North Carolina Department of Health and Human Services: Transitions to Community Living Compliance Implementation Plan

Last Updated: August 25, 2023

NOTE: The TCL Implementation Plan is intended to be a dynamic plan that will continue to evolve as we continue to advance towards substantial compliance.

Contents

Document Purpose

The Transitions to Community Living (TCL) Implementation Plan contains the priority goals and objectives to reach substantial compliance required under the fifth modification of *The United States of America v. State of North Carolina* TCL Settlement Agreement. The TCL Implementation Plan outlines how the North Carolina Department of Health and Human Services ("NCDHHS" or "the Department" in the document) will achieve substantial compliance for the remaining components of the TCL Settlement Agreement provisions by June 30, 2025.

Accompanying Document

This document is accompanied by an excel document, *TCL Pillar Implementation Action Tasks*, which outlines detailed action tasks, timeline, milestones, and dependencies for each TCL Implementation Plan goal and underlying objectives.

Executive Summary

This section outlines the background of the fifth modification, intent and approach of the TCL Implementation Plan, high level timeline to reach substantial compliance by June 30, 2025, and key dependencies.

Background

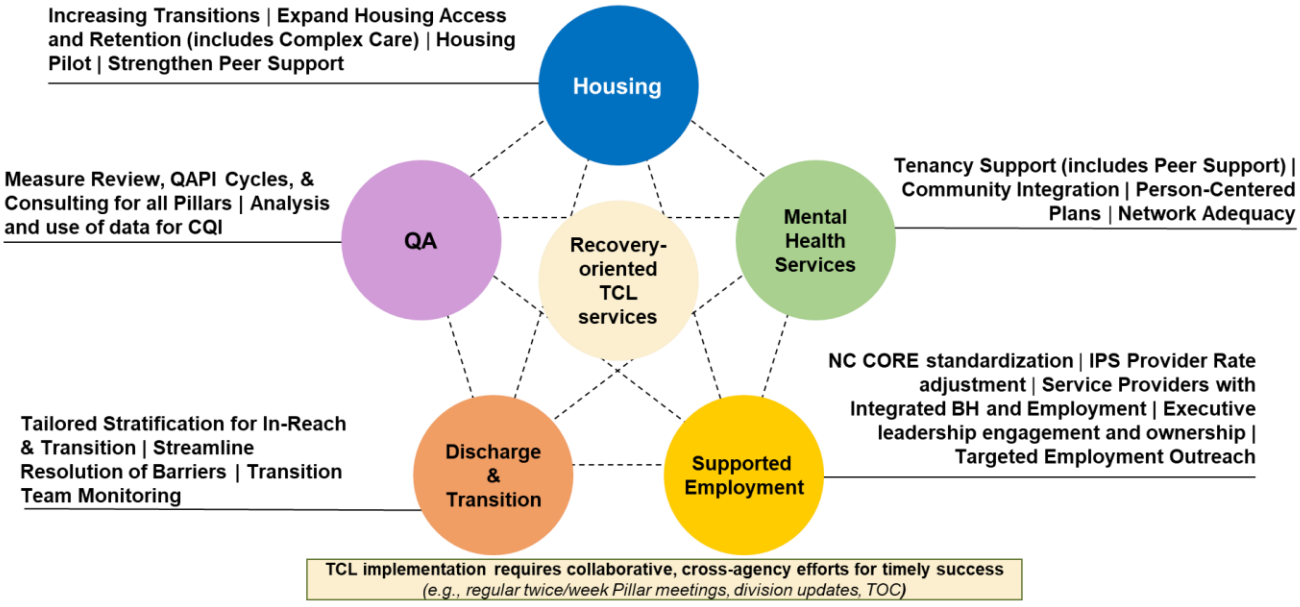
Transition to Community Living (TCL) provides eligible adults living with serious mental illnesses the opportunity to choose where they live, work, and receive services in North Carolina. The program promotes recovery through providing long-term housing, community-based services, supported employment and community integration. In response to the TCL Settlement and fifth modification, NCDHHS is required to submit a TCL Implementation Plan to the Independent Reviewer and the United States Department of Justice (USDOJ) with details of how the Department will reach substantial compliance, including timelines, key tasks, and ownership. The TCL Implementation Plan and accompanying *TCL Pillar Implementation Action Tasks* document outlines the provisions as set by the Settlement Agreement to not only meet compliance but help ensure quality, sustainable TCL service to participants beyond the Settlement Agreement period.

TCL service delivery remains a priority for the State of North Carolina and the Department, with the TCL Implementation Plan highlighting how NCDHHS will continue to build on the progress to date since the initial Settlement leading up to the June 2025 Settlement extension period.

Overview of TCL Implementation Plan Approach

The TCL Settlement Agreement between NCDHHS and the USDOJ created six pillars that provide the TCL framework. Given overlap in the ACH component between the Discharge and transition process pillar and Pre-admission screening and diversion pillar, the two pillars are included in the same TCL Implementation Plan section under **Discharge, Transition, Pre-admission, and Diversion**. The aligned goals and objectives help ensure a holistic strategic approach to ACHs for more sustainable, quality-centered care.

Highlighted below are the north stars each pillar will execute towards to reach substantial compliance:



In addition to the North Stars, below are an outline of the visions, the key strategies and progress to date by pillar.

Clicking on the Pillar information below, will bring you directly to the associated Pillars detailed overview.

① Community-Based Supported Housing:
(referred to as the "Housing" pillar)

Housing Vision:
Provide access to permanent, integrated, affordable housing for people who are TCL-eligible and choose to receive services in the community.

Priority Areas
- Increasing Transitions
- Expand Housing Access and Retention (includes Complex Care)
- Housing Pilot Program

Key Strategies
- Housing Pilot: Vaya & Alliance to build key relationships with property management companies to help identify available units sooner
- Complex Care
- Tailored Housing Stratification Approach

Progress to Date
- **3,200+** TCL individuals transition to community living
- **84%** stayed in housing for 1+ year
- Introduction of **30** RNs and OT Teams to work with individuals with high needs through Complex Care

② Community-Based Mental Health Services:
(referred to as the "Mental Health Services" pillar)

Mental Health Services Vision:
Provide access to the array and intensity of services and supports necessary to enable a person who is TCL-eligible to successfully transition and live in the community.

Priority Areas
- Tenancy Support
- Person-Centered Plans
- Network Adequacy
- Enhance Community Integrations and Peer Services

Key Strategies
- Monitor and ensure quality and effective Tenancy Support services – include milestones in the Housing Incentive Plan
- Actively engage with LME/MCOs
- Provide updated PCP training and guidance
- Monitor services network through QA processes

Progress to Date
- PCP Trainings – **1500** persons trained to date
- Implementation of collaboration between TAC/UNC – **16** teams engaged
- Community Inclusion Expansion – **5** Community Inclusion sites covering **46** counties
- Expansion of ACT and CST to cover **23** rural counties

③ Supported Employment (Individual Placement Supports): (referred to as the "Supported Employment" pillar)

Supported Employment Vision:

Provide supported employment services that assist the person to identify and maintain integrated, paid, competitive employment.

Priority Areas

- NC CORE standardization
- IPS Provider Rate adjustment
- Service Providers with Integrated BH and Employment
- Executive leadership engagement and ownership
- Targeted Employment Outreach

Key Strategies

- Collaborative approach with LME/MCOs and Providers to standardize NC CORE and increase IPS referrals
- Adjust the IPS Provider Rate
- Track IPS enrollment and CIE through incentive plan

Progress to Date

- **2,500+** Individuals receiving Supported Employment
- Increased usage of ACT Services to **5,500+** individuals at risk or in TCL
- Kicked off and conducted 6 of 7 planned NC CORE workgroups

④&⑤ Discharge, Transition, Pre-admission and Diversion (referred to as the "Discharge and Transition" pillar)

Discharge and Transition Vision:

Provide informed decision making and assistance in transitioning from a State Psychiatric Hospital (SPH) or from an Adult Care home (ACH) into permanent supported housing and drive effective diversion from entry to an ACH and movement into permanent, supported housing.

Priority Areas

- Tailored Stratification for In-Reach & Transition
- Streamline Resolution of Barriers
- Transition Team Monitoring

Key Strategies

- Prioritized stratification approach by LME/MCO based on TCL data
- Standardize Barriers resolution
- Focus on improving relationships between LME/MCOs and guardians

Progress to Date

- Informed Decision-Making tool implemented and in use for all 5 DOJ populations
- Over 4,800 total diversions

⑥ Quality Assurance (referred to as the "QA" pillar)

QA Vision:

The TCL quality assurance and performance improvement system operates to ensure that community-based placement and services are developed in accordance with the Settlement Agreement and that individuals receive services and supports they need to ensure health, safety, and welfare

Priority Areas

- Measure Review, QAPI Cycles, & Consulting for all Pillars
- Analysis and use of data for CQI

Key Strategies

- Continue to mature TCL Dashboard
- Use data to inform quality strategies and initiatives
- Resolve and escalate barriers and ad hoc quality issues

Progress to Date

- **TCL Data Dashboard** released in **SFY 2022 Q4**
- Data dashboard includes **100+** quality, performance, and outcome measures for ongoing monitoring
- Quality Assurance Committee convened in **SFY 2023 Q2**

For each of the pillars, the TCL Implementation Plan identifies actionable goals and associated objectives, milestones, metrics, and timelines to address the remaining components of the TCL Settlement Agreement. Each pillar goal is followed by the associated Settlement Agreement provision. The complete mapping of the TCL Implementation Plan goals to Settlement Agreement Provisions can be found in the Appendix.

Progress and High-Level Timeline

Figure 1 below illustrates the high-level timeline at each pillar and project management level to iteratively execute the TCL Implementation Plan leading up to the TCL Settlement deadline. The objective details are outlined in the subsequent Pillar sections, and detailed timelines are included in the accompany document.

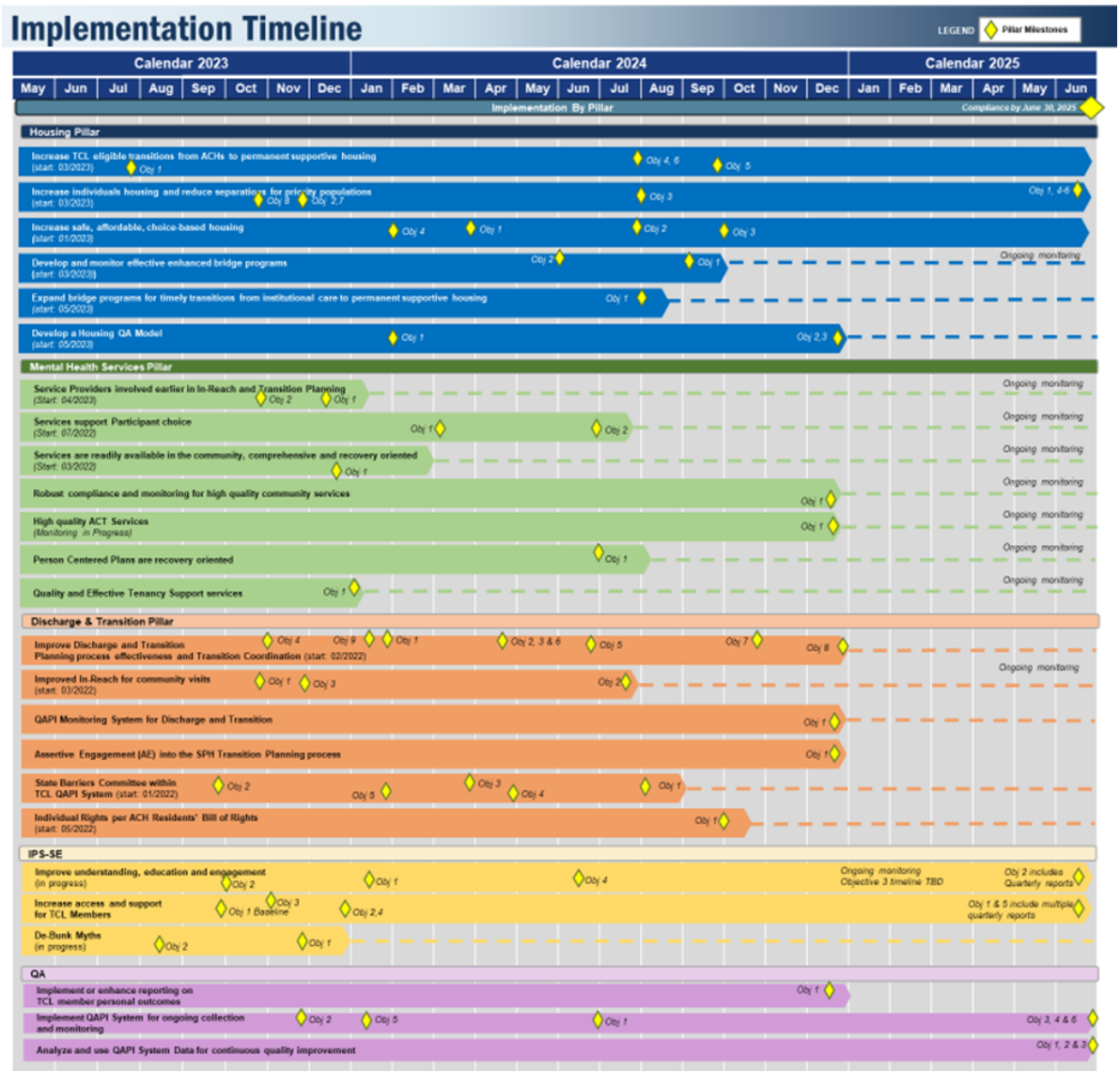


Figure 1: High-Level Pillar Timeline

Contract Amendments

Contract amendments are an important aspect of achieving consistent and timely engagement from the LME/MCOs. The amendments contractually obligate LME/MCOs to provide services consistent with the goals, objectives, and action tasks as outlined in the TCL Implementation Plan. The Department is taking the following steps to submit and execute amendments to support the TCL Implementation Plan:

- Finalize contract amendments to incorporate the requirements of LME/MCOs for the TCL Implementation Plan
- Preview and provide overview of contract amendments to LME/MCOs
- Execute contract amendments by end of Jan 2024 (Figure 2)

Figure 2: Contract Amendments Timeline

TCL Implementation Plan Dependencies

The Department is committed to both TCL compliance and quality service to TCL participants and guardians beyond the Settlement period. While the initiative is a state priority, it is important to acknowledge the critical factors required to execute the TCL Implementation Plan, which are dependent on key factors to enable operational execution. The TCL Implementation Plan is dependent upon:

- **Availability of funds and required appropriation of funds** from the State of North Carolina General Assembly
- Required **workforce to execute the TCL Implementation Plan** (Department, Providers, and LME/MCOs)
- Ongoing **collaboration/engagement by LME/MCOs** notwithstanding competing priorities
    - While the Department will incorporate LME/MCO **contract amendments** to require action tasks needed to accomplish the goals of the TCL Implementation Plan, fulfillment of some of those contractual provisions may **require additional LME/MCO funds and workforce** to reach target timelines
- LME/MCOs active **monitoring and engagement with Providers** to ensure compliance with TCL Implementation Plan requirements, including translation of requirements into LME/MCO provider contracts
- To the extent needed, the TCL Implementation Plan will adapt throughout implementation to address challenges and progress

Additional Department Staff

Given the key dependency on workforce for TCL Implementation Plan success, the Department is conducting critical evaluations of the NCDHHS TCL Team and the positions and staffing resources needed to execute the Implementation Plan. There will be a focus on expedited recruitment and onboarding of additional DHHS staff resources. The Department plans to use Temporary Solutions and other options for promptly onboarding additional personnel to help expedite hiring and onboarding of new staff resources.

Additional LME/MCO Staffing

As part of the commitment to meet Settlement compliance and sustain the TCL program, the Department is awarding key LME/MCO staffing to each LME/MCO to support successful execution of the TCL Implementation Plan. The additional staffing was based on LME/MCO and Department analysis of staffing needs to both execute the TCL Implementation Plan and sustain the program. Staffing role details and expectations can be found in the **Roles & Expectations: Key Additional LME/MCO Staff.**

TCL Implementation Plan Versioning

The TCL Implementation Plan is intended to be a living document that is subject to regular change, based on any number of circumstances, such as: meeting targets earlier than expected; failing to meet targets; receiving funding from the General Assembly or the federal government; or changing the trajectory of goals based on learned experience, or circumstances that are unaccounted for or unforeseen.

In addition to these general factors which apply to the entire TCL Implementation Plan, each Pillar section includes Pillar-specific dependencies to outline specific challenge factors related to each component of the TCL Implementation Plan.

Pillar 1: Housing

The Housing pillar focuses on permanent, integrated, affordable housing for people who are TCL-eligible and choose to live and receive services in the community. The Pillar ensures tenancy support is provided to every person with a housing slot.

Housing: Pillar Compliance Focus Areas

Since the start of the TCL Settlement Agreement, Housing has made significant progress in reaching compliance and transitioning TCL-eligible participants into permanent community housing. TCL participants have been made a priority in housing, and TCL individuals may choose the communities where they want to live. At the end of January 2023, there were 3,318 individuals currently in housing; 62.2% of all individuals placed in TCL remain in housing.

In the remaining Settlement period, Housing is in the final stages of compliance, which focuses on unique populations for ACH transition success, Complex Care expansion, tenancy rights awareness, housing transition, retention, access, and community integration. One of the Housing Pillar's top goals include establishing the work of peers for engagement purposes in ACHs and community integration efforts after the person transitions to housing.

An outline of the priority areas and their associated strategic goal can be found below:

Pillar Priorities	Associated Strategic Goal
Increasing Transitions	Goal 1: Increase TCL eligible transitions from ACHs to permanent supportive housing Goal 3: Increase safe, affordable, choice-based housing
Expand Housing Access and Retention (includes Complex Care)	Goal 2: Housing expectations for all priority populations
Housing Pilot	Goal 2: Housing expectations for all priority populations
Strengthen Peer Support	Goal 4: Develop and monitor effective enhanced bridge programs
Additional Housing Focus Areas: • **Transition Times:** Goal 5 • **QA:** Goal 6	

Housing: TCL Implementation Plan – Goals, Objectives, and Metrics

To address the remaining components of the Settlement, the Department is continuing to execute and deliver six (6) focused goals, twenty (20) underlying objectives, and tactical metrics and milestones to provide sustainable transitions to housing, tenancy, and community support, and increased Complex Care access.

Goal 1 – Increase the numbers of TCL eligible people transitioning from Adult Care Homes (ACH) to permanent supportive housing by a net of 650, by June of 2025. – (II.B; III.B.2. (a)-(e); III.B.3: III.B.5; III.E.1; III.E2) (See Services for services-related topics)	
Objective 1 – Actively engage and educate persons in ACHs through In-Reach so that they can make an informed decision about where they wish to live, work, and receive services In-Reach Informed Decision-Making Tool conversations will be evaluated by a clinical team to determine compliance and effectiveness. See Transitions Discharge/ ACHs Goal 1 Metric	**Metric** – See Transitions Discharge/ ACHs-Goal 1 Metric
Objective 2 – Improve In-Reach engagement and increase the numbers of visits to TCL eligible participants to better engage, educate, and promote community options, address barriers to community, and document and implement strategies for overcoming barriers See Transition/ Discharge Goal 2 Metric	**Metric** – See Transition/ Discharge Goals 2 Metric
Objective 3 – Improve Transition Coordination efforts that begin as early as a decision is made and leads the process from institution to transition to permanent supportive housing See Transition/ Discharge Goals 1a and 1b	**Metric** – See Transition/ Discharge Goals 1a and 1b

Objective 4 – Develop a process by which to identify individuals in the ACHs who may transition to the community more easily during the next two reporting years (fiscal years). Set a monitoring expectation of that process.	**Milestone** – Tailored Stratification Data Approach **Metric** – Performance Measures for ACHs will be monitored quarterly for priority population categories 1-3 through the Incentive Plan and against housing expectations
Objective 5 – Improve understanding and expand implementation of Complex Care initiative with providers, peers, In-Reach staff, Transition Coordinators, guardians, and DSS staff to aid in the transitioning of people from ACHs to the community who have significant and chronic health conditions and functional impairments	**Milestones** – The UNC Contract will be expanded by September 2023. TCL will monitor progress for the following contract requirements through 2023/2024: • Standard protocols and guidelines will be established and communicated with LME/MCOs by Q1 2024 • TA will be provided to RNs and OTs for all LME/MCOs with quarterly report outlining the barriers (such as staff acquisition and retention, public and/or private guardian issues, or durable medical equipment and other medical services access concerns) and resolutions • State-wide trainings twice yearly relating to supporting individuals with complex needs • Trainings will be provided to DSS and Public Guardians at a minimum of once annually • Trainings on supporting high needs individuals will be provided to LME/MCO Transition Coordinators, In-Reach, and Diversion staff • Quarterly review of outcome measurements and expectations for the Complex Care Management program

Objective 6 – Expand the use of peers to work with TCL eligible participants in ACHs who are having difficulty in making a decision or who need a peer to help envision a different life through visits to the community or with people who are leading successful lives in the community	**Metric** – MCO regions, where there is the highest concentration of ACHs by Q4 2024. This work began in Q3 2022/23 and will be completed by the end of Q4 2024 Peers will be expanded to work in ACHs in LMEs
Goal 2 – Increase the number of individuals housed, who maintain housing and reduce the number of people who separate from housing to meet housing expectations for all priority populations by June of 2025. – (III. B. 2 (a)-(e) (See also Services pillar for pre-tenancy, tenancy, and post-tenancy supports)	
Objective 1 – Housing expectations/thresholds pertaining to housing retention and separation reduction will be monitored and incentivized via the Housing Incentive Plan. Note: Including the use of Root Cause Analysis for separations related to level 3 critical incidents and/or deaths	**Metric** – Incentives will be provided for meeting performance measures that focus on improved retention of housing and reduced separations throughout the Settlement. The quarterly rate that was set during Quarter 4 is 4% **Metric** – The housing separation rate will be set annually during Quarter 4 of the previous fiscal year, and we will monitor LME/MCO progress in meeting performance standards quarterly. The previous rate was 3.3% and has been updated based on this review to 4% **Milestone** – The CCME team will review the root cause analysis conducted by LME/MCOs during their biannual reviews to ensure effectiveness beginning Q2 2023/24. Failure to conduct root cause analysis for separations that involve a death will be considered for a performance improvement plan

Objective 2 – Improve the quality and quantity of Reasonable Accommodation request submitted to support individuals receiving TCL to lease, retain tenancy, and to ensure that TCL participants are not denied tenancy solely based on criminal history	**Metric** – Increase Target/Key move-ins through increased Reasonable Accommodation letters that lead to a 70% acceptance rate after a letter is submitted by June of 2024 – North Carolina Housing Finance Agency (NCHFA) will work with DHHS. Reduce the number of denials to Supportive Housing solely based on criminal history by June 2024. Track incidents through CLIVe. DHHS will explore options to incentivize LME/MCOs to engage local legal aid to reduce denials of TCL participants based on criminal history and other barriers to tenancy **Milestone –** NCDHHS will contract with Technical Assistance Collaborative (TAC) and UNC to provide the training and follow-up support to LME/MCOs and providers to support individuals to lease and retain tenancy
Objective 3 – One hundred percent of all housing slots/units will meet Housing Quality Standards (HQS) or HUD's current approved metric, NSPIRE, for certifying units meet health, safety, and habitability standards prior to being occupied by TCL members	**Milestone** – A contract term will require that LME/MCOs complete housing inspections through a 3rd party certified inspector beginning in Q2 of SFY 2024 **Milestone** – The CCME (Carolinas Center for Medical Excellence) will complete site visits in coordination with the LME/MCOs bi-annually that will include checks of the quality and safety of units **Metric** – LME/MCOs to ensure 100% of HQS inspections are conducted by a third-party vendor certified to conduct inspections meeting HQS, or current approved HUD metric, NSPIRE, to ensure that all (100%) units are habitable, decent (livable), safe and sanitary prior to initial occupancy

Objective 4 – Reduce delays and barriers experienced by LME/MCO Housing Specialists and providers to streamline, improve and expand access to Targeted/Key units and to better support member's tenancy	**Metric** – NCDHHS, LME/MCOs and its partners will work together to initiate a pilot to promote an efficient approach to early engagement with developers and property managers, to promote the usage of the target/key units through use of the Incentive Plan. This usage target is proportional to each MCO based on total tenancies expected, and will be monitored quarterly by DHHS **Milestone** – NCDHHS/DAAS with the support of a third-party vendor will conduct an analysis and assessment of processes and practices of the Targeted Program related to access and entry into targeted units, communication protocol, and roles and responsibilities of DAAS Regional Housing Coordinators, and LME/MCO Housing Specialists in working with developers and property manager to be completed by the end of Q4 2024/2025. The purpose of this expert analysis and assessment will be to identify any systemic barriers or challenges and to inform specific improvements that can be implemented to streamline access to targeted/key units and better support members' tenancy in those units
Goal 3 – Increase access to housing that is safe, affordable, and based on choice. (Work with NCHFA to set reasonable goals and to utilize the funding sources at their disposal for growth in areas that people often choose to live with objectives and action steps for growth). – (III.B. 3. (a)-(h); III.B.9.) (NCHFA Goal)	
Objective 1 – Increase available targeted units and integrated supportive housing units in small scale developments	**Metric** – NCHFA will strive to produce approximately 500 additional Targeted units through the QAP, and 50 additional supportive housing units developed through the SHD program annually **Metric** – NCHFA will provide an updated pipeline report of targeted units and SHD-funded units every six months (FY24 and FY25)

Objective 2 – Increase rental assistance resources to ensure targeting as well as market rate units can be fully utilized	**Metric** – Targeted units subsidized with recurring key appropriation with efforts to increase from 20% to 40% (1,400 to 2,800 units) by the end of FY25 **Metric** – 811PRA implementation to result in rental assistance for an approximate 160 targeted units. NCHFA will report quarterly on unit identification and occupancy **Metric** – An approximate 425 additional TCL participants housed with TCLV each year (FY24 and FY25). NCHFA will report quarterly on number of TCL participants leasing housing with TCLV **Metric** – NCHFA will work towards developing an additional 50 TCL participants to lease housing with Mainstream and other local vouchers each year (FY24 and FY25). Report quarterly on number of TCL participants leasing housing with Mainstream and other local vouchers **Milestone** – NCHFA will pursue new Section 811 PRA funding in upcoming HUD NOFO competition in Summer 2023
Objective 3 – Increase the number of private market landlords who lease housing to TCLV holders	**Metric** – NCHFA to use CLIVe data to report quarterly on number of landlords leasing housing to TCLV holders **Metric** – The Housing Collaborative and LME/MCOs to report quarterly on landlord outreach, recruitment, and program satisfaction

Objective 4 – Increase the success rate of TCL participants applying for housing	**Metric** – NCHFA to monitor the successful use of reasonable accommodation during the application progress and report progress quarterly. Explore the use of legal aid to improve access to and retention of housing **Metric** – NCDHHS will set an expectation of a minimum of two LME/MCO staff to attend the "Train the Trainer" Housing curriculum beginning Q3 2023/24
Goal 4 – Through the Incentive Plan, develop and monitor the effectiveness of enhanced bridge programs for high needs individuals transitioning from ACHs to improve physical health management and functional skill development that leads to improved housing retention. – (II.B; III.B.2. (a)-(e); III.B.3: III. B.5; III.E.1; III.E2)	
Objective 1 – Increase enhanced bridge programs using providers and the TCL Complex Care team to assess medical, functional, and behavioral health needs	**Metric** – Enhanced bridge programs will be increased to five by the end of June 2024 with the involvement of the Complex Care team
Objective 2 – Determine the curriculum of trainings required for enhanced bridge programs to promote knowledge regarding skill development and support of high needs individuals in the community. (Completed with the online housing modules going live in Q2 2024)	**Milestone** – Trainings will be conducted by UNC on curriculum identified by end of Q3 2024
Goal 5 – Through the Incentive Plan, expand bridge programs that improve transition times from institutional care to permanent supportive housing.	

Objective 1 – Increase the availability and use of bridge housing for transition purposes from institutional setting or for At Risk TCL eligible participants to community-based housing	**Milestone** – The Housing Director will devise a plan to increase the use of bridge programs from institutions or diversions to community-based housing that will serve to decrease transition times from discharge/transition/ diversion to housing by the end of Q4 2024 **Metric** – TCL current transition times from institution or diversion to permanent supportive housing measured against national housing standards, which will be tracked through the above plan **Metric** – % of TCL individuals eligible for and agree to TCL transition discharged from an SPH into PSH or TCL Bridge Housing, including in guardian agreement cases (target: 20% for SFY 2024)
Goal 6 – Develop a Housing QA Model that includes a review of quarterly housing data, analysis of trends, reports progress and barriers to the QAC, and develops QI plans, as needed. – (III.G.1, III.G.3.g, III.G.4, III.G.7)	
Objective 1 – Data analysis will support each housing goal	**Metric** – Review data and metrics established by the Mathematica and QA team quarterly that includes: housing by priority population, retention, separations, numbers re-housed, tenure in housing by population, evictions, numbers of reasonable accommodation letters, numbers of reasonable accommodation letters that resulted in a leasehold, transition times, numbers of people in bridge housing, numbers of people in enhanced bridge housing. This data is currently tracked through system data (TCLD, CLIVe, monthly entry/exit reporting, etc.) and available in the dashboard. DHHS will coordinate with HFA regarding current tracking regarding reasonable accommodations through vacancy and referral and develop reporting required from MCOs

Objective 2 – Monitor housing activities: - Report barriers - Separation rates - Transition times - Housing retention - Keep report barriers	**Milestone** – The Housing Director will develop a quarterly report that illustrates housing performance through established performance metrics, community integration findings, transition, times, and improved housing retention **Metric** – Findings from the housing performance quarterly report that will be reported to the QAC quarterly beginning the end of Q1 2023/24
Objective 3 – Report progress to the QAC: - Communicate quarterly with the QAC on housing trends - Report quarterly on LME/MCOs compliance with housing contract terms - Report barriers that were systemic in nature and require assistance from the Transition Oversight Committee	**Metric** – Submit quarterly report beginning Q2 2023/24 to discuss housing metrics, monitoring reports, and barriers to community living **Metric** – Meet with the QAC quarterly beginning Q2 2023/24 to discuss housing metrics, monitoring reports, and barriers to community living

Housing: High-Level TCL Implementation Plan

Figure 3 illustrates the high-level Housing Pillar TCL Implementation Plan timeline. The objective milestone target date is based on the latest relevant task data, but ongoing monitoring or reporting will continue beyond Settlement Agreement period.

Figure 3: Housing High-Level Implementation Plan

Housing: Pillar Dependencies

In addition to the overall TCL Implementation Plan dependencies previously highlighted, the Housing Pillar Implementation Plan is dependent upon key factors for timely implementation, which are identified below to illustrate the dependency and impact on TCL Implementation goals.

- Reassessment of the population in Adult Care Homes post-pandemic (Note: This dependency is specifically tied to Housing Goal 1)
- Sufficient funding specifically for rental subsidies (Housing Goal 4)
- Additional staffing request for all LME/MCOs as well as state staff to implement, affect, and monitor all aspects of the pillar

Housing: Detailed Action Plan

For detailed action tasks by objective and a detailed timeline, please reference *NCDHHS TCL Pillar Implementation Plan Action Tasks* document as noted in the Appendix.

Pillar 2: Mental Health Services

The Mental Health Services pillar seeks to increase access to the array and intensity of services and supports necessary to enable a person who is TCL-eligible to successfully transition and live in the community.

Mental Health Services: Pillar Compliance Focus Areas

Robust, quality mental health services are a priority for the Department and USDOJ. The Department is actively working with LME/MCOs and Providers to meet the needs of the TCL population.

Significant progress to date includes implementation of a standardized, state-funded Assertive Engagement (AE) to enable better AE monitoring and engagement with individuals, implementation of a statewide person-centered planning training with accompanying guidance document, increased engagement with CST, ACT and TMS teams to increase technical assistance and training around tenancy supports and services.

In the next two years, **Mental Health Services** will continue to provide tenancy support, improved community inclusion and recovery-oriented services, increased intensity and frequency of community based mental health services, and improved person-centered plans.

An outline of the priority areas and the associated strategic goal can be found below:

Priority Areas	Associated Strategic Goal
Tenancy Support	Goal 7: Quality and Effective Tenancy Support Services
Community Integration	Goal 2: Services support participant choice in daily activities that enable integration with individuals without disabilities to the fullest extent possible in the community
Person-Centered Plans	Goal 6: Recovery Oriented, Strengths Based and individualized PCPs
Network Adequacy	Goal 4: Compliance and Monitoring of care and management practices
Operational Definitions	Goal 3: Services are readily available in the community, are comprehensive, and recovery-oriented
Additional Mental Health Services Focus Areas: • **Early Involvement in In-Reach and Transition Planning:** Goal 1 • **ACT Services provided by ACT teams meeting fidelity:** Goal 5	

Mental Health Services: TCL Implementation Plan – Goals, Objectives, and Metrics

To address the remaining components of the Settlement for substantial compliance, the Department is continuing to execute and deliver seven (7) focused goals, ten (10) underlying objectives, and tactical metrics and milestones to improve the service providers network, identify and reduce service barriers, and provide individualized, person-centered services.

Goal 1 – Service Providers Involved Earlier in In-Reach and Transition Planning Processes – (III.E.1., III.E.2., III.E.4.d Section III E. (3- 4 [a-d.],) (7) and (8).)	
Objective 1 – Service Providers will utilize Assertive Engagement as a short-term outreach service to individuals while institutionalized or "At Risk" of institutionalization to an ACH to connect and strengthen engagement to services that are needed to be successful in community living	**Milestone** – Assertive Engagement SFS available in all settings **Milestone** – Assertive Engagement State Funded Service rate in Diversion and In-Reach on successful engagement with community services **Metric** – AE service rate for TCL members residing in ACHs that results in successful engagement with community services (future TCL Dashboard measure)
Objective 2 – Reduce Barriers to services coordination needed for successful transition to community-based living	**Milestone** – LME/MCO contract amendment requirements updated and Communication Bulletin Issued: a. Service providers to closely coordinate with and take the lead from Transition Coordinator - Section III E. (3-5) (7-8) b. Transition Plan should be the basis for the first PCP - Section III(E) **Metric** – Number of Individuals in ACHs receiving ACT transitioning to community-based housing. **Metric** – Number of individuals in ACHs connected to IPS and other appropriate services

Goal 2 – Services support participant choice in daily activities that enable integration with individuals without disabilities to the fullest extent possible in the community – (III.B.7. (a) –(f))	
Objective 1 – Improve tenancy services offered through CST	**Metric** – Number of CST teams receiving technical assistance and trainings. Provide TA, training, and monitoring of CST teams' tenancy services through UNC/TAC collaboration. Outcomes include: increased community integration, decreased housing separations, increased connections to a peer, decreased hospitalizations and emergency department visits, and enrollment in IPS **Metric** – Number of provider staff completing Permanent Supportive Housing refresher course and number of provider staff attending additional trainings related to pre-tenancy, transition, and tenancy support. Strategy: Staff providing tenancy supports will attend trainings on evidence-based and best practices, including trauma-informed care Trainings will target providers of pre-tenancy, transition, and tenancy support and/or residential service providers. **Milestone** – Monitoring plan operationalized through CCME to measure flexibility and availability of services
Objective 2 – Expand community inclusion opportunities and connection to peer-run organizations through community integration efforts	**Metric** – Number of community events and support groups for TCL individuals implemented through NAMI NC **Metric** – Number of referrals to IPS services through CI projects

	Metric – Number of community inclusion supports provided to TCL individuals in the community **Metric** – Expand CI services by peer-run organizations and community inclusion partners statewide **Metric** – Increase the number of TCL individuals with complex issues receiving community inclusion supports **Metric** – Expanded use of Peers in ACHs (cross reference: Housing community Integration Goal 1, Objective 5 Tasks 1-10) **Milestone** – CI presentation for LME/MCOs on importance of community inclusion **Milestone** – Review and monitoring of monthly data collection from community inclusion projects
Goal 3 – Services are readily available in the community, are comprehensive, and recovery-oriented. – (III.C.1, III.C.2, III.C.4)	
Objective 1 – Provide a comprehensive service array of community mental health services	**Milestone** – QAPI plan established to monitor adequate access to and intensity of services
Objective 2 – Provide Recovery-Oriented Services	**Metric** – Increased Housing Retention through work with CST Teams (TAC/UNC IBP project) **Milestone** – Person Centered Plans are individualized and recovery-oriented
Goal 4 – Develop a compliance and monitoring system that addresses all systems of care and management practices, including clinical care, quality of life, and resident choice. – (III.C.3.a-d, III.C.4)	

Objective 1 – Develop a robust compliance and quality improvement strategy that ensures sustainable improvements	**Milestone** – Updated LME/MCO contracts that establish CQI and QAPI standardized monitoring and quality improvement process for ongoing and emerging quality and performance issues
Goal 5 – ACT services are provided by ACT teams meeting fidelity standards required in clinical policy and service definitions – (III.C.5, III.C.9)	
Objective 1 – ACT teams provide adequate services meeting fidelity standards	**Metric** – Number of individuals getting tenancy support from an ACT Team resulting in a higher number of individuals living in housing of their choice **Metric** – Number of ACT Teams meeting TMACT fidelity requirements according to ACT policy **Metric** – Percentage of time the Peer Specialist is working in their scope of responsibility
Goal 6 – Person Centered Plans are recovery oriented, strengths-based, and individualized. – (III.C.6)	
Objective 1 – Ensure that Person-Centered plans are recovery oriented, strengths-based, and individualized	**Milestone** – PCP webinar training available at no cost **Milestone** – The updated PCP guidance document and templates will be distributed to LME/MCOs **Milestone** – LME/MCOs will implement requirements consistent with PCP guidance. LME/MCOs will ensure all PCPs are recovery oriented and person-centered **Milestone** – LME/MCOs conduct annual PCP reviews as part of their monitoring requirement based on requirements in LME/MCO contracts

	Milestone – CCME will conduct an independent PCP review based on the policy guidance
Goal 7 – Quality and effective tenancy support services that enable individuals to maintain housing are provided to TCL individuals in supportive housing.	
Objective 1 – Deliver quality and effective tenancy support services to improve housing retention and increase the percentage of individuals in TCL supportive housing engaged in core services with a tenancy supports component	**Milestone** – Update Housing Incentive Plan to include a tenancy supports service provision measure, performance target, and incentive **Milestone** – Add a Tailored Plan contract requirement to provide tenancy support services for individuals in TCL supportive housing **Milestone** – Identify tenancy support services quality issues **Milestone** – Improve tenancy support services quality to reduce services separation **Metric** – Quarterly percentage of individuals in supportive housing who received any ACT, CST, or TMS. **Metric** – Housing Separation Rate

Mental Health Services: High-Level TCL Implementation Plan

Figure 4 illustrates the high-level Mental Health Services Pillar TCL Implementation Plan timeline as it targets the June 30, 2025, Settlement Agreement period. Ongoing monitoring and reporting will continue through and beyond the Settlement period.

Figure 4: Mental Health Services High-Level Implementation Plan

Mental Health Services: Pillar Dependencies

In addition to the overall TCL Implementation Plan dependencies previously highlighted, the Mental Health Services Pillar Implementation Plan is dependent upon the following key factors:

- LME/MCOs to monitor and support network adequacy, access, and high-quality services (Goal 1 and 2)
- Complete and thorough coordination between Mathematica, LME/MCO quality business units, NC Medicaid, UNC, and the Carolinas Center for Medical Excellence Review process

Mental Health Services: Detailed Action Plan

For detailed action tasks by objective and a detailed timeline, please reference *NCDHHS TCL Pillar Implementation Plan Action Tasks* document as noted in the Appendix.

Pillar 3: Supported Employment

The Supported Employment Pillar provides supported employment services that assist the person to identify and maintain integrated, paid, competitive employment.

Supported Employment: Pillar Compliance Focus Areas

Access to quality, equitable Supported Employment is critical for TCL participants to transition and sustain community living. The Pillar is proactively expanding access and support for Supported Employment.

The Department is working with all LME/MCOs to roll out an IPS Incentive Plan and monitoring quarterly the number of TCL individuals in IPS and in competitive employment. NCDHHS is moving towards a standardized NC CORE model that includes a reexamination of the rate model and associated rate floor. These are examples of sustainable changes to increase access and incentivize providers for improved individual choice. Alongside model changes, the Department is focusing on de-bunking myths on the impact of work on benefits to drive more Supported Employment engagement and usage. In addition, the Department is working with an independent expert IPS consultant and working to strategically engage executive leadership.

An outline of the priority areas and their associated strategic goals can be found below:

Priority Areas	**Associated Strategic Goal**
NC CORE Standardization	Goal 2: Increased Access and Support for Individuals to Engage in Employment and Vocation of their Choice
IPS Provider Rate adjustment	Goal 2: Increased Access and Support for Individuals to Engage in Employment and Vocation of their Choice
Service Providers with Integrated BH and Employment	Goal 2: Increased Access and Support for Individuals to Engage in Employment and Vocation of their Choice
Executive leadership engagement and ownership	Goal 1: Improve LME/MCO and provider understanding, education, engagement, and ownership of Supported Employment for TCL population
Targeted Employment Outreach	Goal 2: Increased Access and Support for Individuals to Engage in Employment and Vocation of their Choice
Additional Supported Employment Focus Areas: • **De-bunking Myths: Goal 3**	

Supported Employment: TCL Implementation Plan – Goals, Objectives, and Metrics

The Department is continuing to execute and deliver three (3) goals, eleven (11) underlying objectives, and tactical metrics and milestones to increase Supported Employment access, providers, and timely service.

Goal 1 – Improve LME/MCO and provider understanding, education, engagement, and ownership of Supported Employment for TCL population – (III.D.1., III.D.2., III.D.3. C (1))	
Objective 1 – LME/MCO and Provider executive leadership prioritizes the value of supported employment for the TCL population	**Milestone** – Awareness campaign implemented across LME/MCOs, Providers and the Department **Milestone** – Targeted leadership discussions with LME/MCO and provider executives **Milestone** – Bi-monthly meeting cadence established with LME/MCOs **Metric** – Fidelity scores **Metric** – Executive responses to Supported Employment (SE) survey
Objective 2 – LME/MCOs will implement a strategic plan for supported employment for TCL individuals	**Milestone** – LME/MCOs create a strategic plan (by EOY) including an evaluation of their existing Behavioral Health providers that may have potential to increase their array of services by adding supported employment **Milestone** – LME/MCOs demonstrate the IPS Specialist carries out the role as defined in contract language **Milestone** – LME/MCOs identify who provides training for their integrated supported employment teams **Milestone** – LME/MCOs establish a method to manage the referral pipeline and have a plan to identify and resolve capacity issues that arise **Milestone** – LME/MCOs identify how their existing Behavioral Health providers may increase their capacity **Milestone** – Demonstrated assessment of LME-MCO provider network related to both IPS provider and capacity gaps as well as potential areas to

	increase Behavioral Health/IPS integrations conducted through ongoing data analysis **Milestone** – Improving fidelity scores by corrective actions, technical assistance, or other actions **Metric** – LME/MCOs submit quarterly reports to the department for the duration of the plan
Objective 3 – Leveraging Whole Person Care, increase capacity and access to the number of recovery-oriented provider teams with integrated Behavioral Health and supported employment services	**Milestone** – Establish grant or start-up funds encouraging Behavioral Health providers to include supported employment **Metric** – Number of provider teams with integrated Behavioral Health and supported employment services with zero exclusions for employment **Metric** – Capacity of providers who integrate with Behavioral Health and supported employment services **Metric** – Each LME/MCO expands supported employment to include Multidisciplinary behavioral health provider with demonstrated success in ACT, CST or TMS
Objective 4 – Increase education, engagement, and ownership of Supported Employment by building upon strategies identified by the independent expert IPS Consultant	**Milestone** – Establish a collaborative working relationship with the independent expert IPS Consultant to help guide the execution of the supported employment and services components of the implementation plan **Milestone** – Identify strategies that align with North Carolina's structure for the provision of supported employment and Behavioral Health **Milestone** – Operationalize strategies that align with North Carolina's structure for the provision of supported employment and Behavioral Health
Goal 2 – Increased Access and Support for Individuals to Engage in Employment and Vocation of their Choice – (III.D.1., III.D.2., III.D.3. C (1))	

Objective 1 – Increase numbers of TCL participants who receive IPS services	**Metric** – Number of TCL individuals in competitive employment: (IPS Incentive Plan) a. Pre- and Community Housing IPS Service Rate b. Supportive Housing IPS Service Rate c. Supportive Housing Competitive Integrated Employment Rate **Metric** – Number of TCL individuals on ACT teams receiving services from the Employment Specialist **Metric** – TCL Individuals sustained in IPS receive on-going job supports, successful VR case closures, behavioral health provider collaboration (quarterly rotation via fidelity reviews) **Milestone** – IPS reimbursement rates sustainable for providers through utilization of services through paid claims and number of IPS providers **Milestone** – Incentive milestone in progress
Objective 2 – LME/MCO will implement NC CORE (Value Based Payment Model – IPS)	**Milestone** – CORE business model reflects improved client outcomes and streamlines service delivery **Milestone** – Develop TCL monitoring plan for IPS **Metric** – Number of teams meeting fidelity requirements
Objective 3 – IPS reimbursement rates sustainable for providers	**Milestone** – Cross divisional workgroup develops IPS rate that aligns with true cost of service **Milestone** – Updated IPS rate established
Objective 4 – As related to use of 1915(i), continue to identify and implement options to streamline employment services assessment, evaluation, and authorization process and expedite access to employment services	**Milestone** – Continued on-going efforts to overcome challenges with conflict-free case management through communications with CMS and make a final determination of approach before launch of 1915(i) option

Objective 5 – While we are continuing to promote ongoing engagement of all TCL recipients on their interest in employment, we will also conduct a targeted employment engagement campaign to capitalize on the momentum of a successful transition to housing and emphasis on resources to maintain housing for those who have remained in housing for over 6 months and those who recently transitioned (less than 6 months) Targeting these cohorts could have a significant impact on reducing recidivism.	**Milestone** – Together with the LME/MCOs, define a TCL cohort based on data to increase participation in IPS • Cohort 1 – Stable housing (over 6 months in housing) • Cohort 2 – Emerging housing (less than 6 months in housing) **Milestone** – Train/inform LME/MCOs and providers what a successful IPS referral looks like without prejudice or people with significant support needs **Milestone** – Share best practices with the LME/MCOs for a warm introduction from the integrated behavioral health team to the individual **Metric** – Number of cohort participants referred to TCL **Metric** – Number of TCL cohort participants in IPS **Metric** – Number of engagement milestones for the TCL population
Goal 3 – De-bunk the Myths around the Impact of Work on Benefits. – (III.D.1., III.D.2., III.D.3. C (1))	
Objective 1 – Improve the knowledge of LME/MCOs and providers on how to calculate benefits when considering employment	**Milestone** – DVRS releases online benefits counseling tool, DB101 **Milestone** – WIPA Staff will provide a free Statewide Information Session for LME/MCOs and providers to dispel the myths and remove the fear of losing benefits because of work (Recording available for continued use) a. Improve understanding of benefits counseling b. Improve communication with IPS service recipients **Milestone** – SSA Help desk phone # promoted: (benefits consultants are available 24/7 to help with individual work situations and calculations)

Objective 2 – Recognize Champions of IPS and SE in LME/MCOs and Provider Agencies	**Milestone** – Awards and recognition for Providers and LME/MCOs who are champions of SE/ IPS

Supported Employment: High-Level TCL Implementation Plan

Figure 5 illustrates the high-level Supported Employment Pillar Implementation Plan timeline. Ongoing monitoring or reporting will continue through and beyond the Settlement Agreement period.

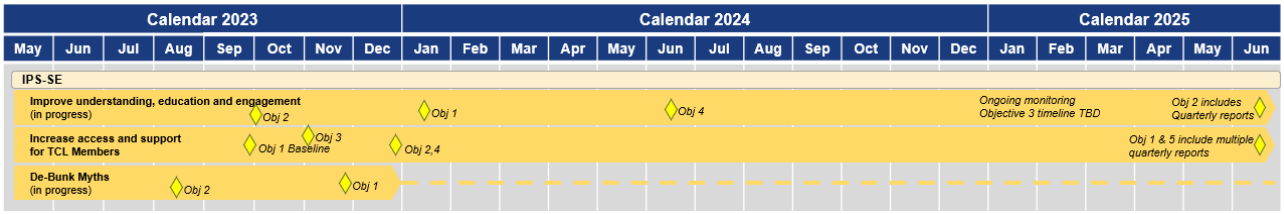


Figure 5: Supported Employment High-Level Implementation Plan

Supported Employment: Pillar Dependencies

The Supported Employment Pillar Implementation Plan dependencies are the same as overall TCL Implementation Plan dependencies previously highlighted in the **TCL Implementation Plan Dependencies** section.

Supported Employment: Detailed Action Plan

For detailed action tasks by objective and a detailed timeline, please reference *NCDHHS TCL Pillar Implementation Plan Action Tasks* document as noted in the Appendix.

Pillar 4 & 5: Discharge & Transition, Pre-admission & Diversion

The Discharge and Transition process leads to informed decision making and assistance in transitioning from a State Psychiatric Hospital or from an ACH into permanent supported housing. Pre-admission screen and diversion pre-emptively diverts entry to an ACH and moves participants into permanent, supported housing.

Discharge, Transition, Pre-admission & Diversion: Pillar Compliance Focus Areas

For Pillar success and meaningful impact, the Department is partnering with LME/MCOs to help ensure individuals and guardians are equipped with a support network and tools to transition to community living.

The Department has implemented Provider trainings, monitoring, and LME/MCO feedback on In-Reach and ACH transitions. The effort is expanded to include SPHs.

To build on progress to date, Discharge, Transition, Pre-admission, and Diversion is focused on:

Priority Areas	Associated Strategic Goal
Tailored Stratification for In-Reach & Transition	Goal 1a: Improve Discharge and Transition Goal 1b: Planning process effectiveness and Transition Coordination Goal 2: Improved In-Reach for community visits
Streamline Resolution of Barriers	Goal 5: State Barriers Committee within TCL QAPI System Goal 6: ACH Residents' Bill of Rights
Transition Team Monitoring	Goal 1a, 1b and Goal 3: QAPI Monitoring System for Discharge and Transition
Additional Discharge & Transition Focus Areas: • **Integrate Assertive Engagement:** Goal 4 • **Individualized Strategies to Address Concerns and Objectives to Community Living:** Goal 1a, 1b	

Discharge, Transition, Pre-admission & Diversion: TCL Implementation Plan – Goals, Objectives, and Metrics

The TCL Implementation Plan includes six (6) focused goals, twenty (20) underlying objectives, and tactical metrics and milestones to identify and reduce discharge barriers, sustain community living, and effectively support ACH residents and public guardians.

Goal 1a– Improve the effectiveness of the Discharge and Transition Planning Process **1b – Intensify Transition Coordination within the transition planning process. – (III.E.1., III.E.2., III.E.3., III.E.4., III.E.5., III.E.6., III.E.7., III.E.8., III.E.10, III.E.12., III.F.2, III.F.3)**	
Objective 1 – Individuals are given the opportunity and support to lead their discharge and transition planning	**Metric** – Average number of face-to-face In-Reach contacts per quarter
Objective 2 – Individuals residing in an institution/facility setting are fully informed about community-based options and benefits and barriers to transition are identified and addressed	**Metric** – Percentage of individuals confirming the opportunity to participate as fully as possible in treatment and discharge planning process (from monthly review of IDM Tools) **Metric** – Average time in TCL In-Reach status **Metric** – Percentage of individuals in In-Reach who made a yes decision **Metric** – Number of Population I-IV transitions to TCL housing
Objective 3 – Individuals at risk of entry into an Adult Care Home (ACH) are fully informed about all the available alternatives to entry into an Adult Care Home (ACH) and steps are taken to address concerns and objections to the admission	**Metric** – Diversion rate **Metric** – Number of individuals not diverted

Objective 4 – Individuals remaining in institution/facility setting are reassessed at least every 90 days	**Metric** – Average number of face-to-face in-reach contacts per quarter
Objective 5 – Transition teams are led by the individual, facilitated by the transition coordinator, include all required participants, and meet frequently enough to complete transitions within 90 days. Transition teams will specify services, service providers, and community activities based in individual's transition plan. The transition team will also set tasks and timelines for transition team members. Barriers will be resolved internally or referred to Local Barriers Committees and State Barriers Committee	**Metric** – <u>Based on desk review of sampled records:</u> Number and percentage of individuals with transition teams facilitated by the TC (POPs 1-5)
Objective 6 – Individuals have opportunities for pre-discharge/pre-transition visits outside of the facility with successfully transitioned TCL participants	**Metric** – Number of individuals with one or more pre-discharge/pre-transition community visits documented that occurred before transitioning into the community
Objective 7 – Preferences, recovery strategies, and goals documented in the In-Reach Transition to Community Living (IR/TCL) Tool are also clearly documented in the individual's transition plan which is the community services Person-Centered Plan (PCP), and if in an SPH	**Metric** – Percentage of CCPs and PCPs in biannual transition reviews with all required In-Reach Transition to Community Living (IR/TCL) Tool elements documented

also within their SPH Continuing Care Plan (CCP)	
Objective 8 – Transition and discharge planning is completed within 90 days of assignment to a transition team	**Metric** – Average number of days from housing slot approval to transition **Metric** – Percentage of individuals who transitioned within 90 days of housing slot approval
Objective 9 – Increase in-person in-reach with the individuals and their guardians especially when these public or corporate guardians are initially unwilling to allow in-reach	**Milestone** – TCL Guardianship Training for public and corporate guardians **Milestone** – Expert-led state-wide training for LME/MCOs, providers, and community stakeholders
Goal 2 – Improved In-Reach Initiation, Frequency, and Opportunities for Community Visits. – (III.E.2., III.E.4., III.E.7)	
Objective 1 – Improve the initiation and frequency of In-reach engagement	**Metric** – Individuals in In-Reach status who had a face-to-face contact (Quarterly) **Metric** – Assertive Engagement service rate for TCL members in facilities (future TCL Dashboard measure)

	Metric – Number of individuals in facilities in in-reach status with initial visit not documented within seven days (Monthly)
Objective 2 – Increase the number of Individuals who remain in facility settings and those who transition into the community that have documented facilitated visits and the opportunity for community visits to meet others with disabilities that already live, work, and receive services in the community	**Metric** – Percentage of individuals who chose to remain in facility settings, confirming the opportunity for in-reach community visits (from monthly review of Informed Decision-Making Tools)
Objective 3 – Improve In-Reach staff knowledge of community services and supports including supportive housing	**Metric** – Number of trainings per quarter that are provided to In-Reach staff by LME/MCOs, that provide education about community services and supports, including supported housing
Goal 3 – Implement QAPI monitoring system for discharge and transition that tracks data trends and develops quality improvement strategies as needed. – (III.G.4)	
Objective 1 – a – Implement tracking on numbers of facility transitions b – Implement monitoring of the quality of facility transitions and discharge through biannual desk review	**Metric** – Quarterly and annual numbers of facility transitions into the community
Goal 4 – Integrate Assertive Engagement (AE) into the facility transition planning process. – (III.E.1., III.E.2.)	

Objective 1 – Community service providers providing Assertive Engagement (AE) will engage and build rapport with members in the facility, be standing members of transition teams, complete assigned transition tasks inside the facility and in the community and be available to be tasked with directly assisting individuals in pre-transition community visitation	**Metric** – Assertive Engagement State Funded Service definition is finalized and implemented **Metric** – Percentage of TCL members in facilities who receive AE services (future TCL Dashboard measure) **Metric** – Transition rate for members who receive AE service
Goal 5 – State Barriers Committee functions within TCL QAPI System to address and resolve local and systemic barriers to SPH transitions. – (III.E.9., III.E.10., III.E.11.)	
Objective 1 – State Barriers Committee (SBC) implements standard documentation, review, analysis, and follow-up procedures to assist local transition teams in addressing identified barriers to transitions from facilities to community housing	**Metric** – Numbers of State Barriers Committee referrals received from local transition teams, numbers solved, and numbers unresolved
Objective 2 – NCDHHS will clarify expectations of the Transition Oversight Committee (TOC) to address system barriers too complex for the SBC, and offer solutions or risk management strategies	**Milestone** – NCDHHS will distribute a revised Barriers Flow to Local Barriers Committees, the State Barriers Committee, and Transition Oversight Committee
Objective 3 – The State through their Transition Oversight Committee (TOC) reviews identified barriers to facility transition to community housing on a monthly basis	**Metric** – NCDHHS annual report summary of barriers referred to monthly Transition Oversight Committee measures taken, and unresolved systemic barriers of which they remain aware for future solution consideration

and develops and implements measures to overcome problems and barriers identified and measures taken. TOC will also problem-solve or be made aware of unresolved systemic barriers unable to be solved at the State Barriers Committee.	
Objective 4 – Local Transition Teams a.k.a. Local Barriers Committees (LBCs) will have TCL Leadership, LME/MCO cross-functional leadership, local Ombudsman, and NCDHHS TCL-specific staff as standing members in these monthly committee meetings. LBCs will invite ad hoc members such as individuals, providers, and other stakeholders. The LBC will maintain an agenda with standing items in addition to current barriers, solutions, State Barriers Committee (SBC) elevations, SBC elevation updates	**Metric** – LBC will complete and send their monthly Local Barriers Tracker and monthly LBC meeting minutes for NCDHHS review and analysis through Mathematica QA system
Objective 5 – Each LME/MCO will develop and submit to NCDHHS and internally and externally train staff and TCL stakeholders in reporting TCL barriers to their LBC and elevations to the SBC	**Metric** – NCDHHS will receive Barriers Process flows from each LME/MCO **Metric** – LME/MCOs report TCL barriers to LBCs and elevate unsolved local barriers to SBC

Objective 6 – Each State Psychiatric Hospital with the active involvement of NCDHHS TCL, SPH Social Work, TCL, and DSOHF Leadership will host a semi-monthly (or more frequent as needed) SPH TCL Barriers and Solutions Committee	**Metric** – Individual and program TCL in-reach and/or transition barriers for TCL recipients will be solved within those meetings or elevated to the State Barriers Committee
Goal 6 – Each individual is free to exercise his or her rights as stated in the ACH Residents' Bill of Rights. – (III.E.14) **Appendix Reference:** ACH Barriers and Technical Assistance Overview	
Objective 1 – ACH Residents' Bill of Rights complaints are monitored and reported to the Department by all people involved with the individual	**Metric** – Number, type, and disposition of ACH complaints reported to the Departmental team of DAAS, Medicaid, DMH, and Secretary's Office through the Local Barriers Committee of each MCO who will record and submit these minutes to the Department

Discharge, Transition, Pre-admission & Diversion: High-Level TCL Implementation Plan

Figure 6 illustrates the high-level Discharge, Transition, Pre-admission, and Diversion Pillar Implementation Plan timeline. Ongoing monitoring or reporting is continuing beyond the end of the Settlement, and the objective is designated by the latest task end date.

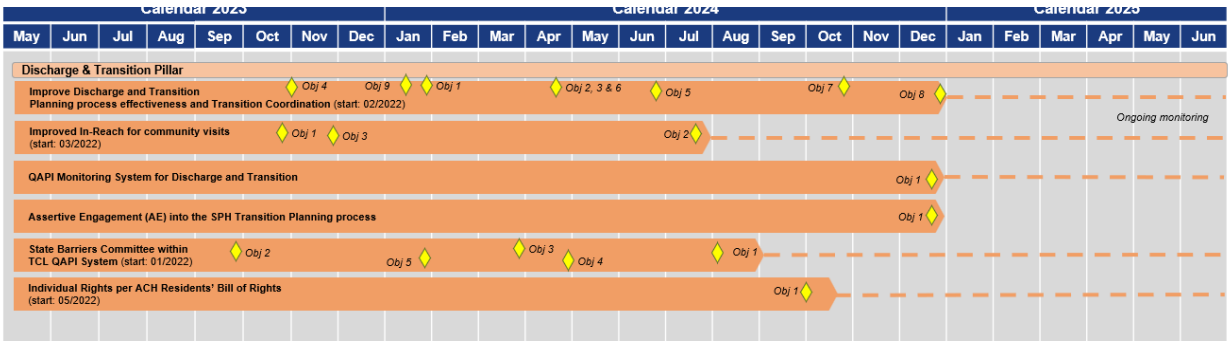


Figure 6: Discharge, Transition, Pre-admission, and Diversion High-Level Implementation Plan

Discharge, Transition, Pre-admission & Diversion: Pillar Dependencies

In addition to the overall TCL Implementation Plan dependencies previously highlighted, the Discharge, Transition, Pre-admission, and Diversion Pillar Implementation Plan is dependent upon the following key factor for timely implementation:

- Active engagement and coordination between the Department and LME/MCOs Transition Teams (Goals 1, 2, and 3)

Discharge, Transition, Pre-admission & Diversion: Detailed Action Plan

For detailed action tasks by objective and a detailed timeline, please reference *NCDHHS TCL Pillar Implementation Plan Action Tasks* document as noted in the Appendix.

Pillar 6: Quality Assurance

As an oversight pillar, QA permeates all program pillars and helps to ensure community-based placement and services are developed in accordance with the Settlement Agreement and that TCL participants receive services and supports they need to ensure health, safety, and welfare.

Quality Assurance: Pillar Compliance Focus Areas

QA involves performance measurement and monitoring, data analysis, communication and reporting, and implementation and evaluation of quality and performance improvement initiatives to drive quality improvement across the TCL service system.

The TCL Data Dashboard was released in SFY 2022 Q4 and with subsequent releases now includes more than 100 quality, performance, and outcome measures for ongoing monitoring. The TCL Quality Assurance Committee convened in November 2022 and has completed the first quality monitoring cycle, to be detailed in the upcoming release of the first TCL Quality Report.

Current activities and planning emphasize the following key objectives:

Priority Areas	Associated Strategic Goal
Measure Review, QAPI Cycles, & Consulting for all Pillars	Goal 1: Enhance reporting on TCL Member Outcomes Goal 2: Implement QAPI procedures, tools and protocols
Analysis and use of data for CQI	Goal 2: Implement QAPI procedures, tools and protocols Goal 3: Continuous Quality Improvement

Quality Assurance: TCL Implementation Plan – Goals, Objectives, and Metrics

The TCL Implementation Plan focuses on three (3) goals, ten (10) underlying objectives, and tactical metrics and milestones to drive quality monitoring and improvement across the TCL system.

Goal 1 – Implement or enhance reporting on TCL member personal outcomes. – (III.G.3.c., III.G.3.g.ii, III.G.3.g.v, III.G.3.g.vii, III.G.3.g.vi)	
Objective 1 – Operationalize and implement or expand standardized dashboard or ad hoc reporting on the following TCL member personal outcomes: a- Institutional patients' community tenure b- Repeat admissions to adult care homes c- Time spent in congregate day programming d- Maintenance of chosen living arrangement e- Number of people employed, attending school, or engaged in community life	<u>Performance Measure or Milestone</u> The following new measures and measure enhancements are implemented and available through the TC Data Dashboard and/or ad hoc analysis and reporting, and verifiable via the Dashboard, NCDHHS annual reports, and/or ad hoc reporting: Metric – TCL Priority Population I-IV members' time in TCL housing or time housed in the community without a TCL slot (Current dashboard measure; Spring 2023 dashboard release will include population group stratifier that will allow for separate reporting for institutional patients) Metric – Number of Population I-III members who separated from TCL housing and had a subsequent NCTracks ACH living arrangement code (Ad hoc measure; provisionally anticipated to be available for inclusion in SFY 2023 annual report) Metric – Time spent in Psychosocial Rehabilitation Services day program, stratified by TCL status and setting (TCL housing, community housing, in-reach/ACH, in-reach/SPH, diversion) (Planned dashboard measure; provisionally anticipated to be available for inclusion in SFY 2024 annual report) Metric – Time in TCL program status, stratified by TCL status and setting (TCL housing, community housing, in-reach/ACH, in-reach/SPH, diversion) (Current dashboard measure; Spring 2023 dashboard release will include population group stratifier that will

	allow for separate reporting for members receiving in-reach in ACHs and SPHs) Metric – Numbers of participants whose NC-TOPPS assessments indicated they: a- sustained employment or obtained newly gained employment (Current dashboard measure) b- were enrolled in educational programs. c- reported engagement in community life. (Measure a is a current dashboard measure; measures b and c are anticipated dashboard measures)
Goal 2 – Implement QAPI System procedures, tools, and protocols for ongoing data collection, monitoring, and quality improvement – (III.G.1, III.G.3.a, III.G.4)	
Objective 1 – Develop Standard Operating Procedures for performance measure and data review, analysis, and evaluation; identification of quality and performance issues; and implementation of QI actions and initiatives related to all TCL pillars	**Milestone** – Development of TCL QAPI Plan
Objective 2 – Develop, implement, and enhance data collection tools, databases and measures for monitoring and evaluation of member housing and services; In-reach, discharge, and transition; pre-screening and diversion; and member outcomes	**Milestone** – Updated versions of TCL Data Dashboard featuring new functionality and additional performance and outcome measures are released (at least one release is anticipated in FY 2024)
Objective 3 – Collect, aggregate, and communicate data on local and systemic in-reach, discharge, and community placement barriers	**Milestone** – State Barriers Committee implements summary reporting on referrals received from local transition teams and systemic barriers identified, including barriers referred to Transition Oversight Committee
Objective 4 – Conduct ongoing monitoring of key administrative, performance, and outcome measures to support quality improvement planning related to all TCL pillars	**Milestone** – TCL Quality Assurance Committee (QAC) convenes and implements QAPI Plan SOPs to support TCL SMEs in performance monitoring, identification and communication of barriers and quality issues,

	and quality improvement planning, with ad hoc activity as needed to respond to critical quality issues. **Milestone** – TCL QAC releases TCL Quality Reports detailing identified quality issues and status of active TCL QAPI projects (anticipated approximately quarterly beginning late SFY 2023/early SFY 2024)
Objective 5 – Require Tailored Plan TCL quality assurance and performance improvement processes, including member outcomes monitoring to assess and ensure the quality and sufficiency of services, and monitoring of the delivery, effectiveness, and outcomes of in-reach, discharge and transition planning, and pre-screening and diversion functions	**Milestone** – Tailored Plan contracts require LME/MCO QAPI Plans to include mechanisms for LME/MCO monitoring of providers and ensuring TCL member outcomes, service quality and sufficiency, and delivery and effectiveness of contracted TCL functions. **Milestone** – Tailored Plan QAPI Plans include monitoring mechanisms and processes related to TCL functions, services, and member outcomes
Objective 6 – Conduct ongoing monitoring of contracted PIHP/Tailored Plan TCL services and functions, including TCL QAPI processes	**Milestone** – Intradepartmental NCDHHS team conducts review of quarterly contract performance data, including TCL-stratified Tailored Plan quality measures and Departmental data on PIHP/Tailored Plan performance of contracted services and functions
Goal 3 – Analyze and use QAPI System data for continuous quality improvement. – (III.G.4, III.G.7)	
Objective 1 – Identify and implement strategies to address identified In-Reach, discharge, and community placement barriers and conduct regular review and analysis of data to assess impact of strategies implemented	**Milestone** – State Barriers Committee implements reporting on barriers resolved and open, including status and resolution of barriers referred to Transition Oversight Committee

Objective 2 – Analyze program data collected by the State, External Quality Review, and PIHPs/Tailored Plans to evaluate progress toward intended program and member outcomes related to community integration, housing stability, and institutional use	**Milestone** – State evaluates program data analysis results and identifies appropriate actions to better meet program goals where improvement is needed
Objective 3 – Implement strategies, action plans, and quality improvement initiatives to address and resolve identified barriers and performance deficits that impact member outcomes and experience	**Milestone** – QAC supports TCL SMEs with data and outcomes analysis and reporting on impacts of implemented QAPI actions and strategies **Milestone** – State communicates, addresses, and resolves identified barriers and PIHP/Tailored Plan quality and performance issues through data sharing, technical assistance, regulatory guidance, quality improvement initiatives, and/or other means as appropriate

Quality Assurance: High-Level TCL Implementation Plan

Figure 7 illustrates the high-level QA Pillar Implementation Plan timeline. The objective milestone target date is designated based on the latest task end date. Ongoing monitoring or reporting will continue beyond the end of the Settlement Agreement period.

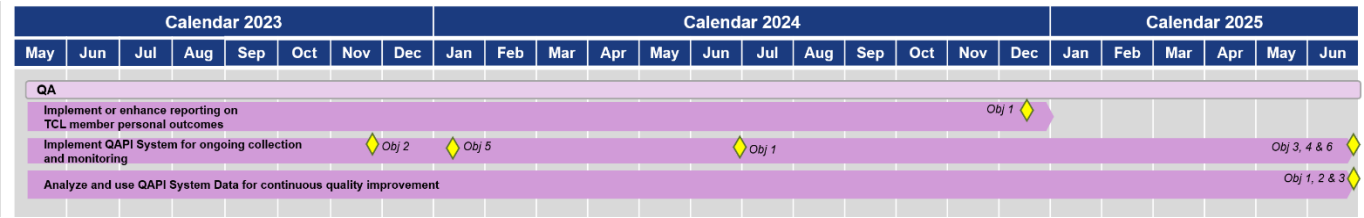


Figure 7: QA High-Level Implementation Plan

Quality Assurance: Pillar Dependencies

In addition to the overall TCL Implementation Plan dependencies previously highlighted, the QA Pillar Implementation Plan is dependent upon the following key factor for timely, successful implementation:

- Availability of additional funds for Mathematica/QA Support

Quality Assurance: Detailed Action Plan

For detailed action tasks by objective and a detailed timeline, please reference *NCDHHS TCL Pillar Implementation Plan Action Tasks* document as noted in the Appendix.

Appendix

The Appendix includes:

1. TCL Implementation Plan Goals to Settlement Provision: Detailed crosswalk of TCL Implementation Plan goals to associated Settlement Agreement Provisions and key topic areas
2. NCDHHS TCL Pillar Implementation Plan Action Tasks: Overview of the detailed Action Plan outlined in the accompanying document, NCDHHS TCL Pillar Implementation Plan Action Tasks.
3. ACH Barriers and Technical Assistance: Documentation on ACH Residents' Bill of Rights and identifying Barriers
4. Abbreviation Legend: List of abbreviations used throughout the TCL Implementation Plan

TCL Implementation Plan Goals to Settlement Provision

The goals and objectives were created based upon careful review of key factors to achieve sustainable compliance on remaining Settlement provisions. Each goal maps to Settlement provision(s) to ensure sufficient compliance to the Settlement by June 30, 2023. **Table 1. TCL Implementation Plan Goal to Settlement** crosswalks the goal to Settlement provision for compliance.

Table 1. TCL Implementation Plan Goal to Settlement Provision

Pillar Goal	Settlement Provision	Topic Area
Housing 1	**II.B; III.B.2. (a)-(e); III.B.3: III.B.5; III.E.1; III.E2**	**ACH and In-Reach Housing**
Housing 2	**III.B.7 (a-e)**	**Tenancy Support and Reducing Separations**
Housing 3	**III.B. 3. (a)-(h); III.B.9**	**Housing Choice**
Housing 4	**III.B; III.B.2. (a)-(e); III.B.3: III. B.5; III.E.1; III.E2**	**Incentive Plan**
Housing 5	N/A – *Standard Housing Practice*	**Permanent Supportive Housing**
Housing 6	**III.G.1, III.G.3.g, III.G.4, III.G.7**	**QA**
Mental Health Services 1	**III.E.1.,** III.E.**2., III.E.4.d Section III E. (3- 4 [a-d.],) (7) and (8)**	**In-Reach and Transition Planning**
Mental Health Services 2	**III.B.7. (a) –(f)**	**Tenancy Services**
Mental Health Services 3	**III.C.1, III.C.2, III.C.4**	**Array of Services**

Mental Health Services 4	**III.C.3.a-d, III.C.4**	**Community Based Services**
Mental Health Services 5	**III.C.5, III.C.9**	**ACT Services**
Mental Health Services 6	**III.C.6**	**Person-Centered Plans**
Mental Health Services 7	**III.B.7. (a) –(f)**	**Tenancy Support**
Supported Employment 1	**III.D.1., III.D.2., III.D.3. C (1)**	**LME/MCO and Provider Engagement**
Supported Employment 2	**III.D.1., III.D.2., III.D.3. C (1)**	**Supported Employment Choice**
Supported Employment 3	**III.D.1., III.D.2., III.D.3. C (1)**	**Benefits and Employment**
Discharge, Transition, Pre-admission, Diversion 1	**III.E.1., III.E.2., III.E.3., III.E.4., III.E.5., III.E.6., III.E.7., III.E.8., III.E.10, III.E.12., III.F.2, III.F.3**	**Discharge & Transition Planning**
Discharge, Transition, Pre-admission, Diversion 2	**III.E.2., III.E.4., III.E.7**	**In-Reach Engagement**
Discharge, Transition, Pre-admission, Diversion 3	**III.G.4**	**QAPI Monitoring**
Discharge, Transition, Pre-admission, Diversion 4	**III.E.1, III.E.2**	**Assertive Engagement**
Discharge, Transition, Pre-admission, Diversion 5	**III.E.9., III.E.10., III.E.11**	**State Barriers Committee**
Discharge, Transition, Pre-admission, Diversion 6	**III.E.14**	**ACH Bill of Rights**
QA 1	**III.G.3. c., III.G.3.g.ii, III.G.3.g.v, III.G.3.g.vii, III.G.3.g.vi**	**TCL Dashboard**
QA 2	**III.G.1, III.G.3.a, III.G.4**	**Ongoing Monitoring**
QA 3	**III.G.4, III.G.7**	**Continuous Quality Improvement**

NCDHHS TCL Pillar Implementation Plan Action Tasks: Detailed Action Plan by Pillar

In the *NCDHHS TCL Pillar Implementation Plan Action Tasks*, Pillars are split out on tabs. Within each Pillar tab, goals and objectives are listed for each of the goals and objectives listed in the TCL Implementation Plan document. Under each objective, Action Tasks have been

compiled by the Department to provide an initial view of the steps to complete to achieve their objectives. Action Tasks include underlying subtasks, activity planned start and end date, activity owner, dependencies, and milestones. The activities will continue to evolve as the TCL Implementation Plan execution progresses.

ACH Barriers and Technical Assistance

Last revised: April 2023

ACH Barriers	Strategies to Address ACH Barriers
ACH staff discouraging individuals from transitioning into the community	• Utilize the Resident Rights and Resource Guide for information regarding individuals' rights, how to collaborate with Ombudsman, and filing a complaint. • Refer to Resident Rights regarding violation of the following rights: • Right #1: To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. • Right #15: To have freedom to participate by choice in accessible community activities and in social, political, medical, and religious resources and to have freedom to refuse such participation. • Staff with LBC and refer to State Barriers Committee if additional support is needed. • **Link for North Carolina's Home Care Bill of Rights:** https://www.ncdhhs.gov/divisions/aging-and-adult-services/long-term-care-ombudsman-advocacy-residents-long-term-care **Ombudsman link:** https://www.ncdhhs.gov/ombud/contact **NC Dept. of Health Service Regulation (filing a complaint) link:** https://info.ncdhhs.gov/dhsr/ciu/filecomplaint.html **State Barriers Committee Email:** Olmstead.Barriers@dhhs.nc.gov

Individuals reluctant to moving into PSH due staff coercion and/or not wanting to include ACH staff in the TCL process due to fear of retaliation	• Refer to Resident Rights regarding violation of the following rights:
	  ○ Right #4: To be free of mental and physical abuse, neglect, and exploitation.
	  ○ Right #11: To be encouraged to exercise his or her rights as a resident and citizen, and to be permitted to make complaints and suggestions without fear of coercion or retaliation.
	• Review with supervisor.
	• Educate individuals about Ombudsman and provide contact information.
	• Contact Ombudsman for assistance.
	• Assist individuals with contacting Ombudsman, as requested.
	• Staff with LBC and refer to State Barriers Committee if additional support is needed.

ACH staff being resistant to assist TCL staff with performance of In-Reach/Transition roles	• Discuss internally with supervisors and executive leadership to formulate a plan for educating ACHs.
	• Develop internal standardize protocol for IR/Transition processes utilizing ACH transition planning best practices, such as:
	  ○ Send NCDHHS letter to facility before TCL staff go for the 1st visit.
	  ○ Confirm and comply with facility visitation protocols, scheduling, etc.
	  ○ Upon entrance to facility, sign in if required, introduce self and role in TCL.
	  ○ Refer to Resident Rights regarding violation of Right #8: To associate and communicate privately and without restriction with people and groups of his or her own choice on his or her own or their initiative at any reasonable hour.
	• Staff with LBC and refer to State Barriers Committee if additional support is needed

Challenges with ACHs supporting linkage to community providers	• Refer to Resident Rights regarding violation of Right #2: To receive care and services which are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations. • Review with supervisor. • Educate individuals about Ombudsman and provide contact information. • Contact Ombudsman for assistance. • Assist individuals with contacting Ombudsman, as requested. • Staff with LBC and refer to State Barriers Committee if additional support is needed.

Difficulty communicating with ACHs by phone to schedule visits and confirm visitation protocols	• Document calls to ACH, providing details of all attempted contacts. • Refer to Resident Rights regarding violation of Right #9: To have access at any reasonable hour to a telephone where he or she may speak privately. • Visit facility in-person to talk with ACH staff and schedule a time to visit individuals. • If communication difficulties continue, staff internally and refer to LBC. Then refer to State Barriers Committee if additional support is needed.
Individuals at ACHs reporting they are not receiving TCL letters	• LME/MCOs should only send letters initially to individuals and/or guardians. It is recommended to send certified to track receipt of letter. • Refer to Resident Rights regarding violation of Right #10: To send and receive mail promptly and unopened, unless the resident requests that someone open and read mail, and to have access at his or her expense to writing instruments, stationary, and postage. • Staff with LBC and refer to State Barriers Committee if additional support is needed.
Difficulty obtaining LME/MCO requested documentation from ACH	• Follow LME/MCO internal process for obtaining documents. • If ACH staff report an individual has a guardian and declines to provide information, refer to NCDHHS TCL Letter (see TCL link below) which specifies ACHs are to assist with providing guardianship information. If ACH continues to not comply with providing guardianship information, contact Ombudsman for next steps. • NCDHHS TCL Letter link: https://www.ncdhhs.gov/about/department-initiatives/transitions-community-living • FL2s are not a state required document – continue to engage with individual until confirmation of diagnosis is obtained. • Utilize ROI to obtain diagnostic information (i.e., CCA) from health provider(s). • Staff with LBC and refer to State Barriers Committee if additional support is needed.

Roles & Expectations: Key Additional LME/MCO Staff

Below are the key roles provided by the Department to LME/MCOs for additional staff. The specific number by role is tailored to each LME/MCO expectation and analyzed need. The Department will require the roles to be filled by November 30 to the extent feasible for timely support and ramp up of staff to support meeting substantial compliance.

Existing LME/MCO Staff Roles:

1. Transition Coordinator
2. Transition Coordinator Supervisor
3. In-Reach Specialist
4. In-Reach Supervisor
5. Housing Supervisor
6. TCL Program Manager

New Staff Roles Included Based on TCL Implementation Plan and Sustainability (role expectations detailed):

1. Outreach Diversion Specialist
2. Supported Employment Specialist
3. Housing Development Coordinator
4. Quality Assurance Specialist
5. Data Analyst
6. Barriers & Training Coordinator

Outreach Diversion Specialist	
Description	NC Peer Support Specialists with experience working with adults with SMI/SPMI on eliciting choices, preferences, and vision to obtain the social determinants of health serving recovery including but not limited to housing, competitive employment/education, community activity, financial and food security, and pro-recovery relationships.
Key Responsibilities:	Applying the skills outlined above to Transitions to Community Living (TCL) for individuals being considered for admission into an Adult Care Home (ACH) through the Referral Screening Verification Process (RSVP) would include: • Educating the recipient (and their family, as appropriate) on the choice to the remain in the community) • Providing referrals and linkages to available individualized community-based supports and services • Developing a Community Integration Plan for those who choose to remain in the community

Outreach Diversion Specialist	
	• Fully inform individuals/guardians about all the available alternatives to entry into an ACH and steps are taken to address concerns and objections to the admission

Supported Employment Specialist	
Description	At minimum, a bachelor's prepared individual with at least two years of experience working with adults with SMI/SPMI obtaining competitive employment preferably utilizing Individual Placement and Supports (IPS), Vocational Rehabilitation, or other research-based nationally recognized employment model. They play a central role in Improve access to the IPS service by educating and working with In-Reach/Transitions/Post-transition and CST/TMS providers to remove barriers and monitor referrals and successful enrollments.
Key Responsibilities:	Applying the skills outlined above to those eligible for Transitions to Community Living would include but not be limited to the following: • As the LME/MCO's point of contact, collaborate, and implement statewide Departmental efforts to expand, improve, and standardize IPS service models such as NC CORE • Assertively develop new Individual Placement and Support Supported Employment (IPS-SE) providers and provide technical assistance in the integration with of conversion from a fee-for-service IPS model into a milestone payment model such as NC CORE • Provide direct technical assistance to sustain existing IPS providers by working within the LME/MCO to implement a stable NC CORE payment model standardized by the Department • Review all provider's current UNC Institute for Best Practices IPS Fidelity Reviews, technically assist providers with recommended improvements, develop plans of correction for long-standing provider fidelity issues, and when required by reviewers assist during IPS Fidelity Reviews • Facilitate, technically support, and invite trainers to in-network IPS Collaboratives that include ACT Employment Specialists, and Peer-run Entities involved in IPS support, and participate in the IPS Steering Committee, if appointed • Ensure and improve providers' NC CORE linkage to Vocational Rehabilitation (VR) offices throughout their catchment, attend key statewide VR meetings, invite VR offices into IPS collaboratives, and assertively engage VR regional leadership to problem-solve and improve NC CORE service to TCL members • Facilitate the expansion of benefits counseling within network providers, improve VR benefits counseling linkage, and when possible, improve relationships with Social Security Administration offices and IPS providers • Serve as the point of contact with the Department for meetings involving the statewide benefits counseling electronic system

Supported Employment Specialist	
	• Maintain the departmentally required TCL IPS data in conjunction with Quality Assurance and/or other related cross-functional LME/MCO departments • Actively participate in local, regional, and statewide job development efforts with businesses and corporations wanting to competitively employ individuals with SMI/SPMI and link those efforts to their IPS providers' workforce of the individuals they serve • Assist linkage between community colleges, universities, employer internships/apprenticeships, with IPS providers increasing TCL individuals' access to supported education, technical training, job certification, internships, and apprenticeships • As opportunities arise, facilitate network development of other researched-based supported employment models aligned with the Settlement Agreement such as Customized Employment, Microenterprise, and similar nationally recognized models

Housing Development Coordinator	
Description	A bachelor's prepared individual with a least two years of experience working with individuals and the housing systems serving people with SMI/SMPI obtaining and maintaining permanent supportive housing (PSH).
Key Responsibilities:	This position would apply the skills outlined above to the development of Olmstead-compliant PSH within the LME/MCO catchment whose duties would include but not be limited to the following: • With the LME/MCO Director of Housing, map existing PSH, PSH utilized by housed TCL individuals, and requested housing locations of TCL individual currently in pre-transition process • Utilize the map and other information sources to develop plans to target new stock development or access to untapped existing stock within the catchment • Engaging public housing authorities (PHAs), Continuums of Care (COCs), and Balance of State (BoS) with LME/MCO, NCHFA, grant, and other housing resources to develop housing stock and access throughout the LME/MCO catchment • Developing regional housing databases for the LME/MCO's catchment connecting public stock with private housing options for TCL staff • Utilizing public notices of newly initiated housing developments, assertively engage private developers linking them with LME/MCO, NCHFA, HUD, and other resources for tax credit, bond, loan assistance, and rehabilitation in exchange for disability access agreements • Technically assist existing TCL staff and TCL provider engagement with their improved accessing of computerized

Housing Development Coordinator	
	housing availability systems giving priority more effectively offering and securing access for TCL individuals into Targeted Key, ISHP, and other similar housing • Specifying the pre-housing, day-of housing, post-housing, and proactive separation prevention expectations during pre-tenancy and post-tenancy transition teams • Ad hoc participation in Local Barriers Committee to address housing barriers and standing participation on Housing Separation and Root Cause Analysis meetings to address provider practices contributing to separations • In collaboration with DHHS Regional Housing Coordinators, develop effective housing access materials, training, and systems for early identification of reasonable accommodation letter needs, consistently quicker registering of those accommodation letters with landlords, informal intervention strategies accommodation denials, and connection to legal support agencies to remedy unfair housing practices • In collaboration with DAAS, improve timely, solution-oriented communication between DHHS Regional Housing Coordinators, landlords, and TCL service providers • Work within the LME/MCO and with external housing providers to develop Enhanced Bridge, TCL priority to LME/MCO or PHA-held master leases, incentivized housing priority to landlords for TCL members, and other novel housing access approaches

Quality Assurance Specialist	
Description	A bachelor's prepared individual with at least two years of experience in QA, preferably in a behavioral or medical managed care environment. They would manage the TCL Quality Assurance Performance Improvement (QAPI) activities outlined in the Settlement Agreement, DHHS mandated QA TCL measures, and PIHP QA activities related to TCL.
Key Responsibilities:	These activities would involve but not be limited to the following: • Serve as the organization's TCL QAPI point of contact for DHHS and manage and coordinate the development and implementation of internal QAPI activities and implementation of State QAPI initiatives • Develop, implement, and evaluate QAPI processes and procedures to monitor and ensure the quality and timelines of contracted TCL functions, including diversion, in-reach, discharge and transition planning, quality of life survey administration, and Root Cause Analyses (RCAs) • Develop and implement monitoring procedures to ensure the coordination of quality of mental health, employment, and other services and that the frequency and intensity of services are sufficient to help individuals achieve housing,

Quality Assurance Specialist	
	employment/education, and community integration thereby lessening reoccurrences of harm, housing separations, or re-institutionalization • Conduct regular review and analysis of TCL quality and performance measures, member surveys and assessments, incidents of harm, mental health and employment services data, institutional admissions, and other data sources to identify quality issues and performance deficits • Design and implement Performance Improvement Projects (PIPs) and other QAPI processes to identify and address quality and performance issues • Provide support for Local Barriers Committee to identify, aggregate, and report barriers to housing, employment, and community integration to maintain community transitions • Develop and strengthen processes as needed to ensure compliance with and timeliness of required provider reporting, member assessments and surveys, and other data submissions, including incidents of harm reporting via the DHHS IRIS system or its replacement, service outcomes assessments via NC-TOPPS, TCL Quality of Life surveys, and other required data submissions and reporting tools • Provide support as needed for TCL team members to develop and implement data collection tools and procedures to ensure all program requirements are met to support tracking, monitoring, reporting, and to evaluate and ensure the quality of TCL services and function

Data Analyst	
Description	A bachelor's prepared individual with at least two years of experience managing the input and output of data in large databases for enterprise-level organizations, preferably in organizations connected to behavioral or physical health.
Key Responsibilities:	Their specific TCL duties connected to meeting existing Settlement Agreement information management in addition to novel TCL Strategic Plan data management efforts to meet substantial compliance would include but be limited to the following: • Serve as the organization's TCL data quality point of contact for DHHS • Manage, coordinate, and carry out TCL Data Integrity Plan procedures and activities, including development, evaluation, and refinement of procedures to support data quality; regular and ongoing data review, validation, and cross-database reconciliation (e.g., TCLD, CLIVe, internal client data management systems, NCTracks extracts provided by the Department); identification of data quality issues and solutions; and data cleaning to ensure timely data entry and updates and data accuracy

Data Analyst	
	• Collect and aggregate data for required TCL reporting • Conduct ongoing monitoring to ensure timely Quality of Life survey administration • Assist with analysis, summary, and interpretation of data related to Performance Improvement Projects, member surveys, and other QAPI processes to support identification of individual and systemic quality issues that require intervention or improvement and evaluation of the effectiveness of QAPI activities and initiatives

Barriers & Training Coordinator	
Description	A bachelor's prepared individual with at least two years of experience working with individuals with severe and persistent mental illness or with a bachelor's degree and four years of professional experience in quality assurance, preferably within the healthcare industry. This individual should also have experience creating training curricula and significant presentation experience.
Key Responsibilities:	These activities would involve but not be limited to the following: • Coordinate and help ensure staff completion of all trainings required by the Department pursuant to this Contract for PIHP staff and network providers serving or supporting TCL members • Develop and/or coordinate and help ensure staff completion of any additional Transition to Community Living (TCL) in-person and virtual trainings which may be required or requested by the Department for PIHP staff and network providers serving or supporting TCL members or the PIHP's TCL efforts • Develop and/or coordinate ad hoc trainings as directed by PIHP for smaller groups of TCL members, guardians and natural supports for TCL members, network providers, and community agencies • Coordinate and facilitate PIHP's monthly Local Barriers Committee meetings, and track and facilitate any potential barrier issues and questions to be addressed by the PIHP and its Local Barriers Committee • Develop or coordinate the agenda for PIHP's Barriers Committee meetings, and be responsible for maintaining and forwarding to the Department the minutes of each Local Barriers Committee meeting and the PIHP's Local Barriers Committee tracker within 14 calendar days after each meeting • Work collaboratively with Local Barriers Committee members, PIHP staff, and network providers to help ensure timely identification and reporting of local barriers; exploration of potential resolutions and mitigation steps for local barriers; and identification of potential barrier

Barriers & Training Coordinator	
	patterns, root causes, and any quality improvements needed to mitigate risk and help improve TCL outcomes • Ensure the Department is notified of any urgent barriers matters and work collaboratively with the Department to address all unresolved barrier matters • Participate in ad hoc barriers intervention meetings scheduled by the Department • Facilitate the identification and tracking of barriers leading to housing separations for TCL members and where applicable, will participate in the PIHP's root cause analysis process for deaths or level 3 incidents involving TCL members

Glossary of Terms

Term	Operational Definition
Recovery-Oriented	A system of person-centered services that builds on the individuals' strengths, gifts, skills, and contributions to help identify and achieve their hopes, goals, and aspirations. Services assist the individual to improve health and wellness, live a self-directed life, work with natural supports, and reach their full potential. Sources: SAMHSA, NC PCP Guidance Document
Comprehensive array of community mental health services	The North Carolina Results First Initiative is a framework that relies on rigorous program evaluations and benefit-cost analysis. The program inventory starts as a comprehensive list of programs in a policy area, along with basic information on the programs' duration, frequency, delivery setting, and target population. Program inventories provide a systematic way to assess what programs are being funded to achieve a policy goal or desired outcome, how those programs are being delivered, and who those programs target. The AMH team and OSBM, with assistance from staff from DHHS's Division of Budget and Analysis, developed the AMH Program Inventory. There are 26 comprehensive adult mental health programs administered in different care settings that aim to reduce the incidence or symptoms of mental health conditions in adults. Below are the TCL-related community mental health services: • Assertive Community Treatment • Individual Placement and Support • Peer Support Services • Mobile Crisis Management

	• Community Support Team • Psychosocial Rehabilitation • Transition Management Services • Assertive Engagement • Person-Centered Planning
Adequate intensity of services	Adequate intensity of services should be based on 3 measures – initial assessment, individual's choice, ongoing assessment. Adequate intensity of services should meet the following conditions: ○ Is the individual receiving services at the intensity and frequency of service to help them achieve their recovery goals identified in their PCP (which is based on their goals and aspirations)? ○ Is the individual being seen at the level specified in the level of care/service being provided (example – ACT, IOP) ○ Is the individual achieving the goals identified in their PCP?
In-Reach	In-Reach is an engagement, education and support effort designed to accurately and fully inform adults who have a serious mental illness (SMI) or a serious and persistent mental illness (SPMI) about community-based mental health services (including Individual Placement and Support-Supported employment (IPS-SE)) and supportive housing options. This includes, but is not limited to, the availability of tenancy support services and rental assistance. (Full definition referenced in the TCL In-Reach/Diversion Manual
In-Reach Extenders	• Contracted peers who serve the role of In-Reach - brought on to expand and assist in In-Reach efforts in the community to reach substantial compliance. • They should focus on regular engagement with TCL individuals to help make an informed transition decision, including engagement through community integration process. • Requires same training and certifications as In-Reach staff. • Needs to be managed by In-Reach supervisors.
Peer Bridge	• Peers who work specifically with individuals who are residing in temporary bridge and enhanced bridge programs. • Same credentials and training as In-Reach staff. • Peer Bridge guidelines and expectations are outlined in the Housing guidelines.
Enhanced Bridge	The Enhanced Bridge Housing model is short-term housing with no pre-determined minimum set stay, and targeted duration of stay up to 180-days; when an individual is transitioning or is being diverted from an institutional setting

	(e.g. ACH, group home, hospital, etc.) and has agreed to a permanent housing option but could benefit from community inclusion planning and skill building activities due to complex needs (i.e. long term institutional stays, medically fragile).

Abbreviation Legend

Acronym	Meaning
ACH	Adult Care Home
ACT	Assertive Community Treatment
AE	Assertive Engagement
CCA	Comprehensive Clinical Assessment
CCME	Carolinas Center for Medical Excellence
CCP	Continuing Care Plan
CST	Community Support Team
DSS	Division of Social Services
IPS	Individual Placement Services
JCB	Joint Communications Bulletin
LBC	Local Barriers Committee
LME	Local Medical Entity
MCO	Managed Care Organization
NAMI	National Alliance on Mental Illness
NCDHHS	North Carolina Department of Health and Human Services
NCHFA	North Carolina Housing Finance Agency
PCP	Person Centered Plan
PSH	Permanent Supportive Housing
QAC	Quality Assurance Committee
QAP	Quality Assurance Process
ROI	Release of Information
SBC	State Barriers Committee
SHDP	Supportive Housing Development Program
SPH	State Psychiatric Hospital
TAC	Technical Assistance Collaborative
TCL	Transitions to Community Living
TCLV	Transitions to Community Living Voucher
TOC	Transition Oversight Committee
TP	Tailored Plan
UNC	University of North Carolina

Table 2. TCL Implementation Plan Abbreviation Legend