individual was blind. Three (3) individuals had received a diagnosis with an illness on the Alzheimer’s spectrum. The individual temporarily placed in skilled nursing had a recent history of falls and had a series of strokes earlier.

Individuals repeatedly expressed concern about their health conditions, particularly those with physical disabilities and several individuals who required constant support and care

management for their chronic medical problems.

It was apparent from this review that, as stated in earlier reports, mental health service providers, including peer support and tenancy support staff who see individuals on a regular basis, get help from health and personal care staff and also need to have basic knowledge of and assist, when appropriate, with daily self-care and/or treatment needs such as taking insulin, checking blood pressure, exercising, adhering to a special diet, etc.

Living Conditions: The Review Team had less access to adult care homes as a result of the pandemic but even with limited access it appears ACHs continue to range from well maintained and inviting places to live, to homes that appeared poorly maintained mostly due to the age of the building and less inviting with crowded and dimly lit hallways and rooms.

A significant number of the rental units where individuals are living in supported housing appear to be in reasonably good condition, well maintained, relatively clean, and not overly cluttered. Most individuals could describe or point to community amenities and spoke about help they were receiving to get groceries and other household items during the pandemic. One young man pointed to a health food store in the next block from where he lived in a small rural community. Another man pointed to a path he took over the hill to get to a community store. But, as expected, many individuals spoke about their loneliness and sadness of being so isolated during the pandemic. Two (2) individuals had scooters to get around town.

Nonetheless, some units were in poor condition and some appeared to be in high crime areas. Staff reported two urban communities, in particular, have a scarcity of affordable, decent private rental units in desirable neighborhoods. TCLI and provider staff spoke about “slumlords” who were willing to rent to individuals with criminal records. These units were in high crime, drug infested neighborhoods, which created an even greater challenge for individuals with criminal records related to their prior drug use or association with drug dealers who used them to distribute drugs. Two (2) individuals were living in trailers.

There is more information about the places that individuals were moving to in the community, when discharged from SPHs/ ACHs or diverted from adult care placements, in the **Discharge and Transition Process (III)(E)** section of the report.

Placements and Choices of Living Arrangements: Based on the FY 2020 reviews and reviews from previous years, individuals discharged from SPHs did not get the choice of the most integrated setting as an option at the time of discharge. Several of the individuals moved to group homes, family care homes, or their families’ homes where the individual was previously living, often unsuccessfully. Four (4) individuals went to shelters (3) and a hotel (1) at discharge; these are unstable housing situations but going there during a pandemic is especially risky. Four (4) individuals moved to group homes and three (3) to family care

homes, generally at the insistence of guardians. On the other hand, three (3) individuals moved to bridge housing while working out permanent supported housing arrangements, one (1) individual returned to their apartment, and one (1) individual moved to supported housing. One (1) individual returned to an Oxford House that no one indicated they had knowledge of with respect to the goodness of fit for that placement and one (1) individual returned to their family because staff indicated no other options were available. Six (6) individuals returned to jail from SPHs after restoration of competency, although it was not clear that in-reach or transitional support would continue for four (4) of the individuals even though they were already eligible for TCLI.

The same issues as reported in previous reports influence an individual's transition to community settings or diversion from institutional care: chronic health conditions, often age related; physical disabilities; housing location and conditions; access to needed supports; and availability of accessibility features and equipment. SPH, TCLI, service provider, and State office staff appear to be improving their understanding that these factors significantly influence an individual's well-being and integration into the community. However, there are still instances when staff do not recognize these factors and take necessary steps to assist individuals with age or disability specific issues during their transition.

When individuals return to living situations where they have had negative experiences or places that are not of their choosing, they are less likely to sustain successful housing. Often these are group settings or institutional placements where individuals do not thrive, become more isolated, and lose their functional living skills. The difference in outcomes between individuals who get housing that works for them and assistance to make a successful transition to the community and those who do not remains apparent and a challenge not only for the individual but for the system overall.

## I. COMMUNITY BASED SUPPORTED HOUSING SLOTS

Major Categories <sup>13</sup>	Standards	Progress towards Meeting the Requirements
<p><b>1. Section III. (B)(1)(2)</b> requires the State to develop and implement measures to provide eligible individuals with access to community-based supported housing.</p>	<p>1. The State has developed measures to enable individuals in all five priority groups to access SH when exiting ACHs; when discharged from an SPH, if they would otherwise become homeless or move to unstable housing; or when an individual becomes TCLI eligible during or after pre-screening.</p> <p>2. The State has implemented such measures to ensure access to SH for all five priority groups.</p> <p>3. The State uses bridge housing to enhance the potential for “access” to permanent housing.</p>	<p>The State continues to develop and take steps to implement <b>(B)(1)</b> to enable individuals to move into supported housing and with improvement in performance of staff assigned to assist individuals to move can meet this requirement in FY 2021. The fall FY 2020 individual reviews revealed that while access was improved it was a problem for a number of individuals, especially those in (B)(a.-c<sup>14</sup>.) this is primarily related to the State’s performance in <b>(B)(7)</b> and the Discharge and Transition Process requirements In <b>Section III. (E)</b>.</p>
<p><b>2. Section III. (B)(3)</b> The State will provide two thousand five hundred and fifty-four (2,554) housing slots by July 1, 2020, and housing slots to three thousand (3,000) individuals by July 1, 2021.</p>	<p>Same as requirement</p>	<p>The State provided housing slots to two thousand five hundred and fifty (2,550) individuals in FY 2020; four (4) short of the FY 2020 requirement. Based on progress in the first six months of FY 2021, the State will meet this requirement in FY 2021.</p>
<p><b>3. Section III. (B)(4)</b>. The State shall develop rules to establish processes and procedures for determining eligibility for SH in accordance with the requirement for priority groups set forth in <b>Section III (B)(2)</b> of the Agreement.</p>	<p>Same as requirement</p>	<p>The State is meeting this requirement.</p>

<sup>13</sup> Major categories and Standards are summarized for some requirements and/or not included if met in previous years (see notes in each section.)

<sup>14</sup> The State refers to this as categories 1.-3.

Major Categories	Standards	Progress towards Meeting the Requirements
<p><b>4. Section III. B. (5)</b> Two thousand (2,000) housing slots will be provided to individuals in priority Categories <b>III. (B)(2) (a-c)</b> over the course of the Agreement. The State determines the proportionate allocation of slots annually, giving priority to Categories <b>(2) (a-c)</b>.</p>	<p>Same as requirement</p>	<p>The State is not meeting this requirement. The number of individuals occupying housing slots after exiting ACHs dropped by five (5) from eleven hundred and thirty-two (1132) to eleven hundred and twenty-seven (1127) in FY 2020. This reduction was constant across the fiscal year, not solely related to COVID.</p>
<p><b>5. Section III. (B)(7)(a.-g.) (summarized)</b> The State will provide housing slots for individuals to live in settings that meet the following criteria:</p> <ul style="list-style-type: none"> <li>a. They are permanent housing with Tenancy Rights.</li> <li>b. They include tenancy support services that enable residents to attain and maintain integrated, affordable housing.</li> <li>c. They enable individuals with disabilities to interact with individuals without disabilities to the fullest extent possible.</li> <li>d. They do not limit individuals' ability to access community activities at times, frequencies, and with persons of their choosing.</li> <li>e. They are scattered site housing, where no more than 20% of the units in any development are filled by the target population.</li> <li>f. They afford individuals choice in their daily activities such as eating, bathing, sleeping, visiting, and other typical daily activities.</li> <li>g. The priority is for single occupancy housing.</li> </ul>	<p>Housing slots meet the following criteria:</p> <ul style="list-style-type: none"> <li>a. They are permanent with rights of tenancy.</li> <li>b. The individual gets tenancy support including support to meet tenancy requirements and advocate for their rights.</li> <li>c. The individual's housing location makes interaction with individuals without disabilities possible to the fullest extent.</li> <li>d. They do not limit access to community activities and with persons of their choosing.</li> <li>e. They meet the scattered site requirement.</li> <li>f. They provide a choice in living activities, accessible features, and personal support.</li> <li>g. Priority is for single occupancy.</li> </ul>	<p>The State continues to make progress toward meeting tenancy rights, access to community activities, and choice of daily life activities requirements and is close to meeting the standard for these requirements based on interviews and site visits conducting during the fall 2020 reviews, although individuals' access is often delayed related to tenancy history and/or the need for individuals to secure assistance for the daily life activities. The State has consistently met the sub-requirements for permanency, scattered site housing, and preference for single occupancy housing. Tenancy support is also part of the primary service an individual receives as reviewed in <b>Section III (C)</b>.</p>

Major Categories	Standards	Progress towards Meeting the Requirements
<p><b>6. Section III. (B)(6)(7)(g)</b> The State has ongoing programs for housing assistance that will continue in effect. The State may utilize those programs to fulfill their obligations as long as the housing slots provided meet the criteria in <b>III.B.(7)(a.-g.)</b></p>	Same as requirement	The State is meeting this requirement.
<p><b>7. Section III. (B)(8)(9)</b> These sections describe where the State cannot use slots and the process for giving individuals the choice of housing after being informed of all the available options.</p>	Same as requirement	The State is meeting this requirement.

**(A) Background**

The Community-Based Supported Housing Slots requirements in the Settlement Agreement require a comprehensive approach to assure the availability of, access to, and retention of affordable, safe, quality housing located in the communities and neighborhoods where individuals in the target population request to live. The approach to meeting supported housing requirements necessitates long term strategic planning to assure the State can meet and sustain compliance with this Settlement Agreement. It requires attention to individuals’ access, including physical access to community activities and amenities, and tenancy rights when trying to lease a rental unit and when retaining housing.

The State has taken major steps to develop a comprehensive approach, including developing a long-range strategic plan to create housing opportunities and to take direct action to meet housing requirements. This is in large part due to the collaborative working relationship between the NC HFA, DHHS, and LME/MCOs securing new housing resources and effectively using those resources. The partners are utilizing and developing resources to more effectively utilize Reasonable Accommodation<sup>15</sup>, to provide access to scarce accessible units, and to modernize the housing application and approval process through its new CLIVE rental assistance operating system.

These actions have enabled the State to nearly meet its FY 2020 requirement for two thousand five hundred and fifty-four (2,554) occupied supported housing slots, missing it by just four (4) slots. Individuals living in the community but not living in supported housing may have been issued a housing slot but either chose not to use it or have left their supported housing unit. More importantly, continuing that pace which will result in the State meeting this major requirement in FY 2021.

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<sup>15</sup> Reasonable accommodation is a protection under the Federal Fair Housing Act (FHA). The FHA prohibits discrimination in housing. It provides individuals with disabilities the right to request a reasonable accommodation in the rules, policies, practices, or services of a housing provider.

The November 2020 Interim Report described in some detail the challenges with safe, affordable housing availability, and the current steps the State is taking to take advantage of federal funding and to create funding opportunities for rental assistance and housing development. Several are worthy of repeating. In the past two and a half years the State has sought and awarded over seventeen hundred (1,700) HUD Mainstream Housing Choice Vouchers. Individuals in TCLI get priority for most of those vouchers. The State secured HUD approval to give TCLI recipients preference in its statewide HUD Mainstream Program managed by the NC Department of Administration.

North Carolina received its first HUD 811 Program Rental Assistance award for one hundred and eighty-eight (188) units for individuals with disabilities to get project-based set aside units that will likely be located in Low Income Housing Tax Credit properties. The NC HFA has begun working with the bond developers to add set aside units and to maximize the previously reported Integrated Supported Housing Program (ISHP) resources to add resources to maximize available set aside units. This innovative program will enable the State to add two hundred and forty-six (246) affordable rental units available to TCLI recipients for an extended period of time. Utilizing CLIVE, the NC HFA can now provide LME/MCOs same day notification when their targeted rental units are available. These changes have resulted in a forty percent (40%) increase in access to “targeted” project based federal Low Income Housing Tax Credit (LIHTC) units in the past year. In summary, the NC HFA and DHHS are now effectively maximizing and managing affordable rental resources for the TCLI population.

The Interim Report included a description and analysis of the State’s shortcomings in meeting the requirement that two thousand (2,000) of the three thousand (3,000) individuals residing in supported housing on the Agreement’s termination date be individuals who transitioned out of adult care homes in **Section III. (B)(5)**. The State is taking steps to increase this number but there is almost no change in the numbers of individuals moving from ACHs and occupying SH. The findings section below describes findings from the individual reviews relevant to this description in the Interim Report.

The Interim Report also referenced the challenges the State is having with meeting its obligations in the housing settings and tenancy support requirements in **Section III. (B)(7)**. These are important requirements as they include the required steps the State must take for individuals to have tenancy rights and to live in integrated settings that afford accessibility and choice of daily living activities, do not limit access to community activities, and enable interaction with non-disabled persons. The number of rejections by landlords of individuals in the target population – referred to as “housing denials” – and the number of individuals who withdrew from the program while searching for affordable housing remained at the same levels as in FY 2019. Individuals report loneliness, isolation, and concern with their health care needs as challenges to living in SH.

The findings section below describes the results from the individual reviews relevant to this finding.

The **(B)(7)** requirement requires the State to provide tenancy support services that enable residents to attain and maintain integrated affordable housing. The State has consistently met three **(B)(7)** requirements: housing is permanent with tenancy rights (7)(a), scattered housing units (7)(c), and priority given to single-occupancy housing (7)(g). There may always be violations of the first requirement, permanent housing with tenancy rights, but the lease agreement always includes tenancy rights, and the State is taking positive steps to minimize this problem. Tenancy support always includes support to assist an individual to identify, prepare for, and move into housing. It also includes post-transition assistance, such as help navigating landlord and neighbor relationships; meeting lease conditions, including paying rent and utilities; and submitting maintenance requests.

Assertive Community Treatment, Community Support, Peer Support and Tenancy Management Support (TMS) definitions include widely accepted tenancy support services. There is a review of tenancy support included as part of the Community-Based Mental Health Services **Section III. (C)** review. The fall 2020 review revealed a number of challenges individuals had with gaining access to supported housing, not necessarily related to availability of housing but rather to staff failures to assist individuals to gain housing.

### ***(B) Findings***

The State will meet **Community Based Supported Housing Slots** requirements for **Section III. (B)(1)**, access to community housing based on the measures the State has taken to make housing available and accessible. There are still access issues for individuals exiting SPHs and ACHs, but these appear to be primarily related to challenges in making improvements to meet **(B)(7)** requirements and Discharge and Transition Process requirements in **Section III.(E)**. The State will meet **(B)(3)** requirements by July 1, 2021, and thus will be in full compliance with this major requirement. The State's performance during the pandemic in assisting individuals to move and remain in housing exceeded expectations. The State fell short of the FY 2020 requirements, two thousand five hundred and fifty (2550) out of the required two thousand five hundred and fifty-four (2554) individuals occupying slots. Regardless, the State increased the number of individuals living in supported housing by three hundred and thirty-one (331) between March 1, 2020, and December 31, 2021. LME/MCO In-reach and Transition staff, with help from their State partners and service providers, are persistent in finding ways to assist individuals to get and keep housing during the pandemic and increased the number of individuals occupying housing by an average of fifty-four and six-tenths (54.6) individuals per month during the last three months of calendar year 2020.

The challenges appear to be related to staff losing track of an individual's whereabouts; during transition particularly if there were not regularly scheduled contacts to assist individuals to move; lost paperwork; staff disregarding an individual's housing choice; lack of staff awareness of steps to address barriers; guardian or family objections, including one brother posing as a guardian and one individual reporting he was told there was a yearlong wait list for housing; staff relaying their doubts to an individual that she could live in the community; or, in one instance, staff telling an individual he had to get his own neuro-psych evaluation to prove he did not have dementia. This demand was rescinded later and he got staff help to get the evaluation but delayed his eligibility for almost a year. The challenges do not appear to be related to the new systems put in place but rather the system not including a rigorous follow-up monitoring process. The State is aware of this issue and active monitoring and issuing performance improvement actions if necessary, will sustain (B)(1) improvements and meet (B)(7) and Section III. (E) requirements

**(B)(5)** providing housing slots to individuals in Categories a.-c. exiting adult care homes, and **(B)(7)** individuals living in housing that meets specific criteria. The State is on track to meet **(B)(1)** and **(B)(7)** by the end of calendar year 2021 or sooner if the State's performance continues to improve. The State is not on track to meet **(B)(5)**.

1. The State continues to develop, implement, and refine measures to improve access to supported housing for individuals in the target population as reported in the Interim Report and as required in **Section III. (B)(1)**. The State has taken a number of steps to utilize multiple fund sources, to streamline the notice of availability of targeted units, and to assist LME/MCO and service provider staff on their pre-tenancy, move-in, and post tenancy requirements. The State is regularly tracking availability and accessibility.
2. Eighteen (18) individuals who moved into supported housing in FY 2020 received the support they needed to move. These 18 represent forty four percent (44%) of individuals seen in the fall 2020 review who are living in supported housing. The others reviewed had moved into supported housing between FY 2017 and FY 2019. Three (3) of the 18 were individuals who had not received assistance previously, left services, and/or assigned to a new provider and received the assistance they needed to move.
3. Provider performance: The first access problem is a consistent lack of staff follow-through to help individuals secure housing. This problem affected at least six (6) individuals reviewed. In their cases, the transition process slowed down or stopped because of a lack of follow-through by staff assigned to assist individuals gain access to housing. This was sometimes related to individuals having to begin working with new staff, either because of changes in teams or changes in specific staff assignments. In some situations, staff took weeks and even months to assist individuals to get the documentation necessary for an individual to move into housing.

In one situation, the process of getting needed documents and staff assigned began last January 2020 when both the individual and his guardian asked about supported housing, but the process was still underway when they were interviewed in November 2020. Below is another description of how provider expectations can interfere with individuals gaining access to housing.

*One young woman's records revealed that over a course of seven months staff told her that she "did not have realistic expectations of housing that she could obtain with her SSI income" and indicated she was in the "first phase of the housing program" saying she did not display behavior that she can live independently. The team notes cited her need for natural supports, her homelessness, her not trusting people and being depressed as reasons she could not move into supported housing again after not succeeding previously. The team then told the woman they were going to stop her bridge housing funding. An Assertive Community Treatment team refused to serve her because of her lack of compliance even though she has consistently remained in services and even though a history of a lack of following through with traditional services is one of the eligibility indicators for Assertive Community Treatment. This young woman's records revealed there was a question about a history of trauma during her first hospital admission, at age sixteen, but there was no follow-up treatment for trauma. The records consistently indicated she was told she was failing rather than given support to succeed.*

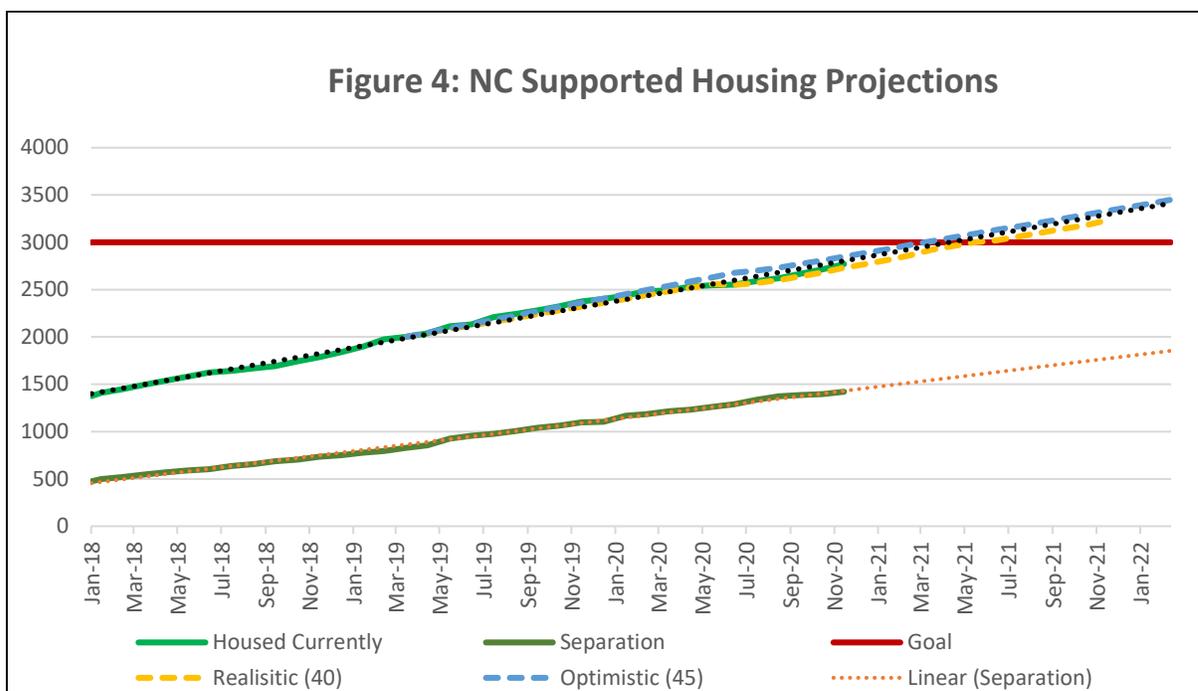
Lack of bridge housing or permanent housing: The second issue affecting access to housing is the lack of available bridge housing or permanent housing. This problem arose for five (5) of the twenty-three (23) individuals exiting state psychiatric hospitals reviewed in August and September and a similar number of individuals not referred in the earlier SPH discharge reviews. Staff's inability to identify bridge or permanent supported housing for individuals discharging from SPHs is usually attributable to a failure to start the discharge planning process early enough to achieve these placements. The challenges with access to bridge housing may be related to COVID restrictions as well as to lack of availability.

Referrals to unsuitable housing: The third issue is that staff continue to refer some individuals to unsafe, poorly maintained housing or housing that is unaffordable and does not meet tenancy rights requirements. These are problems more often found as part of conducting interviews at someone's home or driving by an individual's home. This enables the Review Team to observe these problems more closely.

This problem decreased over time but was still a significant issue for eight (8) individuals six (6) were individuals interviewed at their home and two (2) were individuals interviewed outside with observation of their living setting and interviews with staff and a guardian. The most significant issues were with three (3) individuals renting from the same landlord in

Wilmington, who rents to individuals without regard to their rental history. His rental housing is located in unsafe locations and poorly maintained. This has been an issue for individuals with past criminal or poor rental histories. This has slowly improved over time. LME/MCO housing staff have been more successful in working with landlords and property managers and the HFA tenant selection policies have also contributed to this improvement, but some individuals in TCLI continue to live in unsafe conditions.

4. The state made significant progress toward the number of currently occupied housing slots for the target population in 2020 as required in **Section III. (B)(3)** and tracks progress in filling units by categories listed in **Section III. (B)(2)**. On July 1, 2020—despite the challenges of the pandemic—the State came within four (4) of its annual obligation, housing two thousand five hundred and fifty (2,550) of the two thousand five hundred and fifty-four (2,554) required individuals.
5. It is likely the State will meet the requirement that three thousand (3,000) individuals live in Supported Housing by July 1, 2021, as depicted in **Figure 4** and referenced in the background section above.



6. Separations from housing and challenges for individuals trying to move during the COVID pandemic presented the highest risks to the State not meeting this requirement. During several early months of the pandemic, the State was not able to keep up its earlier pace of filling housing slots, which appears to be related to the slowdown of individuals moving during this pandemic; however, as stated above, these numbers appear to have bounced

back. The number of separations did not increase in the last quarter of FY 2020 nor the first two quarters of FY 2021, which is a positive sign.

7. The State expanded its Targeted Unit Transition Program (TUTP), often referred to as a “bridge” program or “temporary housing,” by forty percent (40%) in FY 2020 and eighty-five percent (85%) in the past four years. The program has demonstrated success as a gateway to permanent supported housing with ninety percent (90%) of those completing the program moving into SH. However, the number of individuals completing the program and moving to permanent housing dropped sharply during the first quarter of FY 2021. Forty-one (41) individuals completed the program in the last quarter of FY 2020 but only three (3) in the first quarter of FY 2021. Six (6) moved into permanent housing in the first quarter of FY 2021 compared to thirty-eight (38) the quarter before. This slowdown could impact the State meeting its housing requirements in FY 2021.

On one hand, bridge housing could, without proper precautions, be a super spreading location for COVID. On the other hand, it is likely safer than being in a shelter or living on the street and, with precautions, can be safer than other environments. Individuals discharged from SPH do not always get access to bridge housing, which could be a safer more controlled environment than a shelter or boarding house. It is important that bridge housing managers carefully screen individuals including requiring testing, regular temperature checks, and other precautions such as isolating residents as much as possible. Not all bridge housing environments enable isolation easily.

There were only three (3) individuals discharged to bridge housing from SPHs in the twenty-three (23) person sample of individuals discharged from SPHs in the first quarter of FY 2021, while two (2) discharged to shelters, seven (7) to group living arrangements, and one (1) to a hotel (not in the bridge program) at discharge.

8. The State is not on track to meet the requirement for two thousand (2,000) individuals living in SH in Categories a.-c. (also referred to as 1-3), individuals residing in adult care homes as required in **Section III. (B)(5)**. The number of individuals living in supported housing after exiting ACHs at the end of FY 2020 was eleven hundred and twenty-seven (1,127), down by five (5) since the end of June in FY 2019. This followed a gain of two hundred and forty-one (241) in FY 2019. This was in part due to COVID but there were reductions across most months in FY 2020, compared with the previous fiscal year. Housing retention is lower for individuals exiting ACHs.

**Figure 5: NC DHHS Transitions to Community Living Initiative Nov. 2020 Report**

<b>(B)(2) Category</b>	<b>Transitions</b>	<b>Retention</b>	<b>SH Census</b>	<b>Required [per III(B)(5)]</b>
a-c: ACH residents	1962 (48% of total)	58%	1133 (42% of total)	2,000

9. The number of individuals living in supported housing after exiting an adult care home dropped by eight (8) in the first quarter of FY 2021, reducing the number of individuals from eleven hundred and twenty-seven (1,127) to eleven hundred and nineteen (1,119) but bounced back to one thousand one hundred and thirty-three (1,133) at the end of November 2020 (**Figure 5**), which is still a lower number than July 2019 when one thousand one hundred and thirty-eight (1,138) individuals were residing in SH.
10. At the end of 2020, five thousand five hundred and twenty-one individuals (5,521) were in TCLI on “In-reach status”. Four thousand and thirty-six (4,036) individuals were residing in ACHs. Five hundred and forty-three individuals (543) were living in the community but not in SH following pre-screening. One thousand two hundred and twenty-six individuals (1226) individuals either are still hospitalized in an SPH or were discharged to the community, many to unstable housing. The State is actively monitoring ACH discharges and reducing the number of individuals who no longer qualify for TCLI from the TCLD data base.
11. We reviewed twelve (12) individuals on the in-reach list identified as living in adult care homes in the fall 2020 review.
  - a. There were two (2) individuals admitted to skilled nursing at the time of the review, one (1) due to recent falls and another after a diagnosis of Alzheimer’s. The individual who had recent falls had lived in supported housing for over two years. She was worried that she was a fall risk following a stroke and would not get the help she needed after a fall. It is not clear that she would have felt comfortable with supports in her home but by the time of her interview she had already given notice on exiting her apartment and was preparing to move to an ACH. Staff report they had not seen the second individual, reported to have Alzheimer’s but had not sent in paperwork to remove his name from the TCLI list.
  - b. Of the other individuals on the in-reach list who are living in ACHs, one (1) reportedly has dementia and one (1) has difficulty standing and walking as a result of a stroke. Staff at the home report he has no interest in moving but there are no records of contact by an in-reach worker. Two (2) individuals did not receive an interview because their guardians did not give permission. One (1) had a family guardian. The second had a public guardian. He was living in an ACH and attending a Psychosocial Rehabilitation program owned by

the ACH. He lived in Broughton Hospital for thirty-five (35) years before moving to the ACH almost five (5) years ago.

- c. Of the remaining six (6) individuals residing in ACHs on in-reach, five (5), and perhaps all six (6), could possibly live in a more integrated setting with supports and services commensurate with their support needs, accessibility features (for two (2) individuals), and access to community amenities and employment.

Of those six (6), two (2) individuals, a married couple, were living in an ACH in a rural county and reported they were very eager to move to the community. The wife is younger and legally blind. Her husband is in his late sixties with COPD and diabetes. They moved to supported housing in March of 2018, but according to records and their responses during their interview, they became fearful of not being able to keep up with household duties and they moved back to an adult care home in December 2019. Their previous service provider was unaware of this move at the time and records indicate the provider was not providing services and supports at the level the couple needed. When the Reviewer visited them in October 2020, their new provider and LME/MCO staff were present for the interview. Staff voiced apprehension about how they could go about making this happen. In part this was because the CST was new and not familiar with the steps to go forward. After discussion about how to go forward to get the couple the supports they needed, the team went into action immediately to make arrangements for an accessible unit and needed supports. LME/MCO staff and their provider recently reported the team had made progress seeking housing and other arrangements. Unfortunately, the couple contracted COVID at the ACH while waiting to move out halting further arrangements during their recovery. (Note: they recovered and moved into their new unit with supports on February 16, 2021.)

A third individual is living in a northern county but wanted to return to Charlotte, ninety (90) miles from his adult care home. He started services with an Assertive Community Treatment (ACT) provider with an office close to the adult care home in October 2019. Both he and his guardian expressed interest in TCLI at the end of calendar year 2019. The ACT team, the in-reach staff, and transition coordinator documented approximately five (5) events monthly beginning in January, when his mother inquired about TCLI eligibility for him, although these events were not always a direct contact with the individual, simply notes in his record. According to staff, this process is still ongoing although staff were not clear what was causing the delay.

The fourth individual, forty (40) years old, was living in an ACH in a small community, but not close to family living in North Carolina. He was ambivalent about moving, unsure if he could manage living on his own. His long-term goal is to move to another state close to his immediate family. He spends much of his time on the internet and expressed interest

in technology and returning to school. He was admitted to a hospital in 2019 and had a long history of hospitalizations. According to documentation, he had seen his current in-reach worker three (3) times in 2020, including once two weeks before the interview. It appeared from the interview with him that with greater attention to engagement and follow through to help him move closer to family, he could eventually live on his own and return to school. According to staff, who had not seen him frequently, he continues to voice ambivalence about moving.

It may be too late to help the fifth individual. He moved to an ACH, with no support, for five (5) years, which profoundly impacted his life. LME/MCO staff had only seen him twice in the five (5) years since he moved to an ACH after several psychiatric hospitalizations. At the time of his move, his brother, who is not his guardian, asserted he had dementia. His clinical records clearly indicate that there were no signs of dementia. The Review Team member indicated that he was oriented to time, place, and person and his recall was intact. He appeared to have some limitations, which could have also been related to intense anxiety at the time of his hospitalizations.

He had been living in his home alone before and could have returned there. At the time of his discharge from his last hospitalization in 2015, hospital staff indicated he would need some support with daily living. There was a referral to TCLI in December 2014 before his discharge. His record indicates an LME/MCO staff person visited him once in March 2015. His screening tool (completed at the time of his referral) referenced that he had been living in his own home, receiving medication management, and was friendly, cooperative with "fair judgement," and needing prompting with some aspects of daily living. Records show he had a brief hospital stay in 2015 for a medication adjustment and the hospital social worker attempted to contact his LME/MCO transition coordinator.

There is no record of any response. LME/MCO staff attempted to send letters to him but his brother told staff he had dementia and would not disclose his location. Then, the LME/MCO In-reach and care coordination notes stopped. The LME/MCO was able to locate him in 2019 and an In-reach worker spoke to him at his ACH when he again expressed his interest in moving to the community. The in-reach worker said he showed no obvious signs of dementia. An In-reach specialist was present when the Review Team member saw him on November 5, 2020. His brother posing as his guardian attempted to stop the visit and, although he does not normally come to visit him, came to the home to try to stop the interview after called by staff at the home.

A sixth individual moved back to an adult care home from his supported housing unit because he expressed that he did not feel safe and was being taken advantage of by other people in the community. Staff described him as extroverted and outgoing. Staff reported this likely contributed to others taking advantage of him. His provider saw him frequently

in the community, but his staff reported he felt his challenges appeared too great to overcome.

- d. These twelve (12) individuals represent a small sample of the total number of individuals residing in an ACH assigned to in-reach staff. Nonetheless these individuals are representative of those individuals living in ACHs reviewed in previous years.
12. There appear to be other reasons ACH residents are not getting an opportunity to move to community settings based on reviewing data and discussion with in-reach and transitions staff. As noted with one (1) individual referenced above, living in a facility may reduce an individual's ability to make decisions and lessen their functional abilities. Over time, this reduces the number of individuals who choose to move back to the community. There may be a higher percentage of individuals living in adult care homes now with guardians who refuse to consider a move, often with the influence of the adult care home staff. As more individuals move, this percentage will only go up, not down. The in-reach and transitions staff also focus more now on diversions than on transitioning ACH residents to the community and/or there may have been more turnover in staff who were previously more knowledgeable and assertive in helping individuals move.
  13. LME/MCOs have employed nurses to assist with assessing needs for individuals choosing to move to the community as well as to review individuals referred through the LME/MCO pre-screening and diversion program. This has been helpful. But other professionals also have skills to offer that are key to helping individuals in the target population move out of ACHs. For example, as this Reviewer has advised previously, occupational therapists (OT) can help with specific individuals or help a team with their general approach to in-reach and transition; however, OT consultation is not a consistent practice among LME/MCO in-reach staff. This is partly related to availability of occupational therapists but also to the need for more focus on the benefits of this service. Occupational therapists can assess and break down independent living skills into more discrete skills and assist individuals to make decisions, adapt to and meet the demands of their new physical and social environment, gain coping and daily activity skills lost while living in an institutional environment, and return to the workforce and/or community activities. Likewise, Certified Peer Specialists are especially skilled at assisting an individual to regain their confidence and skills. This Reviewer has often observed that supervisors or other team members devalue Peer Specialists and ask them to carry out duties other than peer support. This detracts from their ability to use their skills and effectiveness in assisting individuals to achieve success in the community. This is also an indication that an individual's own outcomes do not get measured and reported in the same manner that the system's outcomes are measured and reported.
  14. The State is developing a plan for increasing Categories a.-c. referrals and assisting individuals to be able to live in supported housing. This planning process is in its early stages. State staff

assigned to develop the In-reach and Transition process are already in the process of refining the plan, adding steps to define the number of individuals remaining in ACHs who are eligible for TCLI and interested in moving to a more integrated setting. Staff are taking steps to ensure the plan will include action items to measure progress to reduce barriers, achieve outcomes, and meet process measures.

15. The Fall 2020 individual reviews reveal the State is getting closer to meeting its requirements in **Section III(B)(7)**. The standards for each of these requirements include support to assist individuals to attain and maintain integrated affordable housing; access to community activities at times, frequencies, and with individuals of their choosing; and assistance to interact with individuals without disabilities, and to have a choice in daily life activities. These require attaining and maintaining housing support to ensure there is not discrimination against individuals and they have the full rights of tenancy. These requirements also include affording individuals access to housing with adaptive equipment and accessible features. The Community-Based Mental Health Services section will also cover the State's tenancy support services performance.
16. Annual housing retention data referenced in the Interim Report revealed the obvious: that filling housing slots is the first housing step but assisting individuals to retain their housing is critical to the state meeting its "housing slots occupied" requirement. Even more important is to analyze if individuals are not retaining their housing based on individuals not getting the help they need to live successfully in the most integrated settings possible or other reasons. This question was noticeable again with the fall reviews. The State and several LMEs have begun analyzing these separations and it appears likely they can reduce this problem.
17. Primary service providers play a key role in pre-tenancy, move-in, and assisting individuals to maintain housing. The above finding and repeated observation of CST training during FY 2020 revealed that many providers lack clarity about their role and responsibilities, lack experience, and even lack willingness in a few instances to provide this support.

The State and LME/MCOs have taken some steps through training and expanding job duties in provider contracts. However, it was clear in the recently conducted individual reviews that some provider staff remain unaware of their responsibilities and/or how to carry them out.

In addition to the other problems listed above for individuals who could not access housing or whose housing was delayed in the recent review, thirteen (13) individuals or thirty-two percent (32%) of the forty-one (41) individuals living in supported housing reported (and in most situations confirmed or observed by the Reviewer) LME/MCO and service provider staff responsible for assisting individuals to get access to and maintain housing did not appear to fully understand tenancy rights, individuals' choices in daily living activities, and their role,

nor did they provide assistance to ensure that the housing was safe, in a location that did not limit their activities, and with needed accessible features.

In one situation, a service provider asked one of the Review Team members how she could get information about tenancy rights. One (1) individual living in supported housing has to carry her oxygen tank up and down a flight of stairs. She has not complained, possibly not wanting to lose her unit. This reveals that the individuals helping her move did not appreciate her need for a more accessible unit. This may be because staff were unaware that she could request an accessible unit or were simply hoping this would not be a problem, especially since she was saying she wanted to move. Five (5) individuals were living in unsafe neighborhoods, where they heard gun shots; a drug dealer took over two individuals' apartments.

A service provider reportedly told one (1) individual he should not get a dog even though there were no pet limits in his complex and when he got a dog, he said his life was better and the reviewer noted the dog was a good companion. Perhaps the most troubling situation was staff being unaware of and not following up to resolve a problem. The Review Team reported about a gentleman whose apartment had bed bugs and a fire alarm had been going off in his building routinely for the entire three years he has lived there. He did not want to lose his housing, so he did not complain. Since no one had been to see him for a long time, they were unaware of his living situation.

### ***(C) Recommendations***

The recommendations in this Report fall into three categories and focus specifically on those items where the State needs to make improvements to meet the outstanding Settlement Agreement Community-Based Supported Housing Slot requirements. These are **Section III. B(5) and B(7)** but also recommendations for (B)(1). Each of these requirements is a significant requirement and has implications for the State meeting other requirements as well. These include improvements for access to housing, meeting the provision for two thousand (2,000) slots to individuals from **Section III. (B)(5) Categories (2)a.-c.**, and housing provision criteria. This list does not specifically include a recommendation to increase housing slots to provide supported housing to three thousand (3,000) individuals, as the State will meet this requirement in FY 2021. This list also does not include reference to housing requirements already met, including **(B)(2), (B)(4), (B)(6), (B)(8) (B)(9) and one other, (B)(3)** which the State will meet this year.

#### **Section III.(B)(1).**

1. Develop and implement measures to provide individuals access to community-based supported housing. The State has taken major steps to meet this requirement over time. Accessing housing can be a complex and challenging endeavor that requires breaking down steps into manageable tasks, engaging with an individual to ensure they understand and can follow-through on tasks, and doing it in a manner to assist rather than completing all the tasks

themselves; this can maximize the learning and recovery process. Since timeliness was a significant trend in the Fall 2020 review, LME/MCOs analyze the potential causes of in-reach and transition coordination **Section III. (E)** being slow and sometimes unsuccessful as a result of lack of timely follow through. It is also important to consider how they can improve the move-in experience itself to improve their long-term comfort and success in their housing, for example, by spending time with individuals on Day 1 and making sure they have what they need.

2. The State and LME/MCOs examine housing availability in communities and/or neighborhoods where unsafe housing units tend to be the only option or one of few options available. State leadership has been important in the past for increasing better housing options and improving the tenant selection processes critical to increasing housing access.
3. The State and LME/MCOs address individuals' accessibility and health care requirements as soon as possible after it becomes clear that an individual's move, or successful tenancy, is contingent upon having these met. It is important for the State to complete an assessment based on both the individual's request and their medical history as sometimes individuals may not request assistance, especially if they are afraid that they will not get a chance to move if they do so.

**Section III. (B)(5):** The State recognizes that the requirement that two thousand (2,000) individuals discharged from ACHs live in supported housing by the SA's termination date is a challenge. The State is taking initial steps to develop a plan that includes analyzing and improving performance meeting this requirement. The reviewer recommends the State take the following steps to meet this requirement:

1. Develop a short-term plan with five (5) steps: 1.) Determine the percentage of the total number of ACH residents getting In-reach who have the interest and greatest potential to move to the community with adequate supports and services. Begin by working with each LME/MCO to analyze a subset of individuals qualifying for TCLI, living in an adult care home. Determine the number of individuals in that subset who show some interest in moving who could potentially move to supported housing with adequate mental health services, accessible features, individual supports, home health, care management, and other supports as needed. It is important to interview individuals to make this determination. Ensure that individuals who do this work have the knowledge and skills to make that determination. 2.) Extrapolate the total from that sub-set of the potential number of individuals on In-reach status who may be interested and who could move with adequate services and supports. 3.) Extrapolate the number of individuals who need accessible features, care management, and other services and supports. 4.) State staff work closely with designated LME/MCO staff to define a reasonable number of individuals to engage in the short-term to move into the community. 5.) State staff track the number of individuals on that initial list of who could

move, by LME/MCO; work to address their challenges that require additional supports and assistance; and closely monitor the calculated time required to complete this short-term plan. This also includes re-engaging with guardians to ensure they have adequate information regarding the individual's choices and available services and supports. Public guardians are required to consider these options even if they are ultimately unwilling to allow an individual to move.

There is a need for clear-cut longer-term goals that: 1.) Identify the type of resources and modifications to the review process as needed; 2.) modify the in-reach and transition process, as needed; 3.) ensure resources are available and deployed as needed; and 4.) repeat the process until completed. It is important to manage this process with short-term goals but also to determine what it will take over the long term to meet this requirement and to ensure over the long term that in-reach specialists maintain regular, up-to-date contact with a smaller number of ACH residents at a time.

2. Remove individuals from the in-reach data base who have died, moved to skilled nursing, have dementia, left an ACH under other circumstances or for whom guardians after outreach to them are unwilling to allow individuals to move. This will enable the State to better define the potential number of individuals who could and want to move.

**Section III (B)(7):** This is a requirement for the State to take steps to ensure that settings where individuals live meet specific requirements. These requirements range across criteria for tenancy rights, locations that enable access, and tenancy support for an individual to attain and maintain integrated affordable housing. Supports must be flexible, provided as needed and desired, provided in living settings that do not limit an individual's opportunity to interact with individuals who do not have disabilities, and to provide access to community activities at times, frequencies, and with persons of their choosing. Criteria also require settings to afford individuals choice in their daily living activities, including personal care assistance for individuals, special features for individuals who are deaf or blind, home modifications, and equipment.

1. The HFA and DHHS maintain their momentum to make permanent housing with tenancy rights available, provide competency based Fair Housing training to all direct services staff assisting individuals to get and keep housing, and make accessible housing available at the level needed for individuals needing home modifications and accessible features. DHHS housing staff participate with other DHHS, LME/MCO, and service providers to meet the **(B)(5)** requirements for individuals wanting to move from adult care homes.
2. The DHHS, HFA, and LME/MCOs focus on increasing housing in known "high demand" areas where individuals' only options are units in unsafe locations and housing in poor condition.

3. The State and LME/MCOS take steps to ensure supported housing and bridge housing are available for individuals diverted or discharged from SPHs and SPH staff make referrals to TCLI earlier in the discharge planning process.
4. LME/MCOs ensure the location of housing and the rental unit within a building or complex does not limit access and ensure individuals have access to community amenities at the times, frequency, and with persons of their choosing.
5. LME/MCOs meet individuals' requests for an accessible unit and individual supports in a timelier manner, including arranging home health and personal care services requests. If units are not available and/or staff cannot get assistance to arrange resources, the LME/MCO report this problem to the State Barriers Committee as soon as possible. The State may have to take action to modify policy to ensure individuals with physical disabilities can get access to individual supports. The State encourage LME/MCOs to develop service strategies with a multi-disciplinary care management approach to include nurses, occupational therapists, and peer support specialists to ensure staff have the skills to assist individuals in performing their daily activities to be able to live successfully in the community.

## II. COMMUNITY BASED MENTAL HEALTH SERVICES

Major Categories	Standards	Progress Towards Meeting the Requirements
<p><b>Section III. (C)(1-2)</b> The State shall provide access to the array and intensity of services and support to enable individuals in or at risk of entry to adult care homes to successfully transition to and live in the community. Requirements apply to individuals with a housing slot and to those not receiving a housing slot.</p>	<p>These two requirements specify that access to services and supports for each individual is available with services coverage under the Medicaid State plan or as part of the State funded service array.</p>	<p>The State has not met and is not on track to meet this requirement in FY 2021. The State has not developed effective measures for individuals to access and receive the array and intensity of services necessary for individuals to live in the most integrated setting possible consistent with Settlement Agreement requirements.</p>
<p><b>Section III. (C)(3)</b> The State is required to meet four core requirements (recovery focused and evidenced based, flexible to meet the individualized needs of the individual, help individuals to increase their ability to recognize and deal with situations that could otherwise result in a crisis, and increase and strengthen the individual’s network of community and natural supports, as well as their use of such supports for crisis prevention/intervention).</p>	<p>Services and supports are to be evidence-based, recovery-focused, and community- based. Services are to be flexible, individualized, focused on building community and natural supports, and preventing crises.</p>	<p>The State has not met this requirement and is not on track to meet this requirement in FY 2021. Services are not sufficiently recovery-focused, community-based, flexible, individualized, focused on building community and natural supports, and preventing crises.</p>
<p><b>Section III. (C)(4)</b> requires the State to rely on a specific set of community-based mental health services and any other services included in the State’s service array as set forth in <b>Section III (C)(1)(2)</b> of the Agreement.</p>	<p>There are five services explicitly referenced in this section. These include ACT (summarized with other ACT Settlement requirements below), Community Support Teams (CST), Peer Support, and psychosocial rehabilitation services. The State developed Tenancy Support<sup>16</sup> (referenced in <b>Section III. (B)(7)(b)</b>) in its service array and made a major change in this service in October 2019.</p>	<p>The State has not met these requirements and is not on track to meet them in FY 2021. The State is relying on the services listed in the Agreement. However, the fall 2020 review reveals in some instances, the State does not provide these services consistent with the service definition and pertinent fidelity requirements, or in a manner to satisfy the requirements of this Agreement.</p>

<sup>16</sup> DHHS refers to Tenancy Supports as Tenancy Services Management or “TSM.” It is a direct service funded with State funds.

Major Categories	Standards	Progress Towards Meeting the Requirements
<p><b>Section III. (6)</b> Each individual has a person-centered plan (PCP).</p>	<p>The PCP is current, individualized, and includes the individual’s goals and steps for housing, services, and community integration choices and decisions.</p>	<p>The State is not meeting this requirement and is not on track to meet it in FY 2021. Nearly 60% of the PCPs reviewed in the fall 2020 review were formulaic, often included instructions rather than responses, listed the same interventions for each individual, were not recovery focused, and were often out of date. Some appear written mainly for service authorization purposes.</p>
<p><b>Section III. (3)(7)</b> The State is required to hold the LME/MCOs accountable for providing access to community-based mental health services and for monitoring services and service gaps through LME/MCOs.</p>	<p>These requirements identify the LME/MCO Medicaid managed care requirements generally. LME/MCOs are accountable for providing access to individuals with SMI, who are in or at risk of entry to adult care homes to transition to supported housing, and to monitor that individuals get access to services to achieve long-term success in supported housing. The State and LME/MCOs monitor service for gaps and through contracts to ensure the number and quality of community mental health service providers is sufficient to allow for successful transitions.</p>	<p>The State is not taking all the necessary steps to meet this requirement. The State has not submitted a gaps analysis report for review this year. LME/MCOs reported gaps in TCLI service availability during fall 2020 review calls but the State does not require specific Settlement network requirements match Settlement requirements.</p> <p>The State’s contract requirements for TCLI do not align with the Settlement requirements. LME/MCOs do not take all the steps necessary to ensure community mental health service providers meet standards to ensure successful transitions and long-term stability and success (as tenants) and in some instances ensure services are available as needed. There are still challenges with the State taking steps to hold LME/MCOs accountable for access as set forth in this requirement.</p> <p>The State is making progress to ensure access to services occurs consistent with federal requirements in 42 C.F.R. § 438, although there are still challenges with the State taking steps to hold LME/MCOs accountable for access as set forth in this requirement.</p>

Major Categories	Standards	Progress Towards Meeting the Requirements
<p><b>Section III.(C)(8)</b> specifies who is to receive information and training, requirements for language and accessibility to services, and the types of services required, including Peer Support, ACT, and Transition Year Stability Resources (TYSR) under the Medicaid State Plan in accordance with the original MCO implementation schedule.</p>	<p>There are a number of requirements for LME/MCOs in this section. They range from providing materials and information to every beneficiary consistent with 42 C.F.R. § 438.10 and to local providers, hospitals, homeless shelters, police departments, and Department of Corrections facilities. It references the LME/MCO start-up schedule (no longer applicable) and accessibility requirements.</p>	<p>The State has not yet met this requirement but is taking steps to meet it. Information appears to be available to beneficiaries consistent with federal statutes. Accessibility as set forth in 42 C.F.R. § 438.10 remains an issue but has been a key focus of the Barriers Committee. Their work has already enabled individuals to move into and continue to live successfully in their home. LME/MCO staff have not consistently presented barriers to the State Barriers Committee. Six (6) individuals in the fall 2020 review were not getting support for their accessibility requirements to move to and/or remain in the community. In each situation resources were available.</p>
<p><b>Section III. (C)(5)(9)</b> The State shall provide Assertive Community Treatment (ACT) by teams using a nationally recognized fidelity model. By July 1, 2019, the State will have increased the number of individuals served by ACT teams to fifty (50) teams serving five thousand (5,000) individuals at any one time; individuals receiving ACT will receive services from employment specialists on their team.</p>	<p>These provisions include requirements for the delivery of ACT, by number of teams meeting and number of individuals served. There is a requirement for the provision of ACT by teams that operate to fidelity and meet requirements of the State service definition. All the individuals receiving ACT services will receive services from employment specialists on their ACT teams. (The State selected the TMACT fidelity model.)</p>	<p>The State met the FY 2020 requirement to provide ACT services to five thousand (5,000) individuals in FY 2020 rising to five thousand one hundred and forty-two (5,412) reenrolled by June 30, 2020. The State is not meeting the requirement to provide employment services to individuals getting ACT services. Two (2) out of sixteen (16) individuals receiving ACT who indicated their interest in employment and/or education got assistance with employment. Twenty-one (21) individuals in the fall 2020 review were receiving ACT services at the time of the review.</p> <p>It may not be necessary for every individual receiving ACT to get this support based on their choice and their age related chronic medical condition. But to meet the requirement, individuals get the choice to receive this assistance. The LME/MCOs monitor ACT performance to varying degrees and the State reviewed ACT scores with the LME/MCOs in a webinar in FY 2020. Fidelity scores have identified the weaknesses in service delivery that are preventing the State from meeting the Settlement Agreement Community-Based Mental Health Services requirements. The UNC ACT Technical Assistance Center provides technical assistance on these issues and has consistently presented information on the TMACT fidelity, although not on TCLI specific requirements.</p>

Major Categories	Standards	Progress Towards Meeting the Requirement
<p><b>Section III. (C)(10)(a-c)</b>                      The State shall require that each LME/MCO develop a crisis service system, with a wide range of services and services provided in the least restrictive setting. The State will monitor crisis services and identify service gaps.</p>	<p>There shall be a range of crisis services interventions delivered in locations, including at the individual’s residence whenever practicable, consistent with an already developed individual community-based crisis plan. Crisis services must be accessible and delivered in a timely manner.</p>	<p>The State and LME/MCOs are taking steps to meet this requirement and develop a more robust crisis system. There was not clear evidence of the utilization of crisis plans to deal with situations that may otherwise result in crises. Crisis plans are part of PCP documents and, like PCPs, are poorly written and most individuals could not identify what is in their plan when asked during the fall reviews.</p> <p>There is not sufficient evidence that crisis intervention and stabilization are available to prevent individuals from losing housing. The data indicates individuals’ re-admission to hospitals or using emergency rooms is low after moving into supported housing.</p>

**(A) Background**

The SA's Community-Based Mental Health Services section requires the State to ensure that individuals get access to the array and intensity of services and supports necessary to enable them to successfully transition to and live in community-based settings. Other major requirements are for services and supports to be evidence-based, recovery focused, and community based. Services are to be flexible and individualized to meet the needs of each individual with all of the elements and components of a person-centered plan arranged for the individual in a coordinated manner. Individuals receive support to increase their abilities to recognize and deal with situations that otherwise may result in a crisis and to increase and strengthen their networks of community and natural supports as well as their use of these supports for crisis prevention and intervention.

The State continues to not meet any of the Community-Based Mental Health Service requirements listed above and this failure is a major obstacle to the State's meeting not only this requirement but a number of other Settlement Agreement requirements.

The State's inability to meet requirements also contributes to community and social isolation, lack of personal support, and lack of assistance from natural supports to prevent crises. Individuals institutionalized for a long period of time or intermittently over time have difficulty overcoming their negative symptoms and restoring their functioning lost through isolation, inactivity, and negative perceptions they and others have of them.

The Reviewer's FY 2019 Annual Report listed fourteen (14) recommendations prefaced with a finding that the State's pace and level of change were not sufficient to meet the community mental health services Settlement Agreement requirements by the scheduled end of the Settlement Agreement on July 1, 2021. The FY 2019 Report recommended the State take a focused cohesive approach to meeting these requirements, starting with developing a strategic plan to meet the Settlement's service requirements. This included establishing action steps, priorities, and feedback loops, and communicating proposed changes in clear concrete terms. Sequencing the changes is essential and begins with the State recognizing its role and taking steps to better understand how to create an adequate adult mental health system for adults with serious mental illness, then taking the steps to create it. This also begins with examining the interconnected and multiple types of contracts, policies, practices, and reviews and how they contribute to or are insufficient, are contradictory to standard practice, or create redundancies.

The FY 2019 Annual Report discouraged the State from treating the aforementioned recommendations as stand-alone recommendations to be taken one step at a time. Meeting these requirements requires understanding that taking a specific step may have unintended consequences on meeting other requirements. For example, meeting Discharge and Transition Processes and Pre-screening and Diversion requirements will create more demand for housing

slots for individuals in Categories 4 and 5 of the target population at the same time the State is struggling to meet the requirement to fill slots for individuals in Categories 1-3. It would be a mistake to silo this approach between divisions, state and LME/MCOs, and LME/MCOs and providers.

Individuals with lived experience have critical knowledge that is virtually untapped, as do academic programs with experience researching and teaching best practices to deliver services and supports as well as to utilize assertive engagement and recovery based clinical interventions. Individuals with lived experience are advising, reviewing, teaching, and mentoring staff but they also are valuable direct care staff.

The fall 2020 review of Community-Based Mental Health Services and Supports reflected the challenges individuals face to access support and live successfully in the community. Meeting these requirements requires direct services and supervisory staff to be knowledgeable of and apply recovery-based principles, skilled at using those approaches, skilled and constant in assertively engaging individuals, and aware of resources, interventions, and support that can help an individual live a more successful life, not just be compliant with treatment and rules. The reviews revealed evidence of staff dismissing individuals' expressed needs and a lack of awareness of recognizable challenges, especially the effects of trauma, fear, loss of self-worth and self-confidence, and loss of functional and/or decision-making skills. At times staff approached their work either blaming individuals for their problems or accepting other people's views rather than forming their own impressions.

The fall 2020 review revealed that of the sixty (60) service provider-based teams<sup>17</sup> that provided services to individuals reviewed, six (6) teams provided excellent recovery focused practice as reflected in this example below:

*One woman reported she was at last successful in an apartment, on her third try, because she is now living close to her family and they are her natural supports. Her ACT team is focusing on supporting her recovery. She is using Google calendar as a way to keep a schedule and remember to take her medications. She reports getting a lot of help from the housing specialist on her ACT team. She sees her employment specialist frequently, who has encouraged her to try on-line learning although she says she is not quite motivated to do that yet. She is hopeful she can train her mind to do that. She is eager to consider on-line support groups during COVID.*

More often, though, the fall 2020 reviews revealed that the opposite occurs.

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<sup>17</sup> Six individuals were being served by more than one team at the time of the review.

*One man is receiving services from a peer support specialist. He moved into supported housing in May 2020, but there has not been any update in his PCP since he moved, and the principal goal is still “to get housing,” months after he got housing, and to remain medication compliant. There are no recovery goals in his PCP, including those he has for himself. The highlight of his life is his dog, but the progress notes revealed his peer support specialist advised against getting the dog and directed him to get rid of the dog. The specialist completely missed the importance of the dog, providing the opportunity to get out of the house every day for a walk and, as a result, a great motivator to meet other people.*

*He reported that he got a termination notice of his SSI benefits. He asked the peer support specialist for help to get it re-instated, but the specialist took the letter and has not gotten back to him. This situation is similar to the problem he had when seeking eligibility for TCLI. His TCLI eligibility request was on hold for thirteen months, leaving him on his own to get an assessment to secure eligibility. He moved in with his sister who became his payee and misappropriated his funds while he was waiting on the eligibility assessment. According to the individual, the peer support specialist is mad at him and is demonstrating that by refusing to take him to the food bank. He is now working towards getting another provider.*

The fall reviews also revealed challenges that individuals, eager to remain living in the community, are fearful of not being able to live on their own and not finding ways to overcome their loneliness with so few opportunities to spend time with others or not become a burden to others.

*One man with a severe heart condition is on palliative care requiring equipment and a generator in case of a power outage. He moved into his apartment in June 2020. He is getting assistance from a CST team who contacts or visits him on either a one, two, or three-week interval. When the Review Team member visited with the man, he reported, and the CST staff member confirmed, it had been three weeks since their last contact. The CST team member stated, “he can reach out to me at any time if he needs to.” The man mentioned he did not have a working phone and he expressed the fear that he might need help in an emergency and had no way to contact anyone. The CST staff member said he was unaware of this. The man expressed his fear that his generator might stop working as it had during a recent hurricane.*

*The man has some family in the area but said he was afraid he had worn them out and did not want to bother them. Only one person on the CST team works*

*with him although he was anticipating getting support from a peer specialist in the future. The man mentioned that earlier the LME Post Transition Care Coordinator said she was going to make a referral for personal care services for him, but he said he didn't need help after the CST team member said "PCA is only for helping people with bathing, dressing, and toileting," all things the man can do on his own. He expressed the need for help with daily living skills, which either personal care assistance or individual support staff could help with given his serious medical condition. The CST worker then remarked that this was the first time they had discussed this issue despite the need for individual support documented in the man's clinical assessment four months earlier.*

*His first words upon meeting the Review Team member were "pardon me if I talk too much because I have not talked to anyone in three weeks."*

### **(B) Findings**

1. Individual interviews and desk reviews revealed the State is not meeting **Section III. (C)(1) (3) and (6)** to provide access to the array and intensity of services and supports necessary for an individual to successfully transition and live in community-based settings. These sub-sections include requirements that services be recovery based, community based, flexible, and individualized to meet the needs of each individual, and that services will help individuals increase their ability to recognize and deal with situations that may otherwise result in crisis. These sub-sections require the State to assist individuals to increase and strengthen their networks of community and natural supports as well as their use of these supports for crisis intervention and prevention. There is a requirement that the individual's person-centered plan (PCP) reflect these requirements. It must be current as an individual's living setting, goals, and service needs change over time.

Each review included questions derived from the standards for these **(C)(1), (C)(3)(a-d), and (C)(6)** requirements. **Figure 6**, below, displays the rank order of services' mean scores as referenced in the methodology section above.

A score of 2.5<sup>18</sup> is the primary indicator the State is meeting a requirement or sub-requirement. These mean scores covered services provided by community-based mental health service providers listed below.

While not always a true indicator, the gap between this target score of 2.5 and the State's current score points to the degree to which the State's service system needs restructuring instead of merely overlaying new requirements on top of existing requirements. The gap

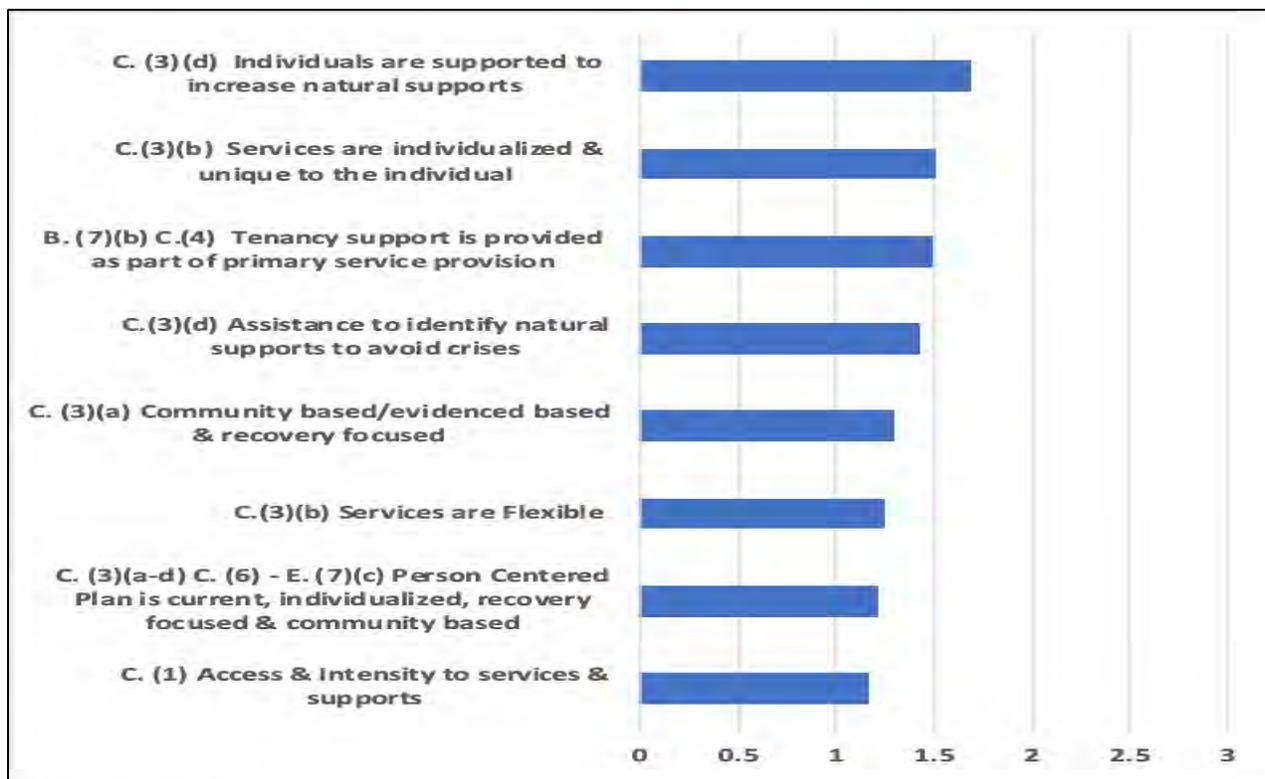
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<sup>18</sup> CMS requires a composite score of 2.5 or above on their HCBS reviews and requires a plan of correction for any state scoring below 85% on their HCBS review.

indicates there are fundamental challenges in the system that require more than training to help providers improve their scores. Closing this gap begins with adopting principles of a recovery-based system, putting those principles into practice, adopting payment models to drive performance, examining rates and definitions, adopting a mentoring approach to practice improvement, and adopting a practical, timely feedback loop to improve performance.

There was not a discernable difference between scores by type of service, although there were differences in scores across providers. As stated above, six (6) teams provided excellent recovery-based services and, if tallied separately, would have likely scored at the mean or above but only for the eight (8) individuals served by those providers and selected for review.

**Figure 6: Services Mean Scores**



2. Tenancy support includes a range of defined interventions that must occur prior to and during move-in, and post tenancy if the State is to be successful meeting **(C)(1)(2) and (4)**. Tenancy support is both a stand-alone service and embedded in three services as described below.
3. The State is not meeting the requirement in **Section III. (C)(2)** referencing services for individuals in or at risk of entry to an adult care home who do not receive a housing slot. The fall 2020 review revealed seventeen (17) individuals became eligible for TCLI in the past year but experienced a delay not related to the COVID pandemic. For some, the delay was in

having a provider assigned; others were assigned to a provider but did not receive timely services or transitional assistance to move into supported or bridge housing. Individuals who experienced a delay but eventually got into supported housing are not included in this group of seventeen.

4. **Section III. (C)(4)** requires the State to rely on specific services plus other services to satisfy the requirements of the Agreement. One key service is tenancy support, which is a standalone State funded service called Tenancy Support Management (TSM). Tenancy support is an embedded requirement in Assertive Community Treatment (ACT) and Community Support Team (CST).

The availability or use of the following services varies widely, according to region and knowledge of the individuals involved in an individual's service planning: Nursing, Home Health, Personal Care Services, Community Alternative Program for Disabled Adults (CAP-DA), Individualized Supports, Integrated Dual Disorder Treatment (IDDT) and other substance abuse treatment interventions, Self-Directed Care (SDC), Cognitive Based Therapy (CBT), other cognitive and trauma informed therapies, Occupational Therapy (OTR), and direct services provided by occupational therapy assistants under the supervision of an OTR. These services and interventions are often key to an individual's success in community living.

Independent Living Supports is a highly effective service first made available in 2019. The State has contracted with the NC Alliance for Disability Advocates (NC-ADA), a Center for Independent Living (CIL), to provide one-on-one support to individuals in TCLI in the Eastpointe LME/MCO catchment area and, more recently, to individuals in the Alliance LME/MCO catchment area. Over eighty (80) individuals referred to the ADA from Eastpointe have had extremely positive interactions with ADA team members and positive outcomes. The ADA project matches TCLI recipients with ADA peer support specialists to assist individuals to gain or regain a skill, get information, get help with a job, training or education, or purchase an item that helps the individual re-engage in the community. The team uses an empowerment model, giving individuals choices and support with the goal that the individual will become more engaged in community and be more independent.

In the fall 2020 review, there were three (3) services provided almost equally among recipients: Assertive Community Treatment, Community Support Team, and Tenancy Management Services. Not all of the individuals were actively engaged in these services although the reviews revealed that individuals were moved or discharged from one service provider to another on a regular basis. Peer support is a stand-alone service and available for individuals receiving TSM and embedded in ACT. Individuals have to give up their standalone peer support services when referred to CST. This happened early in FY 2020, to avoid double-billing Medicaid. Individuals in the fall review continued to express their concern about losing

this support. Three (3) individuals in the fall 2020 review refused services; one (1) of those individuals and his guardian chose placement in a group home as his only service. It was not clear if anyone refused service because they had to change providers and in one situation, they did not want to lose their peer support.

**Figure 7** below references the service provided at the time of the review. Records and staff reporting revealed seventy-four (74) individuals getting a community-based service. Six (6) individuals got TSM and Peer Support. Of those listed as “other,” records showed that two (2) individuals were actually engaged in Psychosocial Rehabilitation Services (a day program) and others reported being enrolled but not attending. Two (2) others reported getting therapy and medication management only. These breakdowns are consistent with previous years’ reviews. Based on records, as well as individual and staff reports, there was a wide variation on how frequently individuals were seen. The State’s data analysis does not include a frequency/intensity review.

**Figure 7: Services Provided to Individuals in the Fall 2020 Review**

<b>Primary Service/ Fall 2020 Review</b>	
Assertive Community Treatment (ACT)	22
Community Support Team (CST)	20
Tenancy Management Service (TSM)	20
Peer Support	14
Psychosocial Rehabilitation	4
Outpatient Therapy	1

5. The State received federal Medicaid approval to expand the responsibilities and number of Community Support Teams (CST) in the fall of 2019. Community Support Team interventions and responsibilities now include skills development, symptom management and recovery, crisis intervention, and coordinating and managing services. Adding skills development, illness management and recovery, crisis intervention, and managing services made the CST service more robust and enables staff to intervene to help reduce separations from housing, to help individuals manage their own symptoms and their crises, and to further develop or restore their community and daily living skills. The standalone TSM service did not include these interventions; TSM staff does provide interventions critical to recovery, self-sufficiency, and community integration but would likely not get approval as a Medicaid service by the federal Centers for Medicare and Medicaid Services (CMS). The State took the step to expand the existing CST service to provide these additional supports and expand the use of federal resources.

CST implementation has been challenging. This stems, in part, from the fact that nearly half of the teams now providing this service had no prior experience with tenancy support, which, as explained above, is now embedded in the CST service. This lack of experience was quite

evident during the fall reviews. One provider asked a reviewer this fall where he could learn about tenancy rights. Other providers did not seem to understand all the tasks included in the three phases of tenancy (transition planning, move-in, and post-transition support) and how to help individuals retain their tenancy, thinking someone getting into housing meant their tasks were complete and all they needed to do was monitor that the individual was still living in their home. Understanding and assisting individuals with their tenancy rights, including reasonable accommodation, is a competency that any CST staff person should have before delivering this service.

Two missing elements to the initiation of the new, expanded CST service in FY 2020 were (a) robust competency-based training prior to the initiation of the service and (b) “on the ground” coaching support, especially to help staff shift the primary focus to recovery-based interventions and away from a focus mostly directed towards treatment compliance and personal deficits. Health professionals typically go through competency-based training and in vivo training such as that provided through internships or field-based training. This did not occur for providers of the new CST service, and the results of the fall 2020 review demonstrate the results of these shortcomings.

The State required LME/MCOs to provide a two-day training on CST requirements during the second quarter of FY 2020. The UNC Institute for Best Practice and Peer Voice (a statewide Peer Advocacy Coalition) began delivering Permanent Supported Housing training for CST and other teams virtually in FY 2020. The Review Team monitored these trainings initially. The Review Team’s collective views were that the UNC training was excellent, providing information in both didactic and experiential presentation formats. The State also held LME/MCO based provider focus groups in August 2020.

6. CST teams failed to refer ninety-two percent (92%) or eleven (11) of twelve (12) individuals from the review sample who expressed an interest in employment or education to IPS-Supported Employment teams. There was one (1) individual getting help from their CST team and eight (8) individuals with challenges that prevented them from seeking employment at the time of the review.
7. The State has selected the TMACT fidelity model for Assertive Community Treatment (ACT) services, complying with **Section III. (C)(5)**. The State exceeded the 2020 annual requirement to provide ACT to five thousand (5,000) individuals at any one time, serving five thousand four hundred and twelve (5,412) individuals on seventy-three (73) teams by June 30, 2020, as required in **Section III. (C)(9)**.
8. Evidence is not sufficient to show that individuals receiving ACT who want to work are receiving services from employment specialists on ACT teams as required in **Section III. (C)(9)**. Sixteen (16) of the twenty-two (22) individuals interviewed who were getting ACT services

reported they were interested in employment but only two (2) were receiving employment services from their ACT team's employment specialist. At least two (2) individuals in the review sample received miscellaneous assistance (related to money management and benefits acquisition) from an employment specialist but received no assistance to get employment.

9. The State cancelled TMACT fidelity reviews when the pandemic halted in-person reviews in March. There were very few changes in fidelity scores from the Reviewer's 2019 Annual Report. Ten (10) teams scored in the exceptional range in their last reviews and almost all in the full certification range. But a review of scores within the range showed that teams' scores were either higher or lower than their previous review. However, due to COVID, reviews stopped in March 2020 so information from most reviews is for years 2017-2019.
10. An analysis of the most recent TMACT team scores revealed two findings consistent with findings in the fall 2020 reviews: 1) The rate of ACT teams' systemic implementation of supported employment implementation was below fifty percent (50%) for sixty nine percent (69%) of the ACT teams across the state; and 2) A review of high and low TMACT sub-scores found the highest rankings on the operations and structure of the teams and core team functions, and lower scores in areas more closely related to Settlement Agreement obligations: frequency and intensity of contact with the individual, frequency of contact with natural supports, full responsibility on psychiatric rehabilitation services, and strengths informing the person centered plan.
11. The TMACT fidelity tool has a larger number of core team and operations and structure items than items more closely tied to the Settlement Agreement requirements. Nonetheless the TMACT is a useful tool, not as a stand-alone monitoring tool, but in its broader monitoring function. The State and UNC recently conducted a webinar for LME/MCO staff on the use of this tool in the LME/MCO review of ACT team performance.
12. The LME/MCOs and the State began inviting ACT teams to tenancy support training in FY 2020 and the State is now requiring all ACT teams providing tenancy support to attend tenancy support training. This is a request ACT teams had made previously. As noted above, tenancy support is embedded within ACT.
13. The Institute for Best Practice has been hosting ACT Collaboratives across the state for several years. These are important opportunities for ACT providers to exchange ideas and get new information from the Institute and the State.
14. The FY 2020 housing separation rate (i.e., the rate of individuals leaving supported housing) remains high but was three percent (3%) lower in FY 2020 than the separation rate in FY 2019. However, there was a three percent (3%) increase in the number of individuals occupying housing in FY 2020 as compared to individuals occupying housing in FY 2019. There was a

decrease of twelve percent (12%) in the rate of individuals returning to ACHs over the previous year, but an increase of fifty-seven (57), or eighty four percent (84%), of individuals whose whereabouts were unknown at the time they separated from housing. There were virtually no changes in percentages of where individuals moved when they left supported housing in the other categories reported by the State. Of the forty-two (42) individuals in the review sample who were living in supported housing at the time of the fall review or who had lived in supported housing, only three (3) had returned to an ACH before the fall FY 2020 review. All three (3) needed more assistance to live in the community than they had received and two (2) were interested in moving back to supported housing as additional supports are arranged for them.

15. Twenty-eight (28) of the one hundred and five (105) individuals in the fall review sample had lost housing one or more times; this means that more than a quarter of the review sample experienced housing instability. Six (6) of those twenty-eight (28) individuals asked for a new provider. A number of other individuals assigned to a new provider by the LME/MCO arranged to change their providers in hopes that they would get the services and supports they needed to sustain their housing.
16. The primary requirement in **Section III (C)(7)** is for the State to implement pre-paid capitation plans and contract with LME/MCOs to operate the plan. The requirement obligates the State to monitor services and service gaps and ensure that the number and quality of community mental health service providers is sufficient to allow for successful transition and diversion of individuals from ACHs. The Settlement Agreement requires the State to do this in such a manner to enable individuals to have success in supported housing and long-term stability in the community.

The State delegates services monitoring and identification of and reducing service gaps to the LME/MCOs in both the Medicaid (Division of Medical Assistance) contract and Mental Health (Division of Mental Health, Developmental Disabilities and Substance Abuse) contracts, as well as the three-way contract for state institutional services. In this arrangement, the responsibility falls to the LME/MCOs to ensure that the number and quality of community mental health service providers is sufficient to allow for the successful transition and diversion of individuals from ACHs.

This delegation comes with State obligations as well. The State has not written contracts with LME/MCOs that spell out LME/MCO obligations for network sufficiency, service provision, level of acceptable performance, and outcomes that meet the Settlement requirements. Unless these obligations are more clearly spelled out, the LME/MCOs will not fully grasp their responsibilities or to what extent they have obligations beyond what is currently written in contracts. Current language is not specific or clear on Settlement Agreement. The State could opt to add obligations in guidelines and bulletins which are also binding documents. This State

responsibility goes beyond the contract documents to the promulgation of policies, guidelines, and bulletins, and, where applicable, operating manuals primarily for the TCLL functions that include tasks and data collection. The State's responsibilities for monitoring these functions are also essential. The State has failed to spell out obligations clearly for specific requirements in contracts and to monitor the effectiveness of their guidance and requirements over time. This has led to the State's failure to meet the services obligations in this Agreement.

These requirements cannot be the sole responsibility of the LME/MCOs and the service providers if the State is to meet the services requirements in the Settlement Agreement. Compliance will require the State's leadership, setting performance standards, providing clear guidance, arranging for coaching and other effective service improvement approaches and monitoring results. Compliance begins, though, with the contracts. These issues are also referenced in the Quality Assurance/Performance Improvement section of this report. The State took steps to meet this requirement by creating a monthly dashboard and by adding "super measures" to its contracts with the LME/MCOs. In this context, a dashboard is defined as an analytical tool used to provide a condensed, visual report on patterns and progress on key performance indicators; in this case performance indicators are synonymous with key Settlement Agreement requirements. Super measures are performance measures the State uses to track LME/MCO performance and the State uses to incentivize LME/MCO performance. The items considered "super" because they are key measures the State tracks for one year and then typically switches to other measures in the following year.

The super measures include a penalty provision if the LME/MCO did not meet its goal for the specific measure. The State did not publish a monthly dashboard illustrating the LME/MCOs' performance on various SA obligations, nor did it create additional measures which the State describes as "super measures" to incentivize performance in FY 2020. The dashboard and super measures used in previous years did not address services issues.

The Reviewer conducted a review of the State's contracts with LME/MCOs in FY 2016, pointing to the lack of consistency between the contract requirements and the Settlement Agreement's requirements and followed this up with reviews of the differences between the State's gaps analysis requirements and the Settlement Agreement's requirements. The State has not forwarded results of the last gaps analysis for review nor has the Division of Mental Health, Developmental Disabilities and Substance Abuse (DMH) responded to this Reviewer's comments on the FY 2019 contract amendments. There were notable exceptions to these shortcomings but none on improvements in services and supports.

17. The LME/MCOs provided copies of their FY 2020 Performance Review Plans, which they use to monitor provider agencies' performance, and there was evidence in individual records of

LME/MCOs providing feedback to service providers on the quality and adequacy of Person-Centered Plans and other chart review documents. The Performance Improvement Plans demonstrate the LME/MCOs' awareness of critical service and support deficits and their attention to improving services. The LME/MCOs began developing performance review plans for TCLI several years ago. These plans identify issue(s) based on data analysis and recommendations from key LME/MCO staff for LME/MCO Performance Review staff to analyze further and make recommendations for improvement. The FY 2020 plans took these issues a step further with direct feedback to providers on actual Person-Centered Plans.

18. **Section III. (C)(8)** is primarily a description of LME/MCO responsibilities to beneficiaries under 42 C.F.R. § 438.10, regarding information accessibility, as well as to hospitals, providers, police departments, homeless shelters, and Department of Corrections facilities. It also references requirements the LME/MCOs assumed when becoming MCOs. It includes the LME/MCOs' responsibilities for meeting federal accessibility requirements. The LME/MCOs meet the federal requirements for providing publicity, materials, and training about the crisis hotline, services, and availability of information, although stakeholders often report that the plans are too general and don't provide information to help individuals make decisions, especially on moving to supported housing and what resources are available to help individuals move to community settings. This became a significant issue when the State and LME/MCOs initiated new pre-screening arrangements in 2018 and 2019. The State and LME/MCOs responded quickly and continue to provide consultation and education on this new arrangement. There are still issues related to accessibility covered in the housing and discharge and transition sections of this Report.
19. **Section III (C)(10)(a-c)** includes requirements for an LME/MCO to develop a crisis service system, for the state to monitor gaps in crisis systems, and for crisis services to be provided in the least restrictive setting consistent with their individualized crisis plan. Crisis systems are in place and monitored through the "gaps analysis." However, the State's data reveals these services are rarely utilized for the Settlement Agreement target population in the transition phase or after they move to the community. Mobile teams appear to be called to adult care homes more frequently than to assist with individuals living in the community.
20. As reported in previous Annual Reports, when individuals experience crises before they move into the community and following their move (including when they are moving into supported housing), the in-reach staff and transition coordinators manage the crisis, including crisis prevention, intervention, and stabilization. The State's FY 2019 utilization data reflects only two percent (2%) of individuals in the transition phase of moving received at least a single unit crisis service and only four percent (4%) of individuals received a crisis service after they moved into the community. Reviewers are aware of In-reach and Transition Coordinators responding because they do so to help individuals whose names are pulled for

reviews.

21. There is clear evidence that individuals are not routinely provided assistance to increase their ability to recognize and deal with situations that may otherwise result in crises, as required by **Section III(C)(3)**, although some individuals report they know their crisis triggers and try to prevent an escalation of situations that result in crisis. The fall 2020 individual reviews revealed that, although a number of individuals' "crisis plans" included some useful contact, diagnostic, insurance, and medication information, they often did not constitute true plans, as the templates were not filled out, but contained only instructions about how to fill out the plan. Likewise, a number of individuals reviewed did not get assistance during recent crises.

**(C) Recommendations**

1. The State develop and implement a strategic plan to meet the Community-Based Mental Health Service requirements as outlined in this Report and previously in the FY 2019 Reviewer's Annual Report. This is a complex task with multiple steps, requiring changes in interconnected and multiple types of contracts, policies, service descriptions, and practices with a review of resources, allocations, and payment models to achieve required performance and outcomes. This will necessitate establishing sequential action steps, priorities, and feedback loops and communicating proposed changes in clear concrete terms.
2. The State expand the array of and improve services is available to the priority populations in a manner that matches the needs of the target population getting ACT, CST, and/or TSM and a greater emphasis on use of health care management arrangements, individual supports, and peer support. The highest priorities for this array are (1) the effective implementation of Community Support; (2) expansion of evidenced based peer support, focused on individuals in the current and future TCLI target population; and (3) expanding capacity of health providers who are knowledgeable on wellness, recovery, and managing and preventing deterioration of chronic health conditions.
3. The State expand evidence based services and supports focused on recovery and building community and natural supports to enable peer led and/or directed services to be available to anyone in the target population and to improve the State's service delivery system. The State expand peer services to include peer-led IPS-SE and/or evidenced based services and assistance to create a new business or service, outreach and peer navigator services, social clubs and drop-in centers, wellness and recovery education, mentoring/coaching, and/or partnerships with health centers and individual, community, and crisis or respite support.
4. The State ensure LME/MCO, SPH, and provider staff have competencies in person-centered planning, including ensuring the individual's goals and choices drive the plan. Ensure all provider staff as well as In-reach staff, transition coordinators, and SPH receive guidance on and have competencies in utilizing the State's recently developed decision making tool. In-

reach staff and transition coordinators are the principal users of this tool, but it is vital for all staff to understand and use it to improve their practice and remove all references to instructions on what to include on the PCP templates.

5. The State and LME/MCOs ensure that person-centered plans are recovery focused, are individualized, meet requirements for intensity and duration, and include supports based on need, choice, goals, wellness and health care, personal care, employment, daily living, and community supports. Ensure that SPH, In-reach, transition staff, and service providers have a common understanding of these requirements and their role in developing not just the plan itself but a recovery approach in their work as well. Ensure authorization is not the primary use for person-centered plans and that Clinical Care Policies reinforce practice that focuses on these requirements.
6. The State improve capacity and performance of service providers to reduce crises that lead to housing separations through expansion of bridge housing and the provision of crisis respite, crisis stabilization, and/or in-home crisis respite. It is generally accepted practice that crisis teams and crisis residences, including peer run residences, are helpful to enable individuals to continue to reside in the most integrated setting possible, including retaining their own place to live. The State consider directing more of these resources, continuing to rely on the primary service provider or some hybrid approach to do both. However, relying solely on the individual's primary service provider may result in providers either over-extending themselves or discontinuing services when they feel overwhelmed and under-resourced.
7. The State conduct regular claims-based data analysis. Include data on services provided to each of the Settlement Agreement priority populations. Analyze longitudinal individual service use data to identify intensity and duration by priority population groups. This includes measuring the intensity of ACT services for each individual served.
8. The State ensure that DMH, the Division of Medical Assistance (DMA), and LME/MCO provider contracts include not just process requirements but specific expectations for performance and outcomes. The State regularly monitor and enforce its LME/MCO contracts and ensure that LME/MCOs monitor and enforce provider contracts. Establish pay for performance requirements but only when there is sufficient attention given to establishing clear expectations and data requirements. Expectations include providing services that: (1) are evidence-based and recovery focused; (2) are flexible and individualized; (3) help individuals to increase their ability to recognize and deal with situations that may otherwise result in crises. This includes the State providing guidance on measures that are effective and that meet Settlement Agreement requirements.

### III. SUPPORTED EMPLOYMENT

Major Categories	Standards	Progress Towards Meeting the Requirements
<p><b>1. Section III. (D)(1)</b> The State will develop and implement measures to provide Supported Employment Services (SE)<sup>19</sup> to individuals with Serious Mental Illness (SMI), who are in or at risk of entry to an ACH, that meet individual needs. Services will assist individuals in preparing for, identifying, and maintaining integrated, paid competitive employment.</p>	<p>1. The State has developed and is implementing<sup>20</sup> measures to provide SE services to individuals who are “in or at risk of entry to an ACH” that meet their individual needs<sup>21</sup>. This includes measures that provides access to integrated employment and mental health services and access to post-employment follow-along support. Individuals get help to prepare for, identify, and maintain employment that meets their individualized needs.</p>	<p>The State has not met these requirements and is not on track to meet them in FY 2021.</p> <p>Only eleven percent (11%) of the thirty-eight (38) individuals reviewed in the fall 2020 review who expressed interest in employment received assistance to identify and prepare for employment. Of that number, one (1) or three percent (3%) received assistance from teams integrating their MH and SE plans and services. There were two (2) referrals to the Division of Vocational Rehabilitation for six percent (6%) of the individuals who expressed interest, and none received post-employment follow-along supports for a year.</p>
<p><b>2. Section III. (D)(2)</b> SE Services are provided with fidelity to an evidenced-based supported employment model for supporting people in their pursuit and maintenance of integrated, paid, competitive employment work opportunities. An established fidelity scale will assess SE.</p>	<p>1. Services must meet fidelity to the IPS-SE model. 2. The State will use the established IPS-SE fidelity scale.</p>	<p>The State has met the requirement to adopt the IPS-SE fidelity scale.</p>
<p><b>3. Section III. (D)(3)</b> By July 1, 2020, the State will provide IPS-SE services to a total of two thousand one hundred and ninety-three (2,193) individuals “in or at risk of ACH placement.”</p>	<p>The standard is the same as the requirement.</p>	<p>The State reported exceeding the FY 2020 requirement, with two thousand four hundred and ninety-one (2,491) individuals “in or at risk” of ACH placement provided SE services; however, the fall 2020 review revealed a number of individuals reported as having received employment services did not have receive services.</p>

<sup>19</sup> SE services refers to IPS-SE services as referenced in #2 below.

<sup>20</sup> Implementation includes monitoring for verification of “in or at risk” and access to both SE and Division of Vocational Rehabilitation (DVR) resources.

<sup>21</sup> Per the Settlement Agreement, severity of an individual’s disability cannot be a barrier to an individual transitioning to an integrated setting appropriate in all domains of an individual’s life (including employment and education) based on the individual preference, strengths, needs, and goals.

**(A) Background**

The Settlement Agreement requires the State to develop and implement measures to provide individuals with SMI, who are in or at risk of entry to an ACH, with Supported Employment (SE) services that meet their individual needs. The Settlement Agreement defines SE services as services that assist individuals in preparing for, identifying, and maintaining integrated, paid, competitive employment. Services may include job development, job coaching, transportation, assistive technology, specialized job training, and individually tailored supervision.

The Settlement Agreement requires the State to select an evidence-based supported employment model. The State selected the Individualized Placement and Support Supported Employment (IPS-SE) model as it is an evidence-based supported employment model. This model is without comparison in its positive outcomes for adults with serious mental illness. It is a widely adopted model<sup>22</sup> implemented through a Learning Community<sup>23</sup> in twenty-one (21) states, the District of Columbia, three (3) regions in other states, and six (6) countries.

As many as sixty six percent (66%) of individuals with serious mental illness want to work, which is consistent with findings in TCLI recipient random interviews over the past five years<sup>24</sup>. At least twenty-three (23) randomly controlled studies demonstrate the efficacy of IPS-SE over other supported employment models<sup>25</sup>. Based on this information and the extensive experience of the Review Team, active, focused, well-organized state and local leadership, coupled with a strong and sustainable financing plan, are essential to effectively implement IPS-SE services and overcome the challenges of assisting individuals in the TCLI target population with seeking work, returning to work, and sustaining that work. An outcome data system that monitors effectiveness and documents that individuals are securing and maintaining competitive employment and further education drives performance.

The fall 2020 review revealed unresolved challenges with access and delivery of this service to assist individuals to identify and maintain employment. This was true for IPS-SE and for individuals served by ACT teams<sup>26</sup>. This report will cover the findings from the fall 2020 review, updating information reported in the FY 2020 Interim Report.

The fall 2020 review focused on analyzing individual experiences regarding access to and provision of supported employment consistent with Settlement Agreement requirements. This included determining:

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<sup>22</sup> <https://ipsworks.org>

<sup>23</sup> A Learning Community connects participating jurisdictions and organizations with a structure by which to align shared goals, metrics, and outcomes.

<sup>24</sup> Burns EJ, Kerns SE, Pullmann MD, Hensley SW, Lutterman T, Hoagwood KE. *Research, data and evidenced based treatment in state behavioral health systems, 2001-2012. Psychiatric Serv.* 2016; 67 (5): 496-503.

<sup>25</sup> Drake RE, Bond, GR, Goldman, HH, Hogan MF, Karakus, M. *Individual Placement and Support Services Boost Employment for People with Serious Mental Illnesses, But Funding is Lacking, Health Affairs.*2016:35(6): Abstract

<sup>26</sup> The State's ACT fidelity model, the TMACT, requires each team to have a full-time employment specialist.

- 1) If supported employment is available, accessible, and offered to individuals who express an interest in employment, education, or participating in IPS-SE services.
- 2) If supported employment services assist individuals in preparing for, identifying, obtaining, and maintaining paid, competitive employment.
- 3) If supported employment services (a) match individuals' needs; (b) enable individuals to achieve their personal employment and education goals, including integrated, paid, competitive employment; and (c) include job development, specialized job training, transportation, job coaching, assistive technology assistance, individually tailored supervision, and on-going support as requested.
- 4) If individuals who express interest in employment and/or education receive employment services including referrals to the Division of Vocational Rehabilitation (DVR). This referral is beneficial for two reasons. One, the DVR provides benefits not available with state or federal services funding, such as paying for fees, uniforms, equipment, etc. Two, the DVR can reimburse supported employment providers for meeting specific milestones which, if utilized, provides additional resources, increases provider agencies' revenue, and based on the timing of meeting specific milestones, improves their cash flow. This strategy provides critical initial, ongoing, and sustainable funding to support the statewide implementation of IPS-SE services.
- 5) If there is integration of supported employment and mental health services at both the team and individual staff level. This includes whether individuals who are employed receive post-employment follow-along supports for up to a year to assist them with successfully maintaining employment and meeting their employment goals.

The methods used to measure the State meeting the supported employment requirements in FY 2020 included:

- 1) A review of services provided to individuals who expressed an interest in supported employment as part of the fall 2020 review. The criteria for "interest" required at least two of the following:
  - a) the individual reported interest in employment and/or education during an interview with a Review Team member
  - b) the individual expressed interest in employment and/or education in one or more of their own goals in their Person-Centered Plan
  - c) there was a staff agreement to provide SE services for the individual in the Person-Centered Plan
  - d) there was reference to interest in employment or education in service provider notes, and/or TCLI staff notes
  - e) there was reference to interest in employment and/or education on the In-reach tool, in a hospital discharge plan, transition notes, or other clinical assessments.

- 2) Multiple observations of regular meetings, multiple provider interviews, and reviews of written materials, plans, and data from TCLI and DMH staff.
- 3) Observations and attendance in competency based on-line trainings that included material on IPS-SE services.
- 4) Follow-up reviews of IPS-SE verifications, enrollment, and follow-up of services provided in FY 2020 for individuals enrolled between July 1, 2019, and March 31, 2020, based on data regarding paid services claims.
- 5) Observations of meetings and subsequent follow-up discussions with Vaya, DMH, the Senior Advisor to the DHHS Secretary on the ADA and Olmstead, and DHHS DVR staff regarding a pilot of a new business model for IPS (Vaya's NC CORE Pilot).

The Interim Report included information regarding the State's LME/MCO contract requirements, the benefits and limitations of using fidelity measures to measure performance as required in the Settlement Agreement, and the four recommendations made in each of the Reviewer's Annual Reports since FY 2016 and the State's actions in response to those recommendations.

The State has not changed LME/MCO contract requirements related to Supported Employment with LME/MCOs in two and half years, nor has it made changes to its monitoring of the LME/MCOs' compliance with contractual obligations related to the SA. The Interim Report referenced the benefits of using the IPS-SE fidelity review tool, but also referred to the current state of these reviews as not being sufficient to measure the State's performance regarding IPS-SE effectively and accurately. While the accurate use of fidelity does provide information about the direction of IPS-SE services (i.e., improvement trends), it does not provide information about the ultimate effectiveness of the services measured in well-defined outcomes. The State has not yet developed outcome measures for IPS-SE services or used them for performance improvement on an ongoing basis. However, the State did discuss these requirements and findings with LME/MCOs in FY 2020, which could help start this process.

The Interim Report also described in detail the State's actions to improve its business model to make Supported Employment Services sustainable and more widely available, which has been one of the four Supported Employment recommendations made in each year's Annual Report. The State initiated a pilot with a new IPS business model with Vaya Health, an LME/MCO that covers twenty-three (23) counties in the western part of the State. The Vaya pilot, called "NC CORE," features a close collaboration between that LME/MCO and the local Vocational Rehabilitation office, with streamlined operational and reimbursement procedures for IPS providers in the region, designed to improve service delivery and provider stability. The "NC CORE" model does incorporate funding based on the achievement of designated milestones in the employment and education process. The State, in partnership with Vocational Rehabilitation

and the LMEs/ MCOs, may be able to apply lessons learned from the Vaya pilot to launch a viable, sustainable business model statewide.

The Interim Report covered the background, goals, specific provisions, and progress of NC CORE in FY 2020. The State continues to actively monitor NC CORE. Vaya and DVR report on key indicators and adjustments to improve the pilot based on information regarding those indicators. The State recently completed work on an inter-division agreement at DHHS that had been in process for a number of months. Cross systems information made available with this agreement is still not processed and available.

This Vaya pilot process began in the fall of 2019 and within months the percentage of caseloads linked between the IPS provider and VR rose from forty eight percent (48%) to seventy three percent (73%). It leveled off then and on July 15, 2020, was at seventy one percent (71%) but is now trending above eighty percent (80%). This model provides financial assistance to IPS-SE providers. The State and Vaya modified their payment structures recently, allowing the IPS-SE teams to remain financially viable during COVID. IPS-SE staff report they can remain in contact with individuals and have reported that jobs are available in their area.

The State has initiated an internal planning process to create a statewide value-based payment model(s) using lessons learned from NC CORE. The effectiveness of this plan relies upon the development and regular use of more accurate and timely data from the NC CORE pilot, including but not limited to outcome data.

The January 2020 to April 2020 increase demonstrates the motivation of service recipients, as well as service providers and VR counselors, to pursue employment and education goals. Individual service authorizations occurred rapidly, demonstrating a greater demand for the service than previously reported.

While initial interest and enthusiasm for IPS-SE services is critical, the leveling off of the referral rate may well be a reminder that identifying interested individuals in services is only the initial step. The next steps require staff to build on this interest and help individuals meet the complex challenges to identify, secure, and maintain employment that matches their goals.

The process of helping individuals identify, secure, and maintain employment was also complicated by the COVID pandemic occurring shortly after the pilot began. The State relaxed reimbursement rules during COVID, allowing providers more opportunity to stay engaged with individuals they were serving virtually; however, this flexibility did not result in continued engagement and progress through milestones to secure and maintain employment for individuals "in or at risk of ACH placement." Results appear better for individuals not in this target population referred to an agency in the NC CORE pilot.

**(B) Findings**

**Section III. (D)(1) The State will develop and implement measures to provide Supported Employment Services to individuals with SMI, who are in or at risk of entry to an adult care home that meets their needs. Supported employment services assist individuals in preparing for, identifying, and maintaining integrated, paid, competitive employment. The standard for this requirement requires mental health and supported employment teams on a regular basis to support individuals to reach their employment goals. The standards include a requirement for individuals to gain access to Division of Vocational Rehabilitation (DVR) resources and to get follow along services for up to a year to assist individuals to maintain employment and meet their employment goals.**

1. The first step taken, to determine the number of individuals who could potentially choose to explore work or further their education, was an analysis to rule out any of the one hundred and five (105) individuals in the community review. The analysis showed that twenty-one (21) individuals either have dementia, could not be located, were living with breathing machines operating twenty-four hours a day, or had moved to a skilled nursing facility. Also included in the 21 were individuals with desk reviews whose records were not current, their public guardian had not allowed any contact over a number of years, or their family guardian did not permit contact. This analysis excluded individuals reviewed as part of the SPH review as the information was not always clear on employment interest and because the SPH reviews did not include in-person interviews.
2. The fall 2020 reviews revealed thirty-eight (38) individuals, or forty-nine percent (49%) of the seventy-eight (78) individuals interviewed. The seventy-eight individuals are those for whom information was available and who expressed an interest in employment and/or education. Only four (4) or eleven percent (11%) of those 38 individuals received assistance to identify and prepare for employment. Three percent (3%) or one (1) of the 22 individuals expressing interest received assistance from IPS-SE and mental health teams that meet together on a regular basis. Only six percent (6%) or two (2) of the 38 individuals who expressed interest received help to apply for Division of Vocational Rehabilitation services and benefits and zero (0) of those who were employed received follow-up supports for up to a year.
3. These findings are consistent with FY 2019 state and Medicaid claims data showing that (a) seven percent (7%) of TCLI recipients received at least one (1) unit of IPS-SE services in calendar year 2019, (b) access to VR resources remains limited, and (c) there is no evidence yet that the State is providing follow-up supports for employed individuals as required in the Settlement Agreement.
4. A number of individuals expressed a strong and continuous interest in employment. As stated above, only a few providers responded by providing some assistance with employment and

education supports. However, this was not the case for most interested individuals, as some other individuals reported staff told them they could not work. For example, one provider reported incorrectly that one (1) individual could only seek employment for two (2) hours per day or they would lose their benefits.

5. Some providers do not respect individuals' expressed interest in or actions toward obtaining employment for several reasons, including the staff member not believing the individual was capable of working or not understanding how to use benefits counseling to help individuals to manage their entitlement and benefits. One CST service provider stated she was confused by the Review Team's questions about the individual's interest in employment since TCLI was "a housing program and not an employment program." Individuals may have identified employment as a goal during the in-reach process and others identified employment as a goal during the person-centered planning process; however, based on the fall FY 2020 review, providers consistently failed to follow up on these employment goals, even when asked to, often because they felt other issues took priority.

*One man said during in-reach visits that it was important for him to get a job. His provider agreed to do a WRAP plan [Wellness Recovery Action Plan] with him but not until after he moved out of the ACH. He stated in the section of the person-centered plan where the individual expressed their interests and goals that he wanted a job. However, his ACT team referenced medication compliance as the sole goal for him in his plan.*

6. The primary service providers (ACT, CST, and TMS) often suggest to individuals, directly or indirectly, that they should settle into their new housing completely before considering employment. In short, individuals frequently get the message they cannot work, which sadly often reinforces, rather than allays their view of themselves as not capable because of their illness.

*One woman first expressed interest in employment while getting in-reach services. Her staff member told her, "We like for people to get housing first before considering employment." At another point the staff member told her she could not work because she has seizures. The individual told the Review Team member she was putting a job application in at a local hotel although she is concerned about losing her benefits.*

7. Two (2) individuals told Review Team members, incorrectly, that they would simply lose their benefits if they went to work. Individuals are eligible to receive counseling services to help them calculate the benefits they can continue to receive while working. The TCLI budget helped underwrite the costs of benefit counselors to IPS providers and ACT teams to assist individuals to better understand the impact of employment income on their benefits and how

to factor that into their employment choices. Trained benefits counselors can calculate income limits and other options for individuals receiving benefits. Two (2) individuals were looking for work on their own after not receiving any help.

*One Review Team member asked a man who had been in the TCLI program and living in his apartment for over three years if anyone had talked to him about working. He responded, “I can’t work because I get Social Security, but I would love to work.” He smiled as he talked about working 20 years as a forklift operator and 10 years at Advanced Auto Parts. After explaining to him that information and education was available to help explain how he could work and get benefits, the CST provider, who was present for the interview, said she would make the referral for supported employment.*

8. The fall 2020 reviews provided data regarding four specific IPS items; none of those items scored above 0.25 (one quarter of one point) on a 3-point (three-point) scale as shown on **Figure 8**.

**Figure 8: Supported Employment Mean Scores**

Review Item	Score	Sum	Entries
Individuals got support to meet their employment and education goals	.11	4	38
Supported employment/ MH teams provided integrated services <sup>27</sup>	.03	1	22
Individuals referred to the Division of Vocational Rehabilitation	.05	2	33

The Review Team attempted to score individuals that received follow along services after employment for up to a year but no one in the sample received the follow along supports. These services help individuals retain their jobs, often helping individuals with ideas of how to work with co-workers and their supervisors or how to think through processes that can help with re-call and remembering their tasks as well as how to respond to workplace demands, especially for individuals who have not been in the workplace for some time. Those employed found jobs on their own but indicated they did not get follow along supports. In **Figure 8**, “entries” are the number of individuals interviewed who were eligible to receive employment services based on their expressed choice and their individual circumstances. Two (2) individuals with serious chronic medical conditions expressed interest but said they simply could not work, and those individuals did not get included in the number of individuals expressing interest.

As previously stated in the background section, the NC CORE pilot is proceeding and recently passed the one-year anniversary date of its launch on January 1, 2020. As stated in the Interim Report, there cannot be a full evaluation of the pilot’s effectiveness until COVID subsides. There is data available that provides information on the pilot’s progress and challenges

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<sup>27</sup> Excludes ACT teams

towards individuals gaining and maintaining employment. Of particular note, there was little progress in Milestones 3 (Job Development/with Retention) for the individuals who completed Milestone 1 and 2 as well as 7A (Vocational Advancement) and 7B (Educational Advancement), as depicted in **Figure 9**. The numbers of individuals at Milestone 3 and 7B have risen slightly since July.

**Figure 9: Active Authorizations in NC CORE**

	Milestone 1	Milestone 2	Milestone 3	Milestone 7A	Milestone 7B
<b>4/15/2020</b>	234	1	0	4	0
<b>7/15/2020</b>	232	1	2	2	10
<b>11/12/2020</b>	123	0	10	1	12

- Measuring NC CORE’s effectiveness for individuals “in or at risk” of ACH admission is also challenging, given the low number of individuals in those target groups referred and remaining engaged in the service as depicting in **Figure 10** below.

**Figure 10 : NC CORE Referrals**

Individuals enrolled in NC CORE	# enrolled	# remain engaged in IPS	Disengaged	Other <sup>28</sup>
IAR (prior to 4/1/20)	7	2	5	0
IAR (4/1/2020-6/30/2020)	1 <sup>29</sup>	1	0	1
TCLI (prior to 4/1/2020)	11	6	5	1
TCLI (4/1/2020-6/30/2020)	8	4	2	2
Totals	27	13	12	3

- Vaya reports the combined caseload sizes for the four NC CORE providers was one hundred and sixty-seven (167) in August 2020, which means that the “in or at risk” and TCLI populations (which totaled 27, as shown in Figure 10) comprised less than twenty percent (20%) of the NC CORE pilot enrollment. This information illustrates the vital and disheartening disparity for the two groups. The NC CORE pilot was in part originally conceptualized to address providers’ concerns that it was more difficult to remain solvent and grow their capacity to serve the “in or at risk” and TCLI populations. It remains unclear that this concern is no longer an issue, at least in part related to challenges assisting individuals to be engaged during COVID, but there may be other factors. This is a question to address further during the FY 2021 spring review process.
- DMH, DMA, DVR, and Vaya data integration is key to effectively monitoring, managing, and evaluating the pilot and SE services overall. Staff reported challenges getting approval on intra-and inter-agency data agreements, with only one agreement approved and a second in

<sup>28</sup> Other includes one individual who was transferred to ACT, one individual who was employed, and one individual employed but who has dis-engaged from services.

<sup>29</sup> Was employed when he entered program but wanted additional supports.

process. Regular monitoring and use of this data, including the “in or at risk” and TCLI populations, will be critical to effectively disseminating and sustaining this program.

12. As previously described, there are unresolved challenges with the implementation and evaluation of the NC CORE pilot, which presents complications in establishing and promoting a statewide value-based payment model for IPS-SE services.
13. The DMH has promoted the development of a provider based IPS collaborative for sharing ideas and information across the IPS provider community. This a good example of the value of peer-to-peer learning. Providers report collaboratives have been especially helpful during COVID.
14. The State did not circulate a dashboard highlighting supported employment, or IPS, metrics in FY 2020. The State circulated a dashboard for daily decision support, including IPS metrics, in prior years. This dashboard depicted LME/MCOs meeting their targets on key measures. The State began reissuing the monthly dashboard in October 2020.
15. The Interim Report included findings on the adequacy of the network (number and location of service providers) as reported to the DMH and DMA in a report entitled “Network Adequacy and Accessibility Analysis.” There do not appear to have been major changes in the availability and location of the IPS-SE providers since this report was issued. Choice of providers continues to be a complicated challenge in both urban and rural areas because of insufficient numbers of providers.
16. The DMH contract states the MCO “shall have the authority to issue corrective action plans and sanctions against Providers who fail to meet the IPS-SE service definition, up to and including termination of the Provider’s contract to participate in the MCO Network, as applicable.” The LME/MCOs submitted comments and questions to the State on the draft contract, along with a request that the State provide additional guidance to the LME/MCOs on how they could meet the Settlement requirements for this service, establish and measure provider performance, and evaluate the quality-of-service delivery and criteria for imposing sanctions. The State finalized the contract without making changes responsive to the LME/MCOs’ questions, either directly or through other guidance. There is not a corresponding section in the LME/MCOs’ DMA contract. There have not been any changes made in contracts since the Interim Report was issued.
17. When taking all of the above findings into account, the State has not developed and implemented measures for individuals with SMI, who are in or at risk of entry into adult care homes, that meet their needs, especially those in the TCLI program.

**Section III. (D)(2) Provide Supported Employment Services with fidelity to an evidence-based supported employment model for supporting people in their pursuit and maintenance of integrated, paid, competitive work opportunities.**

The State adopted the Individualized Placement and Support-Supported Employment Fidelity (IPS-SE) model in 2013 and this service is theoretically available for anyone in the target population except those receiving ACT. The reason is that ACT is a bundled service and is supposed to include an Employment Specialist providing supported employment services. Providing both services at the same time creates an unallowable double billing problem for Medicaid or for state-funded service recipients.

18. Any individual receiving ACT services can get assistance from Employment Specialists who work as members of the ACT Team and individuals who can work, and express interest should get that opportunity.
19. TMACT and IPS-SE Fidelity review results from FY 2018 through early 2020 indicate there is a need for enhanced LME/MCO and service provider executive team support, more frequent team contact with the individuals, more time spent on engagement, and more employer contacts for individuals “in or at risk” and those in TCLI to secure and maintain employment or enhance their education.

**Section III(D)(3): By July 1, 2020, the State will provide IPS-SE services to a total of two thousand one hundred and ninety-three (2,193) individuals “in or at risk of ACH placement.”**

20. The State reports that by June 30, 2020, two thousand four hundred and ninety-one (2,491) individuals have received IPS-SE services over the course of the agreement. This is six hundred and six (606) above the requirement for individuals served by July 1, 2020. There will be additional analysis to confirm this number in FY 2021 because fall 2020 individual reviews revealed that individuals listed as getting this service did not get the service.
21. The Interim Report included information on the number of individuals “in or at risk” and those in TCLI receiving IPS services and ACT-SE services in FY 2019 and FY 2020. It is the responsibility of the LME/MCOs to verify with providers that the number of individuals referred to IPS-SE are eligible as “in or at risk” and TCLI recipients as a subset of that number. Information reported by LME/MCOs<sup>30</sup>, after submission of the Interim Report, revealed that fifteen percent (15%) of the two hundred and eighteen (218) individuals referred to IPS-SE from July 1, 2019, through March 31, 2020, did not get at least one unit of service by the end of the fiscal year. This means that fifteen percent (15%) of the individuals referred during this period were not “provided” IPS-SE as required in **Section III (D)(1)**. Of the number referred to

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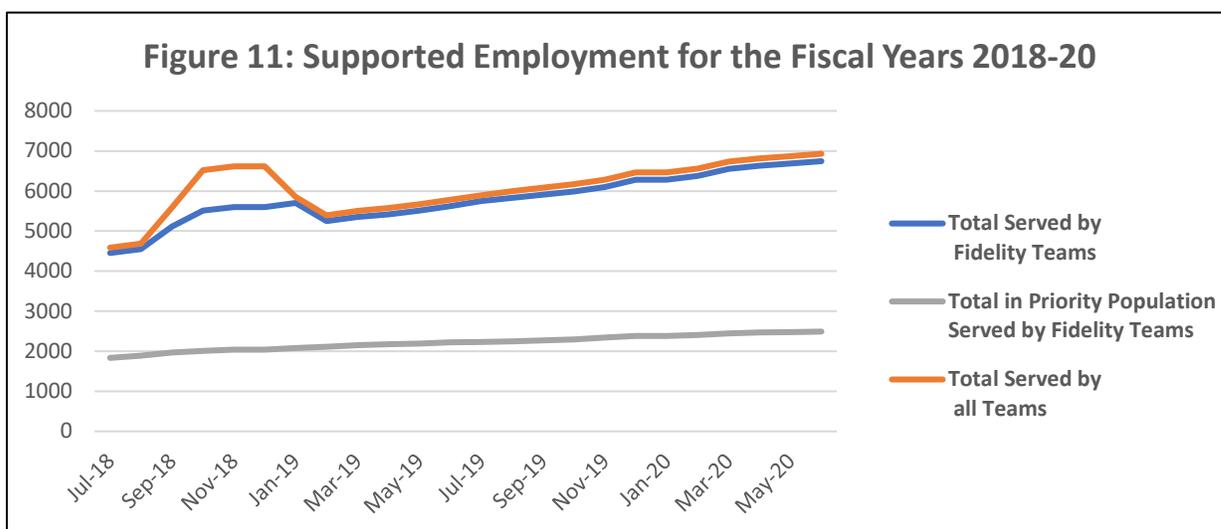
<sup>30</sup> One LME/MCO stated that their report on these numbers did not include data from all of their providers.

IPS-SE, only forty one percent (41%) of individuals were getting services (both the overall number in the “in or at risk” group and TCLI) at the end of the fiscal year.

22. These figures appear similar to findings from the 2017 Human Services Research Institute (HSRI) TCLI Data Analysis<sup>31</sup>. The State has not yet updated the amount and duration of services beyond the information reported by the Reviewer in the Human Services Research Institute (HSRI). The HSRI information revealed a rapid decline in supported employment service participation after individuals moved into the community from ACHs, with a sixty percent (60%) attrition rate in one year. The number served actually went down, not up, after individuals moved into the community. Information reported in interviews following this finding in the FY 2018 data analysis suggests that individuals enrolled in the service but supported employment providers subsequently did not see them again. Some found employment on their own.

In the fall 2020 reviews, thirty-eight (38) out of the seventy-eight (78) individuals reviewed who could potentially choose and receive IPS-SE or employment services from their ACT team, or forty-nine (49%) percent of individuals reviewed, expressed interest<sup>32</sup> in employment.

23. The Interim Report included information and analysis on the number of teams meeting fidelity under contract with each LME/MCO, the number of individuals provided services, and the range of fidelity scores. The State suspended fidelity reviews during COVID, although the State is working with the UNC Center of Excellence in Community Mental Health to conduct quality reviews during COVID.



<sup>31</sup> Completed in July 2018 and appended to the Independent Reviewer’s 2018 Annual Report.

<sup>32</sup> Interest is defined as the individual expressing interest during an interview and in written documents including PCPs, assessments, progress notes, and transition notes and documents two or more times.

24. The State reported fewer new individuals in the Agreement's target population received IPS-SE in FY 2020 than in past years. The number of individuals "in or at risk" of adult care home placement provided an IPS-SE service increased by two hundred and sixty-nine (269) or eleven percent (11%) in FY 2020. This was lower than the four hundred and seventeen (417) individuals added in FY 2019 and the six hundred and six (606) individuals added in FY 2018. **Figure 11** displays the cumulative total of the number of individuals provided IPS-SE services over time.

There is not a link between the COVID pandemic and the decrease in individuals in the target populations served, based on a review of comparable months in each of the last two fiscal years. The numbers of referrals of individuals served by all teams and by teams meeting fidelity are increasing more rapidly than is the number of individuals who are not at risk of ACH placement. The increase is greater for individuals "in or at risk" than individuals in the TCLI program (not shown on the chart). There was a twenty percent (20%) increase in the "in or at risk of" referrals in the first quarter of FY 2021 compared to the previous quarter.

### **(C) Recommendations**

1. This first recommendation is one stated repeatedly over the past four years, beginning in FY 2016 through 2019 and again in the FY 2020 Interim Report:
  - (1) Build a strong collaborative model between the State, LMEs, service providers, and local VR offices to improve service delivery.
  - (2) Implement an effective business model to ensure that the service becomes available consistently across the State and is sustainable over time.
  - (3) Fill the IPS-SE "pipeline," which means which means increasing the number of referrals to existing teams with low caseloads (additional capacity) to serve more individuals.
  - (4) Develop and implement a targeted plan to build IPS-SE capacity where most needed in both the urban and rural areas of the state.
2. Effectively implementing these recommendations will require clear, focused strategic planning combined with ongoing evaluation and monitoring, including action steps, deliverables, responsible parties, and deadlines to complete tasks. It is critical to assure that the plan's measurements for success include employment outcomes, not just process measures. While it is not the Reviewer's role to name the responsible party for leading this work, it is clear it needs to be someone with the expertise on implementing such a plan for supported employment complemented by individuals with successful experience implementing performance models.
3. While the State has made some progress with IPS and ACT programs, including the collaboration of LME/MCOs, providers and staff, and Vocational Rehabilitation within the

development and implementation of the NC CORE pilot, the lack of recent further progress on critical Settlement Agreement issues indicates the need for the State to reassess its strategies and efforts regarding IPS-SE services. The State has worked with the UNC Center of Excellence of Community Mental Health regarding fidelity reviews, technical assistance, and training. The UNC Center has valuable insights and experiences within the system that might be an important resource in developing and evaluating statewide implementation plans and strategies.

4. As part of this effort, the DMH and LME/MCOs take steps to ensure individuals in the TCLI target population have the choice and opportunity for paid, competitive employment in integrated settings. This was an earlier recommendation, but the fall 2020 reviews reinforced that there is a consistent perception among actors in the State's adult mental health system that individuals do not have the ability to work or would lose their benefits or experience a setback by working; these perceptions have continued to undermine the State's progress. This is not an IPS-SE staff problem, but a problem with some LME/MCO TCLI staff and provider agencies failing to understand the therapeutic value of supported employment and, consequently, to make referrals to supported employment, and a failure to educate families and guardians about how supported employment can further their individual's recovery.
5. The State presented a preliminary plan for implementing the NC CORE approach statewide. If improved, this preliminary plan can become part of the State's overall Supported Employment strategic plan. This plan will require further development with more specific detailed information, including how to effectively engage other LMEs/MCOs and providers across the state.
6. The IPS-SE and ACT employment providers widen and increase job choices to accommodate the needs of individuals who want to work but who are worried about their stamina, their ability to ever work again, losing their benefits, or the potential stress of working given their chronic health conditions. It is also these providers' responsibility, along with other ACT team members and mental health services teams, to help individuals get benefits counseling, manage their stress, and learn skills to retain their employment and meet their future employment goals.
7. The effective implementation and sustainment of supported employment services requires active, focused, and public leadership in words and actions. As part of the strategic plan process the State, LME/MCO and agency executives must provide more active leadership and allocate sufficient human and financial resources to further enhance the progress made in implementing this valuable service in NC. The State develop active plans with all stakeholders to identify strategies and mechanisms for effectively sustaining IPS-SE across the whole state. This, in turn, will spur capacity building, stimulate better performance, and enable the State

to meet **Section III(C) (1-4)** Community-Based Mental Health Services and **Section III (D)** Supported Employment requirements.

8. The State update its guidance to the LME/MCOs for reporting only individuals provided IPS-SE services and not just individuals referred for services. The State also update its instructions to LME/MCOs to ensure individuals who are homeless are “at risk of ACH placement.” The State needs to define homelessness more clearly and requiring the referring service providers to explain their living situation more clearly. This will ensure an accurate count of individuals in the SA’s target population who receive supported employment services.
9. The State count individuals in the “in or at risk” population as “receiving services” only if these individuals are in fact referred, enrolled, and receiving services.
10. As referenced in the Interim Report recommendations, continue to analyze the payment structure and the referral and other processes in the NC CORE IPS-SE pilot in the Vaya catchment area to demonstrate that the results of the pilot will show the pilot meets SA standards as follows:
  - a. The State ensure individuals receive services and supports they need, including job preparation, job identification, and supported employment services integrated with mental health services.
  - b. IPS-SE staff help individuals to identify and pursue job opportunities consistent with the individual’s choices and provide employed individuals with individualized follow-up services for up to a year as requested.
  - c. The State ensure the milestone payment model enables providers to engage TCLI recipients (including individuals “at risk of” ACH placement), enroll them in services, provide integrated services, help individuals prepare for employment or education, identify job opportunities consistent with individuals’ choices, and assist individuals to get and maintain employment and get follow-up services for a year as requested. The State also make sure certain milestone payments (or adaptations of this model) are adequate, paid in intervals needed to sustain job assistance at the level required for each task, and ensure adequate follow-up support and/or support when an individual loses a job or needs to change jobs.
  - d. The State (DMH, DMA, and DVR) and Vaya manage, monitor, and adjust the model based on results, challenges, and, most importantly, outcomes.

#### IV. DISCHARGE AND TRANSITION PROCESS

Major Categories	Standards	Progress Towards Meeting the Requirements
<p><b>1. Section III. (E)(1)</b> The State will implement procedures to fully inform individuals with SMI in, or later admitted to, an ACH or State Psychiatric Hospitals (SPHs) or being pre-screened for admission to an ACH, about all community-based options and benefits, including the option of transitioning to SH with rental assistance.</p>	<ol style="list-style-type: none"> <li>1. The State’s policies and procedures<sup>33</sup> for Diversion, ACH, and SPH Transition Processes meet SA requirements (including eligibility policies).</li> <li>2. SPH, LME/MCO<sup>34</sup>, and service provider/staff know and communicate the procedures and community options.</li> <li>3. Public guardians get information about community-based options.</li> <li>4. The State will establish Transitions to Community Living (TCLI) eligibility policies consistent with the SA.</li> </ol>	<p>The State is not meeting this requirement but is making progress to fully inform individuals of options.</p> <p>The fall 2020 review revealed that individuals frequently do not get accurate and complete information about community-based options and benefits from SPH staff who provide information to individuals rather than In-reach and other LME/MCO staff required to provide this information and who have more firsthand knowledge of resources and Settlement requirements including the option to transition to SH with rental assistance.</p>
<p><b>2. Section III. (E)(2)</b> In-reach: Knowledgeable In-reach staff are assigned to: (1) provide education and information and facilitate visits to community settings; and (2) offer opportunities to meet with other individuals with disabilities who are living, working, and receiving services with their families and with providers. Visits are to be frequent.</p>	<ol style="list-style-type: none"> <li>1. In-reach staff meet frequently with residents in ACHs/SPHs when individuals become eligible for TCLI.</li> <li>2. In-reach staff begin meeting with individuals being pre-screened at the point eligibility is determined.</li> <li>3. In-reach staff are knowledgeable about community services and supports.</li> <li>4. In-reach staff provide information and education about the TCLI process, benefits, and other information as routinely requested by individuals, their guardians, and family.</li> <li>5. In-reach staff facilitate individuals’ visits to community settings as opportunities to meet other individuals with disabilities.</li> </ol>	<p>The State is not meeting this requirement. In-reach staff do not meet as frequently as needed and/or required with eligible individuals in ACHs and SPHs. (This problem creates challenges for the State meeting <b>(E)(11)</b> and <b>(E)(12)</b> and rely on letters and calls rather than in-person visits, even before the COVID pandemic.</p> <p>During the COVID pandemic, there has not been a full review of individuals getting community visits although some staff are taking measures to provide this service safely and making arrangements for transportation.</p>

<sup>33</sup> References to State’s policies and procedures also include State-LME/MCOs contract requirements and staff job requirements.

<sup>34</sup> LME/MCO staff include any In-reach, Transition Coordinator, Care Coordinator, or other staff who have any job assignment associated with admission, discharge, and/or transition process and provider assignment and contracting.

Major Categories	Standards	Progress Towards meeting the Requirements
<p><b>3. Section III. (E)(3)</b> The State provides each individual with SMI in, or later admitted to an ACH or SPH (or diverted from an ACH), with effective discharge planning and a written discharge plan.</p>	<p>Discharge planning assists an individual in developing a plan to achieve outcomes that promote growth, well-being, and independence, based on their strengths, needs, goals, and preferences appropriate in all domains of their life.</p>	<p>The State is not meeting this requirement. There is evidence in records and interviews that LME/MCOs do not consistently participate in developing SPH discharge plans.</p>
<p><b>4. Section III. (E)(4)</b> Transition teams include: (1) individuals knowledgeable about resources, supports, services, and opportunities available in the community and each team includes community mental health service providers, including the primary provider; (2) professionals with subject matter expertise about accessing community mental health and community health care, therapeutic services, and other necessary services and supports; (3) persons with linguistic and cultural competence; (4) peer specialists when available; and (5) with consent, persons whose involvement is relevant.</p>	<p>Each transition team includes:                      (1) individuals knowledgeable about resources, supports, services, and opportunities available in the community; each team includes community mental health service providers, including the primary provider; (2) professionals with subject matter expertise about accessing community mental health and community health care, therapeutic services, and other necessary services and supports; (3) persons with linguistic/cultural competence; (4) peer specialists when available; (5) with consent, persons whose involvement is relevant to identifying strengths, needs, preferences, capabilities, and interests to devise ways to meet them in an integrated setting.</p>	<p>The State is not meeting this requirement. LME/MCO staff often do not or are not asked to fully participate in discharge planning, do not make resources available or make effective arrangements for individuals to move to supported housing. (ACH staff are not involved in discharge planning for TCLI participants; for ACH residents in TCLI, discharge and transition planning is conducted exclusively by LME/MCO TCLI staff.)</p>
<p><b>5. Section III. (E)(5)</b> A transition team is responsible for the transition process. A Transition Coordinator (TC) is responsible for administering the required transition process.</p>	<ol style="list-style-type: none"> <li>1. A transition coordinator is responsible for leading the team and administering the transition process.</li> <li>2. The definition of the transition process is consistent with SA requirements.</li> <li>3. The LME/MCO staff (including provider staff) jointly administer the transition process.</li> <li>4. The SPHs and LME/MCOs planning enable SH or diversion “bridge housing” arrangements to be made when identified as a need and choice.</li> </ol>	<p>The State is not meeting this requirement. The LME/MCO TC did not always administer the required transition process; at times they reacted to the SPH making transition arrangements including making supported or bridge housing referrals.</p>

Major Categories	Standards	Progress Towards Meeting the Requirements
<p><b>6. Section III. (E)(6)</b> Each individual is given the opportunity to participate as fully as possible in his or her treatment and discharge planning.</p>	<p>Same as the requirement.</p>	<p>The fall 2020 review and the SPH discharge planning review revealed that approximately thirty percent (30%) of individuals did not get the opportunity to participate as fully as possible in his or her treatment and discharge planning. SPH reviews and reviews of individuals residing in ACHs revealed that facility social workers and family members, who may or may not be guardians, continue to be the primary decision makers.</p>
<p><b>7. Section III. (E)(7)</b> Discharge Planning begins at admission (ACH or SPH) or at which point an individual is pre-screened for admission to an ACH and made eligible for TCLI. It is based on the principle that with sufficient services and supports, people with SMI or Serious and Persistent Mental Illness (SPMI) can live in an integrated community setting. Discharge planning assists the individual to develop an effective written plan to live independently in an integrated community setting. Discharge planning is developed through a person-centered planning (PCP) process in which the individual has a primary role and is based on the principle of self-determination.</p>	<p>a. The State has established the required admission point when discharge planning is to begin (admission point is within 7 calendar days of admission). b. The State has communicated that discharge planning is based on the principle that with sufficient services and supports, people with SMI/SPMI can live in an integrated setting. c. SPHs and LME/MCOs tailor discharge planning to the individual. It is not formulaic. The SPH and the LME/MCO and provider link the discharge plan and PCP to ensure continuity and that individuals' choices are honored consistently. d. The individual has a primary role in the development of their discharge plan, the plan reflects their expressed needs/goals, and the plan is based on the principle of self-determination.</p>	<p>The State is making progressing meeting (B)(7); below are references to improvements and outstanding challenges: a. The State has communicated <b>(E)(7)</b> requirements to SPH and LME/MCO staff. The fall 2020 reviews indicate that SPH residents and individuals in the community diverted from ACH admission receive an initial discharge planning meeting within seven (7) days of admission or eligibility determination for those diverted. There were limitations on fall 2020 reviews due to COVID so there are limitations with this finding for individuals residing in ACHs, although there was evidence that this did not occur for two (2) individuals or twenty two percent (22%) of individuals residing in ACHs for whom there was sufficient evidence to indicate this may not be standard practice. b. The SPHs develop a discharge plan and a Continuing Care Plan though LME/MCO involvement informing those plans and participation in developing those plans with individuals does not occur consistently. LME/MCOs often conduct parallel planning processes or react to the SPH developed plans. c. Individuals frequently do not have the primary role in their discharge plan when staff work more closely with family members and guardians to develop and implement those plans. d. Discharge plans generally reflect an individual's needs and goals although some plans do not address each need and goal an individual has, reducing their potential effectiveness, and at least forty-four percent (44%) of the plans did not show evidence of developed on the principle of self-determination.</p>

Major Categories	Standards	Progress Towards Meeting the Requirements
<p><b>8. Section III. (E)(8)</b> A written discharge plan:</p> <ul style="list-style-type: none"> <li>a. identifies the individual’s strengths, preferences, needs, and desired outcomes;</li> <li>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 the services and supports are “currently” available;</li> <li>c. includes the providers that will provide the identified supports and services;</li> <li>d. documents barriers that will be addressed so the individual can move to the most integrated setting possible (barriers shall not include the individual’s disability or the severity of the disability);</li> <li>e. sets forth the transition/ discharge date, actions before, during, and after transfer and responsibilities for completing discharge/transition tasks.</li> </ul>	<p>Each individual being discharged from an SPH, exiting an ACH, or being diverted from an ACH has a written discharge/diversion plan that meets four criteria listed in the SA: (1) identifies strengths, preferences, needs, and desired outcomes and specific services and supports to meet the needs, etc., listed above, regardless of whether or not they are currently available; (2) includes the providers that will provide the identified supports and services to meet the requirements listed above; (3) documents barriers to moving or living in the most integrated setting possible that do not include the individual’s disability or severity of their disability; (4) identifies crises (precursors) that were factors in re-admissions (where this applies); (5) includes transition and discharge dates and action steps; (6) identifies responsibilities by staff/provider for each required pre-discharge, discharge, transfer, and community-based task and resource acquisition; and (7) includes the individual’s expressed needs and goals.</p> <p>These include benefits restoration/initiation, resource acquisition, and SH pre-tenancy/ move-in tasks. These responsibilities are split between hospital and community staff, are to be completed in a timely manner and with participation of the recipient and any other individual they designate who may provide support (and guardian as needed).</p> <p>Transportation is the responsibility of the LME/MCO and the community provider as designated by the LME/MCO.</p>	<p>The State is not yet meeting this requirement.</p> <p>The SPHs develop detailed discharge plans but with less details on disposition and don’t identify barriers. SPH documentation, especially on initial hospital treatment plans, and other documents and Continuing Care plans are more comprehensive and in line with this requirement.</p> <p>However, the LME/MCOs do not consistently participate in developing the discharge plan of the SPH Continuing Care Plan.</p> <p>The State uses the PCP as its first plan for individuals exiting ACHs, but services do not always get initiated until a provider is assigned. The Community Integration Plan (CIP) required in <b>Section III. (F)(2)</b> serves as the first plan for individuals diverted from ACHs. As referenced in the Community Based Mental Health Services section of this report, the PCPs are formulaic, are not strengths-based, and often do not touch on barriers and steps to overcome them. If written after discharge they do not set the date and actions taken before, during, or after transition of responsibilities.</p> <p>The SPH and LME/MCOs and providers split transportation responsibilities in FY 2020, largely related to the COVID pandemic.</p>

Major Categories	Standards	Progress Towards Meeting the Requirements
<p><b>9. Section III. (E)(9)(10)</b> The DHHS will create a transition team at the State level to assist local transition teams in addressing and overcoming identifiable barriers preventing individuals from transitioning to integrated settings. The team shall include individuals with experience and expertise in how to successfully resolve problems that arise during discharge planning and implementation of discharge plans. The team will oversee the local transition teams to ensure that they effectively inform individuals of community opportunities. The team will ensure training is adequate, including training on person-centered planning. Local teams include LME/MCO and SPH leadership. Local teams address barriers to discharge planning when teams cannot agree on a plan, are having difficulty implementing a plan, or need assistance in implementing a plan.</p>	<p>The State has established a state level transition team to assist local transition teams to address and overcome barriers preventing individuals from transitioning to an integrated setting.</p> <p>The DHHS team includes individuals with lived experience and expertise in successfully resolving problems that arise during discharge planning. The DHHS will ensure adequate training, including training in person-centered planning, for local teams, including LME/MCO staff, public guardians, SPH staff, and community providers.</p>	<p>The State is taking steps to meet this requirement. The State created a state-level Barriers Committee in FY 2019 which has demonstrated effectiveness in reducing and eliminating systemic barriers.</p> <p>There is a need for local teams to make referrals to the State Barriers Committee. Reviewers frequently reminded staff to do this when identifying barriers in the fall 2020 reviews. The State could meet this requirement by reducing the number of individuals with barriers get referred, in the future based on State reports and Reviewer findings.</p> <p>The State should continue to provide guidance and additional training for local teams to ensure that they document barriers and ask for help addressing barriers to transition.</p>
<p><b>10. (E)(11)</b> an individual chooses to remain in an ACH or SPH, the local team documents steps to identify barriers to placement as identified by the individual or their guardian and attempts to address the barriers. The State documents steps taken to ensure this decision is an informed one and provides regular education on community options open to the individual, utilizing methods and timetables described in <b>Section III. (E)(2)</b>.</p>	<p>Same as requirement.</p>	<p>The State is not yet meeting this requirement. Frequently, LME/MCOs send letters or make calls rather than speaking with individuals and guardians regarding barriers and steps to address them. LME/MCO and at times service provider progress notes often reference barriers but not attempts to resolve them. See response above regarding reporting barriers and attempts to resolve barriers.</p>

Major Categories	Standards	Progress Towards Meeting the Requirements
<p><b>11. (E)(12)</b> The State will re-assess individuals with SPMI who remain in ACHs or SPHs for discharge to an integrated community setting on a quarterly basis or more frequently upon request; the State will update the written discharge plan as needed based on new information and/or developments.</p>	<p>Individuals choosing to remain in an ACH or SPH will be re-assessed every 90 days or more frequently upon request and plans are updated based on new developments.</p>	<p>The State is not meeting this requirement based on the findings from the fall 2020 review. The review revealed that six (6) or fifty percent (50%) of individuals who were currently residing in ACHs at the time of the reviewed had not had a re-assessment within 90 days. Records of individuals who had already moved also revealed individuals did not get 90-day re-assessments and that other individuals whose names were still in the TCLI living in adult care homes had not had assessments.</p>
<p><b>12. Section III. (E)(13)(c)</b> Implementation of In-reach, Discharge and Transition Process<sup>35</sup>: Transition and discharge planning will be completed within 90 days of assignment to a transition team, provided a housing slot is available. The team will continue to work with an individual after 90 days, if a housing slot is not available within 90 days, until a slot becomes available.</p>	<ol style="list-style-type: none"> <li>1. The State meets the Transition/Discharge Planning assignment start date across the state and by types of transitions and discharges (SPH, ACH, and Diversion) based on DHHS policy and included in contract requirements.</li> <li>2. Staff complete discharge planning within 90 days.</li> <li>3. The team continues to work with an individual until housing is available, if not within 90 days.</li> </ol>	<p>The State is meeting this requirement. There are exceptions to completing individual discharge planning within 90 days, as discussed in the findings section below.</p>

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<sup>35</sup> SPH start date is at admission; ACH and Diversion start date is determined by DHHS policy but no later than when an individual first indicates they are choosing to move to the community, in the case of ACH transition, and date an individual chooses to be diverted from an ACH.

Major Categories	Standards	Progress Towards Meeting the Requirements
<p><b>13. Section III. (E)(13.d)</b>                      Institutions for Mental Disease (IMD)<sup>36</sup>: The State is required to undertake four procedures with respect to individuals with SMI living in an ACH that has received a notice that it is at risk of a determination that it is an IMD, in addition to following other applicable requirements in the SA as part of priority group (B)(2)(a).</p>	<p>The State meets the requirements set forth for notification, connecting individuals with SMI who wish to transition from the “at-risk” ACH to another appropriate living setting, tracking individuals who move out of the home after the “at risk” IMD notice and providing the same in-reach, discharge, and transition processes, services, and housing requirements as set forth for other individuals eligible for TCLI resources. These individuals are part of Priority Group #2 (III. [B][2][A]).</p>	<p>The State is meeting this requirement. The State has taken steps to conduct a thorough assessment of ACHs to determine if any adult care homes were either IMDs or at risk of becoming an IMD in FY 2020.</p>
<p><b>14. Section III. (E)(14)</b> ACH Residents Bill of Rights: The State and/or LME shall monitor ACHs for compliance with the ACH Residents’ Bill of Rights requirements contained in Chapter 131D of NC Statutes and 42 C.F.R. § 438.100 (Enrollee Rights).</p>	<p>The State and/or the LME/MCO monitors ACH compliance with the ACH Bill of Rights and the C.F.R. § 438.100 requirements protecting the individual enrollee’s rights. This includes the individual’s right to privacy, to communicate privately without restrictions with individuals of their choice, to make complaints and suggestions without the fear of coercion and/or retaliation, to have flexibility to exercise choice, and to receive information on treatment options and alternatives. The State has protocols to protect the individual or LME/MCO, including defining retaliation clearly, providing the individual confidentiality, investigating complaints in a timely manner, and providing feedback to the individual and/or LME/MCO.</p>	<p>The State is not meeting this requirement. There were only twelve (12) reviews of adult care home residents and only seven (7) individuals interviewed. Two (2) of the twelve (12) individuals were living in skilled nursing facilities by the time of the review. There were indications that there were violations of four (4) individuals’ rights while residing in an ACH.</p>

<sup>36</sup> Institutions for Mental Disease are hospitals, nursing facilities, or other institutions of more than 16 beds, which are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Individuals between the ages of 21-64 are not eligible for Medicaid services in IMDs.

*The Discharge and Transition Process requirements overlap with other similar requirements, particularly pertaining to treatment team responsibilities, discharge planning process and time frame requirements for discharge planning and for discharge plans. These overlapping issues extend beyond this section. For example, Section III. (B)(1) requires the State to develop housing access measures but performance meeting those measures often falls under requirements in the Discharge and Transition Process category. Likewise, Person Centered Planning falls in both the Section (C) section and in the Discharge and Planning Processes and Pre-screening and Diversion overlaps as well. Thus, meeting Discharge and Transition Process requirements and requirements it is not always easy to separate from other Categories during the review process but more importantly in practice.*

*The numbers of individuals reported in this section as receiving assistance may be different than the overall numbers of individuals seen and reviewed, as referenced in the Individual Review section of this report. The reviews were conducted at a point when an individual may have been in the process of transitioning or discharge so reviewers could score individuals based on where they were in the process, creating slightly different numerators and denominators depending on the review and the individual's experience.*

#### **(A) Background**

Discharge and Transition Process requirements apply to individuals exiting ACHs, discharged from SPHs, and potentially diverted from ACHs. The FY 2020 review process began with a review of hospital records at Broughton Hospital in November 2019 to determine if there were referrals to TCLI for all of the individuals who could qualify for TCLI and also to conduct a baseline review of discharge planning prior to the State updating its guidance for SPH discharge planning.

The Discharge and Transition Process requirements overlap with other similar requirements, particularly pertaining to treatment team responsibilities, discharge planning process and time frame requirements for discharge planning and for discharge plans. These overlapping issues extend beyond this section. For example, Section III. (B)(1) requires the State to develop housing access measures but performance meeting those measures often falls under requirements in the Discharge and Transition Process category. Likewise, Person Centered Planning falls in both the Section (C) section and in the Discharge and Planning Processes and Pre-screening and Diversion overlaps as well. Thus, meeting Discharge and Transition Process requirements and requirements in these other Categories easily separable during the review process but more importantly in practice.

The COVID pandemic then interrupted the Discharge and Transition Process annual review. To minimize this disruption, the FY 2020 review began with record reviews and virtual interviews for individuals discharged from SPHs in May and June 2020, and this process was repeated again with all three hospitals in August and September 2020.

The rationale for reviewing SPH discharges in both May and June and again in August and September was three-fold. One, the NC SPHs managed to minimize the impact of COVID early in the pandemic with testing, restricting staff and patient flow within the hospitals, and quarantining individuals at admission. This enabled the SPHs to continue to admit and discharge individuals during the pandemic. The overall numbers of SPH admissions and discharges were lower than in FY 2019, but treatment and discharge planning continued without interruption. Two, arranging SPH discharge reviews through teleconferencing with SPH and LME/MCO staff, accompanied with chart reviews, provided a clear picture of the State's progress over time to meet Discharge and Transition Processes for this sub-population. Three, there were greater COVID-related disruptions with non-SPH diversions, ACH in-reach, and transitions, so the review team used time it would have otherwise devoted to those topics to expand the hospital reviews instead during this time frame.

The parties agreed to Discharge and Transition Process standards by March 2020 for each SA requirement. The Review Team rated the State's performance, using these standards for each requirement for each individual reviewed. The ratings ranged from the State fully or substantially meeting the requirement, to partially meeting the requirement, to inconsistently meeting the requirement, to not meeting the requirement.

Discharge and Transition Process requirements include thirteen (13) major categories and sixteen (16) sub-categories. This review covered twelve (12) of the thirteen (13) categories; the thirteenth category relates to steps the State was to take at the outset of the Settlement Agreement and that no longer require review. These requirements provide clear direction for the State to develop and implement effective measures to come into compliance with these provisions. A number of requirements focus on SPH discharges and ACH exits. For example, "in-reach" applies to individuals living in both types of institutions. The State added contractual requirements to SPH-LME/MCO discharge planning and established a diversion transition process in FY 2018 and FY 2019. In FY 2020, the State took a positive step to define "outreach" to apply to diversion and to clearly explain the "outreach" role.

The number of TCLI-eligible individuals on In-reach status decreased from six thousand one hundred and forty-five (6,145) in FY 2019 to five thousand eight hundred and sixty-three (5,863) in FY 2020: a decline of two hundred and eighty-two (282). There are four reasons for this decrease: (1) one hundred and forty-four (144) individuals moved from ACHs to supported housing, (2) some individuals likely moved to skilled nursing generally as the result of dementia diagnoses, (3) some individuals died, and (4) others left ACHs but moved to locations other than supported housing. The 2018 report analyzing deaths found that more TCLI-eligible individuals died while living in ACHs than in supported housing.

The State reports there were six hundred and eleven (611) individuals not diverted from ACHs after being made eligible through pre-screening in FY 2020. Despite the fact these individuals

did not get diverted, the number of individuals made eligible for TCLI still decreased due to some individuals dying during FY 2020, moving to skilled nursing, or made eligible for TCLI initially but then diagnosed with dementia and thus taken off the TCLI in-reach list. There are a number of individuals in the TCLI data base listed as being on In-reach status discharged from SPHs. The State began a new pre-screening process (discussed in **Section III. [F]**) and has made some adjustments to more clearly define individuals who are eligible for TCLI discharge planning and In-reach following discharge.

These numbers reveal that discharge and transition planning requires an active, well organized planning process with staff capable of assisting a large number of individuals in making life decisions on a day-to-day basis. It is challenging for staff to retain a focus on individualized and recovery-based support under these circumstances. One way to help alleviate the tendency to provide cookie-cutter planning rather than giving proper consideration to individuals' choices is for the State and LME/MCOs to spotlight individual successes, especially for individuals who have overcome tremendous challenges to live in the community.

The State has established requirements for discharge and transition processes but the fall FY 2020 reviews and SPH reviews reveal that actual practice is still not fully consistent with requirements. There is evidence that for individuals who transitioned to supported housing the process worked well, beginning at the admission point or when identified as eligible for TCLI and diverted. But based on the fall 2020 review and SPH discharge reviews, if there was not planning to assist the individual with an effective written plan to live independently or through a person-centered process in which the individual has the primary role, individuals will not make a successful transition. This occurred for a significant number of individuals discharged from SPHs and for individuals not yet transitioned from ACHs or for those who experienced many challenges in the transition process that impacted their successful integration to community living. This did not appear to be a serious issue for individuals diverted from ACHs although there were not enough individuals reviewed living in ACHs following a pre-screening review to make that determination.

The fall 2020 review included thirty (30) transition and discharge reviews. This number is slightly different than the number of individuals on In-reach or diversion numbers based on the time the review occurred, in contrast to when transition occurred. Of the thirty (30) individuals reviewed for transition and discharge, twenty-six (26) individuals became TCLI eligible following a pre-screening review. Eighteen (18) had either already moved to supported housing or to another community setting recently, so their reviews covered both discharge and transition and community based mental health service reviews. There were twelve (12) individuals in the diversion category living in the community getting in-reach (outreach) services, so their reviews only covered in-reach.

Each year approximately thirty percent (30%) of names pulled of individuals living in ACHs for annual reviews are of individuals who do not qualify for TCLI, either because they no longer

meet eligibility, did not meet eligibility but enrolled anyway, have died, or moved and their whereabouts are unknown. Based on this data, consistent over time, it is likely that there are approximately three to four thousand (3,000-4,000) individuals eligible for TCLI residing in ACHs.

During FY 2019, the State took steps to improve the language of its SPH-LME/MCO contracts regarding SPH-LME/MCO responsibilities for discharge and transition planning. In FY 2020, the State took steps to improve the SPH-LME/MCO joint discharge planning process for individuals, including issuing guidance and clarifying LME/MCO and SPH responsibilities set forth in contract language and in the SA's requirements for discharge planning. DHHS staff added joint charting requirements as well. All of these changes took effect by March 1, 2020, days before the COVID shutdown. Shifting reviews of the SA Discharge and Transition Process to the final months of FY 2020 and early FY 2021 gave the State the opportunity to implement these updated policies and procedures.

The State has taken steps to break down discharge barriers. The State holds quarterly meetings with hospital and LME/MCO clinical leadership specifically aimed at resolving issues with complex cases. LMEs began adding nurses to transition teams to provide assessments and care management. The Senior Advisor and her staff have made significant contributions to breaking down eligibility barriers and engaging multiple DHHS divisions to assist with making resources available. This has been especially helpful with Medicaid eligibility, county-to-county transfers which could otherwise result in disruptions to services, and helping individuals qualify for Personal Care Assistance (PCA) and other in-home support. The Senior Advisor's staff have also secured assistance for completion of FL2s, a form completed by a physician for attestation that an individual has a qualifying diagnosis for TCLI and for verification of eligibility for personal care needs, skilled nursing, or adult care home placement.

There are additional factors to consider with the review process. The median length of stay (LOS) in the SPHs varies by hospital. Broughton's median LOS is ninety-one (91) days, while CRH's is sixty-eight (68) days and Cherry's is only thirty-eight (38) days, although it is possible there are outliers whose LOSs differ greatly from those medians. Overall, this information suggests discharge planning occurs much more quickly at Cherry than at Broughton and CRH.

Another factor that impacts discharge planning is the percentage of individuals hospitalized on the Incapable to Proceed (ITP) legal status, excluding those admitted on forensic Not Guilty by Reason of Insanity (NGRI) status. DHHS's most recent report on the number of individuals admitted to an SPH on the ITP status is in the twenty-three to twenty-six percent (23-26%) range.

In each SPH discharge review cycle for the past five (5) years, there have been findings that the State has not ensured that individuals (both TCLI eligible and on incapable to proceed (ITP) status) get access to housing and supports following release from jail or dismissal of the charges by the

court. When SPHs discharge individuals classified as ITP to jail, courts often release them from jail to the community following a hearing, either with credit for time served or by dropping their charges. The State has an opportunity to improve access to housing and supports for TCLI-eligible individuals in this population, as discussed in the FY 2020 Interim Report. This process of TCLI-eligible individuals discharging from SPHs to jail, and from jail to the community, creates challenges for LME/MCOs planning follow-up care. Successful transition planning for this population is related to three factors: 1) the degree to which the LME/MCO has a positive working relationship with the local criminal justice system, jail staff, sheriffs, and judges; 2) whether the LME/MCO assigns staff to provide services pre- and post-adjudication and to link individuals post hospital discharge to services and housing; and 3) the degree to which the SPH and the LME/MCOs and their providers are prepared to assist individuals with housing and services before or when they return to jail and are released directly from the hospital or immediately from the jail.

The FY 2020 Interim Report included information summarizing the reviews conducted at Broughton Hospital in November 2019 and the May and June 2020 reviews at all three SPHs. This report does not repeat information and findings included in the Interim Report. There were twenty-three (23) full reviews conducted in August and September 2020 and an additional three (3) reviews of Cherry discharges in November.

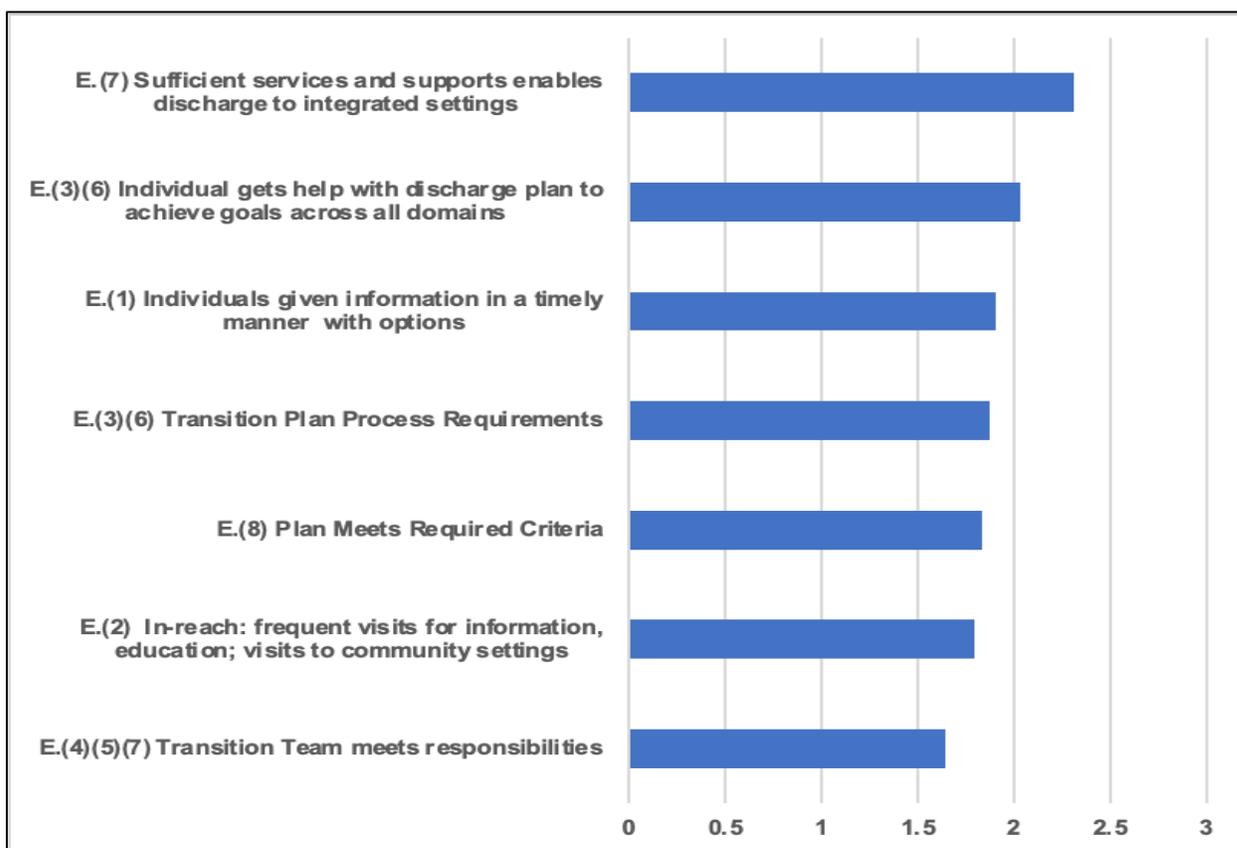
**(B) Findings**

1. The State previously met **(E)(a.) and (b.)** and have now met **(E)(13)(c.) and (d.) in Section III. (E)**. The State did not meet requirements in **Section III. (E) (1-12) and (14)** in FY 2020. The State continues to make progress to make arrangements to meet these requirements but several of these arrangements are relatively changes and have not fully or consistently implemented. It also appears that regardless of when the State made these changes, staff performance remains an issue. There are illustrations of interview scores listed below for the first nine requirements in rank order of their score in **Figure 12**. These are the only items scored in this section through a combination of desk reviews and interviews. There are other items findings in **Section III. (E)** made through interviews and a review of documents and interviews with State staff listed below.

Based on the findings for these items and reporting from the State and LME/MCO staff about their work in progress, it is not likely the State can meet its requirements in **Section III. (E)(1-12) and (14)** in FY 2021. The State appears to be closer to meeting five (5) items if the following steps are taken: **(E)(1)** if In-reach staff rather than SPH staff provide this information and public guardians do not interfere with this process; **(E)(6)** if individuals are given an opportunity to participate as fully as possible in his or her treatment planning and discharge planning; **(E)(7)** if planning arrangements can be updated and carried out in accordance with the Settlement Agreement requirements; and **(E)(9) and (10)** if local transition teams

reported a higher percentage of barriers to the State Barriers Committee than currently reporting. The State has more challenges to meet seven (7) other items. The Reviewer will also conduct a higher number of interviews with individuals on In-reach status living in ACHs in the spring of 2021. It will be clearer after the Spring Review if staff are offering individuals residing in ACHs the necessary discharge and transition assistance as well as services and supports for typical daily activities. The State is aware of their challenges and is taking steps to meet these requirements.

**Figure 12: Discharge and Planning Process Mean Scores**



2. The Settlement Agreement standard requires the State “to implement procedures for ensuring” that individuals in the target population receive accurate, full information about all community-based options as stated in **(E)(1)**. The State has issued guidance on In-reach and Transition Planning. The State has developed procedures for target population members in ACHs and SPHs to receive information about community living options through in-reach education and through the discharge and transition planning process. In 2016, the State issued an In-reach tool and guidance. In 2018, the State issued an In-reach and Transition Manual. In FY 2019, the State modified its contracts with SPHs to improve discharge and transition planning requirements. The State issued guidance to SPHs and LME/MCOs that took effect in March 2020 to clarify requirements for coordinated discharge planning and for

LME/MCO transition coordination staff—who are typically more knowledgeable than SPH staff about community-based housing and service options—to lead the discharge planning for SPH residents. And in September 2020, the State issued a detailed Informed Decision-Making Tool, along with training, to guide in-reach specialists’ conversations with SPH and ACH residents to encourage them to convey full information about supported housing and to document and resolve transition barriers.

Although the State has implemented these procedures, they have not yet been effective to ensure that individuals receive full information about community living options, as detailed below, and in the November 2020 Interim Report, which found that at one of the State’s three SPHs, thirty percent (30%) of individuals reviewed did not receive full information about community living options. Several procedures are too recent to have changed practice statewide. In the fall 2020 reviews, there were only fourteen (14) out of twenty-nine (29) individuals reviewed on this requirement informed of their options, resulting in a mean score of 1.90 on a three-point scale. There were many different reasons individuals did not get information about their options or did not get information in a timely manner. One was timing: individuals had to make decisions about where to live post discharge or when they chose diversion over ACH placement but before seen by TCLI staff because individuals needed a place to live at discharge or when diverted.

Often there were lag times between an individual’s referral to TCLI and staff follow-up. Sometimes this delay was weeks; in one case it was over two months, and in another, over a year. There was a lack of housing or bridge housing for four (4) different individuals in the review. This was related to individuals not given the option to move to bridge housing either because bridge housing was not available at the time or simply was not offered.

Another barrier to individuals receiving full information is the misconception among some SPH social workers that individuals, made eligible for TCLI, have to move to supported housing upon discharge. Individuals who are eligible for TCLI get to choose after fully informed of their options. Guardians sometimes say they do not want to listen to the information about TCLI, thinking it is just about moving to supported housing right away, so neither the guardian nor the individual ever hears the options. Five (5) individuals in the fall 2020 review did not get the information because SPH social workers and/or their guardian did not believe the individuals were capable of living in the community or in supported housing and therefore, did not inform the individual of this option. Outcomes like these are based on an unwarranted assumption that individuals isolated in adult care homes are incapable of a life in the community or that the services and supports they need are not available.

3. In-reach: The State is not yet meeting the in-reach requirement in **(E)(2)** to provide or arrange for frequent education efforts, provide information about the benefits of supported housing, facilitate visits to such settings, and facilitate visits to meet with other individuals living with

disabilities who are living, working, and receiving services in integrated settings, for individuals in ACHs and SPHs with their families and community providers. In-reach staff send letters, which individuals may or may not get. Staff do not always visit every ninety (90) days, provide individuals with all the information about community benefits, or provide correct or enough information about services and supports. Often when in-reach staff call ACHs, they do not get to talk to individuals directly. There were disruptions in providing in-reach in part due to the COVID pandemic in FY 2020. There were also delays related to In-reach staff changes, In-reach specialists forgetting to provide in-reach for a particular individual or becoming overwhelmed by their caseloads and not making the required contacts in a timely manner.

The Reviewer did not conduct a review of the requirement for In-reach specialists to facilitate community visits in FY 2020 due to visit restrictions during the COVID pandemic. A number of In-reach staff were quite creative, taking walks and visiting outdoors, providing virtual tours of housing, and helping individuals shop on-line for furnishings for their new apartment. Yet, overall, the fall 2020 reviews led to a score of only 1.79 for In-reach. There is additional information regarding Transition requirements in findings for **(E)(10)**, **(E)(11)**, and **(E)(12)** that covers some of these same challenges.

4. The Settlement Agreement requires the State to provide individuals with effective discharge planning and written discharge plans to help them achieve goals across all domains in **(E)(3)**. The State is not meeting this requirement. It had a mean score of 2.04 on the fall 2020 review with seventeen (17) of twenty-seven (27) individuals with getting clear, complete, and accurate information regarding supported housing, services, and supports resulting in a written plan designed to achieve outcomes across all required domains.
5. **(E)(4)(5)** Transition team meets responsibilities: The State is not meeting the requirements that transition planning teams with the relevant knowledge and skills **[(E)(4)]** led by the LME/MCO TCLI staff with a Transition Coordinator administer the transition process **[(E)(5)]**. The state's score on this item was only 1.65 on these combined requirements in the fall 2020 reviews. For review purposes, these two requirements are combined given how these requirements are linked. The SPHs have developed a discharge planning form and Continuing Care Plan that are comprehensive, but this is not a document created by the transition team nor does the team consistently participate in the development of the Continuing Care Plan. The fall 2020 reviews uncovered significant evidence of discharge teams not having members with the relevant knowledge and skills for successful discharge planning. For example, nine (9) individuals discharged from SPHs, of the twenty-three (23) reviewed, moved to unstable housing. These placements were either counter-indicated or made without completing housing arrangements. The same was true for individuals exiting ACHs or diverted from ACH admission to supported housing. Three (3) service providers told several individuals they

were “not ready” for community living, but they were not clear what that meant. One (1) woman started looking for housing on her own. There was a delay in one (1) man’s SPH discharge for almost two years because a public guardian overruled his choice and the decisions of the treatment team and the LME/MCO staff. The guardian was subsequently removed.

On the other hand, for three (3) other individuals, their plans were recovery-based, the staff were well prepared, and the planning process was well organized and executed seamlessly. One (1) ACT team was integrally involved in two hospital stays for one (1) person newly referred to TCLI and one (1) person on their caseload. The ACT team physically helped both individuals move into supported housing.

The State is not yet meeting the requirement that transitions are the responsibility of a transition team and the transition coordinator administers the process. Instead, many times, for SPH residents, facility staff—who often lack knowledge of supported housing and community-based services—still drive discharge planning. The standard also requires that discharge planning teams make arrangements for individuals to get supported housing and/or bridge housing prior to discharge or with sufficient time and resources for individuals to not have to move to an ACH or to unstable housing, either at discharge or following pre-screening. In the fall 2020 reviews, one LME/MCO transition coordinator did not take any responsibility for discharge planning for three (3) individuals at one of the SPHs. At least five (5) other individuals did not get access to supported housing because staff did not make the request until too close to the discharge date to start the process for supported housing. LME/MCO staff made arrangements for bridge housing in three (3) of those circumstances, but bridge housing also was not available in those three (3) situations and in two (2) other situations. Luckily one (1) individual got bridge housing within a few days when a judge lifted her ITP status so instead of returning to jail, she was able to move to the community.

6. **(E)(6)** requires the State to offer individuals in ACHs and SPHs an opportunity to participate as fully as possible in his or her treatment and discharge planning. There are challenges with scoring **(E)(6)** because it was not always possible to score this item for individuals getting a desk review who came into the TCLI program in the early years of the Agreement since there was not the opportunity to interview individuals regarding their participation. However, based on current information, the State is not yet meeting **(E)(6)**.

The LME/MCO is responsible for this process for individuals exiting ACHs or diverted from ACHs with the exception of individuals discharged from SPHs, including those who qualify if they would otherwise be moving to unsafe housing or diverted from moving to an ACH. The State did not meet this requirement in FY 2020. Interviews with LME/MCO and SPH staff revealed that with nine (9) participants of the twenty-seven (27), or thirty-three percent (33%), reviewed did not receive an opportunity to participate as fully as possible in treatment

and discharge planning. Each of the nine (9) participants had a transition coordinator, a treatment team, a guardian, or family who disregarded their views and marginalized their participation in discharge planning. (E)(6) also applies to ACH residents, but LME/MCO TCLI staff conduct their discharge planning without ACH staff involvement. As explained elsewhere, because of COVID restrictions, the fall 2020 review sample did not include sufficient ACH residents to assess whether they consistently participate as fully as possible in their discharge planning.

7. The State came close to meeting its **(E)(7)** requirements for individuals in the fall 2020 review, with a score of 2.31. This requirement specifies that discharge planning begins at admission and is based on the principle that, with sufficient services and supports, people with SMI or SPMI can live in an integrated community setting. It requires that the discharge planning assist an individual to develop an effective written plan to live independently in an integrated community setting. It also includes a requirement that discharge planning is developed through a person-centered process in which the individual has a primary role and is based on the principle of self-determination.

This item has six overlapping but somewhat discrete parts. The State can do well with starting discharge planning at admission, but it may not be person-centered nor is the written plan always effective.

The score could also be somewhat inflated because, due to COVID restrictions, the sample size of individuals who successfully transitioned to the community was disproportionately larger than the sample size of individuals who continued to reside in an ACH. Scores for individuals discharged from an SPH were much lower than the scores for the individuals diverted from ACHs or exiting ACHs before COVID. This was a reflection of SPH staff and guardians viewing individuals as incapable of living in supported housing.

The State is meeting the **(E)(7)(a)** requirement that discharge planning begin at admission, at least for SPH residents and individuals diverted from ACH admission. For individuals made eligible for TCLI in the early years of this agreement, it is sometimes difficult to discern now if discharge planning began for individual upon ACH or SPH admission. This was clearly true for individuals already living in ACHs and made eligible for TCLI only after the Settlement Agreement implementation began in 2013. The State is not meeting any of the other requirements in **(E)(7)**. **(E)(7)(b)** requires discharge plans to be based on the principle that with sufficient services and supports, it is possible to discharge (or divert) individuals to integrated settings. But as noted in the findings related to **(E)(4)-(5)**, individuals in the fall 2020 review reported that members of their discharge teams told them they were not capable of community living. The findings for **(E)(4)-(5)** also reference that discharge plans were frequently ineffective at helping individuals live independently in an integrated community setting, as **(E)(7)(c)** requires. And although the State is making progress on giving

individuals a primary role in their discharge plans, as **(E)(7)(d)** requires, at least forty-four percent (44%) of discharge plans reviewed did not show evidence of getting developed on the principle of self-determination, which **(E)(7)(d)** also requires.

8. The SPH written discharge plans cover a wide range of items but is limited in addressing all seven (7) criteria listed in the Settlement Agreement **(E)(8)** with limited information on disposition and the plans for assistance with their primary service provider and with limited, if any, information regarding barriers. There are other documents including admission plans of care and Continuing Care Plans that include more comprehensive information. The scores for individuals discharged from SPHs was slightly higher than the fall 2020 sample. Five (5) LME/MCOs (across three hospitals) had high scores on this item so regardless of the challenges with the hospital's plan, the LME/MCO staff planning was effective.

For individuals transitioning through diversion or exiting ACHs, the scoring for **(E)(8)** is 1.83 on this item. Reviewers reviewed PCPs and CIP documents to arrive at that score. The scoring reflected that some plans were sketchy and did not cover the seven criteria.

9. **(E)(9), (10), (11)**: The State is taking steps to meet these requirements. DHHS TCLI staff hold quarterly meetings with all three (3) SPHs and relevant LME/MCO clinical leadership to address barriers for individuals with complex treatment needs. The State created a state-level Barriers Committee in FY 2019, which has demonstrated effectiveness in reducing and eliminating systemic barriers. The team does not include individuals with lived experience. The State issued a detailed Informed Decision-Making Tool in September 2020, along with training, to guide in-reach specialists' conversations with SPH and ACH residents. The tool includes a form for in-reach specialists and individuals to document barriers to transition, strategies to address them, and to record their informed decision. It is too early to determine whether the new tool is fully implemented to document facility residents' informed decision to remain institutionalized or strategies to address their concerns about community living. There was evidence in the fall 2020 reviews that local teams are not addressing transition barriers or referring them on to the State level barriers committee. There is a need for additional training for local teams who often identify barriers but do not address them adequately or send them onto the State barriers committee.
10. **(E)(12)** is the requirement for individuals remaining in an ACH to get a re-assessment on a quarterly basis, or more frequently, upon request. The State is not meeting this requirement based on the findings from the fall 2020 review. In-reach staff have challenges assessing individuals quarterly or more frequently. Staff make calls but often do not get to talk to the individual directly or they send letters which the individual may or may not see. These are contact methods principally used for three reasons: 1) the high volume of individuals living in adult care homes made eligible for TCLI make 90-day visits challenging; 2) a significant number of guardians do not allow direct contact; and 3) individuals may no longer qualify for

TCLI but are still on the TCLD list as eligible participants. These are not new issues, but the fall FY 2020 reviews demonstrated that these problems prevent the State from meeting not only the requirement for quarterly visits but also the **(B)(5)** requirement that two thousand (2,000) individuals exiting adult care homes are occupying supported housing slots. The State has developed a new informed decision-making tool that could be helpful for assessment purposes but only when individuals are seen for purposes of re-assessment. The requirement for using this tool went into effect in October 2020 and its impact on the State meeting this requirement is not yet known.

11. The in-reach process requires creativity to help an individual feel less vulnerable to change and goes beyond just “talking” to an individual; it requires being active and persistent while building trust. Many staff providing in-reach services have learned this process very well, but it takes time and patience which can be a challenge for staff to provide. There were disruptions in providing in-reach in part due to the COVID pandemic in FY 2020. The fall 2020 review also revealed there were delays in meeting the ninety (90) day timeframe related to staff changes, staff forgetting to provide in-reach for a particular individual, or staff becoming overwhelmed and not making the required contacts in a timely manner.
12. The requirements for **(E)(13a-b.)** are related to tasks that were associated with initiating in-reach and transition and thus no longer reviewed.
13. **(E)(13.c):** The State is meeting the requirement that the discharge planning process be completed within ninety (90) days based on the significant number of individuals whose planning was completed under 90 days when last reported in FY 2019. There is a subset of individuals admitted to SPHs on ITP status and not restored to competency within ninety (90) days or for individuals whose mental condition warrants their continued stay. Discharge planning is also not completed within ninety (90) days for individuals exiting ACHs or diverted from an ACH when they get admitted to a hospital or treatment center, go to jail, or are waiting for a specific newly built housing unit that is not yet approved for occupancy within the ninety (90) days. This occurred more often with the Alliance and Cardinal LME/MCOs. They start the 90-day clock as early as possible, but both had a number of individuals moving to new Integrated Supported Housing Program (ISHP) units and waiting on the unit construction and properties to be “placed in service.” Both LMEs worked diligently with individuals to request reasonable accommodation or sometimes to apply for multiple rental units before getting one because of their history.
14. The fall individual reviews revealed that access to safe supported housing or bridge housing was or had been a problem for thirty-three percent (33%) or seventeen (17) individuals, although six (6) of those individuals eventually got housing after ten (10) to fifteen (15) months of delays. Twenty percent (20%) of the fifty-two (52) individuals seeking supported housing had not gotten it and were not likely to get it in the future. (This does not include

individuals still looking at the time of the review or those denied the opportunity to choose supported housing.)

The State reports the number of individuals admitted to SPHs on an ITP status is twenty-three to twenty five percent (23-25%) of the total number of SPH admissions. Twenty-five percent (25%) of individuals in the fall 2020 review admitted to SPHs were on ITP status and all but one (1) individual returned to jail. The FY 2020 reviews and reviews in earlier years showed that many individuals with this status qualify for TCLI and would benefit from transition planning and assistance prior to release from jail or directly from a court hearing or prior to a hospital discharge.

The Interim Report referenced the need to improve discharge planning for individuals on ITP status who are also TCLI eligible. Jail diversion and re-entry programs are regarded as standard practice and there is a robust body of literature describing effective models which typically require both state and local mental health and justice system cooperation and involvement. Given the number of individuals who are TCLI eligible returning to jail at the point of SPH discharge, it would reduce the number of individuals moving to unstable housing after a short period of incarceration. The State and LME/MCOs both have a role in working with the justice system on linkage to services and supported housing for individuals made eligible for TCLI. Based on these reviews, it is clear that the State needs to clarify LME/MCOs' responsibilities with respect to TCLI-eligible individuals who return to jail.

15. **(E)(13.d)** Institutions for Mental Disease (IMD): The State has met this requirement. The State must complete four (4) steps after finding an ACH is at risk of a determination that it is an IMD. The State completed a comprehensive review of ACHs in FY 2020 to determine if any were at risk of triggering an IMD finding. This review was thorough and sufficient to signal that the State was meeting this requirement.
16. **(E)(14)** ACH Residents Bill of Rights: Due to the COVID pandemic, there were limitations on the fall 2020 review. The review team only conducted twelve (12) reviews of individuals living in ACHs out of the one hundred and five (105) reviews conducted in the fall of 2020. Of that number, there was only sufficient information available to fully review the rights of seven (7) individuals. Of that number, there was information to suggest there may have been violations for four (4) of those individuals. Only one (1) LME/MCO reported a violation of one (1) of these individuals.
17. The findings from this final report portrayed a generally positive trend for the State to meet the SPH discharge and transition process requirements (**see Attachment B**). However, two issues emerged that require attention in order for the State to meet the discharge and transition process requirements across the three hospitals.

The first issue the State needs to address to come into compliance is the need for LME/MCOs to take more responsibility for administering the transition process and for SPH staff to take steps to remove barriers and collaborate with LME/MCO staff: Broughton and Central Regional hospitals get admissions from the Cardinal catchment area and the Central Regional and Cherry hospitals get Alliance catchment area admissions. Alliance and Cardinal are the two largest LME/MCOs based on their population densities. Their discharge and transition process scores were lower when compared with scores of the other LME/MCOs. At Central Regional one of Cardinal's scores was lower because of hospital staff not following through to resolve a problem created by a public guardian who was subsequently removed from her role as guardian. Alliance's score at Cherry was low, in part, related to its transition coordinator not carrying out her responsibilities and Cherry staff conducting the discharge planning for three (3) individuals rather than working with the LME/MCO. There were also challenges with a discharge of a fourth individual who had been living successfully in supported housing for several years. His records revealed that he had stopped treatment approximately six (6) months before admission. Cherry Hospital staff recommended the individual get a higher level of care, Assertive Community Treatment, upon discharge. Instead, his discharge was to a group home with a referral to a day program, outpatient therapy, and medication management. This discharge plan is not recovery oriented, evidence based, or in line with his expressed needs. A return to supported housing with greater assertive treatment is more likely to result in more positive outcomes given his preferences, his presentation, and his history.

The second issue the State needs to address to meet these requirements is to ensure public guardians participate with SPH treatment teams and LME/MCO transition coordinators in discharge planning. The above situations point to the need for public guardians to participate in discharge planning rather than dictating decisions that focus on compliance and control instead of recovery-oriented services. It would likely help to achieve guardian participation, if staff affirm they will provide services and supports to match the individual's need for frequency and intensity of services and provide assertive engagement. It would also help if the LME/MCOs can demonstrate their follow through with these supports. This builds credibility and trust.

***(C) Recommendations***

1. The State, including LME/MCOs and SPHs, continue to work toward fully implementing the joint planning requirements set forth in the March 1, 2020, guidance to SPHs and LME/MCOs to clarify requirements for coordinated discharge planning and for LME/MCO transition coordination staff to lead the process for SPH residents. This includes meeting the SA transition team requirements of **(E)(4)-(5)**.
2. The State continue to develop and implement a viable plan, with targets and action steps,

to assist individuals to transition to the community from ACHs. The State work with the LME/MCOs to reduce the number of individuals on the in-reach list by removing names of individuals who are deceased, who have moved to a higher level of care and not expected to return, and who are not eligible for TCLI so that in-reach specialists can meet with individuals on their caseload with the appropriate frequency. Adjust or add resources as needed to meet the **III. (B)(5)** requirement to provide supported housing to two thousand (2,000) individuals exiting ACHs and ensure individuals can move and live successfully in the community.

3. The State and each LME/MCO continue to work with each Division of Social Services (DSS) to ensure public guardians meet their obligation to receive and consider the information from discharge planning teams before making decisions that limit recovery-based services and integrated housing opportunities for individuals in the SA target population.
4. The State and LME/MCOs pursue agreements with local jails and law enforcement officials to allow LME/MCO staff, including transition coordinators and service providers, to provide in-reach and transition planning for individuals made TCLI eligible while on ITP status and hospitalized at an SPH. These arrangements include permission for visitation and planning for individuals to gain access to bridge housing, supported housing, services, and supports when released.
5. The State, including SPHs and LME/MCOs, reduce SPH discharges to unstable housing through more timely planning and assertive engagement with individuals who may be reluctant to make a safer, more recovery-oriented plan because it often appears to place more demands on the individual or the individual does not feel they will be successful living in their own home.
6. The State improve substance use treatment for individuals in the pre-contemplative stage of recovery and include substance use treatment providers in discharge and community services planning. The State add community-based peer support staff to assist individuals in making decisions and transitioning to the community.
7. The State ensure that SPH or LME/MCO staff make referrals to supported housing early in the SPH treatment/discharge planning process, as soon as someone is assigned a housing slot, at the point an individual becomes TCLI eligible when pre-screened, or when an individual indicates interest in community living while residing in an ACH. Follow the same process for bridge housing for individuals made TCLI eligible while residing in an SPH/ ACH, or at the point someone becomes eligible during the pre-screening process. Provide adequate resources for bridge housing so individuals, discharged or pre-screened, will have enough time to make permanent housing arrangements, especially for individuals who have not lived outside of an institution for an extended period of time.

8. The State ensure that LME/MCO and provider staff check to see that the individual's discharge plan informs their initial PCP and improve the PCP process and the plan itself, making sure to provide individualized services as frequently and intensively as needed.
9. The State develop and implement procedures to ensure that local transition teams transmit requests to the State-level Barriers Committee for barriers that are difficult for individuals who remain in ACHs after expressing interest in supported housing.

## V. PRE-ADMISSION SCREENING AND DIVERSION

Major Categories	Standards	Progress Towards Meeting the Requirements
<p><b>1. Section III. (F)(1)</b> The State will refine and implement tools and training to ensure that when any individual is considered for admission to an Adult Care Home (ACH) the State shall arrange for a determination, by an independent screener, of whether the individual has SMI or not.</p>	<p>1. The State has developed tools and training directly and through the LME/MCOs to evaluate individuals for admission to an ACH for SMI.</p> <p>2. The State makes this determination when considering the individual for admission, not after they move into an ACH.</p>	<p>1. The State has made significant progress implementing their new pre-screening process, Referral Screening Verification Process (RSVP), and is on track to meet this requirement in FY 2021.</p> <p>2. The State can now determine the number of individuals entering ACHs, circumventing the pre-screening process, and take additional steps to eliminate this practice.</p>
<p><b>2. Section III. (F)(2)</b> The State shall connect any individual with SMI to the appropriate LME/MCO for a prompt determination of eligibility for mental health services.</p>	<p>The LME/MCO responds promptly to requests for determination of eligibility for mental health services required prior to admission of an individual to an ACH.</p>	<p>The State will meet this requirement in FY 2021. LME/MCOs have reduced the number of individuals in the “pending” and in the “in process” status with the support of DHHS by fifty two percent (52%) in FY 2020 and are trending lower again in the first quarter of FY 2021 (<b>see Figure 13</b>). DHHS and the LME/MCOs have made improvements in processing, eliminating duplications, and reducing the volume of requests for individuals not eligible for TCLI.</p>
<p><b>3. Section III. (F)(2)</b> Once determined eligible for mental health services the State and/or the LME/MCO will work with the individual to develop and implement a community integration plan. The individual shall get the opportunity to participate as fully as possible in this process.</p>	<p>1. Once eligibility for mental health services is determined, individuals considered for an ACH admission get assistance to develop and implement a community integration plan.</p> <p>2. The individual fully participates in the process.</p>	<p>The State is successfully providing transitional assistance to individuals eligible for diversion. Most individuals appear to be participating in this process fully, which is attributable to the LME/MCOs who begin this planning process.</p> <p>Additional reviews of individuals not diverted will take place before the end of FY 2021 to determine if individuals received adequate assistance to develop a community integration plan and if there were steps taken for them to remain in the community.</p>

Major Categories	Standards	Progress Towards Meeting the Requirements
<p><b>4. Section III. (F)(3)</b> The development and implementation of the community integration plan shall be consistent with the discharge planning provisions in Section III (E) of this Agreement.</p>	<p>The development and implementation of the community integration plan is consistent with provisions in <b>Section III (E)</b> of this Agreement.</p>	<p>The planning process is consistent with the discharge planning provisions in <b>Section III (E)</b>.  See the review of <b>Section III (E)</b> for a review of the State’s performance meeting the discharge and transition process.</p>
<p><b>5. Section III (F)(3)</b> The State will set forth and implement individualized strategies to address concerns and objections to placement in an integrated setting, will monitor individuals choosing to reside in an adult care home and continue to provide in-reach and transition planning.</p>	<p>1. The State has developed and implemented strategies for each individual who objects to placement in an integrated setting to address concerns and objections to such a placement.</p> <p>2. The State is monitoring each individual choosing to reside in an ACH and continues to provide In-reach and transition planning.</p>	<p>The State has not yet met this requirement but made significant progress in FY 20 and the first quarter of FY 21 developing a process to assist individuals to make an informed choice of available alternatives to entry into or continued stay in an Adult Care Home. The State introduced and conducted training on an informed decision-making process and tools for LME/MCOs and guardians that, when fully implemented, will enable the State to meet the initial step of this requirement. The state will need to take additional steps to address concerns and objections including reducing and/or eliminating barriers, so that public guardians fully participate in this process and individuals continue to be provided in-reach services and transition planning after they have chosen to live in an ACH.</p>

**(A) Background**

**Section III (F) Pre-screening and Diversion:** This review updates information provided in the FY 2020 Interim Report. It covers information from the State’s actions to improve the pre-screening process and information regarding the State’s performance in implementing diversion.

In November 2018, the State initiated a new online pre-screening process, called the Referral Screening Verification Process (RSVP), for connecting individuals at risk of ACH admission to the appropriate LME/MCO for a TCLI eligibility determination. This is an on-line system wherein a referring entity (health or behavioral health state or private hospital discharge planner, departments of social services, guardians, healthcare and mental health service provider, homeless services provider or other community agencies, family member, or individuals themselves) can complete a request that goes straight to an LME/MCO. The LME/MCO determines eligibility, often having to request additional information including a clinical assessment. At times, the LME/MCO arranges for a clinical assessment to determine eligibility.

The LME/MCO having completed the RSVP process, quickly refers the individual to the appropriate staff person for In-reach and transition planning. If the individual chooses after apprised of their options to move to an adult care home, this is arranged. However, if made eligible, the LME/MCO continues to provide In-reach and if the individual changes their mind and wants to move back to the community, the LME/MCO arranges for that to happen.

The State has made progress implementing the Pre-screening and Diversion process since introducing RSVP when the State shifted this responsibility to the LME/MCOs. The State had previously contracted this responsibility to an independent organization whose contractors were not as knowledgeable about the living options, supported housing, and community-based services necessary to offer individuals choice. The process was lengthy and fraught with technical and design challenges and flaws. The Reviewer issued a report in 2016 which illustrated the problems with using a vendor with little knowledge of the community system. The State recognized that gatekeeping and providing services options are key roles of any managed care organization.

Since the end of 2018, with LME/MCO input, the State has improved the system, including better defining the process, taking action to correct problems, and providing better guidance to the LME/MCOs and organizations that routinely refer individuals for pre-screening. Several LME/MCOs took much needed action to work with providers, stakeholders, and referring organizations. As a result, the process continues to improve and the State is continuing to make systems improvements, analyzing data and troubleshooting problems as they occur rather than months after the fact. The Interim Report also included summaries of the pre-screening implementation with two LME/MCOs.

Section III. (F) of the SA requires the State to work with individuals, when found eligible for TCLI, to develop a community integration plan consistent with the individualized, person-centered planning process described in Section III. (E) to choose community living or move to an ACH. The individual continues to be eligible for in-reach and transition to the community after moving to an ACH.

Of the twenty-six (26) individuals enrolled in TCLI after pre-screening reviewed as part of the fall 2020 community review, the State diverted twenty (20) individuals meeting TCLI eligibility requirements. Another six (6) individuals secured a housing slot after screening, but information learned during the review cast doubt on their eligibility for the program. They were not at risk of ACH admission; some do not have an SMI diagnosis. This does not appear to be a systemic issue, but rather a staff issue which the State has already addressed. The fall review sample included individuals diverted to the community but included fewer individuals coming through the RSVP portal than in the past two years. There will be a further review in FY 2021 to determine if the State has sufficiently addressed diversion issues. The primary principal challenge to the State in meeting all of the requirements in Section III (F) is to ensure that individuals who choose to move

to an adult care home after Pre-screening get the required In-reach and Transitional assistance as set forth in **Section III (E)**. There will be a further review in FY 2021 to determine if the State has sufficiently addressed diversion issues. Diversion is also a transition process and will be part of the **Section III (E)** in the 2021 spring review.

**(B) Findings**

1. The State has continued to make progress implementing the new pre-screening RSVP process, both in improved timeliness of response to initial requests for eligibility determination and in reducing the number of individuals in pending status. This progress is significant given the start-up challenges the State faced when initiating the new process.
2. The State has increased funding and makes funding adjustments to enable the LME/MCOs to make timely and well-informed eligibility decisions, offer informed community choice, and redirect individuals not eligible for TCLI. Based on the timing of these adjustments, this has helped the LME/MCOs better manage their workflow.
3. As shown in **Figure 13** below, there were eleven thousand five hundred and forty-eight (11,548) individuals referred to LME/MCOs for an adult care home placement eligibility determination between November 1, 2018, and June 30, 2020. According to DHHS, after November 1, 2018, three thousand two hundred and forty-two (3,242) individuals or twenty-eight percent (28%) of the total referrals were eligible and added to the Transitions to Community Living Database (TCLD)<sup>37</sup>. This includes individuals not diverted from ACH placement as well as those diverted.

**Figure 13: RSVP Referrals and Progress in Processing (November 2018-September 2020)<sup>38</sup>**

	11/2018-6/2020 RSVP Referrals Submitted	11/2018-6/30/2020 Individuals Determined TCLI Eligible	In Process June 19	In Process June 20	In Process Sept 30 2020	Pending June 2019 <sup>39</sup>	Pending June 2020	Pending Sept. 2020
Alliance	1577	545	256	138 (-118)	24	27	1 (-26)	0
Cardinal	3243	786	339	148 (-191)	31	157	0 (-157)	0
Eastpointe	761	206	23	22 (-1)	11	7	0 (-7)	0
Partners	1349	203	57	23 (-34)	7	34	3 (-31)	0
Sandhills	866	258	40	25 (-15)	12	108	32 (-76)	0
Trillium	1638	434	116	92 (-24)	8	31	19 (-12)	14
Vaya <sup>40</sup>	2114	810	221	171(-50)	33	11	11 (0)	0
<b>Total</b>	<b>11,548</b>	<b>3242</b>	<b>1,052</b>	<b>619 (-433)</b>	<b>126</b>	<b>375</b>	<b>66 (-309)</b>	<b>14</b>

<sup>37</sup> This is the database that includes names and key information regarding the target population.

<sup>38</sup> This chart displays “in-process” and “pending” numbers through September 2020 to display the impact of progress made in FY 2020 to improve the pre-screening process.

<sup>39</sup> After seven (7) months; new approach began November 1, 2018.

<sup>40</sup> Vaya’s Care Coordination manages the Pre-screening process.

4. Between November 1, 2018, and June 30, 2020, the State determined that two thousand two hundred and sixteen (2,216) of the eleven thousand five hundred and forty-eight (11,548) individuals referred through RSVP were not eligible for TCLI. In addition, the State withdrew six thousand two hundred and one (6,201) individuals because they were duplicates or not entered correctly for other reasons. This reveals the enormous volume of work for the State and the LME/MCOs as they administer the new RSVP pre-screening system. The State and the LME/MCOs have taken major steps to educate referring organizations about eligibility criteria and anticipates this will decrease as the program progresses.
5. There were fourteen hundred and sixty-three eligible individuals (1,463) of the three thousand two hundred and forty-two (3,242) eligible individuals who were admitted to ACHs rather than diverted between November 1, 2018, and June 30, 2020. The average number of diversions in the first quarter of FY 2021 was virtually identical to the average in the fourth quarter of FY 2020.
6. Pending and In Process numbers are on a steep downward slope, with in process referrals dropping forty one percent (41%) in FY 2020 and another eighty percent (80%) in the first quarter of FY 2021, demonstrating the LME/MCOs' increased capacity to manage RSVP, the results of education and consultation with referring organizations and the State's "clean-up" of duplicates, counting, and coding errors. Likewise, pending referrals dropped by eighty two percent (82%) in FY 2020 and another seventy nine percent (79%) in the first quarter of FY 2021. Due to the State cleaning up their data base in FY 2019, it is unclear if referrals have remained constant, but these appear to be as accurate as possible.
7. LME/MCOs continue to report there were some individuals admitted to ACHs before the LME/MCOs could complete eligibility determination. The State has taken steps to identify admissions and manage this process more effectively.
8. The fall 2020 review revealed as many as six (6) individuals out of twenty-six (26) or twenty three percent (23%) made eligible who did not meet TCLI eligibility criteria. Five (5) of the six (6) had moved to supported housing at the time of their review. None of the six (6) individuals was at risk of ACH placement. One (1) individual stated that he did not understand how he qualified and did not know what an ACH was. He had one hospitalization because of his substance use diagnosis and a diagnosis of generalized anxiety disorder which is not a qualifying diagnosis. He appreciated the rental assistance but because of his income, indicated he would be moving when his lease expired. Another individual who became homeless after a hospitalization had the same diagnoses because of his substance use. He reported he understood he needed to get involved with AA again (he has been a sponsor for twenty years) and stay in touch with family and friends who are positive influences in his life. He had lost his phone and was homeless for a while but is self-employed in the construction industry. He does not qualify for any benefits. One (1) individual had a more serious diagnosis

when younger, but this finding was disputed and changed in his most recent clinical assessment.

9. State staff responsible for the oversight of the Pre-screening and Diversion process have investigated these issues and report they appear to be isolated issues. These situations, though, demonstrate the need for State staff to continue monitoring the TCLI eligibility process.
10. The Interim Report referenced challenges LME/MCOs faced in FY 2020 in the RSVP eligibility determination process, primarily (a) delays in getting paperwork to confirm individuals' disabilities, (b) limited options for places where individuals could live when first seen, and (c) challenges involved in serving individuals with serious medical problems. The issue of available accessible units and necessary modifications continues to surface, although less frequently, as a delay and a deterrent to community living as referenced in the Discharge and Transition section. These issues point to the need to work closely with referring organizations to get information about potential referrals as early as possible.
11. The State took two major steps in FY 2020 to improve its pre-screening implementation for individuals who may have had concerns and objections to choosing community living, as required by **(F)(3)**. The first was to provide clarity on the role of In-reach for individuals determined eligible for TCLI following their RSVP referral. The State did this through an April 2020 webinar and follow-up to clarify In-reach roles and clarify requirements for "outreach" for individuals referred for ACH placement but still in the process of deciding to move to an ACH or to a community setting and individuals discharged to the community from SPHs when made eligible for TCLI. In September 2020, the State initiated an "informed decision making" process and introduced a tool for LME/MCO staff to utilize for the purpose of fully informing individuals of their choice of where they want to live and assisting individuals with making that decision. The State's process includes individuals and staff identifying barriers to community living. State staff are fully committed to improving this process and meeting this requirement. LME/MCO staff expressed concerns with adding this tool while still requiring the In-reach tool which also includes sections on individuals' choices and what relationships and activities are important and meaningful to the individual.
12. The fall 2020 reviews revealed the State will need to take additional steps to identify and address concerns and objections, that public guardians fully participate in this process and to ensure In-reach services and transition planning occurs on a timely basis. This has been an ongoing issue. Often staff perceive concerns as a resource problem and that there is no solution to the concerns or problems. This appeared in part to be related to some In-reach specialists and transition coordinators, due to staff turnover, not being knowledgeable about resources, not utilizing the Barriers Committee process to address these barriers, and/or lack of staff creativity in helping individuals overcome their objections. Guardians often refused

to consider community living or even listen to options. This may have been in part related to their view that TCLI was just about housing, not about providing services and supports or their view that for most individuals, recovery and community living is not possible. LME/MCOs expressed mixed success working with Long Term Care (LTC) Ombudsman when problems are related to ACH personnel. Several LME/MCOs, though, were positive about LTC Ombudsman interventions. SPH staff also have responsibility supporting LME/MCOs addressing concerns and objections and identifying barriers.

13. The fall reviews also revealed these issues as referenced in the Discharge and Transition Process section of this report. The fall reviews also revealed that “continued” follow-up by in-reach specialists was often formulaic, through letters, phone calls, or quarterly visits. Written documentation corroborated by staff and individuals seen in fall reviews revealed that In-reach staff had not seen three (3) individuals or thirty percent (30%) of individuals on a quarterly basis even though LME/MCOs monitor this process. The FY 2021 review process can provide more information on the impact of the State’s FY 2020 actions referenced above.

***(C) Recommendations***

1. The DHHS staff responsible for the oversight and management of Pre-screening and Diversion continue to take actions to reduce the need for manual clean-up and perform their oversight proactively.
2. The State and LME/MCOs conduct periodic quality reviews of ACH admissions. This analysis examine the reasons for admissions, including the lack of accessible and available housing, services, and supports as part of its overall Quality Assurance and Performance Improvement Plan. These reviews should also determine if the individual and guardian received adequate education and information about these services and supports. If these reviews reveal problems and barriers, the State and the LME/MCOs take action to remediate these problems.
3. The State and LME/MCOs are already giving significant attention to improving the RSVP process and include conducting periodic quality reviews of pre-screening approvals as well as provide education to RSVP staff making eligibility determinations and to referring organizations on the eligibility criteria. This should include information and education on eligibility criteria for presenting problems, diagnoses, and risks of ACH placement.
4. The State monitor and provide consultation to fully implement the informed decision-making process and eliminate redundancies with the TCLI In-reach tool to enhance transition planning, which includes diversion.
5. LME/MCOs record and identify individuals’ and guardians’ objections and concerns about community living and take steps to address concerns and assist individuals and guardians to overcome objections. This is not a one-time discussion, but rather a continuous process.

6. LME/MCOs forward all unresolved objections and concerns to the Barriers Committee for review, including referring concerns raised by guardians and individuals that resulted in individuals moving into and/or remaining in adult care homes or other congregate settings.
7. The State continue to ensure public guardians assume their responsibility to participate in the informed decision-making process and to consider community options when staff have effectively addressed their concerns.

## VI. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Major Categories	Summary of Standards	Progress Towards Meeting the Requirements
<p><b>Section III. (G)(1)(3)(4)</b> The State will develop and implement a Quality Assurance and Performance Improvement (QA/PI) monitoring system to ensure community-based placements and services are made in accordance with this Agreement. As part of the quality assurance system, the State shall complete an annual PHIP and/or LME EQR process by which an External Quality Review (EQR) Organization will review policies and processes for the State’s mental health service system.</p>	<p>This requirement specifies that the state develop and implement a QA/PI system. The system’s goal is to ensure that all the State’s services are of good quality and sufficient to help individuals to achieve increased independence, gain greater integration into the community, obtain and maintain stable housing, avoid harms, and decrease the incidence of hospital contacts and institutionalization.</p> <p>The requirement specifies the State collect, aggregate, and analyze data on seven items and seven sub-items in III (G)(3) (g) related to in-reach, person-centered discharge, and community placement, including identifying barriers to placement. This requirement includes the State reviewing this information on a semi-annual basis to develop and implement measures to overcome barriers. The External Quality Review (EQR), established for a more broadly defined purpose, includes a review of internal TCLI policies and procedures.</p>	<p>The State has not made progress toward developing a QA/PI monitoring system. The State is developing a plan to begin this process in 2021.</p> <p>The State’s TCLI database, TCLD, provides data on a number of key metrics but the State did not disseminate a dashboard for monitoring monthly progress on placement efforts in FY 2020. The State has re-started this process in FY 2021.</p> <p>The State has not reported measures and their steps to overcome identified problems and barriers on a semi-annual basis. The State has not released its Annual Report. The State’s Barriers Committee is successful in identifying barriers and taking steps to minimize or eradicate them, but the Committee does get referrals on all of the barriers reported to them after the fact, including barriers observed in the fall 2020 review.</p> <p>The State is meeting the EQR and Quality of Life (QOL) survey requirements although the QOL instrument and approach has limited value compared to other approaches.</p>
<p><b>Section III.(G)(2)</b> A Transition Oversight Committee will be created at DHHS to monitor monthly progress of implementation of this Agreement. This includes the LME/MCOs for reporting monthly progress on discharge related measures as listed in the Settlement Agreement.</p>	<p>The Transition Oversight Committee chair is the DHHS designee (Deputy Secretary). Membership includes three divisions, the State hospital CEOs, the State hospital team lead, the Money Follows the Person Program, and LME/MCOs. The committee is required to report on implementation progress. This includes the LME/MCOs for reporting monthly progress on discharge related measures.</p>	<p>The State reported the Transition Oversight Committee met three times in FY 2020. The committee’s charge is to review progress and challenges on critical issues. The meeting minutes do not reflect whether the committee proposed any action steps to meet the Settlement requirements or remediate problems. The State must verify that the Committee is monitoring monthly progress and that LME/MCOs are reporting monthly progress to meet this requirement. The last set of minutes did not identify whether the required members attended or sent representatives.</p>

Major Categories	Standards	Progress Towards Meeting the Requirements
<p><b>Section III.(G)(5)</b> 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 a state psychiatric hospital. The survey is voluntary.</p>	<p>The State is required to implement three quality of life surveys at specific intervals: (1) prior to an individual transitioning out of a facility; (2) eleven months after transitioning; and (3) twenty-four months after transitioning.</p>	<p>The information available to review performance prior to the Reviewer submitting her draft report to the parties was not available. The latest information available is from FY 2019. The Quality-of-Life Survey approach does not provide useful information to use in quality assurance and performance improvement by the State or LME/MCOs and service providers.</p>
<p><b>Section III. (G)(6)</b> The State shall complete an annual LME/MCO External Quality Review (EQR) process.</p>	<p>The State is required to meet specific EQR requirements in ten areas. An external EQR organization completes this review annually.</p>	<p>The State is meeting this requirement. The EQR organization has taken proactive steps to include a review of TCLI policies, conduct TCLI staff interviews, and record reviews.</p>
<p><b>Section III. (G)(7)</b> Each year the State will aggregate and analyze the data collected by the State, LME/MCOs, and the EQR organization on the outcomes of this Agreement. If data collected shows the Agreement's intended outcomes of increased integration, stable integrated housing and decreased hospitalization and institutionalization are not occurring, the State will evaluate why the goals are not being met and assess whether action is needed to better meet those goals.</p>	<p>The State is required to aggregate and analyze data collected by the State, LME/MCOs, and the EQR organization on the outcomes of this Agreement. If this data shows that the intended outcomes of increased integration, stable integrated housing, and decreased institutionalization/hospitalization are not occurring, the Agreement specifies that the State evaluate why they are not meeting their goals and whether action is needed to better meet those goals.</p>	<p>The State is not meeting this requirement. The State collects, aggregates, and analyzes data but not on all the outcomes listed in this section of the Agreement. The State aggregates and tracks data on the number of individuals accessing integrated supported housing by the housing priority categories in the Agreement but does not measure stability in housing other than supported housing as required in the agreement.</p> <p>The State published its FY 2020 Annual Report in January 2021 after the Reviewer submitted her draft to the Parties. As such a review of this requirement could not take place for this report.</p>

Major Categories	Standards	Progress Towards Meeting the Requirements
<p><b>Section III. (G)(7)</b> the State will publish, on the DHHS website, an annual report identifying the number of people served in each type of setting and service described in this Agreement. The State will detail the quality of services and supports provided by the State and community providers using data collected through quality assurance and performance improvement system, the contracting process, the EQRs, and outcome data described above.</p>	<ol style="list-style-type: none"> <li>1. The DHHS publishes an annual report of the number of individuals served by type of setting and services described in this Agreement.</li> <li>2. The annual report includes details on the quality of services and supports provided by the State, LME/MCOs, and providers collected through the QA/PI system, the contracting process, the EQRs, and the outcome data described above in the QA/PI requirements.</li> </ol>	<p>The State has published their Annual Report on or about November 1<sup>st</sup> each year, which in the past meant the review of this requirement occurred after the submission of the Reviewer’s Annual Report. Even with this Annual Report delayed because of COVID, the FY 2020 Annual Report was not available before the Reviewer sent her draft Annual Report to the parties. The State’s FY 2019 Annual Report was an improvement over earlier reports and met the Settlement Agreement requirements for issuing an Annual Report. The State anticipates completing a Quality Assurance/Performance Improvement Plan and implementing a quality assurance system which would then enable the Reviewer to fully review this item when completed and published.</p>

**(A) Background**

QA/PI requirements reference quality assurance and performance improvement system tasks, action steps, and processes essential to ensure the development of community-based placements in accordance with this Agreement. This provision includes reporting on progress towards establishing goals for individuals to achieve greater independence, live a life more integrated in their community, obtain and maintain stable housing, avoid harm, and decrease institutional use. The Settlement Agreement requires the State measure and monitor the State’s performance and individuals’ outcomes on meeting these goals.

To be in full compliance with **Section III.G(1)**, which is the overarching obligation to create a QA/PI system, the State must identify accountability performance improvement requirements and hold itself (DHHS Divisions, the SPHs, and the NC HFA) and the LMEs/MCOs accountable for all the specific requirements in the Settlement Agreement. The Agreement contemplates that QA/PI is a system, not just a disparate set of ad hoc charts and reports. It is a system with a coherent set of action steps, thresholds for requiring corrective actions, and, more importantly, with a well-developed decision loop built in to reduce barriers and improve performance.

The DHHS, Division of Mental Health has primary responsibility for developing this system within input and requirements for other Divisions, the NC HFA and LME/MCOs. Beginning in early 2019,

the Reviewer requested that the State submit a Quality Assurance Plan for review and continuously requested a time to review the plan. In July 2020, the division staff presented a document with narrative regarding committees and processes used in the division's QA/PI processes taken from the FY 2019 Annual Report and a "process table" listing all the Settlement Requirements in a mostly blank table. It included a reference in a heading to a "TCLI Oversight Review." There was no reference to the review's focus or methods and when it would occur. A heading referenced a "report or measure" but there was no column for measures.

When asked about presenting and using data for decision-making as part of this effort, staff report challenges with reporting "output data" which is essential for creating an adequate feedback loop. In addition, some of the metrics used to measure performance were not sufficient nor accurate to make required improvements.

Since this effort failed, the State's Senior Advisor to the Secretary on the ADA and Olmsted proposed securing assistance from Mathematica, a well-respected research and consulting organization with expertise in the provision of information collection and analysis. Their team includes experts in disability, mental health, and long-term care policy. They provide technical assistance to the Centers for Medicaid and Medicare (CMS) among other national and state organizations.

Mathematica is slated to provide technical support to the State to meet its obligations in this agreement and on Olmstead planning more broadly, including: (1) performance measurement planning; (2) data management and analysis; (3) creating and using data dashboards; (4) overall quality assurance and performance improvement development and implementation; and (5) project management and reporting to create a useable prototype for reporting metrics. Their engagement to complete this work will extend over a number of months. If they can complete their work in six to nine months, their proposals meet Settlement obligations, and the State adopts and implements a new plan, integrated throughout the state and local systems, it will then be possible to evaluate the QA/PI system to determine if it meets the requirements of this Settlement Agreement. This assumes the State would have developed the capacity to administer the plan by that time. This means the State has to be prepared to take steps to create a structure, define responsibilities, and hold staff accountable for implementing a system that meets the Settlement requirements. This also assumes the new system is not too burdensome with adding new requirements over the old requirements but rather modernizes the metrics, collection, and dissemination methods.

This section of the SA has eight (8) requirements. One of these has five (5) sub-requirements; one has eight (8) sub-requirements. Requirements in the first category are interrelated as described below.

QA/PI is both a transformational (changes associated with changing a system) and a transactional (organizational performance toward meeting compliance or a goal) review and decision-making process. The focus of Quality Assurance is on compliance and performance improvement. It is a proactive process focused on continuous improvement. A challenge for the State in meeting Settlement requirements is that these processes are the responsibility of six (6) separate DHHS divisions, the HFA, LME/MCOs and service providers. As reported in previous Annual Reports, it appears staff see these interactions, transitions, and decisions as being separate and, in some instances, divisions do not establish requirements within their purview, assuming it is another division's responsibility.

The Senior Advisor to the Secretary on the ADA and Olmstead has placed importance on cross division collaboration for performance improvement. These efforts have succeeded in creating the Barriers Committee, the NC Housing Finance Agency staff utilizing the CLIVE system for reporting and monitoring valuable supported housing information and creating a dashboard for daily decision support and the Division of Medical Assistance establishing a system for monitoring Institutions for Mental Disease (IMDs) as referenced in the Discharge and Transitions Process section of this report. The Advisor has also initiated performance improvement action step processes with selected LME/MCOs, and her staff have attempted to review specific requirements as singular activities rather than as part of an overall plan.

The Carolinas Center for Medical Excellence (CCME), a qualified External Quality Review Organization, conducts an External Quality Review<sup>41</sup> (EQR) of each LME/MCO annually. For the past five (5) years, as part of the annual review, the Reviewer has participated with the CCME in a review of one LME/MCO's EQR. The CCME team has gained knowledge of and expertise in the Settlement Agreement obligations and provides an excellent review of each LME/MCO's responsibilities for TCLI recipients, including reviewing records and policies and interviewing key staff.

The State did not publish its FY 2020 TCLI report prior to the Reviewer sending her draft report to the parties so the findings section below references information published in the FY 2019 report. This means this review is not current and thus cannot serve as a review of the FY 2020 Annual Report.

### **(B) Findings**

1. The State has not developed the required QA/PI monitoring system in accordance with the required system **(G)(1)**. The State is attempting to meet the requirements but needs to make improvements to meet the requirements in **(G)(2)**. The State has not identified all the steps

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<sup>41</sup> EQR is the analysis and evaluation of aggregated information on quality, timeliness, and access to the health services that a managed care plan and its contractors furnish to Medicaid beneficiaries [see 42 C.F.R. § 438.320]. In North Carolina, the EQR conducts an annual review with each LME/MCO.

necessary for and is not meeting the requirements in **(G3)**, **(G4)**, and **(G7)**. The State has not provided current information to evaluate progress on meeting **(G)(5)** and **(G)(8)**.

2. The State has taken the steps necessary to meet the Transition Oversight Committee requirements in **(G)(2)**. The committee meets quarterly, not monthly. The Senior Advisors and DHHS staff report on key issues. The minutes do not reflect outcomes of discussions nor decisions, although the Settlement Agreement only requires that the Committee “monitor monthly progress.” LME/MCOs do not report on issues as required in the Settlement Agreement. The Settlement Agreement lists the required members. According to meeting minutes, representatives of the required members attend regularly.
3. The **(G)(3)** requirements specify steps the DHHS agreed to take related to QA/PI. The State has historically reported on developing and implementing the following: uniform tracking of institutional census, a standard report on hospital readmissions and implementing protocols for reporting incidents of harm, hospital re-admissions while in housing and maintenance of supported housing, and individuals who do not have a housing slot.

The Reviewer contracted for an external services analysis report in FY 2017 to include information and analysis on the amount, frequency, and duration of services one year pre- and post-community placement and six months pre- and post-community placement. In FY 2019, the State reported on the number of individuals receiving IPS-SE, ACT, CST, TMS, and Congregate Day Programming (at least one unit of service) in FY 2019<sup>42</sup> but did not report on the intensity and duration of services, which is the standard for a service utilization report. The State produced the report for individuals residing in supported housing, settings without a housing slot, in pre-transition and transition status, and in-reach status. The service report on the pre-transition, transition, and in-reach status was for community-based services delivered at the same time as pre-transition, transition, and in-reach services. These were not in-reach and transition services but rather community-based services. The number of individuals receiving ACT, CST, psychotherapy, and Evaluation & Management Office/outpatient visits services while on pre-transition or in-reach status exceeded the number of individuals living in supported housing or in the community without a housing slot in FY 2019. The State’s analysis was not comparable to the analysis conducted by HSRI in 2018, which included references to amounts of service and key issues on duration, among other findings.

The State did not publish dashboards in FY 2020 but resumed this practice in FY 2021. The dashboard provides information for monthly decision support but not daily decision support, with one exception. The HFA has taken steps to expand implementation of its Community Living Integration Verification (CLIVE) data system to provide daily decision information to

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<sup>42</sup> Individuals included in this review had at least one claim for more than 123 days.

LME/MCOs for targeted housing unit availability. This is a key step to enable the State to fully inform discharge planning with its centralized data system, although fully implementing this requirement necessitates the LME/MCOs to create a daily decision support system for availability of housing contracted with private owners locally (not tracked by the HFA). The CLIVE data system provides data for oversight on a consistent basis. Information from SocialServe, another system implemented by the HFA, provides direct feedback from landlords and property managers. The HFA and the Senior Advisor's office track and trend this data for quality management and performance improvement purposes. The Senior Advisor's team has made progress on developing and utilizing pre-screening data for decisions. The HFA and pre-screening decision support features are models for how to meet the Settlement requirements for decision support.

The Settlement Agreement requires the State to publish a template for its annual progress report. The State has not done this. Publishing a template provides the opportunity to assess whether the State is measuring the requirements in the Settlement Agreement before, rather than after, publishing the Annual Report.

The State has not fully embraced monitoring and evaluating personal outcome measures, especially of items listed in the agreement: individuals employed, engaged in community life, or attending school; repeat admissions to adult care homes, inpatient facilities including State hospitals or emergency rooms; or time spent in congregate day programming. The State collects information on a portion of the above requirements, but the metrics do not accurately reflect information required in the Settlement Agreement and the State does not use the information consistently and fully for quality assurance and performance improvement purposes. The State does not conduct independent primary source reviews other than standardized QOL surveys administered by providers. Given the Settlement Agreement requirements, this type of review could provide both valuable qualitative and quantitative data.

Excerpts from the Settlement Agreement provide clarity on the requirement to create a quality assurance system (taken from the introductory paragraph to this Section and in **(G)(1)** and **(G)(4)**):

*These sections are clear on three points: 1) the State provides services and supports that individuals need for health, safety, and welfare; 2) with a performance monitoring system to ensure ....that all mental health and other services and supports be of good quality and are sufficient to help individuals achieve increased independence, gain greater integration into the community, obtain and retain stable housing, avoid harm and decrease the incidence of hospital contacts and institutionalization; and 3) collects, aggregates and*

*analyzes data related to in-reach, person centered discharge and community placement efforts, including but not limited to information related to both successful and unsuccessful placements, as well as the problems or barriers to placing and /or keeping individuals in the most integrated setting.*

The State has taken ad-hoc steps to collect and monitor this information. The State's FY 2019 Annual Report identifies a number of committees and a quality assurance system structure but its report of the work of singular committees does not reflect an adequate plan and system for addressing the critical issues preventing the State from meeting its Settlement Agreement obligations and action steps to meet those requirements. There is also no reference in the materials to the fact that some reports include the State's total population while other reports are specific to TCLI or the broader mental health system. The State fails to convey that its claims reporting is for a single unit of service per quarter for individuals living in supported housing or in transition to housing. There is one exception to its reporting frequency and duration, and that is with congregate day programming.

Overall, though, the report does not convey any information on the frequency, intensity, and duration of integrated community-based services nor does it convey services provided to individuals in TCLI not living in supported housing. The single unit for individuals in in-reach is not a service claim but rather an in-reach contact and it does not provide information on frequency of visits.

The State has not reported reviewing this information on a semi-annual basis and identifying the problems and barriers. The State does take steps to review problems and barriers (see references in the **(G)(7)** description below).

4. The State effectively met the **(G)(5)** requirement for Quality of Life (QOL) Surveys in FY 2019, although the State has not provided a report for FY 2020. The State's QOL requirement is simply to implement three surveys at specific points in time. There has not been any reference made by either LME/MCOs or the State on the use of this in measuring and initiating performance improvement activities. There is a growing body of knowledge of the use of satisfaction tools and shared decision-making processes increasingly used to assist providers and consumers to make decisions consistent with consumer choices.
5. The State's annual audit of LME/MCOs by the Carolinas Center for Medical Excellence (CCME) consistent with C.F.R. 438.58 fulfills the EQR requirement **(G)(6)**. The EQR continues to be a relevant review process for TCLI. It includes reviews of policies and procedures, individual records, job descriptions, access issues, and transition processes. LME/MCO staff have the opportunity to identify key TCLI initiatives. Each year this Reviewer monitors a CCME LME/MCO audit. This year it was the July 2020 audit of Partners Behavioral Health Management. CCME staff provided useful and appropriate feedback on TCLI items. The CCME

staff review these findings with LME/MCO and DHHS staff. The State could benefit from increasing CCME's role in quality review. The State is meeting this requirement.

6. The **(G)(7)** Use of Data requirement is in part covered in **(G1), (G)(3) and (G)(4)**. References in findings for each of these requirements points to the fact the State does not consistently use data, including primary source data, to identify goals and assess actions to achieve outcomes on increasing integration and decreasing institutionalization. Decreasing institutionalization would include using data on re-institutionalization to ACHs. Individuals discharged from SPHs have low re-admission rates, which points to the effectiveness of supported housing.

The Senior Advisor and her staff have taken steps to use data to create strategic plans for Supported Housing and for Pre-screening and Diversion and the same with the HFA on creating and implementing a plan for Supported Housing. These efforts have enabled the State to make progress meeting Pre-screening and Supported Housing requirements. The Senior Advisor and her team have recently initiated efforts to use data to create a strategic plan for Discharge and Transition Processes, which has the potential to increase ACH Supported Housing placement and decrease institutionalization (ACH) and re-institutionalization. These plans have incorporated protocols and collection method templates that could be helpful to use in developing the broader integrated QA/PI system.

The Senior Advisor has also taken steps, following information gleaned in earlier reviews and information analyzed by her office, to establish performance expectations for selected LME/MCOs. Information gleaned from annual reviews, including the recent fall 2020 review, demonstrates that many service providers act (sometimes repeatedly) in such a manner that is detrimental to the health, safety, and welfare of individuals left without recourse for these providers' actions or inaction. There are no competency-based contract requirements or sufficient monitoring of their actions, as stated in the Community-Based Mental Health Services section of this Report.

The Senior Advisor and DHHS divisions, with the NC HFA or with specific LME/MCOs, sometimes take these steps together but more often this is a siloed effort not conducted in a manner that will effectuate change. One good example is that changes in the State LME/MCO contracts could be beneficial to setting performance expectations. The State has made only one change in three years, when the State made major changes to the State (both DMA (Medicaid) and DMH-State psychiatric hospital) contracts two years ago. The State has been rolling out new expectations based on those changes since then. But the major review of the outcomes of those changes occurred through the Reviewer's annual reviews in FY 2020, not through a State and LME/MCO monitoring system.

There are ongoing discussions of these challenges but not in a manner to trigger needed changes. Nowhere was this more evidenced than in the fall 2020 review results, which provide clear evidence of the consequence of not having an adequate QA/PI system.

7. The State had not published an Annual Report for FY 2020 as required in **(G)(8)**., prior to the Reviewer issuing her draft Annual Report to the parties. The State published its FY 2019 Annual Report after the Reviewer submitted her FY 2019 Report which occurred approximately four months after the FY 2019 year ended. The FY 2019 Annual Report did not include adequate detail on the quality of services and supports.

**(C) Recommendations**

1. Ensure the Transition Oversight Committee meets quarterly and monitors monthly progress on the implementation of the Agreement. If the committee gets a report or the Senior Advisor identifies barriers, incomplete action items, or a negative trend, ensure the responsible party takes steps to meet the requirement and, if necessary, develop a short-term corrective plan to correct problems. Update any items requiring a corrective plan at each meeting until successfully resolved or completed.
2. Assign roles and responsibilities with clear accountability measures. Examine accountability measures to avoid unintended consequences and to assure required performance.
3. As referenced in the Community Based Services section of this report, identify LME/MCO responsibilities more specifically and provide clearer network management and service level performance expectations. Complete this analysis and establish guidance for performance expectations in DMH and DMA contracts. Analyze information already provided prior to adding new requirements.
4. With assistance from Mathematica, complete the design of the quality assurance and performance improvement plan and monitoring system as required in the Settlement Agreement. Develop the capacity to manage the system.
5. Complete and use services utilization reports on a regular basis to track services rendered to individuals in TCLI (a) in in-reach, (b) in transition, (c) in supported housing with a slot, (d) who have a slot but are not using it, and (e) living in the community without a housing slot. Include data on amount, frequency, intensity, and duration. Conduct independent primary source data and use it in conjunction with the utilization data to analyze performance in each of these services and supports and across these functions.
6. Update the DMH and DMA contracts with LME/MCOs to reflect responsibilities for monitoring and improving performance across multiple Settlement Agreement measures.

**ATTACHMENT A**

**STATE AND LME/MCO MEAN SCORES ON SETTLEMENT AGREEMENT  
REQUIREMENTS IN**

**SUPPORTED HOUSING, DISCHARGE AND TRANSITION, COMMUNITY'BASED  
MENTAL HEALTH AND SUPPORTED EMPLOYMENT**

**Table 1: Agreement Requirements Rated as part of the FY 2020 Annual Review**

Requirement: Condensed on Following Charts	Settlement Agreement Requirement
<b>Section III. E. Discharge and Transition Process</b>	
<b>E.(1) Individuals get info in timely manner and informed of all community-based options</b>	<b>(E.)(1.) The State will implement procedures for ensuring that individuals with SMI in, or later admitted to, an adult care home or SPH will be accurately and fully informed about all community-based options including the option of transitioning to supported housing, its benefits, the array of services and supports available to those in supported housing, and the rental subsidy and other assistance they will receive while in supported housing.</b>
<b>E.(4. (5) Transition Team meets responsibilities</b>	<b>(E.) (4.) Discharge planning will be conducted by transition teams that include: (a.) persons knowledgeable about community resources; (b.) professionals with subject matter expertise about accessing care, including complex care and necessary services and supports; (c.) persons who have linguistic and cultural competence; (d.) peer specialists when available; and with consent (e.) individuals with relevant information to devise ways to help individuals meet their goals in an integrated community setting.</b>
	<b>E.(5.) The LME Transition Coordinator serves as the lead contact with the individual leading up to transition from the ACH or SPH including during transition team meetings and administers the required transition process.</b>
	<b>E. (7.) Discharge Planning: (a.) begins at admission; (b.) is based on the principle that with sufficient services and supports, including assistance with developing an effective written plan, individuals can live independently in an integrated community setting; and (c.) developed and implemented through a person-centered planning process in which the individual has a primary role and is based on the principle of self-determination.</b>
<b>E.(2) In-reach: provide frequent education, information and visits to community settings</b>	<b>E.(2.) The State will provide or arrange for frequent education efforts to targeted individuals in ACHs and SPHs. In-reach staff will provide information about the benefits of supported housing, facilitate visits to such settings, offering opportunities to meet with other individuals with disabilities, with their families and community providers. In-reach staff are knowledgeable about community services and supports including SH, provide in-reach to ACH residents on a regular basis but not less than quarterly.</b>
<b>E.(3)(6) Individual participates fully and helped with developing a discharge plan to achieve goals across all domains</b>	<b>E.(3.) The State will provide each individual with SMI in, or later admitted to a ACH or SPH with effective discharge planning and a written discharge plan. The goal of disc. Planning is to assist the individual’s growth, well-being and independence, based on the individual’s strengths, needs, goals and preferences in the most integrated setting appropriate in all domains of their life (community living, activities, employment, education, recreation, healthcare and relationships.</b>

<p><b>E.(7) Sufficient services and supports enables discharge to community settings</b></p>	<p><b>E.(7.) Discharge planning: (a.) begins at admission; (b.) is based on the principle that with sufficient services and supports, people with SMI or SPMI can live independently in an integrated community setting; and (c.) is developed and implemented through a person-centered process in which the individual has a primary role and is based on the principle of self-determination.</b></p>
<p><b>E.(8) Plan Meets Required Criteria</b></p>	<p><b>E. (8.) The discharge planning process results in a written discharge plan that (a.) identified the individual’s strengths, preferences, needs and desired outcomes; (b. and c.) identifies specific supports that build on the individual’s strengths and preferences and includes a list of specific providers that provide the identified supports and services to meet the individual’s needs and achieve desired outcomes; needed services and supports are identified regardless of whether those services and supports are currently available. The plan (d.) documents any barriers preventing the individual from transitioning to a more integrated setting and sets forth a plan for addressing those barriers; (d.)(i.)such barriers shall not include the individual’s disability or the severity of the disability and (d.)(ii.) for individuals with a history of re-admission or crises, the factors that led to re-admission or crises shall be identified and addressed; (c.) sets forth the transition date and timeframes for all the needed steps to transition and (f.) prompts the development and implementation of needed actions to occur during, before and after transition.</b></p>
<p><b>Section III.B.(1)(7): Supported Housing</b></p>	
<p><b>B.(7)(a)(b) Rights of Tenancy with Support</b></p>	<p><b>B.(7.) Housing Slots are provided for individuals living in settings that meet the specific criteria:</b>  <b>(a.) They are permanent housing with Tenancy Rights; (b.) they include tenancy support services that enable residents to attain and maintain integrated affordable housing. Tenancy support services are flexible and available as needed and desired but are not mandated as a condition of tenancy.</b></p>
<p><b>B.(7) (c)(d) Location: access to their community, place of choice and to safe housing.</b></p>	<p><b>(c.) They enable individuals with disabilities to interact with individuals without disabilities to the fullest extent possible and (d.) They do not limit individual’s ability to access community activities at times, frequencies to the fullest extent possible. Safe options are also referenced in E.4.a.</b></p>
<p><b>B.(7). Housing affords access to living activities and supports and meets the individual’s accessibility requirements</b></p>	<p><b>B.(1.) the State shall develop and implement measures to provide individuals access to community-based supported housing.</b>  <b>(B)(7).(f.) They afford individuals choice in their daily activities, such as eating, bathing, sleeping, visiting and other typical daily requirements.</b></p>

Section III. (C) Community -Based Mental health Services	
C. (1) Access and Intensity of Services	C. (1.) The State shall provide access to the array and intensity of services and supports necessary to enable individuals in or at risk of entry in ACHs to successfully transition to and live-in community-based settings. <i>(This requirement also references eligibility for a housing slot and funding for services but not part of the individual review question).</i>
C. (3) Community based/evidenced based and recovery focused	C. (3): Services and supports shall be: (3.)(a.) evidenced based, recovery-focused and community-based
C.(3) Services are flexible	(3.) (b.) flexible to meet the needs of each individual; also see B. (7)(b.) below
C.(3) Services are Individualized and unique to the individual	(3.)(b.) individualized to meet the needs of each individual
C. (3) Individuals are supported to increase natural supports	(3.)(d.) increase and strengthen individuals’ networks of community and natural supports, as well as use those supports for crisis prevention and intervention
C.(3) Assistance to identify natural supports to avoid crises	(3.)(d.) increase and strengthen individuals’ networks and use those supports for crisis prevention and intervention
B. (7)(b) -C.(4) Tenancy support is part of service provision	B. (7.)(b.)A housing slot is provided to individuals to live in settings that include tenancy support services to enable residents to attain and maintain integrated, affordable housing. Tenancy support services offered to people living in supported housing are flexible and are available as needed and desired. But the service is not mandated as a condition of tenancy. C. (4.) The State will rely on community mental health services to satisfy the requirements of this agreement.
C. (3)(a-d)C. (6) - E. (7)(c) PCP is current, individualized, recovery focused, and community based	C. (3.)(a.-d.) <i>The PCP reflects that services meet C.(3)(a.-d.) requirements</i> C. (6.) A person-centered plan shall be developed for each individual, which will be implemented by a qualified professional who is clinically responsible for ensuring that all the elements and components of the plan are arranged for the recipient in a coordinated manner. E. (7.c.) Discharge planning is developed and implemented through a person-centered process in which the individual has a primary role and is based on the principle of self-determination,
Section III. D. Supported Employment	
D. (1) prepare, identify and maintain employment	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 into ACHs, that meet their individual needs. Supported Employment is defined as services that will assist individuals in preparing for, identifying and maintaining integrated, paid competitive employment. Services offered may include job coaching, transportation, assistive technology assistance, specialized job training and individually tailored supervision.
<i>We also scored three SE requirements (standards related to VR involvement, integrated MH/SE services and follow along supports) but scores were extremely low and not included on the charts but referenced in the SE findings section.</i>	

**TABLE 2: STATE SCORES BY SETTLEMENT REQUIREMENT CATEGORY**

All Items	Mean Score
<b>Discharge/ Transition Process (III.E. requirements)</b>	
Individuals get info in timely manner and informed of options	1.91
Transition Team meets responsibilities	1.65
Transition Plan process requirements	1.87
In-reach: frequent visits for information, education and to comm settings	1.79
Individual helped with disc. plan to achieve goals across all domains	2.04
Sufficient services & supports enables discharge to integrated settings	2.31
Plan Meets Required Criteria	1.83
<b>Supported Housing (III.B. requirements)</b>	
Rights of Tenancy with Support	2.10
Location: access to their community, place of choice and to safe housing	2.21
Housing affords access to living activities & supports and meets accessibility requirements	2.02
<b>Services (III.C. requirements)</b>	
Access & Intensity to services & supports	1.17
Community based/evidenced & recovery focused	1.29
Services are Flexible	1.24
Services are individualized & unique to the individual	1.52
Individuals supported to increase natural supports	1.69
Assistance to identify natural supports to avoid crises	1.43
Tenancy support is part of service provision	1.48
PCP is current, individualized, recovery focused & community based	1.22
<b>Supported Employment (III.D. requirements)</b>	
Prepare, identify, and maintain employment	.13

**TABLE 3: STATE AND LME/MCO SCORES BY REQUIREMENT CATEGORY<sup>43</sup>**

All Items	State	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya
Individuals get info in timely manner and informed of options	1.91	1.88	1.73	3.0	2.0	0.5	na	3.0
Transition Team meets responsibilities	1.65	0.86	2.00	3.0	1.5	0.5	na	1.67
Transition Plan process requirements	1.87	1.29	1.93	3.0	2.0	0.5	na	3.0
In-reach: frequent visits for information, education and to comm settings	1.79	1.6	2.00	2.33	1.25	0.5	3.0	1.5
Individual helped with disc. plan to achieve goals across all domains	2.04	1.43	2.21	3.0	1.5	1.0	na	3.0
Sufficient services & supports enables discharge to integrated settings	2.31	1.86	2.43	3.0	2.0	na	na	2.5
Plan Meets Required Criteria	1.83	1.5	1.79	3.0	1.5	0	na	3.0
Rights of Tenancy with Support	2.10	1.85	1.84	2.5	2.67	1.75	2.57	2.33
Location: access to their community, place of choice and tto safe housing	2.21	2.08	2.11	3.0	2.33	2.0	2.13	2.33
Housing affords access to living activities & supports and meets accessibility requirements	2.02	1.69	2.11	2.0	2.17	2.0	2.13	2.17
Access & Intensity to services & supports	1.17	1.64	0.81	0.83	1.25	1.17	1.5	1.17
Community based/evidenced & recovery focused	1.29	1.5	1.14	0.5	1.67	1.17	1.88	1.17
Services are Flexible	1.24	1.71	0.86	0.67	2.0	1.17	1.75	0.83
Services are individualized & unique to the individual	1.52	1.77	1.36	1.33	1.83	1.17	2.0	1.17
Individuals supported to increase natural supports	1.69	1.62	1.57	2.0	1.83	1.4	2.38	1.17
Assistance to identify natural supports to avoid crises	1.43	1.92	0.82	1.33	1.83	1.17	2.25	1.5
Tenancy support is part of service provision	1.48	1.46	1.15	1.4	2.17	1.17	2.13	1.5
PCP is current, individualized, recovery focused & community based	1.22	1.15	0.91	1.5	1.6	1.2	1.75	1.17
Prepare, identify, and maintain employment	.13	0.09	0.12	0	0	0.4	0.17	0

<sup>43</sup> Based on the random selection of individuals for each LME-MCO, some individuals may not have been scored for a particular service. This applies to Trillium where very few individuals reviewed were in the transition process. There were a number of challenges getting referrals completed in the Sandhills area. As a result, their scores hinged on the quality of services for fewer individuals and should not be the sole indicator of services provided in the Sandhills area.

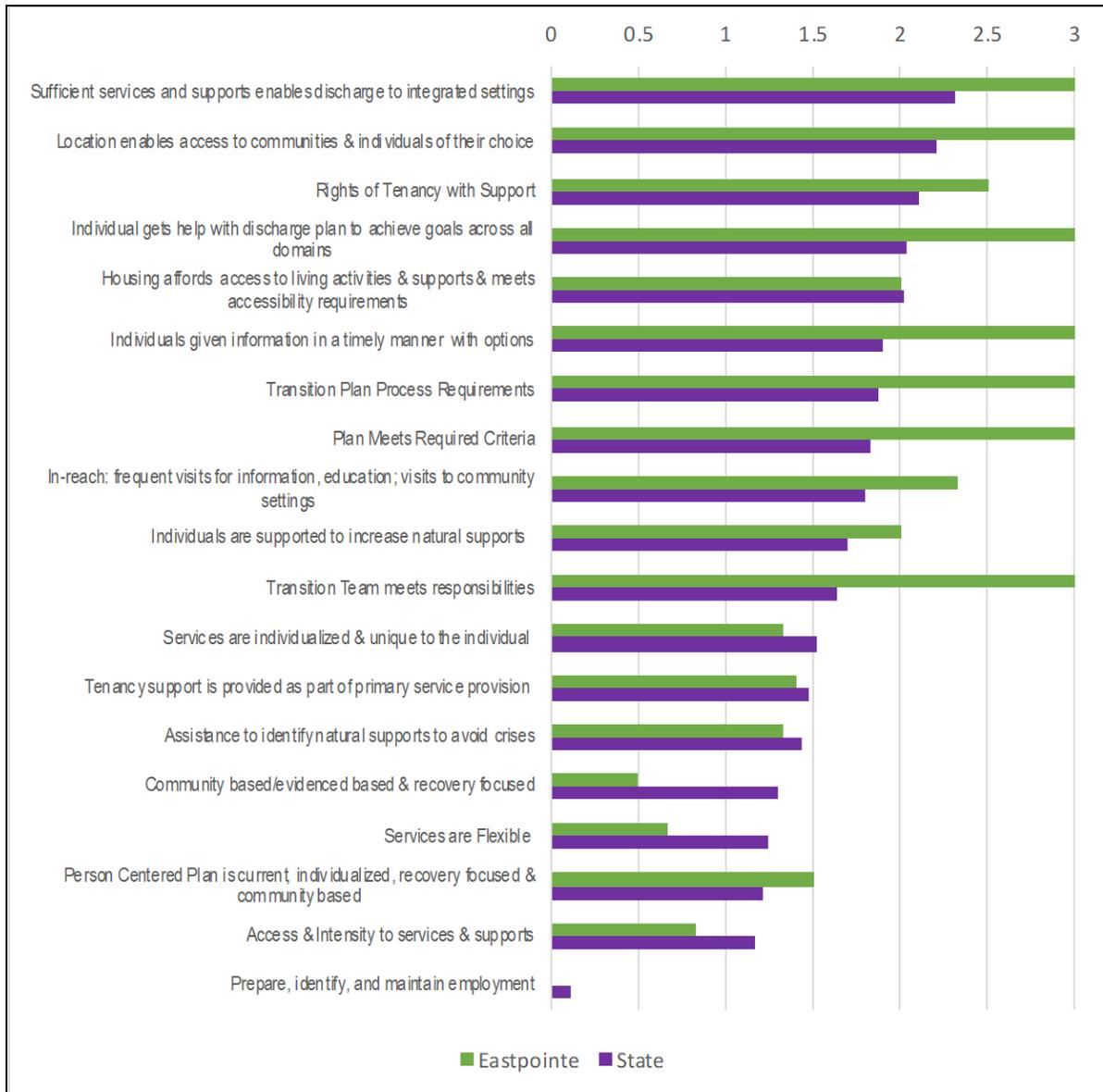
**GRAPH 1: STATEWIDE-ALLIANCE BEHAVIORAL HEALTH COMPARISON  
(by State Score Rating)**



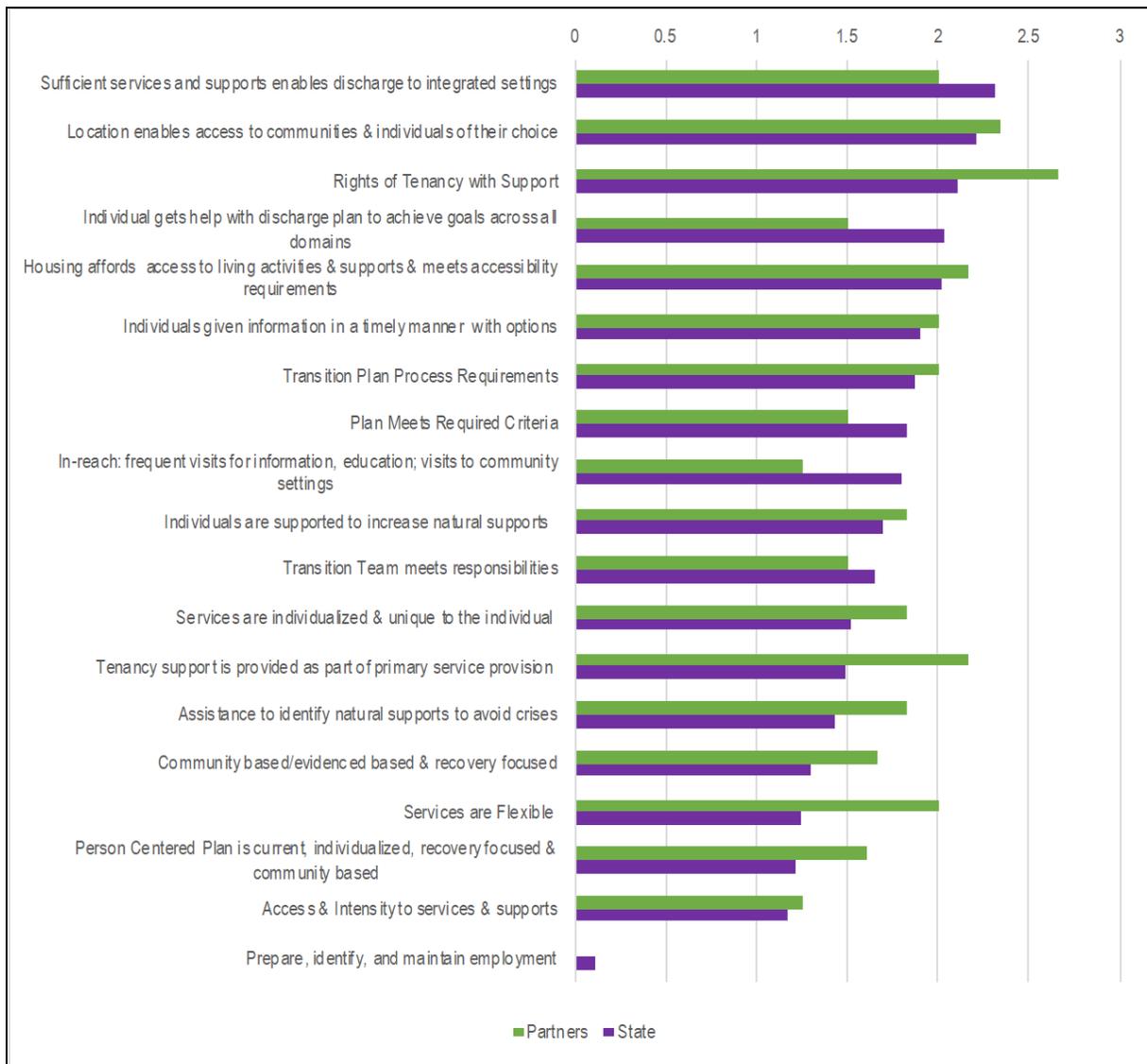
**GRAPH 2: STATEWIDE-CARDINAL INNOVATIONS HEALTHCARE COMPARISON  
(by State Score Rating)**



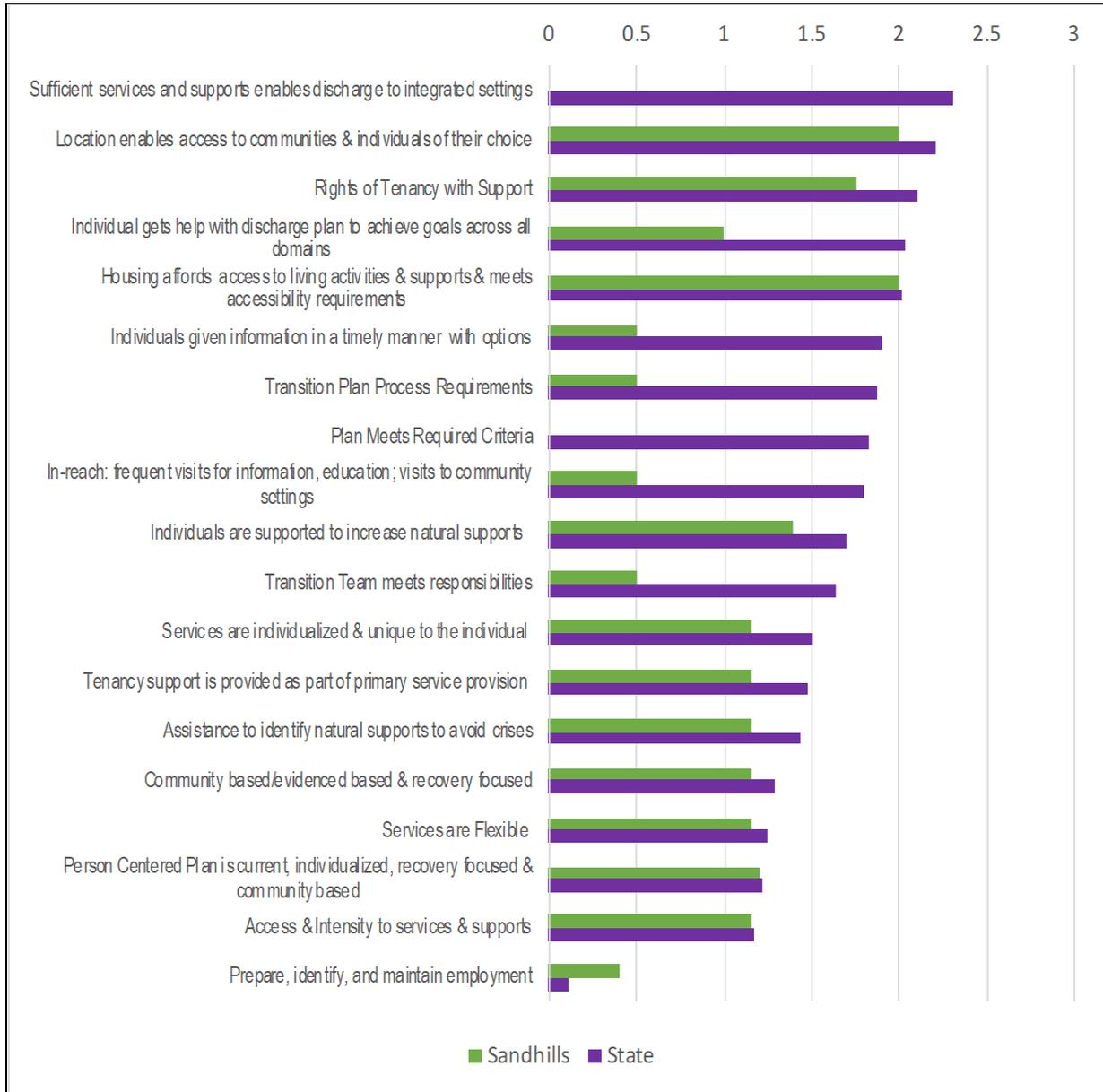
**GRAPH 3: STATEWIDE-EASTPOINTE SCORES COMPARISON  
(by State Score Rating)**



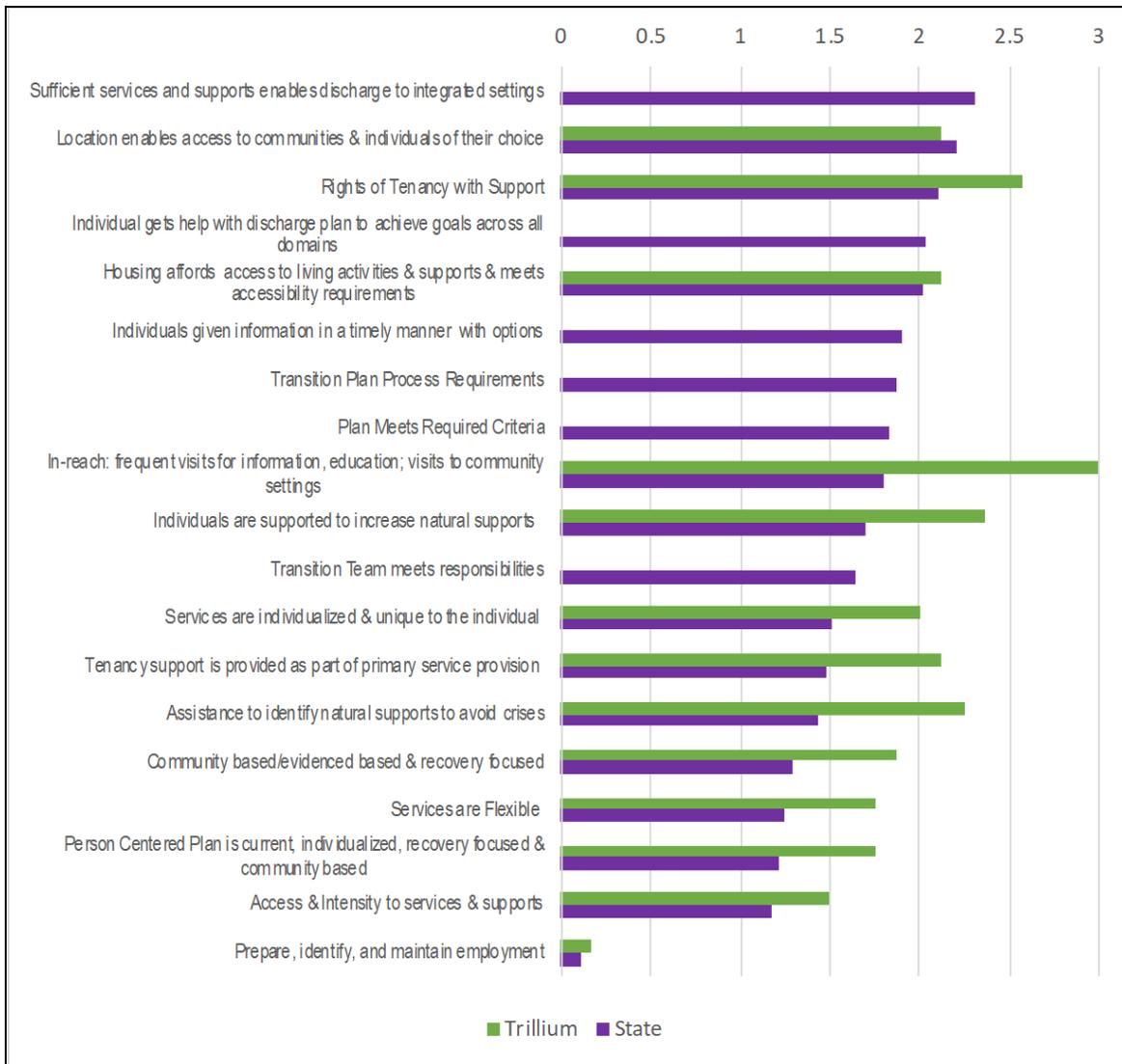
**GRAPH 4: STATEWIDE-PARTNERS BEHAVIORAL HEALTH COMPARISON  
(by State Score Rating)**



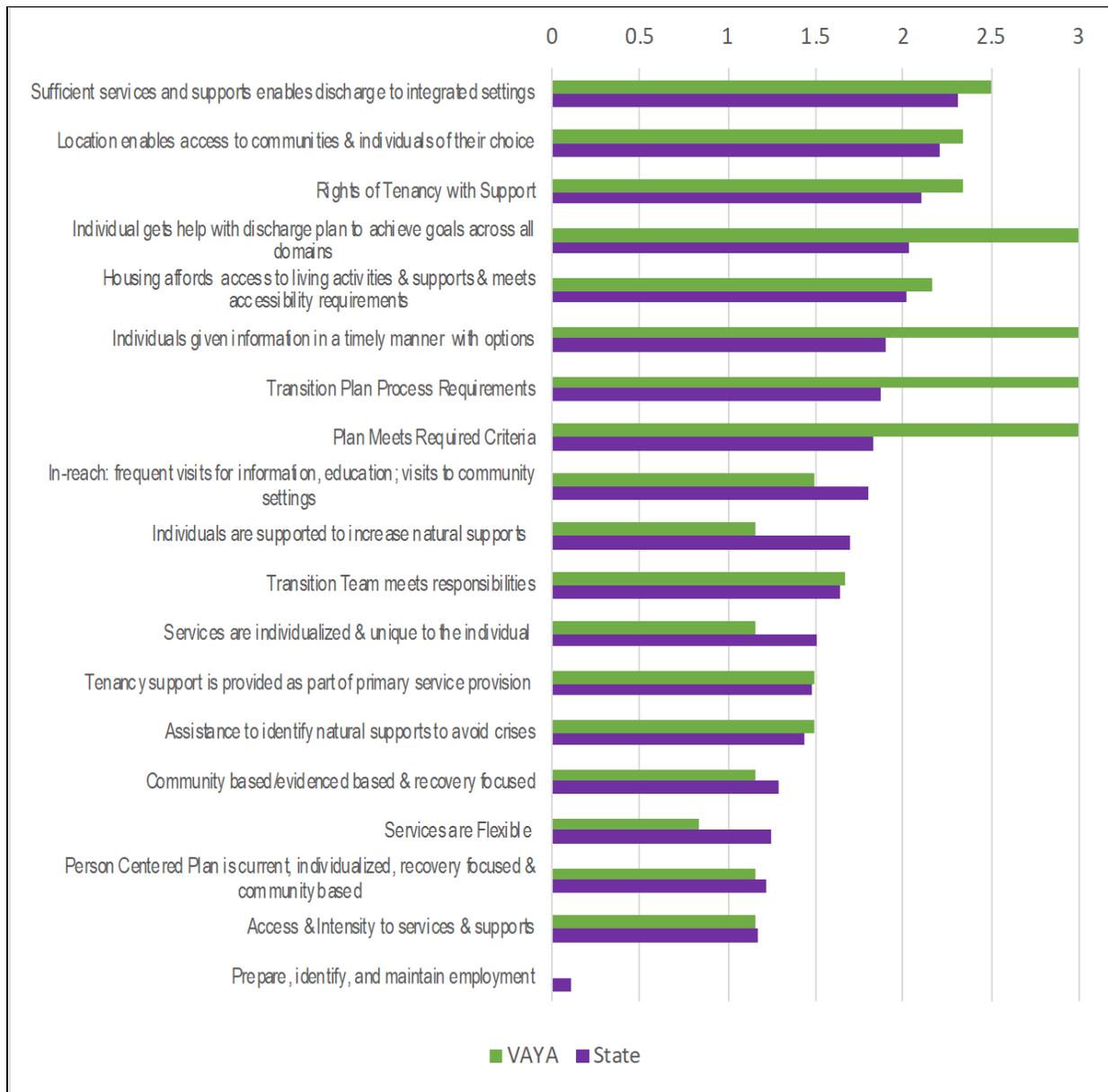
**GRAPH 5: STATEWIDE-SANDHILLS CENTER COMPARISON  
(by State Score Rating )**



**GRAPH 6: STATEWIDE-TRILLIUM HEALTH RESOURCES COMPARISON  
(by State Score Rating)**



**GRAPH 7: STATEWIDE-VAYA HEALTH COMPARISON  
(by State Score Rating)**



## **ATTACHMENT B**

### **STATE PSYCHIATRIC HOSPITALS-LME/MCOS DISCHARGE AND PLANNING PROCESS REVIEW MEAN SCORES**

In August and September 2021, the Reviewer's SPH review team conducted a review of the State Psychiatric Hospital discharge and transition planning requirements following the same process reported in the FY 2020 Interim Report. The team conducted a review of twenty-four (24) individuals discharged, one to three months prior to the review, from Broughton, Central Regional and Cherry Hospitals. This was the second review of individuals discharged from Central and Cherry Hospital's in June and July 2020. The team also conducted reviews for three additional individuals in November 2020. These were individuals who were part of a separate review but added to the list for an interview based on the challenges they faced in the discharge process from Cherry Hospital. This report includes findings for the twenty-seven (27) individuals.

There are twenty-three (23) discharge and planning process requirements and ten (10) sub-requirements for individuals made TCLI eligible after admitted to one the State's three (3) State Psychiatric Hospitals. Standards were set for these requirements. These later reviews included eight (8) additional questions. These additional questions pertain to the treatment team responsibilities. The State has been updating their processes for joint (SPH-LME/MCO) treatment team responsibilities. The later review provided the opportunity to examine the State's performance on the more current requirements.

This later review also provided the opportunity to examine the State's improvements longitudinally. The scores listed below reflect the differences in findings for this additional span of time. FY 2021 reviews will follow the same process and can again show the State's improvement over time although. The FY 2021 review instrument will include additional questions regarding ITP transition planning.

The Annual Report provided information regarding trends with discharge planning. The reviews revealed that the State is facing the same issues in both the earlier and later reviews although there were improvements. There are issues requiring more attention for the State to meet these requirements including staff taking steps to gain support of the guardian, family and others to support the discharge plan, ensuring the individual has a primary role in discharge planning and the planning enables the individual to move to a setting that can facilitate recovery. It appears that staff and Guardians sometimes confuse TCLI believing it is a program rather than an eligibility category. There is also a need for Individuals in TCLI discharged back to court or to jail to get active transition planning and follow-up.

**In-Reach:**

1.-4. In-reach: staff provide education and information about the benefits of supported housing and to facilitate visits to such settings and offering opportunities to meet with individuals with disabilities who are living, working, and receiving services in integrated settings and visits with families and providers.			
	Central Regional	Cherry	Broughton
June-July 2020	0.7	2.7	na
August-Sept. 2020	1.9	2.1	2.2

**Discharge and Planning Process:**

1. The individual’s discharge planning begins at admission (within 7 days)			
	Central Regional	Cherry	Broughton
June-July 2020	2.3	3.0	na
August-Sept. 2020	2.6	2.5	1.7
2.a.-b. The principle that individuals can live in an integrated setting guides the development and implementation of discharge planning through a person-centered planning process.			
	Central Regional	Cherry	Broughton
June-July 2020	2.6	2.5	na
August-Sept. 2020	2.1	2.1	2.1
2.c. The discharge planning enables the individual to move to a safe affordable location in a setting that can facilitate recovery.			
	Central Regional	Cherry	Broughton
June-July 2020	1.4	1.5	na
August-Sept. 2020	1.6	2.6	1.7
2.d. Discharge planning provides the individual with assistance in their recovery.			
	Central Regional	Cherry	Broughton
June-July 2020	1.8	1.8	na
August-Sept. 2020	1.9	2.6	1.7
2.e. The individual’s guardian, family, and other supports support the implementation of the discharge plan.			
	CRH:	Cherry:	Broughton
June-July 2020	1.1	2.4	na
August-Sept. 2020	1.9	2.1	2.0

3.a-e. The planning process carried out by the transition team identifies barriers that exist for the individual, but the team cannot consider the individual’s disabling condition as a barrier. The team is taking steps to overcome barriers in the following domains: housing access, housing location, income, benefits or county of origin change, reasons for re-admission, as applicable, and other barriers.

	CRH	Cherry	Broughton
June-July 2020	1.6	1.3	na
August-Sept. 2020	1.9	2.6	2.0

**Discharge Plan:**

1-4. The discharge plan identifies the individual’s strengths, preferences, needs, and desired outcomes, assists the individual in developing an effective written plan to live in an integrated setting, informs the community-based PCP, and identifies community-based services and supports, the individual’s primary provider and other providers/organization who are or will provide services and supports<sup>44</sup>.

	Central Regional	Cherry	Broughton
June-July 2020	1.7	1.6	na
August-Sept. 2020	2.5	2.4	2.5

5-6. The discharge documents barriers to an individual moving to the most integrated setting and how staff mitigate these barriers—*this cannot include the individual’s disability or severity of disability*—and the document identifies precursors to readmission where applicable.

	Central Regional	Cherry	Broughton
June-July 2020	2.1	2.6	na
August-Sept. 2020	2.7	2.7	2.7

7-8. The discharge plan includes the proposed discharge date, action steps, and responsibilities by staff/provider-prior to, during, and post-discharge and the individual got a copy of their discharge plan.

	Central Regional	Cherry	Broughton
June-July 2020	1.6	2.5	na
August-Sept. 2020	2.1	2.6	2.8

<sup>44</sup> The SA Community Based Mental Health Services requirements specifies that the individual’s discharge arrangements are coordinated for all elements and components of the plan..

**Transition Team:**

1.-4. The Transition Team is responsible for the transition process. A Transition Coordinator is responsible for administering the transition process, from admission through discharge. The team includes SPH, LME/MCO and service provider staff and peer specialists when available.			
	Central Regional	Cherry	Broughton
August-September 2020	1.9	2.6	2.3
5. Discharge planning occurs in a timely enough fashion to make direct placement to bridge housing or to supported housing if possible, prior to discharge.			
	Central Regional	Cherry	Broughton
August-September 2020	2.0	1.5	2.3
6.-9. The transition team is knowledgeable about resources, supports, services and opportunities in the community, includes professions with subject matter expertise, has linguistic and cultural competence and assists individuals in making choices and arrangements for accessible units and features. The individual's proposed community provider is an active member of the transition.			
	Central Regional	Cherry	Broughton
August-September 2020	1.7	1.9	2.8
6.10 With consent, persons whose involvement is relevant to identifying strengths, needs preferences capabilities and interests and to devising ways to meet them in an integrated setting is a member of the team.			
	Central Regional	Cherry	Broughton
August-September 2020	1.5	2.5	2.5

**FY 2020 INTERIM REPORT OF THE INDEPENDENT REVIEWER**

**In the Matter Of**

**UNITED STATES OF AMERICA v. THE STATE OF NORTH CAROLINA**

**Case 5:12-cv-00557-D**

**Submitted By: Martha B. Knisley, Independent Reviewer**

**November 13, 2020**

## Table of Contents

<b>EXECUTIVE SUMMARY.....</b>	<b>3</b>
<b>INTRODUCTION.....</b>	<b>7</b>
<b>METHODOLOGY .....</b>	<b>9</b>
<b>I. SUPPORTED HOUSING.....</b>	<b>12</b>
<b>II. SUPPORTED EMPLOYMENT .....</b>	<b>29</b>
<b>III. DISCHARGE AND TRANSITION PROCESS.....</b>	<b>44</b>
<b>IV. PRE-ADMISSION SCREENING .....</b>	<b>60</b>

## EXECUTIVE SUMMARY

This is an Interim Report<sup>1</sup> 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 North Carolina's (the State's) progress in meeting selected June 30, 2020 requirements and the State's overall progress in meeting all the Settlement Agreement (SA) obligations by June 30, 2021. This report will reference repeatedly the program the State designed to comply with the obligations of the SA, which is known as the Transitions to Community Living Initiative (TCLI). Individuals are considered part of TCLI if identified as eligible for In-reach, transition, diversion, supported housing and supported employment.

The worst health crisis in the United States in the past one hundred years stymied the State's efforts to meet the FY 2020 requirements and interfered with the Independent Reviewer's planned field work to measure the State's progress toward compliance with all of the 2012 Settlement Agreement requirements. Nonetheless this unprecedented event which led to this being an Interim Report has not stopped the review process and a final FY 2020 Annual Report will be issued at a future date.

The State made substantial progress in meeting two of the four major provisions of the Settlement Agreement reviewed during this interim period: Supported Housing and Pre-screening. The State is not on track to meet Supported Employment requirements in FY 2021 based on the FY2020 initial review. The review of individuals discharged from State Psychiatric Hospitals revealed that the State is making only minimal progress on key Discharge and Transition Process requirements. The initial review of the Discharge and Transition Process only covered State Psychiatric Hospital discharges. Further reviews are in progress to complete State Psychiatric Hospital, Adult Care Home, and Diversion discharges and transitions and Supported Employment reviews.

This Interim Review does not cover Community-Based Mental Health Services and Quality Assurance and Performance Improvement. These requirements are being reviewed now and will be reported in the final FY2020 Annual Report. Interviews held with the State, LME/MCOs, stakeholders, and SPH staff, along with data from state and client records provided by the SPHs and LME/MCOs, provided sufficient information to make findings on forty-five (45) of the one hundred and three (103) Settlement Agreement requirements. These are requirements that do not require first-person interviews with accompanying staff and public guardian interviews and documentation. Below are specific findings in each of the four major requirements reviewed.

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<sup>1</sup> The Settlement Agreement requirements extend through July 1, 2021.

The state made substantial progress in FY 2020 meeting the **Section III. (B) Supported Housing** requirement for filling housing slots with individuals discharged from State Psychiatric Hospitals and individuals diverted from adult care homes and is in a good position to meet the requirement to fill three thousand (3,000) housing slots in FY 2021. However, the State is not making progress to provide supported housing for two thousand (2,000) individuals exiting adult care homes by June 30, 2021, as required in Section III(B)(5) of the SA. The State is not making enough referrals of individuals in this category to meet this requirement. The number of individuals living in supported housing after exiting adult care homes dropped by five (5) individuals from FY 2019 to the end of FY 2020.

There are several explanations for the State falling far short of meeting this requirement. These explanations relate to allocation of resources, the greater level of attention directed toward diverting admissions, and the inability of LME/MCOs to manage mounting outreach demands. Separation rates of individuals who moved to supported housing from adult care homes and those discharged from State psychiatric hospitals or diverted from adult care homes are proportionately the same.

The State has also made good progress in developing housing options, utilizing, and leveraging multiple types of federal funds, and improving decision making support so that LME/MCO housing coordinators have the level of support needed to assist with individuals getting housing.

The State still needs to make improvements with pre and post tenancy support to ensure individuals have access to and can keep their housing, including getting housing with accessible features as well as housing that enables individuals' access to community amenities and to personal and in-home support. It is not yet clear if the State is on track to meet the requirements listed in **Section III. (B)(7)**. The final FY 2020 Annual Report will include a summary of all of the supported housing requirements with special attention to **Section III. (B)(5) and (7)**.

The State is not meeting the **Section III. (D)(1) Supported Employment** requirement to develop and implement measures to provide supported employment to individuals "in or at risk of entry into" adult care homes. The State met the requirements for **Section III. (D)(2)**, meeting fidelity requirements in 2013, **and Section III. (D)(3)** meeting the FY 2020 Supported Employment Services utilization target. There was an increase in the number of TCLI participants referred for the service based on verification results, exceeding the FY 2020 requirement to provide Supported Employment. However, the State needs to refine the verification process to accurately count individuals "at risk of" adult care home placement. The State needs to take further action to demonstrate that individuals in TCLI who are interested in employment are given the opportunity and access to supported employment and are provided assistance with preparing for, identifying, and maintaining employment. Not all providers utilize VR funding and there is limited access to supported employment in some areas of the state. It is understandable this would be a challenge in rural areas but is also the case in some urban areas.

The State took one major step to increase the effectiveness of the IPS-SE program. This step was to test out a new financing and incentive model to increase TCLI referrals and to cover expenses for individual engagement and follow along supports. This model creates a full partnership between LME/MCOs, service providers, and vocational rehabilitation counselors. The model is in a pilot phase with the Vaya LME/MCO, their providers, and VR. The program began in January 2020 and was beginning to show good preliminary results when COVID interrupted the process. Managing this process requires the pilot managers to have cross systems data (VR, mental health and Medicaid) to track results and demonstrate the effectiveness of the model in assisting individuals in TCLI to get and maintain employment. The State was slow in completing a data sharing agreement between three DHHS divisions responsible for financing and implementing IPS-SE. This agreement is vital for the state to measure the effectiveness of this model which in turn is vital to determine what steps are necessary to meet Supported Employment requirements. The State has discussed expansion of this model, but no concrete steps have taken place to make this happen.

The review of **Section III. (E) Discharge and Transition Process** only covered the discharge and transition process for individuals admitted and discharged from State psychiatric hospitals. This limited review was the result of the COVID outbreak during the spring review period restricting access to adult care homes. The review became possible when State staff reported in April 2020 that the state psychiatric hospitals were mostly successful in controlling the COVID outbreak. This provided an opportunity to do a joint interview with state psychiatric staff and LME/MCOs, including an in-depth record review in addition to an earlier review at Broughton Hospital in November 2019.

The State updated their guidance on transition planning for state psychiatric hospital discharges in FY 2020 to better align practice with the SA requirements. The joint reviews revealed the State is not yet meeting all the requirements for state psychiatric hospital discharges. More reviews were conducted in the first quarter of FY 2021 to determine the impact the new guidance has had on changing practices in addition to reviews of individuals exiting adult care homes and those diverted from adult care homes. The results of these reviews will be reported in the final FY 2020 Annual Report.

The State has made good progress implementing the pre-screening requirements in **Section III. (F) Pre-Screening and Diversion** and is on track to meet the pre-screening requirements in FY 2021. The State initiated a new pre-screening and diversion system in November 2018. The start-up of this system was fraught with challenges in educating referents, software glitches, and the State and the LME/MCOs adapting to new processes. The State worked diligently to make adjustments in resource allocations, guidance to the field, education, and managing and fixing software and data problems. The LME/MCOs also worked diligently to carry out their requirements in a timelier manner, with greater education and to fix problems, including

allocating internal resources. The result is that in FY 2020, the number of referrals that were pending and in process improved and there was a reduction in the percentage of individuals admitted to adult care homes.

The final FY 2020 Annual Report will focus on a review of the timeliness of processes and further changes in managing and verifying data. It is unclear to what degree this reduction was related in part to COVID, but the reduction occurred over the full year and not just in the last three months. The Settlement Agreement specifies the development and implementation of a community integration plan, which guides the diversion process to be consistent with **Section III. E Discharge and Transition Processes**. To avoid duplicating reviews and creating confusion with scoring findings, the Diversion review will be a part of the Discharge and Transition Process review in the fall of 2020.

Overall, the State has made progress in FY 2020 despite wrestling with the COVID pandemic which curtails some activities for individuals eligible for housing, services, and supports required in this Settlement Agreement.

The fall 2020 review will reveal the degree to which the State has made progress meeting requirements for providing access to the array, frequency, and intensity of recovery based services and supports necessary to enable individuals to transition to and live in community-based settings. This is a cornerstone requirement of this agreement and essential for individuals to live in the most integrated setting possible.

The fall review will also hopefully include a review of the State's ability to develop and implement a Quality Assurance and Performance Improvement system consistent with standard practice for collecting and using information and to meet the requirements in this Settlement Agreement.

## INTRODUCTION

This is an Interim Report<sup>2</sup> 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 North Carolina's (the State's) progress in meeting selected obligations by June 30, 2020, and the State's overall progress in meeting all the Settlement Agreement (SA) obligations. This report will reference repeatedly the program the State designed to comply with the obligations of the SA, which is known as the Transitions to Community Living Initiative (TCLI). Individuals are considered part of TCLI if identified as eligible for In-reach, transition, diversion, supported housing and supported employment.

The worst health crisis in the United States in the past one hundred years stymied the State's efforts to meet the FY 2020 requirements and interfered with the Independent Reviewer's planned field work to measure the State's progress toward compliance with all of the 2012 Settlement Agreement requirements.

Governor Cooper issued Executive Orders the second week in March suspending visitations to Adult Care Homes (ACHs) and severely restricting travel, in person meetings, and other activities necessary for the State, its Local Management Entities/Managed Care Organizations (LME/MCOs), and housing organizations to expand services and make more housing available. This resulted in slowing down the work of housing specialists and community outreach workers. The State at once focused its attention and energy on this unprecedented crisis. The Independent Reviewer suspended all in-person community-based reviews, including halting planned field work scheduled from March 23<sup>rd</sup> through June 5<sup>th</sup>.

This crisis and the suspension of community-based reviews has made it impossible to issue a full Annual Report as required in this Settlement Agreement at this time. The State and the LME/MCOs attempted to fulfill their obligations in the last quarter of the annual compliance period (Apr. 1 – July 1) but to evaluate a full year of work was not possible. This was especially true since so many of the Settlement Agreement requirements require first person verification interviews and since the State's LME/MCOs, responsible for day to day community services and housing operations in seven regions of the state, made major adjustments in their work just two weeks before the fourth quarter of the annual compliance period began. Interviews were conducted in October and early November 2020 along with provider and LME/MCO staff interviews and will be reported on the final FY 2020 Annual Report.

With encouragement of the Parties, the review process for this Interim Report was conducted through virtual reviews with State and local staff and data analysis. Year-end data was available, but with adjustments in the analysis and projections to account for the fifteen-week disruption. This report captures information from virtual interviews, State Psychiatric Hospitals (SPHs)

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<sup>2</sup> The Settlement Agreement requirements extend through July 1, 2021.

interviews (prior to the pandemic), chart reviews, and data from the Transition to Community Living Data (TCLD)<sup>3</sup> base, other state level information and reports from LME/MCOs. In several instances, the review provides comparisons of progress before and after the disruption began.

There were limits to the virtual review process due to the disruptive nature of the pandemic. Staff focused on shifting responsibilities to crisis management, providing new guidance, and changing regulations and reimbursement requirements for LME/MCOs and providers and assisting community-based staff with getting needed resources. This was especially true with providing resources for supported housing because it is a safer place to live if social distancing and other precautions are taken than living in an institution, on the street, or in a shelter where precautions are more difficult to maintain. The State and LME/MCOs recognized this fact and took steps to assist individuals to live in the safe places when possible. (The North Carolina fiscal year (July 1 to June 30) tracks the annual compliance periods for this Agreement.)

The focus of this report is entirely on the State's progress and challenges in complying with a majority of the requirements in four major provisions of the Settlement Agreement: Sections III.B (Community-Based Supported Housing Slots), III.D (Supported Employment), III.F (Pre-screening, excluding Diversion), and III.E (State Psychiatric Hospital (SPH) Discharge and Transition Process requirements, a sub-section of the Discharge and Transition Process requirements).

There are two reasons for these selections. First, data made available at the end of FY 2020 was more definitive of the State's progress and projected progress in the four areas chosen for this review. For example, the State maintains a robust database on supported housing updated monthly, including housing by type and by catchment area and separations from housing. The State's progress on availability of housing, both for current and future referrals, was also available. Pre-screening data is available, although not as quickly available as housing data. Second, it is less time-consuming and logistically challenging to conduct SPH discharge reviews than community-based reviews.

With these factors in mind, it was determined that these four areas provided the best opportunity for more conclusive findings than Adult Care Home (ACH) In-reach and Transition reviews as well as Diversion Outreach and Services reviews. These will require more extensive interviews, chart reviews, and first-person verifications. The State has not provided a data driven proactive Quality Assurance and Performance Improvement plan that guides the entire system's approach toward performance improvement with input from service recipients, key stakeholders, the managed care organizations, and providers. The State has taken steps to identify and fill gaps in services and to report data on a monthly basis.

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<sup>3</sup> The Transitions to Community Living Data base is the reference used by the State to identify policies, resources, approaches, and functions employed to meet the requirements in this Settlement Agreement. The State refers to this work as the Transitions to Community Living Initiative (TCLI).

The final Annual Report will include interviews, chart reviews, and data analysis on ninety-six (96) randomly selected individuals. The randomization will be stratified by four groups to ensure there is sufficient information available about all aspects of the Settlement Agreement requirements. These groups are: 1. individuals discharged from SPHs in the past six months who qualify for TCLI; 2. individuals getting in-reach or transition assistance to exit ACHs or outreach and transition for individuals being diverted from ACHs; 3. individuals living in supported housing; and, 4. individuals who qualify for TCLI but who are living in the community in settings other than supported housing. The fourth group may include individuals who can qualify and can choose supported housing in the future or were in supported housing at one time.

### **METHODOLOGY**

This report follows the same methodology used in the reports for the four previous years, with two exceptions. The first change is that first person interviews were not possible. First person interviews are essential to gauge any differences in the individual's experience and needs, especially for frequency and intensity of services based on the individual's requests and needs as documented in the individual's record. First person interviews also provide the opportunity for the Reviewer to see where the individual lives as well as obstacles to the individual having access to community amenities, friends, family, and services. An individual's space is revealing in determining the individual's accessibility needs and needs for personal support. Simply said, first person interviews are necessary to determine if the State is meeting the Settlement Agreement (SA) Supported Housing, Discharge and Transition Process, Community-Based Mental Health Services, Supported Employment and Diversion requirements.

The second difference is associated with clarifying the requirements with clear language in the form as standards. This adds specificity to the SA requirements for items that do not include numeric measures.

The state collects data to report progress meeting requirements with numeric measures. I verified that the collection process is valid and reviewed its accuracy through interviews and responses to interview questions on a routine basis. For requirements that do not include numeric measures, the review includes identifying measures, norms, or models in comparative evaluations and standard practices across multiple jurisdictions. Standard practices are further verified through interviews with practitioners and administrators who have demonstrated success in establishing and implementing programs in other jurisdictions. Following this process, standards were established for each requirement along with a rating system used in comparative evaluations. These were reviewed and accepted by the Parties to this Settlement Agreement.

The State's progress in meeting the provisions of the Settlement Agreement was assessed in

monthly work sessions, data analysis, and review calls with State staff on Pre-Screening, Supported Housing, and Supported Employment, as well as frequent contact to clarify data and information from the more formal review calls. The Reviewer also assessed progress through discussions with providers and community stakeholders, LME/MCO reviews, SPH and LME/MCO interviews, and chart reviews for individuals recently discharged from SPHs. The calls with LME/MCOs included three (3) supported housing calls, five (5) supported employment calls, and two (2) pre-screening calls divided across the LME/MCOs.

The review team conducted three reviews of State Psychiatric Hospital (SPH) discharge planning practices. The first review, held at Broughton Hospital in November 2019, focused on two SPH discharge planning issues. First, the review team looked at the efficacy of the State's new pre-screening tool, known as "RSVP," for diverting individuals discharging from SPHs to Adult Care Home, including a look at whether hospitals were discharging people instead to unstable housing, homeless shelters, and ACHs or family care homes without pre-screening them for TCLI eligibility. To accomplish this, the team reviewed twenty-three (23) individuals discharged from Broughton Hospital in August and September 2019. The second planning issue the review team looked at in this first SPH review was the review process itself to determine if the Settlement Agreement requirements were being followed. To determine this, the Reviewer randomly selected eight (8) individuals discharging from Broughton who were identified as eligible to participate in the Transitions to Community Living Initiative (TCLI), and would be discharging to geographic areas within the responsibility of three LME/MCOs (Cardinal, Partners, or Vaya). We conducted three (3) desk reviews<sup>4</sup> and interviews with SPH and LME/MCO staff responsible for discharge planning. There were five (5) other interviews planned but not held because the individuals were either discharged or not available. Each of these individual's records were reviewed and where possible both LME/MCO and SPH staff were interviewed. A transition coordinator from Partners arrived at the hospital for an interview only to find out that the hospital failed to alert the staff member from Partners that the individual had been discharged that morning through arrangements with another Partners staff member.

The second and third SPH discharge reviews, conducted in May and June 2020, focused on transition planning for fourteen (14) SPH residents referred to TCLI and discharged from Central Regional and Cherry Hospitals before March 2020. These reviews included chart reviews and five (5) virtual interviews with staff from the SPHs, the Department of Health and Human Services (DHHS), Division of State Operated Healthcare Facilities (DSOHF), and five (5) LME/MCOs (Cardinal, Sandhills, the Alliance, Eastpointe, and Trillium).

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<sup>4</sup> Desk reviews in this context are defined as a review of hospital medical records including admitting and discharge plans, assessments, and progress notes and LME/MCO In-reach, transition notes and person-centered plans. The SPH and LME/MCOs now track the transition process through a single document which was also reviewed.

In addition to the SPH reviews, the Reviewer and members of her team met with LME/MCO staff, including TCLI teams, network management, care coordination, utilization management, housing, and agency leadership. The reviews covered Pre-screening (2 LME/MCOs), Supported Housing (4 LME/MCOs), and Supported Employment (4 LME/MCOs). DHHS Division of Vocational Rehabilitation (DVR) and supported employment provider staff were included in the Vaya Supported Employment interview. The Reviewer interviewed DHHS and NC HFA staff. Each team received a list of questions to either review and submit responses beforehand and/or be prepared to answer in the interview. Each questionnaire included questions to measure the State's progress, or lack thereof, and challenges meeting the recently developed standards for each of the requirements in the SA.

Elizabeth Jones, Damie Jackson-Diop, and Patti Holland continued to provide assistance with reviews and interviews. Charlyne Boyette, Dr. Beth Gouse, David Lynde, and Katherine Burson joined the team in FY 2020 to provide expert consultation in anticipation of a more comprehensive review in the Spring of 2020.

Charlyne Boyette is a Certified Clinical Addictions Specialist and a Certified Peer Specialist with both law and divinity degrees. She recently served as a Peer Services Program Manager in Asheville, North Carolina. Dr. Gouse is a Clinical Forensic Psychologist and former Chief Clinical Officer, Chief of Staff, and Interim CEO of St Elizabeth's Hospital in the District of Columbia and focused on hospital reviews. David Lynde is a Licensed Clinical Social Worker with a long-term affiliation with the Dartmouth Psychiatric Research Center at Dartmouth College, including co-directing the Dartmouth Center on Evidenced Based Practices. He has had multiple academic affiliations, consulting experience, and a fifteen-year history as a clinician and administrator for the Center for Life Management in New Hampshire. He was a co-author of the Individualized Placement and Supported Employment Fidelity Scale. Katherine Burson, a former member of the team, is an Occupational Therapist and Psychiatric Rehabilitation Counselor and was formerly Deputy Director for Science to Practice in the Illinois Division of Mental Health. Katherine's work as an Occupational Therapist, especially on rehabilitation and recovery of individuals who have a psychiatric disorder, is nationally recognized.

## I. COMMUNITY BASED SUPPORTED HOUSING SLOTS

Major Categories	Summary of Requirements	Progress towards Compliance
<p><b>1. Section III. (B)(1)(2)</b> requires the State to develop and implement measures to provide eligible individuals with access to community-based supported housing.</p>	<p>a. The State has developed measures to enable individuals in all five priority groups to access SH when exiting ACHs, discharged from an SPH, if they would otherwise become homeless or move to unstable housing, or when an individual becomes TCLI eligible during or after pre-screening.</p> <p>b. The State has implemented such measures to ensure access to SH for all five priority groups.</p> <p>c. The State uses bridge housing to enhance the potential for “access” to permanent housing.</p>	<p>a-b. The State made progress in developing and implementing measures to provide housing slots for individuals in Categories 4 and 5 and progress with individuals retaining those slots in FY 2020. The State did not make progress with providing individuals in Categories 1-3 (listed as a.-c. in the SA) the opportunity to live in SH, with a net loss of five (5) individuals living in SH from those three categories in FY 2020.</p> <p>c. The State increased discharges to supported housing by seven percent (7%) but discharged twenty-eight (28) individuals to bridge housing, which increased individuals’ access to more permanent supported housing.</p>
<p><b>2. Section III. (B)(3)</b> The State will provide 2,554 housing slots by July 1, 2020 (and housing slots to 3,000 individuals by July 1, 2021).</p>	Same as requirement	The State provided housing slots to 2,550 individuals in FY 2020, four (4) short of the FY 2020 requirement.
<p><b>3. Section III. (B)(4).</b> The State shall develop rules to establish processes and procedures for determining eligibility for SH in accordance with requirement for priority groups set forth in <b>Section III (B)(2)</b> of the Agreement.</p>	Same as requirement	The State has established processes and procedures for eligibility and has established income standards.
<p><b>4. Section III. B. (5)</b> Two thousand (2,000) housing slots will be provided to individuals in priority Categories <b>III. (B)(2)(a-c)</b> over the course of the Agreement. The State determines the proportionate allocation of slots annually, giving priority to Categories <b>(2)(a-c)</b>.</p>	Same as requirement	The State is not making measurable progress meeting this requirement. The number of individuals exiting adult care homes living in SH dropped by “5” over the course of the year. and was not solely due to COVID.

Major Categories	Summary of Requirements	Progress towards Compliance
<p><b>5. Section III. (B)(7)(a.-g.) (summarized)</b>  Housing slots will be provided for individuals to live in settings that meet the following criteria:</p> <ul style="list-style-type: none"> <li>a. They are permanent housing with Tenancy Rights;</li> <li>b. They include tenancy support services that enable residents to attain and maintain integrated, affordable housing;</li> <li>c. They enable individuals with disabilities to interact with individuals without disabilities to the fullest extent possible;</li> <li>d. They do not limit individuals' ability to access community activities at times, frequencies and with persons of their choosing;</li> <li>e. They are scattered site housing, where no more than twenty percent (20%) of the units in any development are filled by the target population;</li> <li>f. They afford individuals choice in their daily activities, such as eating, bathing, sleeping, visiting, and other typical daily activities;</li> <li>g. The priority is for single occupancy housing.</li> </ul>	<p>Housing slots meet the following criteria:</p> <ul style="list-style-type: none"> <li>a. they are permanent with rights of tenancy.</li> <li>b. The individual gets tenancy support including support to meet tenancy requirements and support to help the individual advocate for their rights as a tenant.</li> <li>c. The individual's housing location makes interaction with individuals without disabilities possible to the fullest extent.</li> <li>d. They do not limit access to community activities and with persons of their choosing.</li> <li>e. They meet scattered site requirement.</li> <li>f. They provide a choice in living activities, accessible features as needed, and personal support.</li> <li>g. There is priority for single occupancy.</li> </ul>	<p>The State has consistently met the requirements for permanency and preference for single occupancy housing. As referenced in earlier reports, the State still needs to meet the requirements related to location and access for interaction with non-disabled individuals, accessibility, tenancy support, and personal support prior to FY 2020. The final FY 2020 Annual Report will address this issue.</p>
<p><b>6. Section III. (6)(7)(g)</b> The State has ongoing programs for housing assistance that will continue in effect. The State may utilize those programs to fulfill their obligations under the SA as long as the housing slots provided meet the criteria in <b>III.B.(7)(a.-g.)</b></p>	<p>Same as requirement</p>	<p>The State is meeting this requirement. The State has significantly expanded the use of ongoing programs.</p>
<p><b>7. Section III. (B)(8)(9)</b> These sections describe where the State cannot use slots and the process for giving individuals the choice of housing after being informed of all the available options.</p>	<p>Same as requirement</p>	<p>The State appears to be meeting this requirement and is being reviewed again as part of the fall review.</p>

**(A) Background**

The Community-Based Supported Housing Slots requirements in the Settlement Agreement require a comprehensive approach to assure the availability of, access to, and retention of affordable, safe, quality housing located in the communities and neighborhoods where individuals in the target population request to live. The approach to meeting supported housing requirements necessitates long term strategic planning to assure the State can meet and sustain compliance with this Settlement Agreement. This requires attention to individuals' access, including physical access, access to community activities and amenities, and tenancy rights when trying to lease a rental unit and when retaining housing.

Safe, decent, affordable housing availability continues to be a major challenge across the country and in North Carolina. The state has a shortage of 196,231 rental homes that are affordable and available to extremely low-income renters, whose income is at or below the poverty guideline or up to thirty percent (30%) of their Area Median Income (AMI)<sup>5</sup>. Individuals with disabilities make up forty six percent (46%) of all households at the extremely low-income level. With a rental subsidy, which could cover up to one hundred and ten percent (110%) of Fair Market Rent (FMR), most individuals still cannot find a suitable unit since not enough affordable units are available in North Carolina for individuals and families with low incomes.

Only forty-three (43) affordable and available rental homes exist for every one hundred (100) extremely low-income (ELI) renter households (thirty percent (30%) or below of the Area Median Income [AMI]) and sixty-five (65) units for every one-hundred household units for those fifty percent (50%) or below of the AMI. Seventy percent (70%) of the ELI households are paying more than fifty percent (50%) of their income on housing. Individuals who are in the ELI group face a shortage in every state and major metropolitan area. In the Charlotte (including Gaston and Cabarrus Counties), Raleigh (including Johnston, Franklin, Durham, and Orange Counties), Asheville (including Henderson County), Camden, Currituck, and Dare counties, the average cost for a basic unit is above one hundred percent (100%) of the monthly Supplemental Security income (SSI) income of \$771<sup>6</sup>.

In order to overcome these challenges states must take every step possible to increase the supply of housing and rental assistance to meet the demand for housing for individuals with disabilities living at extremely low incomes. Federal resources, if sought and secured, can help reduce the gaps referenced above. Accessing and using these funds is difficult for states, developers, and community organizations. States and local communities need to seek these funds, leverage them with private resources, give priority to producing housing for very low income renters, and allocate and manage the funds so housing becomes accessible to individuals with disabilities and

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<sup>5</sup>*The Gap Report: A Shortage of Affordable Homes*. The National Low-Income Housing Coalition (2020).

<sup>6</sup> *Out of Reach: A Shortage of Affordable Homes*. The National Low-Income Housing Coalition (2020).

to this Settlement Agreement's target population. Rarely are eligibility requirements and other rules consistent across funding sources.

DHHS and the NC Housing Finance Agency (NC HFA) have, over time, recognized these opportunities and challenges and are taking important steps to take advantage of opportunities to make more affordable housing available. The DHHS continues to contract with the Technical Assistance Collaborative (TAC), to provide guidance on steps the State can take to meet the Settlement goals for supported housing. In 2018, TAC recommended the State take advantage of more rental financing and funding opportunities, including the HUD Mainstream program described in the findings section below, making changes in the Qualified Allocation Plan (QAP) to provide more incentives in the Low Income Housing Tax Credit (LIHTC) program for the target population, and applying for HUD Section 811 Project-Based Rental Assistance (PRA) funds.

The State took full advantage of TAC's recommendations to work with the NC HFA on a plan for income averaging<sup>7</sup> and to continue to utilize available funds for the Integrated Supported Housing Program (ISHP) and the Supported Housing Development Program (SHDP). ISHP and SHDP are HFA funding programs designed to increase the number of new and renovated affordable rental units and to pay the rents for units occupied by individuals in the target population. TAC recommended that DHHS and the NC HFA continue to pursue resources for the private rental market and take advantage of opportunities to work with local Public Housing Authorities (PHAs) to create project-based rental vouchers. TAC also recommended the NC HFA utilize the National Housing Trust Fund as a resource since this program received federal funding increases over the past two years. The NC HFA has done this and is now driving the process, continually seeking resources, and better managing access to these resources.

The State and the LME/MCOs worked with twenty-one (21) local Public Housing Authorities (PHAs) to apply for Housing Choice Vouchers awarded to local Public Housing Authorities through competitive solicitations in FY 2018 and FY 2019. Each PHA that applied for these vouchers is required to establish a working relationship with referring and service organizations. DHHS and the HFA are working with the State Department of Administration on allocating their award and getting approval for vouchers to be used as a preference for TCLI. In FY 2018, six (6) PHAs that collaborated with LME/MCOs were awarded one hundred and fifty-two (152) vouchers and fifteen (15) PHAs applied and were awarded vouchers in FY 2019 in collaboration with LME/MCOs. Three (3) PHAs were awarded vouchers in both rounds.

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<sup>7</sup> Federal legislation in 2018 allowed developers to use income averaging that allows greater income diversity in individual properties by permitting higher-income units (up to 80% of average median income to offset deeper income designations or allow more lower-income units (below 30% of AMI. The previous 60% of AMI ceiling did not provide enough operating funds from rent to support a sufficient number of units for individuals and families with lower incomes.

Each of the PHAs was awarded supplemental funds in FY 2020 without having to apply for additional funds. This represents a major infusion of funds for the State to add more housing resources and offset the future expense of State funded rental vouchers. Several PHAs are working with individuals and organizations who serve individuals who are disabled and are not eligible for TCLI. However, LME/MCOs have commitments for at least five hundred and fifty-six (556) vouchers for individuals referred to the PHA from the LME/MCO.

The LME/MCOs and their service providers have played an important role in utilizing these resources. Their performance has evolved over time to work closely with landlords and property managers, to take the steps to help more individuals transition into housing from institutions and to divert individuals who choose community living.

Despite the challenges of creating housing opportunities, the State with the LME/MCOs and service providers, with support from community-based support organizations, and target population members' families, significant others, and friends, took advantage of the opportunities described above and the State came close to meeting its FY 2020 housing slots "occupied" requirement. On the compliance date, two thousand five hundred and fifty (2,550) individuals in the target population were residing in qualified units, four (4) short of the July 1, 2020, requirement of two thousand five hundred and fifty-four (2,554), despite the COVID pandemic impacting the last quarter's operations.

The housing requirements in the Settlement Agreement require the State to assist individuals overcome the obstacles to accessing and maintaining housing and to assure access across five (5) priority groups of individuals who are eligible for the housing and services described in the agreement terms. While the State is close to meeting the requirement for filling housing slots, it must meet other important actions and interventions to assist individuals as described in the Agreement to access and maintain housing.

The State is not on track to meet the requirement that two thousand (2,000) of the three thousand (3,000) individuals residing in supported housing on the Agreement's termination date be individuals who transitioned out of Adult Care Homes. These individuals are referred to as "Category 1-3 individuals," relating to Categories 1-3 referred to in **Sections III (B)(2)(a)-(c) and III(B)(5)**. The numbers of individuals living in SH from Categories 1-3 on the compliance date – one thousand one hundred and twenty-seven (1,127) — was lower in this compliance year than it was in the previous year—one thousand one hundred and thirty-two (1,132)—. This reduction is not solely related to COVID. By the end of February 2020, eight months into the State's fiscal year and prior to the onset of COVID restrictions the number of individuals living in SH from Categories 1-3 was thirty-seven (37) less than the number living in SH on June 30, 2019 or one thousand and ninety-five (1095). The number actually increased to one thousand one hundred and thirty-two (1,132) during the COVID period when visitation to ACHs was extremely limited. The decrease appears to be related in part to the fact that in-reach workers who visit with ACH

residents must now also assist non-ACH residents who would like to be diverted from ACH admission to SH, the growing number of individuals in the In-reach status and/or a myriad of challenges with engaging and assisting individuals in their decision making. The increase after COVID restrictions went into effect appears to be related to a number of individuals preparing to exit adult care homes at the time the restrictions went into effect. The fact remains, the number of individuals moving from adult care homes to supported housing has decreased over time.

Due to Covid-related restrictions on the Review Team's ability to conduct first person interviews and visits to individuals residing in SH, it is not clear yet if the State is on track for meeting its obligations in the housing settings and tenancy support requirements in **Section III. (B)(7)**. These are important requirements as they include steps the State is required to take for individuals to have tenancy rights and live in integrated settings that afford accessibility and choice of daily living activities, that do not limit access to community activities, and that enable interaction with non-disabled persons. The number of rejections by landlords of individuals in the target population – referred to as “housing denials” – and the number of individuals who withdraw from the program while searching for affordable housing remain at the same levels as in FY 2019. Individuals report loneliness, isolation, and concern with their health care needs as challenges to living in SH. The final FY 2020 Annual Report will include a comprehensive review of the “living settings” requirements.

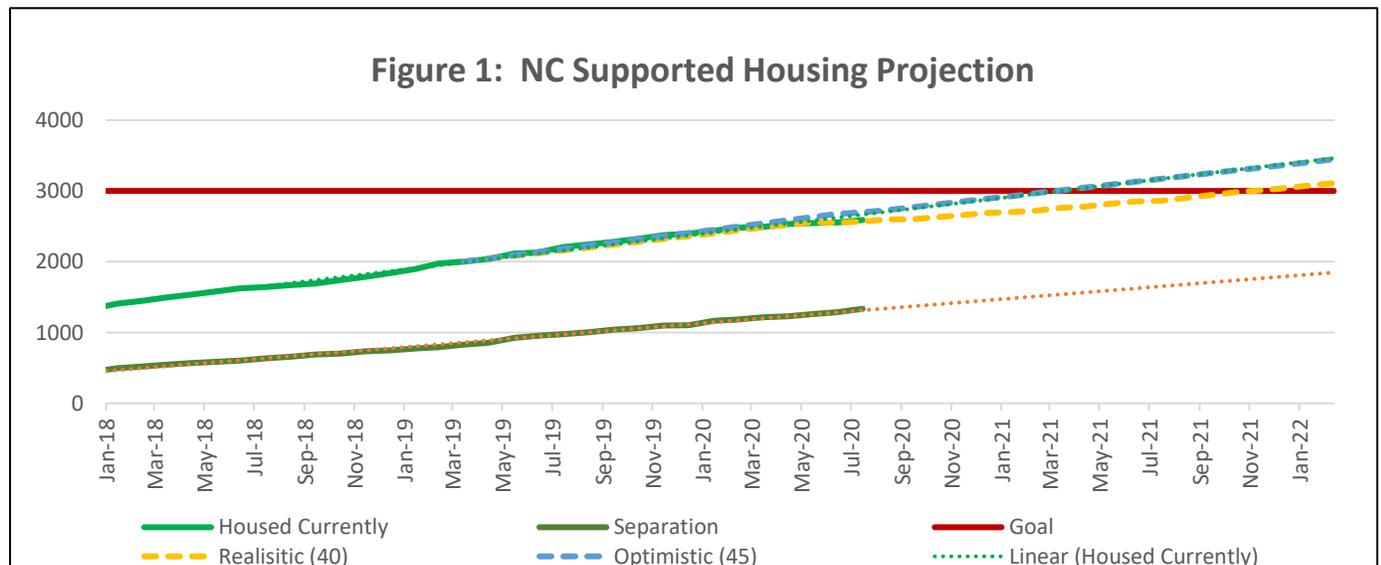
The **(B)(7)** requirement requires the State to provide tenancy support services that enable residents to attain and maintain integrated affordable housing. Tenancy support always includes support to assist an individual to identify, prepare for, and move into housing. This is referred to as “pre-tenancy” and “move-in” support. It includes making applications, getting approved, as well as selecting housing that the individual chooses and that meets their needs for accessibility requirements and proximity to community amenities and supports. Tenancy support also includes assisting an individual to meet their obligations and rights as a tenant. Tenancy support is also considered a service and can be reimbursed as part of Assertive Community Treatment, Community Support, Peer Support, or simply as a standalone tenancy support service. Thus, tenancy support is reviewed as part of the **Section III. (B)** Community Based Supported Housing Slot review and the Community-Based Mental Health Services **Section III. (C)** review.

The State's service strategies are not as robust and clear as needed for individuals to get and keep housing. There are breakdowns in communication with handoffs between staff (Regional Housing Coordinators, TCLI staff, and service providers) and in treatment and care coordination both in the pre-tenancy and post-tenancy phases of housing. These sometimes result in individuals access to housing being delayed and also leads to a reduction in availability of housing. As units are elased to other individuals. TAC has also raised this with the State. The State has taken steps to improve these services through providing clearer expectations, defining tenancy support in their new Community Support Team service, and providing provider and LME/MCO

training. Tenancy support will be further reviewed and reported on in the final FY 2020 Annual Review.

**(B) Findings**

1. The state made significant progress toward the number of currently occupied housing slots for the target population in 2020 as depicted in **Figure 1**. It displays a straight line (in red) of the Settlement Agreement requirements for number of individuals living in housing and it projects the realistic number of individuals that will be living in supported housing based on historical data by June 30, 2021. **Figure 1** also shows a more optimistic trend assuming more individuals will move into housing and more housing will become available in FY 2021. **Figure 1** depicts the number of individuals who have separated from housing because they moved or abandoned their housing, their lease was not renewed, they returned to an adult care home, were hospitalized but did not return to their housing or they became ill and either went into skilled nursing or were deceased. Separation from housing and challenges for individuals getting housed during COVID present the highest risks to the State not meeting this requirement. Lack of available, affordable safe housing and housing application denials also pose risks and State actions to overcome all the risks will be monitored closely.
2. Four hundred and fifty-five (455) additional individuals must be living in SH or an average net gain of forty (40) per month for the State to meet this requirement in 2021. The net gain over the last three months of FY 2020 was sixty-nine (69) or an average of twenty-three (23) per month. The number of individuals living in SH only increased by nine (9) in April, thirty-nine (39) in May, and seventeen (17) in June. Clearly COVID took a toll on housing placements during that time.



The LME/MCOs continue to fill units in general proportionate with their population numbers, Medicaid enrollment, and location of ACHs, their priority population for filling units (**Figure 2**). There were only minor changes in the percentage of units filled by each LME/MCO in FY 2020. Cardinal, the Alliance, and Vaya are more successful in utilizing the targeted units, but all three have more targeted units in their catchment area.

One hundred and thirty (130) of the one hundred and fifty-six (156) ISHP units either in use or approved to be used are in these three LME/MCO catchment areas. The five largest counties in these three catchment areas include forty percent (40%) of the filled targeted units.

**Figure 2: FY 2020 Currently Housed by Type of Unit by LME/MCO**

LME/MCO	TCLI recipients	Targeted/ Key Units	Other <sup>8</sup>	Private Units (TCLI)	% of Units Filled <sup>9</sup> by each LME/ MCO-FY 19	% of Units Filled by each LME/MCO-FY20
Alliance	341	130	4	207	14%	13%
Cardinal	702	138	15	549	29%	28%
Eastpointe	234	28	11	195	8%	9%
Partners	276	60	11	205	13%	11%
Sandhills	295	49	10	236	11%	12%
Trillium	372	92	12	268	13%	14%
Vaya	330	131	20	179	12%	13%
<b>Total</b>	2550	628	83	1839	100%	100%

- The LME/MCOs continued to expand the use of private, non-targeted (low-income housing tax credit unit) units. The LME/MCOs have cultivated property owners and managers and used incentives for referrals. Eastpointe and Sandhills had the largest percentage gain in individuals living in units with TCLI rental subsidies and these two LME/MCOs, along with Cardinal, had the largest gains of the LME/MCOs in FY 2020. Partners' percentage of filled units was consistently higher than their percentage of the state's population but their rate of filled units has dropped in the past two years. Nonetheless their percentage of units filled remains consistent with their percentage of the state's population despite dropping from sixty-three (63) units filled from FY 2018 to FY 2019 to thirteen (13) filled in FY 2020. This results in Partners dropping from a gain thirty-three (33%) from FY 2018 to a six percent (6%) gain of units filled between FY 2019 and FY 2020. All the other LME/MCOs, except Eastpointe, experienced a drop in their percentage gain of private units but increases in other types of units bolstered their overall gains (**Figure 3**).

<sup>8</sup> These are private units and individuals have rental subsidies and do not require the use of TCLI vouchers

<sup>9</sup> Percentage of units filled statewide

**Figure 3: FY 2019-2020 Currently Housed in a Private Rental Unit by LME/MCO**

LME/MCO	# of TCLI recipients in SH in FY 20	Private Rental Units Occupied in FY 19	Private Units as % of LME/MCO Units in FY 20	# and % Change from FY 19
Alliance	341	171	61%	36 (17%)
Cardinal	702	482	78%	67 (12%)
Eastpointe	234	138	83%	57 (29%)
Partners	276	192	74%	13 (6%)
Sandhills	295	182	80%	54 (33%)
Trillium	372	223	72%	35 (13%)
Vaya	330	136	54%	43 (24%)
<b>Total</b>	2550	1534	72% of total	305 (17%)

In some areas of the state individuals may have limited choices for housing based on their immediate need for housing, the scarcity of available units, and the locations where individuals want to live. This is not just a rural issue. There are limited options in some high valued communities and neighborhoods because the federal voucher does not cover HUD's Fair Market rent<sup>10</sup>.

- The State made progress filling targeted units and utilizing "other" housing resources (**Figure 4**). There was a seventeen percent (17%) increase in targeted units filled and units filled using other resources in FY 2020 from FY 2019. There was a fourteen percent (14%) increase in the number of targeted units placed in service in FY 2020 and forty percent (40%) increase in units filled with "other" resources. These increases are largely the result of the State making strides using other resources, including Mainstream Vouchers, and taking advantage of every opportunity to add funding for development costs through ISHP which includes funds transferred from unexpended TCLI funds (year-end balances), the Supportive Housing funds, the National Housing Trust Fund, and adoption of income averaging with LIHTC programs. Two hundred and forty-seven (247) units are being placed into service with IHSP set asides. Of those, there are sixty-two (62) of the units filled, thirty-six (36) vacant, eight (8) with referrals, and one hundred and eighty-five (185) units still "not placed in service." Most are under construction.
- The Targeted and Key program has grown from approximately two thousand (2,000) units filled with individuals with disabilities in 2015 to thirty-four hundred and forty-three (3,443) through April 30, 2020. Most of these residents are not target population members; individuals in TCLI only represent eighteen percent (18%) of the total of filled Targeted and Key units.

<sup>10</sup> Fair Market Rent is generally calculated as the 40th percentile of gross rents for regular, standard quality units in a local housing market.

**Figure 4: FY 2018-2019 Currently Housed in a Targeted/Key Unit by LME/MCO**

LME/MCO	TCLI recipients	Targeted and Other Units Occupied in FY 19	Targeted/Key Units/(Other) Occupied in FY 20	Overall (Targeted and Other) % Change
Alliance	341	118 (2)	130 (4)	11%
Cardinal	702	126 (7)	138 (15)	13%
Eastpointe	234	32 (4)	28 (11)	8%
Partners	276	61 (11)	60 (11)	1%
Sandhills	295	44 (7)	49 (10)	14%
Trillium	372	61 (5)	92 (12)	37%
Vaya	330	99 (13)	131 (20)	22%
<b>Total</b>	<b>2550</b>	<b>541 (49)</b>	<b>628 (83)</b>	<b>17%</b>

6. Over the first nine months of the fiscal year the number of individuals living in SH increased by three hundred and sixty-seven (367) for an average of forty-one (41) per month. The number of individuals in Category 5 living in housing at the end of FY 2020 increased thirty-four percent (34%) compared to an average of a twenty percent (20%) average increase for each of the five (5) previous years. The number of individuals living in SH who are in Category 4, discharged from State Psychiatric Hospitals increased by ninety-seven (97) from three hundred and sixty-six (366) to four hundred and sixty-three (463), a forty three percent (43%) increase. The State is at one hundred and forty-two percent (142%) of the one thousand (1,000) individuals who should be living in supported housing from the priority populations 4-5 by June 30, 2021 (**Figure 6**).

**Figure 6: Increase in Units Filled by Priority Population Categories**

	Alliance	Cardinal	Eastpointe	Partners	Sandhills	Trillium	Vaya	Total
<b>Cat.1-3 FY 13-19<sup>11</sup></b>	85	331	95	158	139	139	186	1132
<b>Cat. 1-3 FY 2020</b>	5	-14	9	-16	6	6	9	1127 (-5)
<b>Cat. 4 FY 2013-19</b>	134	58	48	35	44	36	11	366
<b>Cat. 4 FY 2020</b>	14	13	17	1	28	22	2	463 (97)
<b>Cat. 5 FY 2013-19</b>	72	226	32	71	50	114	51	616
<b>Cat.5 FY 2020</b>	41	108	35	20	30	55	70	960 (344)

7. The State is not on track to meet the requirement for two thousand (2,000) individuals living in SH in Categories 1-3, individuals residing in Adult Care Homes. This is the rate projected based on the current pace of filling slots from those three (3) categories. The number of

<sup>11</sup> This is total filled from FY 2013 through FY 2018

placements in FY 2020 was one hundred and forty-four (144), down from a gain of four hundred and fifty (450) in FY 2019. This was in part due to COVID but there were reductions across most months of the year compared with the previous two years. The number of individuals in these three categories living in SH at the end of FY 2020 was five (5) less than individuals in those categories living in SH at the end of FY 2019.

8. The State continues to develop, implement, and refine measures to improve access to supported housing for individuals in the target population. The State and the LME/MCOs have taken measures to increase the number of individuals discharged from State Psychiatric Hospitals (Category 4) to SH, either directly or after a short stay in bridge housing. Seven percent (7%) or eighty-one (81) individuals of SPH discharges moved directly into supported housing in FY 2020. Twenty-eight percent (28%) of individuals were discharged to bridge housing while final housing arrangements were being made. There was a reported increase of nineteen (19) individuals discharged to bridge housing when compared to FY 2019. Twenty-three (23) individuals got this opportunity in FY 2020 compared to four (4) in FY 2019 based on state reporting. The evidence is clear. Readmission rates are lower if individuals move into bridge housing first or directly into supported housing with pre-tenancy, move-in, and immediate post tenancy support and immediate follow-up appointments, peer support, and a focus on helping the individual build their own support systems. Choice of housing and of provider is essential to this process.

These FY 2020 increases occurred as there was a thirty three percent (33%) decrease in SPH discharges to ACH and Family Care Homes and a twenty three percent (23%) decrease in SPH discharges to boarding homes, shelters, and hotels. The NC HFA is taking steps to enhance daily decision support with targeted units so units can get filled more quickly. This support is provided directly to LME/MCO housing staff, cutting down on the length of time for information on vacancies to get to these staff. This shift will alleviate the challenges referenced in last year's report in the timeliness of notifications and multiple handoffs creating communication challenges. The NC HFA is also taking steps to provide information to enhance the use of data in overall decision making and performance improvement.

9. The Targeted Unit Transition Program (TUTP), often referred to as a "bridge" program or "temporary housing," expanded by forty percent (40%) in the fiscal year and eighty-five percent (85%) in the past four years. The program has demonstrated success as a gateway to permanent supported housing with ninety percent (90%) of those completing the program moving into SH (**Figure 7**). All the LME/MCOs are now participating in the program. The goal of the program is to assist an individual with a stable place to live while establishing their eligibility and finding a permanent place to live. A place to live on an interim basis fills an immediate need for a safe, stable place to live. A strong case can be made for expanding the program during COVID, especially for individuals who are at risk of institutional placement.

Individuals using the program are typically beginning the housing search process, gathering eligibility documents, and/or waiting on a unit to become available. An individual can remain in the program up to ninety (90) days.

The LME/MCOs, the Alliance, Eastpointe, Sandhills, Trillium and Vaya greatly expanded their programs in FY 2020 and join Cardinal as the highest users of the program. The success rate, as measured by an individual gaining access to permanent housing, is eighty nine percent (89%). LME/MCOs have used several different options including hotels, apartments leased to a provider, and a Single Room Occupancy (SRO) style apartment arrangement. The LME/MCOs have expressed concern about using hotels, motels, or isolated apartments. Cardinal and the Alliance have been utilizing small residences in addition to hotels and motels and Trillium added a small residence in late FY 2020.

**Figure 7: The FY 2017- FY 2020 Change in Use of Bridge Housing**

LME/MCO	FY 17	FY 18	FY 19	FY 20 <sup>12</sup>	Annual % change <sup>13</sup>	Moved to PSH <sup>14</sup>	% of Individuals who moved to PSH <sup>15</sup> Accumulative and (FY20 change)
Alliance	5	36	44	73	60%	68	91% (-5%)
Cardinal	22	41	54	63	14%	55	87% (+5%)
Eastpointe	0	0	25	82	69%	66	80% (+12%)
Partners	5	7	19	31	39%	31	100% (same)
Sandhills	0	0	9	29	93%	26	90% (nc <sup>16</sup> )
Trillium	0	10	33	52	63%	46	88% (+22%)
Vaya	29	45	61	72	15%	66	92% (+7%)
<b>Total</b>	<b>61</b>	<b>139</b>	<b>248</b>	<b>402</b>	<b>38%</b>	<b>358</b>	<b>90% (+3%)</b>

10. The requirements in **Section III(B)(7)** include a wide range of criteria, including the State responsible for arranging support to assist individuals to attain and maintain integrated affordable housing, access community activities, interact with individuals without disabilities, and have a choice in daily life activities. Attaining and maintaining housing requires support to ensure individuals are not discriminated against and have the full rights of tenancy. These requirements also include ensuring individuals are afforded access to housing with adaptive equipment and accessible features. The Community-Based Mental Health Services section of the FY 2020 Annual Report will also include a review the State's tenancy support services performance.

<sup>12</sup> Accumulative over the life of the program

<sup>13</sup> % of those who moved during their stay or after they completed TUTP in FY20

<sup>14</sup> Individuals moved to supported housing at the end of the TUTP eligibility period (accumulative).

<sup>15</sup> Percentage of individuals who moved into permanent supported housing (accumulative).

<sup>16</sup> Program started in late FY 2020, first full year in the program

Annual housing retention data is available and is previewed below, illustrating the State's performance in assisting individuals to maintain housing. Many factors influence retention, including those related to individuals aging, needing a higher level of care for their medical care, or dying because of an advanced illness and/or age. These are naturally occurring reasons that affect retention. Other factors are considered negative reasons, including eviction related to lease violations, abandonment, the need for more intensive services and/or services appropriate to their clinical or personal care needs, individual support, home health support or care management for their co-occurring medical or substance abuse treatment needs.

The retention rate for the life of the program was sixty seven percent (67%) at the end of FY 2020, down from sixty nine percent (69%) at the end of FY 2019. Sandhills and Trillium had slightly higher retention rates in FY 2020 than the other LME/MCOs but only Eastpointe improved their rate in FY 2020, from sixty percent (60%) to sixty seven percent (67%), bringing their rate in line with the state average. Overall, the Alliance and Cardinal have fewer separations per capita. The number of separations from LIHTC properties (targeted units) is relatively the same as separation rates from the properties not in the LIHTC program that are getting TCLV rental subsidies.

Retention rates will go down the longer individuals live in the community but increasing the number of individuals moving into housing the past three years should more than offset that reduction. The final FY 2020 Annual Review process will provide more information to determine the state's progress in meeting the requirement for assisting individuals to maintain integrated, affordable housing.

The State is taking steps to increase in-home support, especially for individuals with complex medical and personal care needs. These steps are important for more individuals to access and maintain housing. It is also important to identify the root causes of abandonment and potential lease violations that lead to eviction, individuals exiting housing before eviction, or leases not being renewed, and take steps to reduce these problems to increase the number of individuals who maintain housing.

11. **Section III(B)(1)** requires the State to implement measures to provide SH access to individuals in the target population. **Section III(B)(7)** requires permanent housing with Tenancy Rights. One standard for this requirement is that "the individual gets tenancy support including support to meet tenancy requirements and support to help the individual advocate for their rights as a tenant." Data on housing denials, application withdrawals, and observation during community support (tenancy support) suggests the State faces several challenges to meet these requirements by July 1, 2021. This item requires first-person and provider interviews and additional LME/MCO SH reviews, which are planned to occur before the submission of the final FY 2020 Annual Report.

12. The NC HFA has taken steps to work with property managers and owners to further fair housing, establishing a Fair Housing and Tenant Selection Policy in 2018 and following up with owners where denials are high or appear problematic. They, along with the NC Justice Center's Fair Housing Project and Legal Aid of North Carolina, provide training and legal assistance. Nonetheless, denials continue, and individuals often withdraw their name prior to making an application for housing or during the application process. Seventy-two (72) individuals withdrew their name before making contact with a property manager or landlord, another ten (10) during the process, another nine (9) after denial, including two (2) before an appeal decision. Eight (8) individuals withdrew after they got their application approved. These numbers are consistent with findings in FY 2019.
13. A review of targeted unit denials revealed that follow-up occurred with only twenty percent (20%) of referrals and five (5) denials were subsequently approved. This indicates that reasonable accommodation of rental policies is either not sought or successful. Typically, reasonable accommodation requests are successful fifty percent (50%) of the time. The final FY 2020 Annual Review will include an analysis of why individuals withdraw their names for housing.
14. The State recommends that provider staff and LME/MCO staff take Fair Housing competency based training as a pre-service requirement with annual updates and that each LME/MCO identify and establish a working relationship with housing rights specialists at one of the state's twenty (20) Legal Aid offices or other legal services organizations that have experience and expertise in assisting individuals to advocate for their tenancy rights and minimize discrimination. Information gleaned from previous interviews and observations of SH training in FY 2020 demonstrates that some staff do not understand or accept their tenancy assistance responsibilities, lack understanding of tenancy rules, may be conveying misinformation, or have failed to provide assistance to individuals on tenancy issues. This inaction or misinformation has likely led to individuals either not following through with applications, exiting housing, or being evicted.
15. Primary service providers play a key role in pre-tenancy, move-in, and assisting individuals to maintain housing. The above finding and repeated observation of Community Support Team(CST) services training during FY 2020 reveal that many providers lack clarity about their role and responsibilities, lack experience, and even lack willingness in a few instances to provide this support. The State and LME/MCOs appear to understand the implications of this issue. They have taken some steps through training and LME/MCOs expanding job duties in provider contracts.

Training and explaining new requirements will not result in meeting the Settlement obligations and better outcomes for individuals to get and keep housing. Rather, implementing a change of this type, especially for providers who have been providing a

different service, requires a structured implementation process with program assessments scheduled on a regular basis beginning just prior to implementation and continuing for one to two years. This includes assessing organizational support for the new service and assessment of the supervisors' and staff competencies with constant attention to building competencies. Typically, case study reviews are utilized for this purpose. If this process does not appear to be achieving necessary results it may also require service providers and LME/MCOs to submit and operate under corrective action plans. The success of this process is predicated on the State and LME/MCOs securing individuals/teams with the requisite knowledge and skills to provide training and consultative support.

16. Section III(B)(7) also includes requirements regarding access to community amenities and daily community activities at the frequency and with persons of the individual's choice, enabling individuals to interact with individuals without disabilities, housing units being scattered, and individuals having choice in daily activities. This last item implies that individuals will get personal and in-home support for daily activities and that this assistance includes accessibility features including modifications as needed. Location is also a factor but within buildings, topography, and distance from amenities or assistance to get to amenities. Assessing these issues will require first person verification, visits to places where individuals live, a description of the places and how staff are assisting individuals to meet their needs and make progress on their goals. The plan is to conduct on-site interviews prior to the submission of the final 2020 Annual Review.

***(C) Recommendations***

The recommendations in this Interim Report are listed below in five categories focused specifically on those items where the State needs to make improvements to meet the outstanding Settlement Agreement Community-Based Supported Housing Slot requirements. These include improvements for access to housing, availability of resources to meet requirements, meeting the provision for two thousand (2,000) slots to individuals from Categories 1-3 and improvements in two (2) requirements related to tenancy support. This list does not specifically include a recommendation to increase housing slots to reach three thousand (3,000) filled slots, although ensuring availability and timely access to housing cover the primary steps to meet this requirement. Each of these require multiple entities. DHHS (including the Division of Mental Health, the Division of State Operated Facilities, the Division of Social Services and the Division of Health Benefits have specific responsibilities), the State Housing Finance Agency (NC HFA), the LME/MCOs and service providers have responsibilities for taking required steps for each of these below. It is the responsibility of the State to assign and monitor that these responsibilities are being met. Each requires close collaboration among these entities for the State to meet its housing obligations.

***Access to Housing***

1. The State and LME/MCOs ensure that accessible features, building and unit location, daily support for medical care, and community activities, with persons of their choosing including non-disabled persons, are accessible, for someone to move into and retain their housing.
2. DHHS, NC-HFA and LME/MCOs work with local Public Housing Authorities to ensure HUD Mainstream Vouchers are utilized to the greatest extent possible, improving the PHA processes where necessary to use the vouchers when awarded.

***Availability***

1. The State ensures bridge housing funding is available to individuals exiting SPHs, being diverted from ACHs or other situations when permanent housing is not immediately available in each LME/MCO catchment area. Where possible, the LME/MCOs should expand the choices of types of bridge housing to enhance the success of individuals whose needs may vary.
2. The State should provide sufficient funds to cover the costs of housing slots and improve use of mainstream vouchers to maximize federal funding for rental vouchers.

***Meeting the Settlement Agreement provision for providing two thousand (2,000) housing slots for individuals in Categories 1-3***

1. The State and LME/MCOs take steps to ensure individuals in Categories 1-3 get the assistance they need to move to supported housing. This includes making contact and providing assistance in a timely manner for individuals to make decisions and get their pre-tenancy needs met.

This is possible for individuals living in homes that do not have active COVID outbreaks and it includes taking the necessary precautions to visit individuals and assist those who chose to move during the COVID pandemic. This is already being done with virtual housing search, lease signing and selection of furniture and household items. It does take more time to help individuals through the actual move-in process, but staff are learning creative ways to stay safe and help individuals move at the same time.

2. The State and LME/MCOs ensure individual accessibility and health care requirements are addressed as quickly as possible when an individual indicates their consideration of a move is contingent upon have these met.

***Requirements for Tenancy Support***

1. Pursue requests for reasonable accommodation for all rental denials where the owner does not appear to be treating the applicant fairly and when applicant agrees to make request.
2. Provide timely and adequate pre-tenancy support.
3. Mandate competency-based Fair Housing training for ACT Housing Specialists, CST and Tenancy support staff, and LME/MCO housing staff. Establish guidance for reasonable

accommodation and follow-up arrangements which could be through a formal or informal agreement depending on need and location with Legal Aid attorneys in the State's 20 Legal Aid offices and with attorneys with experience in housing discrimination matters in legal assistance offices and Legal Aid.

4. Ensure the location of housing and the rental unit within a building or complex does not limit access and ensure individuals have access to community amenities at the times, frequency, and with persons of their choosing; provide assistance with individuals' choice of daily life activities.
5. Monitor and comply with individuals' accessible unit and individual supports, including home health and personal care services requests. This may include modifications of policy to ensure individuals with physical disabilities can get access to individual supports.

## II. Supported Employment

Major Categories	Summary of Requirements	Progress Towards Compliance
<p><b>1. Section III. (D)(1)</b> The State will develop and implement measures to provide Supported Employment Services (SE)<sup>17</sup> to individuals with Serious Mental Illness (SMI), who are in or at risk of entry to an ACH, that meet individual needs. Services are defined as services that will assist individuals in preparing for, identifying, and maintaining integrated, paid competitive employment.</p>	<p>a. The State has developed and is implementing<sup>18</sup> measures to provide SE services to individuals who are “in or at risk of entry to an ACH” that meet their individual needs<sup>19</sup>. This includes measures that ensure access to integrated employment and mental health services and to post employment follow-along support so that individuals get assistance to prepare for, identify and maintain employment.</p> <p>b. Measures developed and implemented by the State ensure SE services meet individuals’ needs.</p>	<p>a. The State has not met this requirement and there is not sufficient evidence to project the State as being on track to meet this requirement in FY 2021.</p> <p>b. The final FY 2020 Annual Report will include analysis of SE services meeting requirements for individual needs being met and individuals getting access to this service if they voice a preference for and chose to pursue supported employment.</p>
<p><b>2. Section III. (D)(2)</b> SE Services will be provided with fidelity to an evidenced-based supported employment model for supporting people in their pursuit and maintenance of integrated, paid, competitive employment work opportunities. An established fidelity scale will assess SE.</p>	<p>a. Services will be provided with fidelity to the IPS-SE model.</p> <p>b. The State will use the established IPS-SE fidelity scale.</p>	<p>The State has met this requirement.</p> <p>a. The State has adopted the IPS-SE Fidelity Scale.</p> <p>b. The State has discussed but has not proposed a method for using items in the ACT TMACT<sup>20</sup> fidelity tool which are consistent with IPS-SE fidelity model items to verify ACT teams are providing supported employment services that meet fidelity.</p>
<p><b>3. Section III. (D)(3)</b> By July 1, 2020, the State will provide IPS-SE services to a total of two thousand one hundred and ninety-three (2,193) individuals “in or at risk of ACH placement.”</p>	<p>The standard is the same as the requirement.</p>	<p>The State exceeded the FY 2020 annual requirement, with two thousand four hundred and ninety-one (2,491) individuals “in or at risk” of ACH placement.</p>

<sup>17</sup> SE services refers to IPS-SE services as referenced in #2 below.

<sup>18</sup> Implementation includes monitoring for verification of “in or at risk” and access to both SE and Division of Vocational Rehabilitation (DVR) resources.

<sup>19</sup> Per the Settlement Agreement, severity of an individual’s disability cannot be a barrier to an individual transitioning to an integrated setting appropriate in all domains of an individual’s life (including employment and education) based on the individual preference, strengths, needs, and goals.

<sup>20</sup> Tool for measurement of Assertive Community Treatment (TMACT).

### **(A) Background**

The Settlement Agreement requires the State to develop and implement measures to provide to individuals with SMI, who are in or at risk of entry to an ACH, Supported Employment (SE) services that meet their individualized needs. The Settlement Agreement defines SE services as services that will assist individuals in preparing for, identifying, and maintaining integrated, paid, competitive employment. Services may include job coaching, transportation, assistive technology, specialized job training, and individually tailored supervision.

The Settlement Agreement requires the State to select an evidence-based supported employment model. The State selected the Individualized Placement and Support Supported Employment (IPS-SE) model as its evidence-based supported employment model. This was a good decision on the part of the State. This model is without comparison in its positive outcomes for adults with serious mental illness. It is a widely adopted model<sup>21</sup> implemented through a Learning Community<sup>22</sup> in twenty-one (21) states, the District of Columbia, three (3) regions in other states, and six (6) countries.

As many as sixty six percent (66%) of individuals with serious mental illness want to work, which is consistent with findings in TCLI recipient random interviews<sup>23</sup>. At least twenty-three (23) randomly controlled studies demonstrate the efficacy of IPS-SE over other supported employment models<sup>24</sup>. This information and the Reviewer's experience indicate active and well organized state and local leadership, coupled with a strong and sustainable financing plan, is essential to overcome the challenges of assisting individuals in the TCLI target population, with returning to work, seeking out work the first time and sustaining that work. It can only be successful if driven by an outcome data system that monitors effectiveness and documents competitive employment and education. There are multi-level challenges in the current NC system to assist individuals in the TCLI target population to achieve their own employment goals either returning to work or going to work for the first time.

For purposes of this review, and consistent with Settlement Agreement requirements, effective measures for Supported Employment include the following:

- 1) The service is available and accessible to any individual in the priority target population.
- 2) The service best matches the individual's needs and enables individuals to achieve their personal outcomes including integrated, paid, competitive employment.

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<sup>21</sup> <https://ipsworks.org>

<sup>22</sup> A Learning Community connects participating jurisdictions and organizations with a structure by which to align shared goals, metrics, and outcomes.

<sup>23</sup> Burns EJ, Kerns SE, Pullmann MD, Hensley SW, Lutterman T, Hoagwood KE. *Research, data and evidenced based treatment in state behavioral health systems, 2001-2012. Psychiatric Serv.* 2016; 67 (5): 496-503.

<sup>24</sup> Drake RE, Bond, GR, Goldman, HH, Hogan MF, Karakus, M. *Individual Placement and Support Services Boost Employment for People with Serious Mental Illnesses, But Funding is Lacking, Health Affairs.* 2016:35(6): Abstract

3) The service includes specialized job training, transportation, job coaching, assistive technology assistance, individually tailored supervision, and on-going support.

The methods used to review IPS-SE in FY 2020 included:

- 1) Interviews with four (4) LME/MCOs and the State TCLI staff, DMH, DMA, and DVR.
- 2) Reviewing the State's analysis of data on service use for individuals living in supported housing.
- 3) Interviewing stakeholders (providers, the UNC Technical Assistance (TA) team, and LME/MCO staff) involved in training, fidelity reviews, managing contracts, and developing IPS-SE as a unique service.
- 4) Conducting regular meetings, interviews, and reviews of written materials and data from TCLI and DMH staff.
- 5) An in-depth review of IPS-SE verifications and IPS-SE provider fidelity scores.
- 6) Meetings and follow-up discussions with Vaya, DMH, the Senior Advisor, and DHHS DVR staff regarding a pilot of a new business model for IPS (Vaya's NC Core Pilot).

As reported previously, IPS-SE is a relatively new service in North Carolina, initiated in late 2013. Implementation is a continuing challenge for the State. The development of sustained interest and engagement from multiple stakeholders, including individuals, family members, guardians, service providers, community employers, and VR staff. Most importantly it requires constant coordinated active leadership from the State in close collaboration with the LME/MCOs and local VR offices.

Like many evidence-based practices, IPS-SE requires ongoing workforce development, outreach, and active monitoring to assure teams are available in all areas of the state. It also requires IPS-SE and mental health services to be fully integrated via joint treatment meetings, and planning sessions that offer individuals the chance to receive IPS-SE services and succeed in preparing for and maintaining employment. Developing effective measures for delivering the service is complex. IPS-SE teams must meet fidelity requirements to assure good outcomes and navigate between two systems (MH and VR) that have different payment models. The State and LME/MCOs must work collaboratively to develop mechanisms monitoring the documented service requirements, reimbursement rates, and financing so that they drive rather than hinder performance.

There are requirements for MCOs in their DMA contract to contract only with providers that meet fidelity. The contract also requires MCOs to:

- 1) Provide reasonable training and technical assistance.
- 2) Link a specific number of individuals to IPS-SE as determined by the Settlement Agreement and communicated by DHHS to the MCO.

- 3) Establish and measure provider performance.
- 4) Monitor IPS-SE providers to evaluate the quality of service delivery and compliance to the waiver service description in the FY 2019 contract.
- 5) Contract with a sufficient number of providers for IPS-SE services for “enrollees” with SMI/ Serious and Persistent Mental Illness (SPMI), including those in the TCL Special Healthcare Population, in accordance with waiver service descriptions.

There is not a corresponding section in the DMH contract with LME/MCOs, although there is reference to and some corresponding language.

IPS-SE fidelity measures provide an excellent framework for essential service delivery obligations (e.g., six (6) in-person job development contacts per employment specialist per week). Customized State-LME/MCO contract language is critical to articulate and meet requirements in the Settlement Agreement and hold LME/MCOs accountable. While meeting fidelity and adding contract language are both necessary, they do not substitute for robust planning, implementing an effective financing model, setting performance targets and measuring performance. The State continues to need to implement a comprehensive plan with adequate funding for appropriate and sustainable supported employment services.

Multiple sources of information suggest that there is wide variability in how people at all levels of the system (State, LME/MCOs, IPS-SE providers, mental health providers) understand the fidelity process and the potentially very useful Quality Improvement data that is generated from these reviews.

Since FY 2016, the Independent Reviewer’s Annual Reports have included four (4) broad recommendations. These tie the State’s progress and consistency of efforts across the years on implementing these recommendations. The State’s Corrective Action Plan for Supported Employment submitted in June 2016 included goals and action steps consistent with these recommendations. Below is a list of those recommendations and references to the State’s actions in response.

**The first recommendation** was for the State to clarify State (DMH, DVR, and DMA), LME/MCO, and specific service provider roles, responsibilities, and expectations, and to tie them to LME/MCO and provider expectations in contracts. During this time ample evidence has emerged for the State and LME/MCOs to take specific actions aimed at improving performance. This should be done without penalizing new teams struggling to meet requirements for the first time. The State has taken steps to clarify roles, but recent interviews suggest that actions to increase cross-agency collaboration and agreements necessary for providing resources for the “in or at risk” population are incomplete as reflected in VR billing, DMH/DMA data, and responses in recent LME/MCO interviews.

The State could also add outcome-based performance measures for its own work and in contracts between the DMA/DMH with LME/MCOs, between the LME/MCOs and service providers, and with the DVR system. This includes taking steps to conduct quality monitoring and strengthen collaborative engagement and training. Each report has referenced the need for the State to provide guidance on performance measures and expectations, increasing collaboration and contracts between local DVR offices and IPS service providers, and setting clearer expectations for serving individuals in TCLI, not just individuals "in or at risk" of entry into an ACH. The State and LME/MCOs have also had time since this recommendation was made to examine the attributes of organizations performing well and those that are not doing well. The State and LME/MCOs could take the step to disseminate the attributes of teams doing well and take steps to assist teams performing less well.

**The second recommendation** was to develop and implement a sustainable IPS business model. This was considered essential because the service requires robust funding to assist individuals in the TCLI program to identify, prepare for, and secure employment. This is also true for assisting individuals in TCLI to retain employment. The current model works to help individuals with fewer challenges to get through the process. The result has been that fewer individuals in TCLI are being referred and getting the assistance they need to get employed even after there is robust evidence that a significant number of individuals in this target population are interested in returning to work or furthering their education. The State began a pilot with the Vaya LME/MCO and local DHHS Division of Vocational Rehabilitation offices in FY 2020. This pilot is a beginning step toward the State adopting sustainable business model. However, it is too early in the process to conclude that the pilot will demonstrate desired outcomes for individuals "in or at risk" and especially individuals in the TCLI program. Progress to date is discussed in detail below.

**The third recommendation** was to develop an Action Plan to fill the "IPS pipeline." The pipeline in this context starts with individuals referred for this service who are identified as interested in employment or furthering their education or training, to identifying and preparing for employment and becoming employment. Data shows there is consistent movement to fill the pipeline but less so for individuals in the "in or at risk"<sup>25</sup> population and even less so for individuals in that population who have already enrolled in TCLI. The State has repeatedly urged providers and LME/MCOs to take steps to include TCLI recipients. Conversely, stakeholders report hearing that only individuals in TCLI can get IPS services.

Only thirty-six percent (36%) of the total referrals are individuals in the "in or at-risk category." A review of LME/MCO verifications of referrals shows that, of the number of individuals in the "in or at risk of" category only twenty-two percent (22%) are in the TCLI population. This low number is revealing considering that last year's Annual Review revealed that only fifty percent (50%) of

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<sup>25</sup> "in or at risk" refers to individuals living in adult care homes or at risk of moving into an adult care home.

individuals interviewed who indicated their interest in seeking employment or furthering education were given the opportunity to get IPS-SE services.

**The fourth recommendation** was to develop and implement a targeted plan to build IPS-SE capacity in the most needed areas of the state. There has been no change in the number of teams providing IPS-SE services in the past fiscal year. The numbers of providers in rural areas and high demand urban areas has not changed.

The State took its first action step to improve the business model as referenced in the second recommendation above by piloting a new IPS business model with Vaya, an LME/MCO that covers twenty three (23) counties in the western part of the State. The Vaya pilot, called “NC Core,” features a close collaboration between the LME/MCO and the local VR office, with streamlined operational and reimbursement procedures for IPS providers in the region, designed to improve service delivery and provider stability. The State can use lessons learned from the Vaya pilot to launch a viable, sustainable business model statewide.

There are four requisites with the Vaya pilot opportunity. One, it requires the development and routine use of a data base to readily collect and evaluate current outcomes, especially TCLI recipients. Two, if the pilot demonstrates success in meeting SA requirements in the number of TCLI recipients who seek, get, and keep jobs, it could be implemented across the state. Three, it requires the State, in collaboration with VR and all of the LME/MCOs, to develop a rolling statewide implementation plan while securing active leadership at multiple system levels. Four, it would require the development of training and consultation methods and mechanisms for IPS-SE providers, mental health providers, and VR. It may require some modifications with sequencing milestones or methods of payment. Regardless of adaptations, the four requisites apply.

DMH, DVR, their providers, and local VR counselors in the Vaya catchment area have voiced a strong commitment to the pilot; this same commitment is necessary statewide. Pilot results for preparation, identification of integrated, paid competitive employment, and assistance for maintaining employment for individuals in TCLI are still inconclusive with the key questions related to the sequencing and sufficiency of the payments.

The goal of the pilot’s approach is to reimburse providers for a cluster of activities intended to incentivize staff to assist individuals to develop an individualized plan for employment, and then customizing job development and job search leading to employment based on the individual’s plan. This model enables the VR counselor to work with an individual to customize their plan rather than paying for services in discrete but generic and less individualized segments. It provides incentives to prioritize individuals with greater vocational needs. The Vaya-State-Provider-VR Counselor team meets monthly to review data and troubleshoot problems as they arise. Before the pandemic, VR counselors were co-locating at IPS-SE service provider offices for

at least a half day a week. Likewise, Vaya adopted the model clustering their payments into discrete milestones.

The State is actively monitoring the process and Vaya and DVR are reporting on key indicators and have made resource and other adjustments. Staff report frustration with not being able to integrate data to provide a clearer picture of effectiveness. This is not possible until the State completes work on an interagency agreement at DHHS that has been in process for a number of months.

This Vaya pilot process began in the fall of 2019 with an official start date of January 1, 2020. Unofficially, caseloads linked at least two months earlier. Between January 2020 and April 15, 2020, the percentage of caseloads linked between the IPS provider and VR rose from forty eight percent (48%) to seventy three percent (73%). It leveled off then and on July 15 was at seventy one percent (71%). The January to April increase demonstrates the motivation of the providers and VR counselors to get off to a good start. Individual service authorizations happened quickly, demonstrating a greater demand for the service than previously reported. However, the leveling off is also a stark reality of identifying individuals for the service being less of a challenge than assisting individuals to secure and maintain employment. This process was also complicated by the COVID pandemic occurring shortly after it began.

There cannot be a full evaluation of the pilot’s effectiveness and outcome data available until COVID subsides. When the process came to a halt, individuals’ progress towards employment and maintaining employment, Reimbursement Milestone 3-7B, as depicted in **Figure 8**, remained relatively flat. The four service providers remained somewhat upbeat on a recent call. The State and Vaya were able to create a modified payment structure, allowing the IPS-SE teams to stay in business during COVID. Staff report they can remain in contact with individuals and have reported that jobs are available in their area.

**Figure 8: Active Authorizations in NC CORE**

	Milestone 1	Milestone 2	Milestone 3	Milestone 7A	Milestone 7B
<b>4/15/2020</b>	234	1	0	4	0
<b>7/15/2020</b>	232	1	2	2	10

While several other LME/MCOs have discussed the possibility that they, too, may want to test out the Milestone model or some adaptation of it, none of the LME/MCOs have taken formal steps to begin a new process. Fidelity review results from FY 2018 through early 2020 suggest the model will need to enhance provider executive team support, more frequent team contact with the individual, and more employer contacts.

Individuals receiving ACT services can get assistance from Employment Specialists who are a part of the ACT Team. The State could also disseminate information regarding ACT teams that provide

employment services consistent with the IPS teams that demonstrate fidelity to the IPS model. This has not yet occurred.

As part of this review, quantitative data from ACT fidelity reviews (completed from 2018 through early 2020) revealed employment specialists only saw thirty one percent (31%) of individuals more than once every four weeks. This low percentage may be in part due to the demands of the ACT team overall and Employment Specialists specifically to spend their available time providing other services. Regardless of the reasons for this low frequency of support, it does not meet a frequency standard essential for supported employment.

The same reviews revealed that only thirteen percent (13%) of the ACT teams statewide were providing supported employment assistance for at least forty percent (40%) of their members, and that eighteen percent (18%) of the teams were providing this assistance to twenty percent (20%) of their members. Individuals served by ACT can vary in their needs and many individuals have acute symptoms, which means the focus of ACT is primarily treatment. These two issues will be explored further during individual reviews to be conducted prior to submission of the final FY 2020 Annual Report and reported on as part of the review of access, frequency, and intensity of employment services as part of ACT in the Community-Based Mental Health Services section of the report.

### **(B) Findings**

- 1. The State will develop and implement measures to provide Supported Employment Services to individuals with SMI, who are in or at risk of entry to an adult care home that meets their needs. Supported employment is defined as services that will assist individuals in preparing for, identifying, and maintaining integrated, paid, competitive employment (III.D.[1]).**

Individuals, in TCLI, service needs for preparing and maintaining employment have not been fully reported by the State. The State does not report the number of individuals in TCLI employed or individuals who maintain employment. The State reported the percentage of TCLI recipients referred and getting at least one unit of IPS-SE services was seven percent (7%) of the individuals identified as TCLI recipients, excluding individuals on In-reach status<sup>26</sup>, in calendar year 2019<sup>27</sup>. The State reports the number of individuals in the “in or at risk” group served in the 4<sup>th</sup> quarter of FY 2020 was three hundred and twelve (312) or sixteen percent (16%) of the total number of individuals served in IPS/SE. This increase is important but falls short of the number of individuals in TCLI who expressed interest in employment in FY 2019

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<sup>26</sup> If individuals on In-reach status were included, 3% of TCLI recipients received at least one unit of IPS-SE services in calendar year 2019.

<sup>27</sup> The State’s utilization data was reported in June 2020 for calendar year 2019. Utilization is usually reported after claims are submitted and adjudicated, which is why there is a six-month lag in reporting.

interviews. In FY 2019, twenty-three (23) individuals out of forty-six (46) individuals, or fifty percent (50%) of individuals, interviewed expressed interest in employment .

2. The State has not updated the amount of services and length of time in service beyond the information reported by the Reviewer in the Human Services Research Institute (HSRI) study conducted for the Reviewer in 2018<sup>28</sup>. The HSRI information showed a rapid decline in service participation after individuals moved into the community from ACHs, with a sixty percent (60%) attrition in one year. The number served actually went down, not up, after individuals moved into the community. Information reported in interviews following this finding in the FY 2018 data analysis suggests that individuals were enrolled and subsequently not seen again or found employment on their own. The final FY 2020 review will possibly yield further information about this phenomena.
3. Four (4) LME/MCOs were interviewed to discuss their progress and challenges with their contractors providing IPS-SE and ACT, regarding their employment related performance. All reported drops in enrollment during COVID, although earlier data suggests that some agencies are struggling with maintaining caseload size. Maintaining a full caseload enables the agency to meet fidelity requirements and break even financially. Even with the NC Core pilot in Vaya, two (2) of the four (4) agencies participating had an eight percent (8%) decrease in enrollment from January through June 2020; one (1) had the same size and one (1) increased by fifteen percent (15%). This trend could lead to less access for individuals in TCLI getting IPS-SE services.
4. The State has improved its process for verifying that individuals deemed “in or at risk of ACH placement” are truly at risk. The process requires one additional change (outlined in the Recommendations section) to ensure the verification process for individuals “in or at risk” is meeting the SA requirement.
5. As referenced in previous reports, LME/MCOs submit information regarding their provider network (services) in a report to the DMHDDSAS and DMA entitled “Network Adequacy and Accessibility Analysis.” These reports provide insight to both the State and the LME/MCOs perception of their compliance with network adequacy and access standards. However, these reports do not fully address the SA’s requirements for choice, access, and availability of services. Access is in part defined as the number of TCLI recipients receiving IPS-SE or ACT employment services, but it does not include individuals who want but can’t get or have not been referred to IPS-SE or to ACT employment support. Access may be related to a lack of resources for engagement, an individual’s sense of well-being and worth, and/or financing. This issue needs further exploration. There is a discussion on choice and availability below.

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<sup>28</sup> This review was covered extensively in the FY 2018 Annual Report.

6. Choice of providers continues to be a complicated challenge in rural areas. In two (2) rural areas, one (1) provider is providing services in eleven (11) counties and the other in nine (9) counties where there is no other provider. There are six (6) providers covering at least five (5) counties and six (6) providers covering three (3) counties. In a limited number of situations, two (2) providers may be serving individuals in two (2) or more of these counties. Establishing a viable team that can cover the geography, make employer visits, develop career profiles, and provide job coaching and follow up support is challenging. The services payment model rewards higher volume. This is less likely to occur in rural areas.

There are challenges in urban areas as well. In the state's largest counties, there should be a choice of at least two (2) providers to meet the demand and provide choice as required in the Settlement Agreement. Three (3) out of the ten (10) largest counties in North Carolina only have one (1) provider that meets fidelity requirements, whose office is located in the county. One (1) provider serves individuals in three (3) counties, but that provider's office is located in one (1) county. Staff travel to the other counties. This reduces the ability of the job placement specialist to increase job opportunities.

7. According to IPS standards, individuals employed must have face-to-face contact with their employment specialist (on the IPS team) at least monthly for a year or more, on average, after working steadily, if desired. IPS employment specialists also contact individuals within three days after learning of a job loss. Given this requirement, the length of time in the IPS-SE would likely be twelve (12) to twenty-four (24) months for individuals securing competitive employment. Vaya staff referenced this as a challenge with the current funding model because not enough time has elapsed since the pilot began to determine if this requirement can be met using this model.
8. The DMH has promoted the development of a provider based IPS collaborative for sharing ideas and information across the IPS provider community. This a good example of the value of peer-to-peer learning. Providers report collaboratives have been especially helpful during COVID.
9. The background section above describes the State initiating a pilot with Vaya, called NC Core, to determine the extent that closer collaboration between local DVR offices, a local LME/MCO, and SE providers, as well as a shift to a new payment model and incentives for serving individuals in the TCLI target population, could lead to critical improvements in the State's implementation of IPS-SE as described in III. D.(1) in the Settlement Agreement. This pilot officially began January 1, 2020. Due to COVID, findings are incomplete. There are many unanswered questions. The number of individuals enrolled and actively authorized for VR services increased from forty nine percent (49%) in January 2020 to seventy four percent (74%) in May 2020 before leveling off to seventy two percent (72%) in June. Due to data integration challenges, the amount of billing for each of the four (4) provider agencies

participating in the pilot is unknown but all four (4) agencies increased their overall billing by between sixteen percent (16%) and thirty two percent (32%) from May through July 2020.

10. In general, to have a viable payment model, caseloads must be full. NC Core needs some turnover, but individuals need to be employed for at least ninety (90) days to get sufficient post-employment milestone payments. In short, teams must balance their caseloads helping individuals remain employed while adding new individuals to retain a sufficient caseload size. These adjustments are critical to teams generating TCLI referrals and meeting the SA requirement to assist individuals to maintain employment. This year's review will include an assessment of these issues and a review of outcomes and other issues if they emerge.
11. DMH, DMA, and DVR data integration is key to effectively monitoring, managing, and evaluating the pilot and SE services overall. Staff reported challenges getting approval on an intra-agency agreement necessary for this data integration in March 2020.
12. DMH and DVR have encouraged other LME/MCOs to adopt the NC Core or similar models. Discussions are underway but not finalized. Vaya's staff have a great deal of cross-systems experience that gave them a good start and a working understanding of how a pilot of this type might work. This is a factor for expansion plans.
13. The State did not circulate a dashboard in FY 2020. The State circulated a dashboard for daily decision support, including IPS metrics, in prior years.
14. The DMHDDSAS contract states the MCO "shall have the authority to issue corrective action plans and sanctions against Providers who fail to meet the IPS-SE service definition, up to and including termination of the Provider's contract to participate in the MCO Network, as applicable." There were comments on this draft submitted to the State, along with a request that the State provide additional guidance to the LME/MCOs regarding meeting the Settlement requirements for this service, establishing and measuring provider performance, and evaluating the quality of service delivery. This was an outstanding question in FY 2019 and remains an outstanding question today.
15. There is not a corresponding section in the DMA contract; there are references to IPS-SE.
16. When taking all of the above findings into account it is not possible to report that the State has developed and implemented measures for individuals with SMI, who are in or at risk of entry into adult care homes, that meet their needs, especially those in the TCLI program.
17. **Supported Employment Services are provided with fidelity to an evidenced-based supported employment model for supporting people in their pursuit and maintenance of integrated, paid, competitive work opportunities (III.D.[2]).**

The State reported thirty-five (35) teams were meeting IPS-SE fidelity on June 30, 2020 (**Figure 9**). This is one (1) less team than reported in FY 2019. Four (4) agencies opened and

then quickly closed teams, two (2) other teams closed, one (1) consolidated with another team, and one (1) closed after several years of operation. One (1) other team opened and at least one (1) is waiting on a fidelity review, which was postponed. This fluctuation is an indication of a system still going through a start-up and stabilization period related to the financial and work force challenges that providers face maintaining this service.

**Figure 9: Individuals Served by IPS-SE Teams That Met Fidelity in FYs 19-20**

	# of IPS-SE Teams Meeting Fidelity <sup>29</sup> (2020/2019)	# of individuals "in or at risk" served by 6/30/2019	# of individuals "in or at risk" served by 6/30/20	% Change of individuals served
Alliance	6//6	392	474	18%
Cardinal	8//8	680	761	11%
Eastpointe	5//5	107	125	9%
Partners	2//2	93	100	9%
Sandhills	4//4	151	177	15%
Trillium	7//6	448	490	9%
Vaya	4//4	351	364	4%
Totals	36//35	2222	2491	11%

18. Overall, twenty-four (24) teams or sixty eight percent (68%) of the IPS-SE teams in North Carolina meeting fidelity are scoring in the “fair” range of fidelity in their last review<sup>30</sup>. Eight (8) or twenty three percent (23%) are scoring in the “good” range and one (1) team is scoring in the exemplary range. Of the twenty-seven teams (27) reviewed for fidelity in 2018 and 2019, twenty-four (24) scored at the same level as their previous review. Five (5) of those teams scored lower within that range than in an earlier review. Twelve (12) teams scoring in the fair range had higher scores in their previous review even though they did not move into a higher range. Three (3) teams scored at the “fair” level on their first review and one (1) team scored in the good range on their first review. Two (2) teams moved into the fair range after not meeting fidelity initially. One (1) team that had scored in the good range consistently dropped to the fair range. One (1) provider shut down their team and one (1) lost staff and closed.

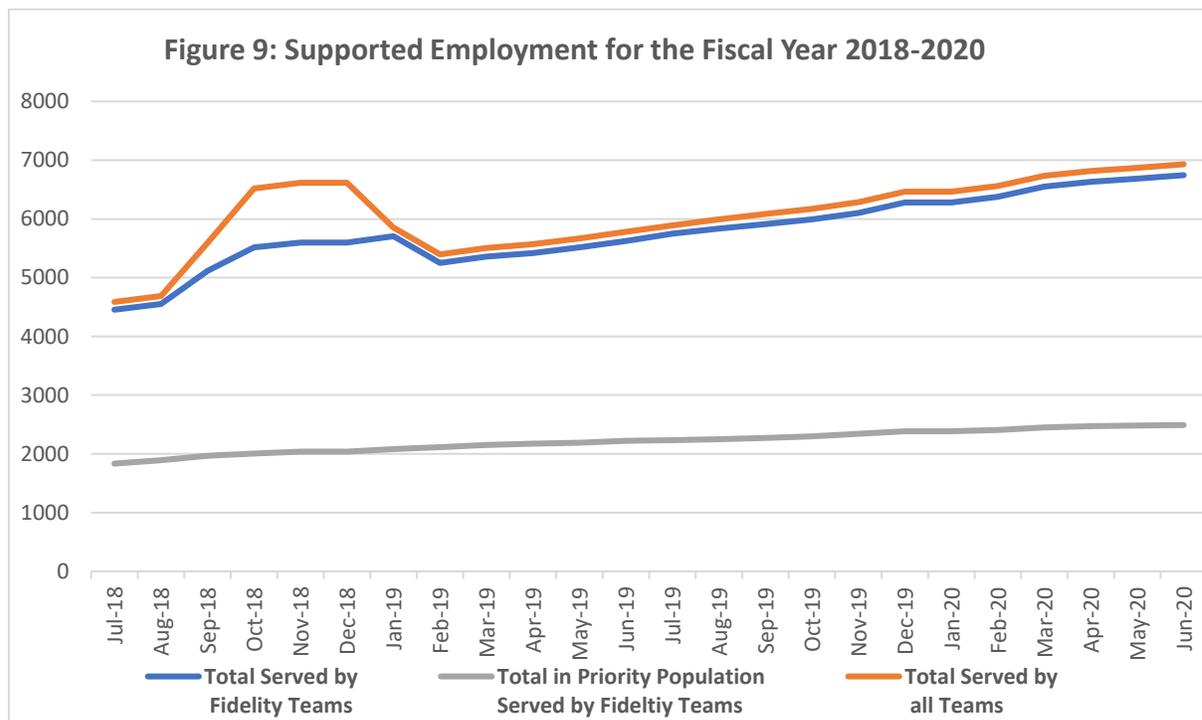
19. State claims data reveals that seven percent (7%) of TCLI recipients received at least one (1) unit of IPS-SE services in calendar year 2019, access to VR resources remains limited, and

<sup>29</sup> Comparison of numbers of teams meeting fidelity in FY 2020 compared to FY 2019.

<sup>30</sup> Reviewers conduct IPS-SE reviews for IPS-SE fidelity at least every two years or more often depending on requests and circumstances. The review totals in this Report include teams last reviewed in either FY 2018 or 2019. There were some reviews that took place in FY 2019 not scored at the time of this report so until their final score is posted their previous score is used for this calculation.

there is no evidence yet that the State is providing follow-up services as required in the SA. Based on IPS-SE reviews, frequency of contact remains at forty percent (40%) for the SE providers statewide. FY 2020 verification data reveals that fifty nine (59) or twenty two percent (22%) of individuals referred for IPS-SE who are “in or at risk of an ACH” were TCLI recipients, with the exception of Vaya recipients; sixty one percent (61%) of Vaya referrals were TCLI recipients. The State is attempting to improve measures through a pilot, NC Core, in the Vaya catchment area, that if successful would improve access and outcomes for TCLI recipients and increase provider stability overall. The State cannot demonstrate success at this point and the pilot is only occurring in one catchment area of the State. The State has improved their IPS-SE “in or at risk” verification process but the State must provide additional information for verification.

20. **The State met the requirement for the total number of individuals provided supported employment by supported employment teams meeting fidelity to the IPS-SE model by July 1, 2020.** There were two thousand four hundred and ninety-one (2,491) individuals served in FY 2020; six hundred and six (606) above the requirement for individuals served by July 1, 2020.



21. Fewer new individuals in the Agreement’s target population received IPS-SE in FY 2020 than in past years. The number of individuals “in or at risk” of Adult Care Home placement receiving IPS-SE services increased by two hundred and sixty-nine (269) or eleven percent (11%) in FY 2020. This was lower than the four hundred and seventeen (417) individuals added in FY 2019 and the six hundred and six (606) individuals added in FY 2018 (**Figure 10**).

There is not a link between the COVID pandemic and this change in individuals served based on a review of comparable months in each of the last two fiscal years. The number of referrals of individuals served by all teams and teams meeting fidelity is increasing more rapidly than is the number of individuals who are “not” at risk of ACH placement. The increase is greater for individuals “in or at risk” than individuals in the TCLI program (not shown on the chart).

There are reports from IPS staff verified by the Reviewer’s data that reimbursement structures are such that time spent to help individuals who are not in the priority population, who tend to have lower service needs, is more cost-effective for IPS-SE providers than serving individuals in the TCLI priority population and/or individuals with greater challenges returning to the workforce. DVR funds agencies serving individuals made eligible for DVR services as individuals move through a sequence of steps including career development and employment. Thus, serving individuals with fewer needs results in providers being paid on a more predictable level helping the organization with cashflow. Plus serving individuals more likely to be successful in meeting VR requirements more quickly results in greater reimbursement and VR counselors are evaluated based on the percentage of positive case closures (individuals secure employment). Likewise, mental health services reimbursement for individuals who have fewer challenges is typically better than serving individuals who have more challenges.

**(C) Recommendations**

1. Implement the four recommendations made in FY 2016-19.
  - (1) Build a strong collaborative model between the State, LMEs, service providers, and local VR offices.
  - (2) Implement an effective business model.
  - (3) Fill the IPS-SE pipeline.
  - (4) Develop and implement a targeted plan to build IPS-SE capacity where most needed in both the urban and rural areas of the state.
2. The DMH and LME/MCOs take steps to ensure individuals in the TCLI target population have the choice and opportunity for paid, competitive employment in an integrated setting. Widen and increase job choices to accommodate the needs of individuals who want to work but are worried about their stamina, their ability to ever work again, losing their benefits, or the potential stress of working given their chronic health conditions.
3. Provide active leadership and human and financial resources to further enhance the progress that has been made in implementing this valuable service in NC. Develop active plans with all stakeholders to identify strategies and mechanisms for effectively sustaining IPS-SE across the whole state. This, in turn, will spur capacity building, will stimulate better performance,

and will enable the State to meet **Section III(C)(1-4)** Community-Based Mental Health Services and **Section III (D)** Supported Employment requirements.

4. Modify “in or at risk” requirements to define homelessness more clearly and require an explanation of an individual’s homelessness.
5. Report progress on the NC CORE IPS-SE pilot in the Vaya catchment area to demonstrate that the results of the pilot will show the pilot meets SA standards as follows:
  - (1) Continued increase in TCLI referrals and eligibility rates ensuring individuals in TCLI or at risk of adult care home placement who express interest in employment are referred to IPS-SE.
  - (2) Individuals for IPS-SE and VR services receive services and supports they need, including job preparation and integrated mental health services.
  - (3) IPS-SE staff identify job opportunities consistent with the individual’s choices and individuals gain and maintain employment with individualized follow-up services for up to a year as requested.
  - (4) Ensure the milestone payment model being adopted by the State and VAYA enables providers to engage TCLI recipients including individuals “at risk of” ACH placement, to enroll them in services, provide integrated services, help prepare individuals for employment or education, identify job opportunities consistent with individuals’ choices, assist individuals to get and maintain employment, and get follow-up services for a year as requested. Make sure certain milestone payments (or adaptations of this model) are adequate, paid in intervals needed to sustain job assistance at the level required for each task and ensure adequate follow-up support and/or support when an individual loses a job or needs to change jobs.
  - (5) The State (DMH, DMA, and DVR) and Vaya demonstrate the ability to manage, monitor, and make adjustments in the model based on results, challenges, and outcomes.
6. LME/MCOs and providers in other catchment areas, with support from the State, use lessons learned from the NC Core program to create and adopt a sustainable and financially stable IPS-SE program in their area that demonstrates desired outcomes for individuals in TCLI.

### III. Discharge and Transition Process (Initial FY 2020 SPH Reviews only)

Major Categories (summarized)	Summary of Requirements	Progress Towards Compliance
<p><b>1. Section III. (E)(1)</b> The State will implement procedures for ensuring individuals with SMI in, or later admitted to, an ACH or State Psychiatric Hospitals (SPHs) or being pre-screened for admission to an ACH will be fully informed about all community based options and benefits, including the option of transitioning to SH with rental assistance.</p>	<p>a. The State’s policies and procedures<sup>31</sup> for Diversion, ACH and SPH Transition Processes meet SA requirements (including eligibility policies).                      b. SPH, LME/MCO<sup>32</sup> and service provider/ staff know and communicate the procedures and community options.                      c. Public guardians are informed of community-based options.                      d. The State will establish Transitions to Community Living (TCL) eligibility policies consistent with the SA.</p>	<p>a. The State has made progress in meeting this requirement, but further review in the fall of 2020 is necessary to determine if requirements are being met.                      b. The State developed contract language for SPH-LME/MCO contracts in FY 2019 and introduced policies and guidance to provide individuals with full information about all community-based options and benefits, including SH rental assistance.                      c. Implementation is underway but there were indications that not all the LME/MCO staff assigned to assist individuals described community-based options There was a breakdown in ensuring TCL staff were involved in discharge planning for four (4) individuals in the November 2019 review.                      d. There were indications in the November 2019 Broughton review that as many as thirty percent (30%) of individuals reviewed, and, where applicable their guardians, did not receive sufficient information to understand what community-based options are available.</p>
<p><b>2. Section III. (E)(5)</b> A transition team is responsible for the transition process. A Transition Coordinator (TC) is responsible for administering the required transition process.</p>	<p>a. A transition coordinator is responsible for leading the team and administering the required transition process.                      b. The transition process is defined and is consistent with SA requirements.                      c. The SPH transition process is jointly administered by SPH and the LME/MCO transition team (including provider).                      d. The Diversion and SPH process is completed with sufficient time to meet discharge timeframes and to make SH or “bridge housing” arrangements.</p>	<p>a-b. The State introduced new guidance in FY 2020. The final FY 2020 review is necessary to determine if the State is meeting this requirement.                      c. The SPH and LME/MCOs do not always jointly administer the discharge and transition process.                      d. Discharge planning does not always occur with sufficient time and in a manner to meet discharge timeframes and to make SH or bridge housing arrangements.</p>

<sup>31</sup> References to State’s policies and procedures also includes State- LME/MCOs contract requirements and staff job requirements.

<sup>32</sup> LME/MCO staff include any In-reach, Transition Coordinator, Care Coordinator, or other staff who have any job assignment associated with admission, discharge and/or Transition Process and provider assignment and contracting.

<p><b>3. Section III. (E)(4)</b> Transition teams include:  (1) individuals knowledgeable about resources, supports, services, and opportunities available in the community and each team includes community mental health service providers, including the primary provider; (2) professionals with subject matter expertise about accessing community mental health and community health care, therapeutic services, and other necessary services and supports; (3) persons with linguistic and cultural competence; (4) peer specialists when available; and (5) with consent, persons whose involvement is relevant to identifying strengths, needs, preferences, capabilities, and interests and to devising ways to meet them in an integrated setting.</p>	<p>Each transition team includes:  (1) individuals knowledgeable about resources, supports, services, and opportunities available in the community; each team includes community mental health service providers, including the primary provider;  (2) professionals with subject matter expertise about accessing community mental health and community health care, therapeutic services, and other necessary services and supports;  (3) persons with linguistic and cultural competence;  (4) peer specialists when available;  (5) with consent, persons whose involvement is relevant to identifying strengths, needs, preferences, capabilities, and interests and to devising ways to meet them in an integrated setting; and  (6) for individuals hospitalized at an SPH, transition teams that meet the above requirement conduct discharge planning.</p>	<p>A review of this requirement will occur prior to the submission of the final FY 2020 Annual Report.</p>
<p><b>4. Section III. (E)(2)</b> In-reach: Knowledgeable In-reach staff are assigned to: (1) provide education and information and to facilitate visits to community settings; and (2) offer opportunities to meet with other individuals with disabilities who are living, working, and receiving services with their families and with providers. Visits are to be frequent.<sup>33</sup></p>	<p>a. In-reach staff meet frequently with residents in ACHs/SPHs after the point individuals are deemed eligible for TCLI.  b. In-reach staff begin meeting with individuals being pre-screened at the point eligibility is determined.  c. In-reach staff are knowledgeable about community services and supports.  d. In-reach staff provide information and education about the TCLI process, benefits, and other information as routinely requested by individuals, their guardians, and family.  e. In-reach staff facilitate individuals’ visits to community settings as opportunities to meet other individuals with disabilities.</p>	<p>The State is not yet meeting this requirement based on interviews and chart reviews conducted in FY 2020 at Cherry and Central Regional Hospital (CRH). The fall review included additional reviews and this requirement will be reported on again in the FY 2020 Annual Report.</p>

<sup>33</sup> “Frequent” is defined as the required intervals needed to engage an individual in their decision-making process; this is less than 90 days for individuals in the contemplative stage of decision making. For individuals hospitalized at an SPH, their visits need to be more frequent if an individual’s hospital stay is likely to be less than two months. For individuals in diversion status, “frequent” needs to be adjusted to provide information for individuals before they make a decision about moving to an ACH. This is typically a short period of time, within days, not weeks or months. Transition coordinators and community providers may assist with In-reach and their contact and visits will count towards the LME meeting this requirement.

<p><b>5. Section III. (E)(3)</b> The State provides each individual with SMI in, or later admitted to an ACH or SPH (or being diverted from an ACH) with effective discharge planning and a written discharge plan<sup>34</sup>.</p>	<p>Discharge planning (includes diversion planning) assists an individual in developing a plan to achieve outcomes that promotes growth, well-being, and independence, based on their strength's, needs, goals and preferences in the most integrated setting appropriate in all domains of their life.</p>	<p>The State is not meeting this requirement. The State Psychiatric Hospitals have developed a comprehensive discharge plan, but the plan does not meet all necessary requirements.</p>
<p><b>6. Section III. (E)(6)</b> Discharge Planning begins at admission (ACH or SPH) and at which point an individual is pre-screened for admission to an ACH and made eligible for TCLI. It is based on the principle that with sufficient<sup>35</sup> services and supports, people with SMI or SPMI can live in an integrated community setting. Discharge planning assists the individual to develop an effective written plan to live independently in an integrated community setting.</p> <p>Discharge planning is developed through a person-centered planning (PCP) process in which the individual has a primary role and is based on the principle of self-determination.</p>	<p>a. The State has established the required admission point when discharge planning is to begin (admission point is within 7 calendar days of admission).</p> <p>b. The State has communicated that discharge planning is based on the principle that with sufficient services and supports, people with SMI/SPMI can live in an integrated setting.</p> <p>c. Discharge planning is developed and implemented through a PCP process that is individualized and not formulaic.</p> <p>d. The individual has a primary role in the development of their discharge plan, their expressed needs/goals are included in the plan, and the plan is based on the principle of self-determination.</p>	<p>a. The FY 2020 review revealed the State is making progress meeting this requirement although one LME/MCO appeared confused about this requirement. Further reviews are being conducted as part of the fall review and reported in the FY 2020 final Annual Report.</p> <p>b. The State has communicated this requirement, but it is not yet standard practice with SPH discharges.</p> <p>c. Based on SPH reviews in FY 2020, the State is not meeting this requirement.</p> <p>d. The State has made progress with the individual having the primary role in their discharge plan.</p>

<sup>34</sup>This is referred to as a Transition Plan for individuals exiting an ACH and Community Integration Plan for individuals in Diversion [Section III. (3)(E)].

<sup>35</sup> The SA refers to services and supports as based on the principle that with “sufficient” services and supports, an individual with SMI/SPMI can live in an integrated setting. Sufficient, in this context, will be reviewed for each individual getting services and supports they need to meet their goals, including their housing, employment, education, personal, and social goals, to have support to learn how to live in their own home and their community, and to have resources necessary to live in their own home, meet their tenancy obligations, meet their illness management needs based on past and current issues, to have the community integration opportunities, to be able to avoid or successfully deal with crises, and secure other resources and benefits as they are eligible to receive.

<p><b>7. Section III. (E)(8)</b> A written discharge plan<sup>36</sup>:</p> <p>a. identifies the individual’s strengths, preferences, needs, and desired outcomes;</p> <p>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 the services and supports are “currently” available;</p> <p>c. includes the providers that will provide the identified supports and services;</p> <p>d. documents barriers that will be addressed so the individual can move to the most integrated setting possible (barriers shall not include the individual’s disability or the severity of the disability);</p> <p>e. sets forth the transition/ discharge date, actions before, during, and after transfer and responsibilities for completing discharge/transition tasks.</p>	<p>Each individual being discharged from an SPH, exiting an ACH, or being diverted from an ACH has a written discharge/diversion plan that meets four criteria listed in the SA: (1) identifies strengths, preferences, needs, and desired outcomes and specific services and supports to meet the needs, etc. listed above, regardless of whether or not they are currently available; (2) includes the providers that will provide the identified supports and services to meet the requirements listed above; (3) documents barriers to moving or living in the most integrated setting possible that do not include the individual’s disability or severity of their disability; (4) identifies crises (precursors) that were factors in re-admissions (where this applies); (5) includes transition and discharge dates and action steps; (6) identifies responsibilities by staff/provider for each required pre-discharge, discharge, transfer, and community-based task and resource acquisition; and (7) includes the individual’s expressed needs and goals.</p> <p>These include benefits restoration/initiation, resource acquisition, and SH pre-tenancy/ move-in tasks. These responsibilities are split between hospital and community staff, are to be completed in a timely manner and with participation of the recipient and any other individual they designate who may provide support (and guardian as needed). Transportation is the responsibility of the LME/MCO and the community provider as designated by the LME/MCO.</p>	<p>The discharge plans developed by the SPHs are comprehensive and include most SA requirements. However, the LME/MCOs do not always participate in developing the plans. A further review of this item will occur prior to the submission of the final FY 2020 Annual Report.</p> <p>Responsibilities are outlined in most plans and the LME/MCO provides transportation as required.</p>
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<sup>36</sup> An SPH discharge plan and community care plan, a Community Integration Plan (CIP), a Transition Plan and a PCP have common elements. The discharge plan standard requires hospital and community plans to be consistent, not redundant (goals, action steps, and tasks, reflecting the individual’s desires and goals) where possible and with a clear transfer of care. There shall be one community-based PCP, developed by the individual’s primary provider and that includes all the planned and/or authorized behavioral health services in the community and references all the community-based PCS and health care services.

<p><b>8. Section III. (E)(9)(10)</b> The DHHS will create a transition team at the State level to assist local transition teams in addressing and overcoming identifiable barriers preventing individuals from transitioning to integrated settings.</p> <p>The team shall include individuals with lived experience and expertise in how to successfully resolve problems that arise during discharge planning and implementation of discharge plans. The team will oversee the transition teams to ensure that they effectively inform individuals of community opportunities. The team will ensure local teams are adequately trained, including training on person-centered planning. Local teams include LME/MCO and SPH leadership. Local teams address barriers to discharge planning when teams cannot agree on a plan, are having difficulty implementing a plan, or need assistance in implementing a plan.</p>	<p>The State has established a state level transition team to assist local transition teams to address and overcome barriers preventing individuals from transitioning to an integrated setting.</p> <p>The DHHS team includes individuals with lived experience and expertise in successfully resolving problems that arise during discharge planning. The DHHS will ensure adequate training for local teams including LME/MCO staff, public guardians, SPH staff, and community providers including training in person-centered planning.</p>	<p>The State is taking steps to meet this requirement. The State created a state-level Barriers Committee in FY 2019 which has demonstrated effectiveness in reducing and eliminating systemic barriers.</p> <p>A review of DHHS oversight and training of local teams will be reported in the final FY 2020 Annual Report.</p>
<p><b>9. Section III. (E)(13)(c)</b> Implementation of In-reach, Discharge and Transition Process<sup>37</sup>: Transition and discharge planning will be completed within 90 days of assignment to a transition team, provided a housing slot is available. The team will continue to work with an individual after 90 days, if a housing slot is not available within 90 days, until a slot becomes available.</p>	<ol style="list-style-type: none"> <li>1. The Transition/Discharge Planning assignment start date is consistently applied across the state and by types of transitions and discharges (SPH, ACH, and Diversion) based on DHHS policy and included in contract requirements.</li> <li>2. Discharge planning will be completed within 90 days.</li> <li>3. The Team continues to work with an individual until housing is available, if not within 90 days.</li> </ol>	<p>This requirement is primarily related to ACH and to Diversion transition planning. This requirement is being reviewed as part of the fall review and will be reported on in the final FY 2020 Annual Report.</p>

<sup>37</sup> SPH start date is at admission; ACH and Diversion start date is determined by DHHS policy but no later than when an individual first indicates they are choosing to move to the community, in the case of ACH transition, and date an individual chooses to be diverted from an ACH.

<p><b>10. Section III. (E)(13)(d)</b>                  Institutions for Mental Disease (IMD)<sup>38</sup>: The State is required to undertake four procedures with respect to individuals with SMI living in an ACH that has received a notice that it is at risk of a determination that it is an IMD, in addition to following other applicable requirements in the SA as part of priority group (B)(2)(a).</p>	<p>The State meets the requirements set forth for notification, connecting individuals with SMI who wish to transition from the “at-risk” ACH to another appropriate living setting, tracking individuals who move out of the home after the “at risk” IMD notice and providing the same In-reach, discharge, and transition processes, services, and housing requirements as set forth for other individuals eligible for TCLI resources. These individuals are considered part of Priority Group #2 (III. [B][2][A]).</p>	<p>The State will make information available in the first quarter of FY 2021 regarding this requirement.</p>
<p><b>11. Section III. (E)(14)</b> ACH Residents Bill of Rights-The State and/or LME shall monitor ACHs for compliance with the ACH Residents’ Bill of Rights requirements contained in Chapter 131D of NC Statutes and 42 C.F.R. § 438.100 (Enrollee Rights).</p>	<p>The State and/or the LME/MCO monitors ACH compliance with the ACH Bill of Rights and the C.F.R. § 438.100 requirements protecting the individual enrollee’s rights. This includes the individual’s right to privacy, to communicate privately without restrictions with individuals of their choice, to make complaints and suggestions without the fear of coercion and/or retaliation, to have flexibility to exercise choice, and to receive information on treatment options and alternatives. The State has protocols to protect the individual or LME/MCO, including defining retaliation clearly, providing the individual confidentiality, investigating complaints in a timely manner, and providing feedback to the individual and/or LME/MCO.</p>	<p>A review of this item will occur prior to the submission of the final FY 2020 Annual Report.</p>

<sup>38</sup> Institutions for Mental Disease are hospitals nursing facilities, or other institutions of more than 16 beds, that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Individuals between the ages of 21-64 are not eligible for Medicaid services in IMDs.

**(A) Background**

Discharge and Transition Process requirements apply to individuals exiting ACHs, discharged from SPHs, and potentially diverted from ACHs. The COVID pandemic interrupted the Discharge and Transition Process annual review. To minimize this disruption, record reviews and virtual interviews for individuals discharged from SPHs in May, and June 2020 were conducted with individuals discharged from Cherry Hospital and Central Regional Hospital.

Planning for a Discharge and Transition Process review of randomly selected individuals is underway for the fall of 2020 to review progress and challenges with individuals diverted from ACHs, individuals choosing to exit an ACH, and additional interviews of individuals discharged from SPHs.

The FY 2020 review process began with a review at Broughton Hospital in November of 2019 to assess if referrals are made to TCLI for all the individuals who could qualify for TCLI and also to conduct a baseline review of discharge planning prior to the State updating their guidance for SPH discharge planning.

The rationale for reviewing SPH discharges again in May and June was three-fold. One, the NC SPHs managed to minimize the impact of COVID early into the pandemic with testing, restricting staff and patient flow within the hospitals, and quarantining individuals at admission. This enabled the SPHs to continue to admit and discharge individuals during the pandemic. The overall number of SPH admissions and discharges were lower than FY 2019, but treatment and discharge planning continued without interruption. Two, arranging SPH discharge reviews through teleconferencing with SPH and LME/MCO staff accompanied with chart reviews provided a clear picture of the State's progress to meet Discharge and Transition Processes for this sub-population. Three, there were greater disruptions with non-SPH diversions, ACH in-reach, and transitions related to the spread of COVID, with NC restrictions making chart reviews less useful for review purposes.

As stated in the introduction of this Interim Report, the parties agreed to standards by March of 2020 for each SA requirement. Reviewers rated the State's performance, using the newly adopted standards for each requirement for each individual reviewed. The ratings ranged from the State fully or substantially meeting the requirement, partially meeting the requirement, inconsistently meeting the requirement, or not meeting the requirement.

Reviews took place again August and September for individuals discharged from June to early August from all three hospitals. The final FY 2020 Annual Report will include results of these reviews. This will enable the reviews to cover discharges during the same timeframe with each of the hospitals and will give the SPHs and the LME/MCOs the opportunity to better assist individuals to move to the most integrated setting of their choice with effective services and supports.

During FY 2019 the State took steps to improve the LME/MCO-SPH responsibilities for discharge and transition planning in SPH-LME/MCO contract language. In FY 2020, the State took steps to improve the LME/MCO-SPH joint discharge planning process for individuals, including issuing guidance and clarifying LME/MCO and SPH responsibilities set forth in contract language and the SA requirements for discharge planning. DHHS staff added joint charting requirements as well. The final changes took effect on March 1, 2020, days before the COVID shutdown. Shifting reviews to record performance on SA Discharge and Transition Process to the final months of FY 2020 and early FY 2021 gave the State the opportunity to implement these updated policies and procedures.

Discharge and Transition Process requirements include thirteen (13) major categories and sixteen (16) sub-categories. This review covered twelve (12) of the thirteen (13) categories. These requirements provide clear direction for the State to develop and implement effective measures to come into compliance with these provisions. A number of requirements focus on SPH discharges and ACH exits. For example, “In-reach” applies to individuals living in both types of institutions. The State added contractual requirements to SPH-LME/MCO discharge planning and established a diversion transition process in FY 2018 and FY 2019. In FY 2020, the State took a positive step to define “outreach” to apply to diversion and to clearly explain the “outreach” role.

The State has taken steps to break down discharge barriers. The State holds quarterly meetings with hospital and LME/MCO clinical leadership specifically aimed at resolving issues with complex cases. LMEs began adding nurses to transition teams to provide assessments and care management. The Special Advisor and her staff have made significant contributions to breaking down eligibility barriers and engaging multiple DHHS divisions to assist with making resources available. This has been especially helpful with Medicaid eligibility, county-to-county transfers which could otherwise result in disruptions to services, helping individuals qualify for Personal Care Assistance (PCA) and other in-home support, securing assistance for completion of FL2s, a form completed by a physician for attestation of personal care needs, skilled nursing, or Adult Care Home placement. It is used for verification that an individual has a qualifying diagnosis for TCLI.

There are additional factors to consider with the review process. The median length of stay (LOS) in the SPHs varies by hospitals. Broughton’s LOS is ninety-one (91) days, while CRH’s is sixty-eight (68) days and Cherry’s is only thirty-eight (38) days. This shows that discharge planning needs to be conducted in a much more compressed time at Cherry than at Broughton and CRH.

Another factor that impacts discharge planning is the percentage of individuals hospitalized on the Incapable to Proceed (ITP) legal status, excluding those admitted on forensic Not Guilty by Reason of Insanity (NGRI) status. DHHS’s most recent report on the number of individuals admitted to a SPH on the ITP status is in the twenty-three to twenty six percent (23-26%) range.

In each SPH discharge review cycle for the past five (5) years, there have been findings that the State has not ensured individuals in the target population and on ITP status have access to housing and supports following release from jail. The State has an opportunity to improve access to housing and supports for this population. Lower courts (District or Superior) are the primary source of referrals on the ITP status. Individuals found capable to proceed typically return to jail and are often released following a court hearing, either with credit for time served or with their charges dropped. This process creates challenges for LME/MCOs planning follow-up care. Their degree of success appears to be related to three factors: 1) the degree to which the LME/MCO has a positive working relationship with their local criminal justice system, jail staff, sheriffs, and judges; 2) the LME/MCO assigning staff to provide services and pre- and post-adjudication and post hospital discharge linkage to services and housing; and 3) the degree to which the SPH and the LME/MCOs and their providers are prepared for and assist individuals with housing and services prior to the individuals returning to jail or with charges dropped and directly discharged from the hospital.

Much of the work to improve discharge planning for individuals on ITP status is the responsibility of local initiatives and linkages. However, given the scope of this problem, it could be helpful for the State to provide assistance encouraging the justice system to work with the LME/MCOs on linkage to services and supported housing.

A review conducted of Discharge and Transition Processes at Broughton Hospital on November 12-14, 2019, provided information related to the State's Discharge and Transition Processes and information regarding referrals to the TCLI program. This review including testing out the new tool for measuring performance and implementation of policies and protocols for the required discharge and transition process. This review provided baseline information for conducting the full discharge and transition planning review in the Spring of 2020. Another aim of this review was to ask two questions regarding referrals to TCLI. Are there individuals not referred to TCLI who meet TCLI requirements and who could benefit from a TCLI referral? And are individuals referred to "unstable housing" or to homelessness and, if so, why?

The review included thirty-two (32) chart reviews of individuals hospitalized at Broughton and discharged during August and September 2019 and three (3) interviews of individuals still hospitalized, already referred to TCLI.

There were nine (9) reviews conducted on May 12 and 13, 2020, of individuals discharged from Central Regional Hospital in February and March and eight (8) reviews conducted on June 17 and 18, 2020, of individuals discharged from Cherry Hospital during the same time period. The CRH reviews included five (5) individuals assigned to the Alliance LME/MCO, two (2) individuals assigned to the Cardinal LME/MCO, and two (2) assigned to the Sandhills LME/MCO. The Cherry interviews included two (2) individuals assigned to the Eastpointe LME/MCO and three (3) individuals assigned to the Trillium LME/MCO. The findings section of this Interim Report

includes summaries of ratings for the discharge planning process, in-reach, and the discharge plan. This report does not include a section pertaining to the transition team responsibilities. The rationale for not including this rating is that the State updated its expectations for this process on March 1, 2020. The August and September reviews will cover transition team responsibilities.

**(B) Findings**

1. In FY 2020, the number of individuals discharged to TCLI and supported housing increased by twenty eight percent (28%) from FY 2019 and the number of individuals referred to ACHs decreased by thirty three percent (33%) as depicted in **Figure 11** below. Referrals to bridge housing and supported housing increased to eleven and one half percent (11.5%) of the total SPH discharges, an increase of three and two-tenths percent (3.2%) of the total discharges from FY 2019. Group home discharges also increased.

There were a number of individuals admitted from and returning to group homes in the FY 2020 review sample. There was indication in the records that the LME/MCO transition coordinators and SPH social workers did not always give individuals a choice of living in a more integrated setting and may not have taken into consideration the challenges the individual may have had living in the group home. The State has made that shift with fewer individuals discharged to ACHs from SPHs, but data shows this is not the case with discharges to group homes.

**Figure 11: SPH FY 2019-FY 2020 Discharges**

	FY 2019	FY 2020	% Change
<b>Supported Housing, including Bridge Housing<sup>39</sup></b>	75	113	+33%
<b>Adult and Family Care Homes</b>	121	93	-24%
<b>Boarding Homes, Shelters, Hotels<sup>40</sup></b>	115	80	-30%
<b>Group Homes</b>	119	145	+21%
<b>All SPH Discharges</b>	1452	1300	-10%

Forty percent (40%) of individuals in Category 4 of the SA target population appear to have moved into SH at discharge or after a brief stay in bridge housing. This means that individuals qualified for Category 4 but were not directly moving to SH. Since bridge housing is successful as a step to supported housing for a significant portion of individuals discharged from State Psychiatric Hospitals, it is likely it will result in an individual moving into supported housing. However, if not included as a supported housing placement at the point of discharge the increase in the number of individuals moving directly to supported housing would have been twelve percent (12%), not thirty-three percent (33%).

<sup>39</sup> Bridge housing identified for every month in FY 2020 but not identified in FY 2019

<sup>40</sup> This number includes one individual discharged to a camper in December 2018

2. As referenced above, the number of individuals admitted to SPHs on an ITP status is twenty-three to twenty five percent (23-25%) of the total number of admissions. The FY 2020 reviews and reviews in earlier years showed that many individuals with this status qualify for TCLI and would benefit from transition planning prior to SPH discharge and assistance prior to release from jail or release directly from a court hearing or hospital discharge. Three (3) LME/MCOs demonstrated success following individuals, working with jails and sheriffs, enabling individuals to move into SH. However, other LME/MCOs did not have this success.
3. A number of individuals in the TCLI program have public guardians. Often the Director or staff of the local county DSS agency serve in this capacity as do agency guardians appointed by local Clerks of Superior Court. State statutes define the roles and responsibilities of DHHS for guardianship. DHHS sets rules concerning guardianship and has responsibility for training on the powers and responsibilities of guardians. The DHHS has articulated that individuals be allowed to exercise their rights that are within their comprehension and to participate in all decisions affecting their lives, including their right to live in the most integrated setting possible.

Over the course of the SA implementation, a number of public and agency guardians have either refused to discuss any community living option, allowed individuals to participate in decisions or have established pre-requisite requirements for an individual to move to a community based option that were unattainable for the individual to achieve. The DHHS has consistently provided guidance to local DSS offices on their responsibilities during the course of this Agreement. There is only limited data that providing this guidance has resolved issues regarding individuals participation or consideration of the individual's right to live in the most integrated setting possible. The number of individuals discharged to adult care homes from SPHs has decreased which may be in part treatment team decisions but also to public and agency guardians agreeing to community living options. Likewise, when problems with Public Guardians failing to consider options or allowing individuals to participate is brought to the attention of DHHS leadership, these problems are resolved.

The SA does not require the public guardian to always agree to a community living option more integrated in the community than a group home or an ACH. The failure to review options disregards the potential the individual may have in their own recovery, the opportunity for the individual to improve their functioning and develop community and self-care skills, and other decision-making skills and social and personal relationships. Failure to engage in this process is disrespectful and potentially harmful to the individual. In FY 2020, reviews of records and interviews with individuals discharged from SPHs revealed two public guardians did not agree to discuss these options but neither of these problems came to the Reviewer's attention until well after decisions had been made.

4. Broughton Review

This review further substantiated earlier review findings that eligibility determination remains a persistent problem at Broughton. Records reveal discharges to “unstable housing” even though individuals met eligibility criteria and could have benefitted from the referral. Based on a record review of the twelve (12) individuals not referred to TCLI, six (6) individuals were discharged to unstable housing/homelessness, one (1) to a higher level of care without consideration of referral for a housing slot, and one (1) to a community provider without the benefit of the individual having choice of provider or a housing slot that would have entitled the individual to additional resources.

According to an SPH social worker, five days before a scheduled discharge, TCLI staff reported to the SPH social worker that “no housing is available” for an individual referred to TCLI who had been initially referred two and a half months before discharge. Likewise, there were two housing referrals made only five (5) days prior to a planned discharge. In both of these situations it did not appear there was a close working relationship between the LME/MCO staff and the SPH social worker. There was not any reference in the records of a referral to bridge housing.

One of the LMEs created additional confusion with discharge planning related to what appeared to be role confusion within the LME/MCO between TCLI and the hospital liaison. This resulted in communication problems and likely contributed to several individuals not referred to TCLI nor provided discharge planning at the level required in the Settlement. This occurred with the other two LME/MCOs but to a much lesser extent with the other two LME/MCOs.

5. Central Regional and Cherry Hospital Reviews

The CRH (May) and Cherry (June) reviews were of individuals already made eligible for TCLI prior to COVID. At CRH, reviews included five (5) individuals assigned to Alliance, two (2) assigned to Cardinal, and two (2) assigned to Sandhills. Cherry reviews included three (3) individuals assigned to Trillium and two (2) to Eastpointe. This sample is representative of SPH admissions from LME/MCO catchment areas. There was a pattern of a higher number of discharges to shelters from the Alliance area and with Central discharges overall. The Cherry and Central reviews are preliminary, not the final reviews for FY2020. These discharges occurred just prior to or at the same time the State issued its updated guidance on transition team and charting responsibilities. This preliminary review does not include transition team scores.

6. Discharge and Transition Process, In-reach, and Discharge Plan ratings for Central and Cherry Hospital discharges.

The scores for this review reflect that discharge planning generally begins at admission although the Alliance staff appeared confused about the requirements for In-reach contact. Assigned providers were not always engaged during an individual's hospitalization. There was almost no evidence of individuals provided facilitation for community visits prior to discharge. This may in part be attributable to COVID, but the State had not met this requirement prior to COVID. The level of joint planning between the LME/MCOs and hospital staff varied between the hospitals and across the LME/MCOs. The CRH staff invited joint planning and demonstrated knowledge of effective engagement, needed supports, and benefits of SH.

A number of items scored "could not determine" because there was little engagement between the SPH, LME/MCOs, and local correctional facilities and courts. The SPH staff and LME/MCOs did not always attempt to develop a viable community plan for individuals. The same was true when a public guardian refused to engage with the LME/MCO and was adamant with SPH social workers they would not consider a placement in an integrated setting. While the numbers of individuals reviewed was low, Eastpointe and Cardinal LME/MCOs both made successful attempts to work with local corrections officials to offer community options for individuals upon their release from jail.

Discharge and Planning Process: There are eleven (11) discharge and planning process requirements. For this preliminary review, similar items with similar scores are clustered into three (3) groups. The SPHs and LME/MCOs scored higher on implementing the process in a timely manner, conducting discharge planning in accordance with the principle that the individual can live in an integrated setting. Scores were lower on the SPH, public guardians, and LME/MCOs taking steps to enable individuals to live in the most integrated setting, with choice to assist them in their recovery. Scores were also lower on identification of barriers in the housing, overcoming physical and functional level barriers, resources, and re-assessing barriers to re-admission. Cherry's lower score was partly attributable to a guardian refusing to identify any barriers or to participate in a planning process of any kind and the LME/MCO being unable to get cooperation from the jail to assist the individual prior to their release. This lowered the number of individuals getting a score, which makes achieving a higher score more difficult. Central's lower scores were more related to lack of active engagement and follow through by two (2) LME/MCOs.

The reviews also reflected that individuals at Broughton and Central were more likely to be discharged to unstable housing, either because planning for other options wasn't done in a timely manner, because the individual did not engage with LME/MCO staff to choose other options, or bridge housing wasn't available or offered. Reviews also revealed the need for more focus on providing integrated substance abuse treatment, particularly for individuals in the pre-contemplative stage of recovery prior to and planned after discharge.

The Individual's Discharge Planning begins at admission (within 7 days)	
CRH: 77%	Cherry: 100%
The discharge planning process was conducted in accordance with the principle the individuals can live in an integrated setting, developed, and implemented through a person-centered planning process in which the individual has a primary role.	
CRH: 85%	Cherry: 83%
The individual's discharge planning is implemented in a manner to enable an individual to move to affordable location in a setting that can facilitate recovery.	
CRH: 48%	Cherry: 50%
Discharge planning is conducted in a manner to provide the individual assistance in their recovery.	
CRH: 59%	Cherry: 57%
The individual's discharge planning is implemented with the support of the individual's guardian, family, and other supports.	
CRH: 37%	Cherry: 80%
The planning process carried out by the transition team identifies barriers that exist for the individual but cannot consider the individual's disabling condition as a barrier. The team is taking steps to overcome barriers in the following domains: housing access, housing location, income, benefits or county of origin change, reasons for re-admission, as applicable, and other barriers.	
CRH: 52%	Cherry: 43%

In-Reach: There are four (4) In-reach requirements in the SA. The requirements for In-reach are similar and connected, so in this review they are clustered into one finding. These range from LME/MCOs arranging frequent in-reach visits to provide information and education about the benefits of SH to facilitating visits to the community with individuals with disabilities and having knowledge of and providing education about community services, supports, and resources. Scores varied widely across the LME/MCOs on this item. Since these reviews were of individuals discharged before COVID, there were fewer impediments for staff facilitating visits for individuals to the community than exist now.

In-reach is assigned to staff to provide education and information about the benefits of supported housing and to facilitate visits to such settings and offering opportunities to meet with individuals with disabilities who are living, working, and receiving services in integrated settings and visits with families and providers.	
CRH: 23%	Cherry: 90%

Discharge Plan: The Discharge Plan requirements in the Settlement Agreement are explicit and consistent with standard practice. The State has had challenges with ensuring LME/MCOs participate in establishing the discharge plan. This is generally related to the LME/MCOs and providers not taking part in developing the plan, but one chart review revealed the SPH did

not provide the LME/MCO the opportunity to participate. Reviewers found the Person-Centered Plans (PCPs) to be formulaic, lacking specificity on overcoming barriers to discharges and continued stays in unstable housing. Two PCPs revealed a disconnect between the provision of substance abuse services and mental health services. One PCP failed to reference assistance for an individual’s serious medical conditions. CRH discharge plans were comprehensive with evidence that staff sought to participate in a single plan. The ratings fall into three categories: the first identifying plan attributes; the second identifying factors to mitigate barriers so an individual can move to an integrated setting and identification of precursors to readmission; the third category identifying responsibilities and action steps prior to, during, and after discharge.

1-4. The discharge plan identifies the individual’s strengths, preferences, needs, and desired outcomes, assists the individual in developing an effective written plan to live in an integrated setting, informs the community based PCP, and identifies community based services and supports, the individual’s primary provider and other providers/ organization who are or will provide services and supports <sup>41</sup> . Note the community-based primary service provider (and care or transition coordinator when applicable) is responsible to ensure all the elements and community-based services (including mental health, substance use treatment, medical, tenancy support and other supports) of the discharge plan are implemented with the recipient in a coordinated manner.	
CRH: 56%	Cherry: 53%
5-6. The discharge documents barriers to an individual moving to the most integrated setting and how these barriers might be mitigated— <i>this cannot include the individual’s disability or severity of disability</i> —and the document identifies precursors to readmission where applicable.	
CRH: 70%	Cherry: 87%
7-8. The discharge plan includes the proposed discharge date, action steps, and responsibilities by staff/provider-prior to, during, and post-discharge and the individual has been given a copy of their discharge plan.	
CRH: 54%	Cherry: 83%

**(C) Recommendations**

1. The State, including LME/MCOs and SPHs, should fully implement the joint planning requirements set forth in the January 2020 guidance. This includes meeting the SA transition team requirements.
2. The State and each LME/MCO continue to work with each DSS to ensure public guardians

<sup>41</sup> The SA Community Based Mental Health Services specifies that all elements and components of the plan are arranged for the recipients in a coordinated manner.

participate fully in the requirements for discharge planning before making decisions that limit recovery-based services and integrated housing opportunities for individuals in the SA target population.

3. The State and LME/MCOs pursue agreements with local jails and law enforcement officials to allow LME/MCO staff, including transition coordinators and service providers, to make arrangements for visitation, planning, and SH and other supports when individuals are released from jail or following a court hearing.
4. The State, including SPHs and LME/MCOs, reduce SPH discharges to unstable housing through more timely planning and assertive engagement with individuals who may be reluctant to make a safer, more recovery oriented plan that often appears to place more demands on the individual or because the individual does not feel they will be successful living in their own home.
5. Improve substance abuse treatment for individuals in the pre-contemplative stage of recovery and include substance abuse treatment providers in discharge and community services planning. Where possible add peer support services for individuals prior to and after discharge.
6. Make bridge housing available for individuals discharged from SPHs when necessary to allow for time to make permanent housing arrangements and provide additional assistance, especially for individuals who have not lived outside of an institution for an extended period of time.
7. Ensure the individual's discharge plan informs their initial PCP and improve the PCP process and the plan itself, making sure to provide individualized services as frequently and intensively as needed.

**IV. PRE-ADMISSION SCREENING**

Major Categories	Summary of Requirements	Progress Towards Compliance
<p><b>1. Section III. (F)(1)</b> The State will refine and implement tools and training to ensure that when any individual is being considered for admission to an Adult Care Home (ACH) the State shall arrange for a determination, by an independent screener, of whether or not the individual has SMI.</p>	<p>1. The State has developed tools and training directly and through the LME/MCOs to ensure that any individual considered for admission to an ACH is evaluated for SMI.</p> <p>2. The State makes arrangements for this determination. Independent screeners make this determination when considering the individual for admission, not after they move into an ACH.</p>	<p>1. The State has made progress implementing their new pre-screening process, Referral Screening Verification Process (RSVP) and is on track to meet this requirement in FY 2021.</p> <p>2. The State has not yet ensured screening occurs before an individual moves into an ACH but has a plan to reduce this problem.</p>
<p><b>2. Section III. (F)(2)</b> The State shall connect any individual with SMI to the appropriate LME/MCO for a prompt determination of eligibility for mental health services.</p>	<p>The LME/MCO responds promptly to requests for determination of eligibility for mental health services required prior to admission of an individual to an ACH.</p>	<p>The State is on track to meet this requirement in FY 2021. LME/MCOs have reduced the number of individuals in the “pending” and in the “in process” status with the support of DHHS. They have made improvements in processing, eliminating duplications, and reducing the volume of requests for individuals who are not going to be found eligible for TCLI.</p>
<p><b>3. Section III. (F)(2)</b> Once determined eligible for mental health services the State and/or the LME/MCO will work with the individual to develop and implement a community integration plan. The individual shall be given the opportunity to participate as fully as possible in this process.</p>	<p>1. Once eligibility for mental health services is determined, individuals being considered for an ACH are provided assistance to develop and implement a community integration plan.</p> <p>2. The individual fully participates in the process.</p>	<p>Review of this item will occur after first person verifications during the fall review.</p> <p>Review of this item will occur after first person verifications during the fall review.</p>

<p><b>4. Section III. (E)(3)</b> The development and implementation of the community integration plan shall be consistent with the discharge planning provisions in Section III (E) of this Agreement.</p>	<p>The development and implementation of the community integration plan is consistent with provisions in Section III (E) of this Agreement.</p>	<p>Review of this item will occur after first person verifications during the fall review.</p>
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**(A) Background**

This is a preliminary review of the State’s progress on **Section III (F) Pre-screening and Diversion**. The review included a review of the State’s documentation of the number and disposition of pre-screenings conducted in FY 2020 to ensure that when an individual is being considered for admission to an Adult Care Home, the individual is screened to determine if they have a Serious Mental Illness (SMI) and is eligible for mental health services. The SA requires the State to work with the individual, if found eligible, to develop a community integration plan with the individual and assist the individual through the transition process (**Section III. (E)**) to choose community living or move to an ACH. The individual continues to be eligible for In-reach and transition to the community after moving to an ACH.

The State has delegated Pre-screening and Diversion operations to the LME/MCO while retaining responsibility to monitor the implementation and provide technical support and data management.

This review included an interview of DHHS staff responsible for pre-Screening and diversion and interviews with two LME/MCOs, Vaya and Sandhills. The review included an analysis of data collected on the numbers of individuals diverted, those not diverted from adult care placement, those with their names withdrawn including those found ineligible and the total number of diversion attempts in FY 2020. The review included an interview of DHHS staff who manage the pre-screening and diversion process including a review of their data collection methods, challenges, and their follow-up to ensure data integrity. Reviewers interviewed staff of two LME/MCOs who manage pre-screening and diversion, TCLI, and care coordination. Reviewers also interviewed DHHS staff and staff of each LME/MCO to determine if each organization was meeting the pre-Screening and diversion requirements and standards in the Settlement Agreement and to identify challenges and obstacles to their meeting requirements.

The review did not include any first-person verifications of individuals’ perceptions of their involvement in the process nor a review of individual specific records. The Discharge and Transition Process review includes a review of the State meeting diversion requirements per the

requirement in **Section III (F)** of the SA. The reviewer will complete first-person interviews when possible and will conduct interviews with the five (5) remaining LME/MCOs interviews to report on overall progress in the final FY 2020 Annual Review.

The State began a new process for Pre-screening in November 2018. This occurred following the recognition that the previously selected process for pre-screening and eligibility determination was seriously flawed and would not meet the SA requirement of offering real choice for individuals who were deemed eligible for an ACH of a more integrated living option or ACH placement. The State had contracted this responsibility to an independent organization whose contractors were not as knowledgeable about the living options, supported housing, and community-based services necessary to offer individuals choice. This arrangement failed to provide timely decisions and choice. Some individuals were approved for TCLI when not eligible for the program. LME/MCOs assumed In-reach responsibilities after individuals moved to ACHs but were too late to assist individuals with diversion. Often LME/MCOs had difficulty locating individuals and/or were denied the opportunity to interview individuals. The State also recognized that gatekeeping and providing options is a key role of any managed care organization. LME/MCOs have shown they are better suited to carry out Pre-screening and DHHS staff assigned to Pre-screening have played a pivotal role in this improvement.

The transition to a new process was lengthy and fraught with technical and design challenges and flaws. The DHHS provided funding for these tasks but did not provide funding based on the potential volume and pressure on LME/MCOs with a larger population base. At the time there was a significant backlog of individuals whose eligibility determinations were “in process.” This increased demand on the LME/MCOs at the point when they were trying to implement new processes. The LME/MCOs did not get the opportunity to test out the system before being required to go live, which led to some unforeseen and some predictable glitches. A number of referring organizations misinterpreted the new process, believing there was an opportunity to get a housing slot for individuals regardless of their being “at risk of” admission to an ACH.

With LME/MCO input, the State focused on improving the system, including better defining the process, taking steps to correct problems, and providing better guidance to the LME/MCOs and referring organizations. Several LME/MCOs took much needed action to work with providers, stakeholders, and referring organizations. There are still technical glitches with the RSVP software requiring the State to make corrections manually. This delays reporting which is essential to management and process improvement as well as providing data to complete this report. The State has committed the staff time to make these adjustments and corrections and has increased funding to LME/MCO with the greatest demand.

The two LME/MCOs reviewed, Sandhills and Vaya, both reported progress over the past year. Vaya continues to have a large number of individuals “in process” but also has the highest number of individuals found TCLI eligible, number of diversion attempts, and number of

individuals diverted even though they do not report the highest number of RSVP submissions. Their process flow is slightly different than the process flow followed by other LME/MCOs. They embed their RSVP functions into their Care Coordination unit functions to maximize providing options and coordination for services and resources early in the process.

Vaya staff report they are continuously making changes in their process, including team building between their Care Coordination and TCLI staff to improve communication and increase Care Coordination staff knowledge of TCLI resources and processes. They conduct nursing consultations early in the process and work diligently to provide education to public guardians and Department of Social Services staff. They reported providing sixty-seven (67) education and consultation sessions with stakeholders, referring organizations, providers, and staff during FY 2020.

**(B) Findings**

1. The State has continued to make progress implementing the new RSVP process, both in improved timeliness of response to initial requests for eligibility determination and in reducing the number of individuals in pending status.
2. This progress is significant given the start-up challenges the State and the LME/MCOs faced when initiating the new process.
3. The State has increased funding and made funding adjustments to enable the LME/MCOs to make timely and well-informed eligibility decisions, offer informed community choice, and redirect individuals not eligible for TCLI.
4. It is difficult to make comparisons between the State's FY 2019 performance and their FY 2020 performance based on different time spans, changes in reporting, and start-up challenges. The pre-screening process may begin in one fiscal year and be completed in the next year.
5. As shown in **Figure 12** below, there were four thousand eight hundred and thirty-eight (4,838) individuals referred to LME/MCOs for an adult care home placement eligibility determination between November 1, 2018, and June 30, 2020. According to DHHS, after November 1, 2018, one thousand four hundred and forty three (1443) individuals or twenty-nine percent (29%) of all referrals were found eligible and added to the Transitions to Community Living Data (TCLD) base<sup>42</sup>. This includes individuals not diverted from ACH placement as well as those diverted.
6. There have been two thousand two hundred and sixteen (2,216) individuals considered ineligible of those referred through RSVP and six thousand two hundred and one (6,201) individuals withdrawn by the State as duplicates or not entered correctly for other reasons

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<sup>42</sup> This is the data base that includes names and key information regarding the target population.

since November 1, 2018. This reveals the volume of work for the State and the LME/MCOs as they administer RSVP. This should decrease as the State identifies and corrects errors.

7. There were fourteen hundred and sixty-three individuals (1,463) admitted to ACHs rather than diverted between November 1, 2018, and June 30, 2020. However, the monthly average of those not diverted compared to those diverted has dropped by forty eight percent (48%) in FY 2020 from the FY 2019 monthly average.
8. Pending and In Process numbers dropped between FY 2019 and FY 2018, which demonstrates the LME/MCOs’ increased capacity to manage RSVP, the results of education and consultation with referring organizations and the State’s “clean-up” of duplicates, counting and coding errors.
9. LME/MCOs continue to report there were some individuals admitted to ACHs before the LME/MCOs could complete eligibility determination. Sandhills reported that twelve (12) individuals moved in to ACHs before being screened in FY 2020. This problem requires further review after additional LME/MCO reviews and before completion of the final FY 2020 report. The State is aware of this problem but developing a software solution to correct the problem fully will require more time.

**Figure 12: RSVP Referrals and Progress in Processing (November 2018-June 2020)**

	Total RSVP Referrals Submitted	RSVP Screenings Withdrawn	In Process June 19	In Process June 20	Pending June 2019 <sup>43</sup>	Pending June 2020
Alliance	1577	755	256	138 (-118)	27	1 (-26)
Cardinal	1243	2025	339	148 (-191)	157	0 (-157)
Eastpointe	761	420	23	22 (-1)	7	0 (-7)
Partners	1349	790	57	23 (-34)	34	3 (-34)
Sandhills	866	539	40	25 (-15)	108	32 (-74)
Trillium	1638	866	116	92 (-24)	31	19 (-12)
Vaya <sup>44</sup>	2114	806	221	171(-50)	11	11 (0)
<b>Total</b>	<b>11548</b>	<b>6201</b>	<b>1052</b>	<b>619 (-433)</b>	<b>288</b>	<b>66 (-77)</b>

10. Both LME/MCOs that accounted for fifty-nine process have been below the overall provider average when accounting for Eastpointe’s percentage of the state’s referral population.
11. There is a continuing need for education for referring organizations and assistance to referring organizations with regard to other services and housing options for individuals not eligible for TCLI. Public guardians have an obligation to participate in considering all living options instead of refusing to participate, insisting on ACH admission as the only option. Each

<sup>43</sup> Seven (9) months; new approach began November 1, 2018

<sup>44</sup> Vaya’s Care Coordination manages the Pre-screening process

LME/MCO should also assess the effectiveness of their training in assessing patterns of referrals after training. Vaya provides extensive education and training but it is not yet clear the degree to which other LME/MCOs are continuing to provide education and training.

12. Both Vaya and Sandhills reported immediate health needs, delays in getting paperwork to confirm individuals' disabilities, and limited options for places where individuals could live when first seen as problems they encounter working with individuals at the point they are being pre-screened. The issue of available accessible units and necessary modifications continues to surface as a delay and a deterrent to community living.
13. LME/MCOs and providers continue to voice concern that the decrease in numbers of individuals referred and found eligible for TCLI is not a reflection of there being fewer needs for supported housing and services for individuals with either a SPMI or a SMI, but rather an indication of the degree of unmet need for individuals who do not meet TCLI eligibility requirements.
- 14.** percent (59%) of the total individuals pending their initial eligibility review at Cardinal and Sandhills have reduced their pending referrals in FY 2020. They reduced the number of individuals "in process" by more than fifty percent (50%) between FY 2019 and FY 2020. Eastpointe's averages on both pending and referrals in **(C) Recommendations**
  1. Take the steps necessary to ensure that when an individual is being considered for admission to an ACH, a determination is made by an independent screener of whether or not the individual has SMI and made eligible for mental health services through the RSVP and consistent with the SA requirement in **Section III. (F)(1)**.
  2. Take additional steps necessary to ensure public guardians work with the staff assigned by the LME/MCOs to consider community options before placement in an ACH. It is recommended DHHS track incidences when this does not occur, correct the problems, and analyze patterns with guardianship agencies and local Department of Social Services "public guardians." DHHS provide education and monitor guardians and their offices to ensure this is no longer an obstacle to individuals being given support and choices in options for community living.
  3. Take steps to ensure individuals have a decent stable place to live if they choose supported housing after screening, for the time it takes for the individual to move into SH.
  4. Continue to take steps to reduce the need for manual clean-up of the pre-screening data. This will enable DHHS staff to spend more time proactively improving and managing pre-screening and diversion.