

Annual Report

NC Department of Health and Human Services Transitions to Community Living Initiative



April 24, 2014

The Department of Health and Human Services (DHHS) is pleased to provide its inaugural Annual Report on the Transitions to Community Living Initiative. There has been tremendous systems change since the voluntary settlement agreement was signed on August 23, 2012. The continued commitment by the Department as well as the General Assembly has led to the infusion of over forty-four million dollars (\$44,000,000) of state funds appropriated for the first three years of implementation. Below are some of the highlights of progress resulting from the Department's partnership with the LME/MCOs, contractors and other stakeholders.

- Implemented new service definition for ACT that requires TMACT fidelity.
- Developed supported employment for individuals with a diagnosis of serious mental illness and implemented new service definition for supported employment.
- Developed, implemented and refined the screening process for individuals requesting admission into an adult care home.
- Designed and implemented the Tenant Based Rental Assistance Program that includes subsidy administration, Transitions Year Stability Funds, Community Living Voucher for individuals not eligible for Special Assistance and tenancy supports.
- Designed, implemented and refined the in-reach and transition process.
- Provided training around Transitions to Community Living (TCL), ACT, Supported Employment, PASRR screening, In-Reach and Transition, Person Centered Recovery Planning, Person Centered Thinking, Tenancy Support, Special Assistance In-Home, Housing, Introduction to Socialserve, benefits and employment, and peer support.
- Began assisting individuals to move into their new apartments within 6 months of agreement.
- Hosted summits on Transitions to Community Living for Adult Care Homes to better educate facilities regarding the initiative.
- Monthly phone meetings with LME/MCOs and quarterly face-to-face meetings to enhance process and assist with barriers.
- Developed and implemented a new web based information system specific to Transitions to Community Living.
- Began to have individuals ask to be part of promoting the Transitions to Community Living Initiative and have had several individuals share their stories through newsletters.

One key ingredient to the long term success of the Initiative is that the Department is committed to making sustainable systems change, not merely developing specialty services, support efforts or planning processes that apply only to individuals who meet criteria to participate in the Initiative.

While the list above is not all inclusive, it shows some of the many important changes North Carolina has already made toward systems change. The Department will continue to work diligently to assure individuals with a diagnosis of serious mental illnesses or severe and persistent mental illness have an opportunity to choose where they live, work, go to school, play or retire and are provided access to services and supports necessary to best meet their needs and choices.

Jessica L. Keith

Transformations

Individuals in first year of moving asked, “where do you think I should live?”

In second year in program “I want to live _____.”

Individuals first receiving In Reach said, “No, I can’t live on my own.”

Following In Reach, “I want to move like my friend.”

Before wrap around services were provided individuals said, “I can’t get anywhere.”

After training with the bus system, “I took the bus and visited my family.”

Before living independently and working with a payee company, “I didn’t buy my family Christmas presents.”

Now living independently and working with a payee company, “I bought my family Christmas gifts this year.”

Before transitioning, “I hate where I live.”

After transitioning, “I love my apartment.”

Before transitioning and working with a payee company, “my credit is too bad.”

After transitioning and working with a payee company, “I finished paying off my debts.”

Before transitioning, “No one ever gave me a chance.”

After transitioning, “Thank you for giving me a chance.”

Accomplishments

Community Based Mental Health Services

Summary

Olmstead's motto of "*Community Integration for Everyone*" is the guiding factor in the development of the community-based services. As referenced in research, the State is "ensuring that each individual has every opportunity to participate in community life and to be valued for his or her uniqueness and abilities, like everyone else"¹. The service approach is based on Psychiatric Rehabilitation which is designed to help people be successful and satisfied in the living, working, learning, and social environments of their choice². Training on this foundation has started and will continue throughout the next year to bring attention to the principles of these approaches and the idea of dignity of risk, motivational interviewing, and recovery outcomes.

*"We all have value despite where we are on our journey
and what challenges we are facing.*

[A job and an apartment] is worth struggling for and worth the risk"

Assertive Community Treatment (ACT)

North Carolina has implemented various measures to promote and ensure that the ACT services provided to individuals are of high quality. In FY2012, the state completed an initial survey of the existing ACT teams using the Dartmouth fidelity model. (DATCS) 50 teams met the fidelity of that model, serving 3575 individuals.

The Department also researched another fidelity model, the Tool for Measurement of Assertive Community Treatment (TMACT) The TMACT is a more comprehensive measure of

¹ http://tucollaborative.org/comm_inclusion/community_integ_intro.html

² <http://www.bu.edu/cpr/products/books/titles/prprimer.pdf>

evidence-based ACT as it can better discriminate between low and high fidelity ACT teams, and is more sensitive to change over time as a team develops its practices.

North Carolina is moving towards a goal of transitioning all ACT teams from meeting DACTs fidelity to meet TMACT fidelity model. TMACT Evaluations involve a two-day onsite review by at least two independent evaluators. Staff from the ACT Technical Assistance Center & the Department partner with peer evaluators (e.g., ACT clinical directors, program managers, team leaders) from provider agencies to carry out these reviews. The use of peer evaluators is less expensive), and is an investment in broader quality improvement (e.g., trained ACT providers then return and re-invest their knowledge and expertise within their parent agency). Currently, we have trained 10 ACT provider-evaluators, with a plan to train 4 more in late spring 2014.

FY 2013 year to date TMACT and DACTS data (only when TMACT not yet performed), there are have 69 teams operating with basic fidelity to ACT serving 4,680 people. More specifically there are 26 teams that have met at least 3.0 on TMACT (mean is 3.5, max rating 4.2), serving 1996 individuals and 43 teams, who have yet to undergo a TMACT evaluation, met at least a 4.0 on DACTS Screen, serving 2684 individuals. Since January 1, 2014, at least 30 teams are in queue for TMACT evaluations. As part of the TMACT evaluation, practices around housing supports and supported employment are assessed and receiving specific practices recommendations.

The *ACT Technical Assistance Center* developed through the UNC Center for Excellence in Community Mental Health³ helps lead evaluations. Through UNC, the State is strengthened with a research base and guidance around best practices in community mental health services, as well as a source for assistance in performance monitoring and outcome data tracking.

³ <https://www.med.unc.edu/psych/cecmb/community/unc-assertive-community-act-team-training-center>

Training and beginning of implementation of the TMACT fidelity measures has required significant training and technical assistance for both providers and LME/MCOs. Some of the improvements include: richer staffing ratio (1:9) for large teams; increased nursing time; dedicated vocational specialist for all teams regardless of size; emphasis on quality and scope of practice; minimal fidelity standards; expectation for cross-training and ongoing performance improvement via continued education.

There has been 180 staff trained since July 2013 in 3-day High-Fidelity ACT Trainings, being held every other month. These trainings have been receiving very strong positive reviews, as evidenced by the following comments capture from a recent training:

Example Feedback from various trainings
Excellent Training!!
This was a monumental training for all ACTT employees. I feel that it should be given earlier on and frequent so that the work that we do in serving the people we serve produces effective outcome.
Sorry I missed day 3. This was a very helpful workshop that gave me so much information about what ACT can and should be.
I loved this training. Definitely one of the best I have attended in my career, no exaggeration. The only thing I would like to discuss more is how to merge old-school medical model with recovery model.
I am very glad that I attended this training. My staff and I are still talking about it, so much so that other staff members are making plans to attend. We've incorporated the Parking Lot method to our meetings and we're already experiencing reduction in the time we're spending in meetings. We were going over by at least 20 minutes. We're incorporating ITT teams next week. We're looking to put charts on the wall so we can see who's employed, want to be employed, and not interested as you suggested. I could go on and on with what we learned and are implementing. We're going for a 5 on the TMACT!!!
This training was very informative. I walked away with a lot more knowledge about ACTT and what it should look like. You ladies did a great job in presenting the information!
Very good training. Informative. Time was used wisely.
I thought the Wellness Recovery Management guest were great!
I would like for a little more time to be devoted to TL role since it is one of the primary roles on the team. More information on how to balance administrative role along with clinical role.
All of the presenters did a great job and it was obvious they were very knowledgeable. A great training especially for me being a new member of ACTT. Thank you.
Very Informative

Additionally, monthly webinars are being held on the Transition to Community Living initiative, its overarching goal of community integration, how it fits in with TMACT fidelity, and how each person on an ACT team has a role to serve for positive consumer outcomes and high fidelity. At least 240 staff have participated since July.

A series of ACT-related trainings were offered to LME/MCOs across the State in July and August of 2013, orienting care coordinators and utilization management staff in the expectations of ACT teams and how LME/MCOs can support efforts to implement high fidelity ACT. Individual consultation has been provided to LME/MCO staff as it relates to ACT (e.g., utilization management to ensure that teams are serving the intended population and ACT rate-setting, particularly how payment process can affect fidelity).

Supported Employment (SE)

North Carolina has developed a new infrastructure to provide the evidence-based model of Supported Employment for individuals with SMI/SPMI, known as Individual Placement and Support (IPS). Individual Placement and Support – Supported Employment is the model identified within the SAMHSA toolkit, developed and validated through extensive research by the Dartmouth Psychiatric Research center, and referenced in the Settlement Agreement. Through revision in policy and practice, the State will ensure that Supported Employment is aligned with recovery-oriented practices and meets high-fidelity.

Since the inception of the new Individual Placement and Support – Supported Employment service definition in May 2013, LME/MCOs and providers have worked together to identify providers through network re-enrollment and start-up necessary to meet fidelity. It became apparent early in FY2013 that providers who had been offering traditional supported employment services (mostly through Division of Vocational Rehabilitation Services) needed to learn how to

implement the evidence-based model and how to restructure their organizational approach to provide high-fidelity services. Most LME/MCOs developed Requests for Proposals based upon community needs assessments to identify interested providers who had the internal capacity and organizational commitment to devote to learning how to implement the Individual Placement and Support – Supported Employment model.

By late December 2013, the Request for Proposals, issued by LME/MCOs during the first and second quarters resulted in contracts with 27 Individual Placement and Support – Supported Employment providers in the state. Out of the 27, almost half are new providers who have never offered Supported Employment before but have a strong recovery focus and behavioral health service array; the others are providers that have mostly offered traditional Supported Employment through Division of Vocational Rehabilitation Services. Many providers are still in the start-up phase due to the restructuring needed to ensure Supported Employment and Behavioral Health is integrated per the fidelity scale. Often individuals who have been disenfranchised from community life and employment lose motivation and need joint counseling/support from Individual Placement and Support – Supported Employment providers working in collaboration with In-Reach teams in order to inspire these individuals to view employment as an attainable goal. We anticipate that as referrals grow, additional financial supports will be generated through the addition of Medicaid B3 Supported Employment funds, included in the 1915 b/c waiver for mental health, beginning July 2014, as well as through the joint partnership with Division of Vocational Rehabilitation Services.

The Department and the NC Employment First Technical Assistance Center have assisted staff from all of the existing LME/MCOs and providers to focus on increasing current provider capacity to a maximum of 160 individuals per team before needing to add more providers. The impact of having a high number of Supported Employment programs starting up at the same time has led to a significant need for technical assistance, community collaboration and implementation

support. Per the evidence-based model's Fidelity Manual⁴, a provider cannot be evaluated to fidelity if providing service for less than 6 months and serving less than 15 individuals.

As of July 1, 2013, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services began fidelity evaluations for new providers using the IPS-SE Fidelity Scale⁵. Since providers are new to this model, it has required significant dedication from evaluators from Division of Mental Health, Developmental Disabilities, and Substance Abuse Services who are still in the process of training leads and co-leads (as each review requires 2 staff on site). From July 1, 2013 to December 31, 2013, evaluators identified one provider that met the aforementioned criteria to evaluate for fidelity. The provider met fair fidelity and was serving 25 individuals as of the date of the on-site visit (with their numbers served increasing through present). Other providers were still working on increasing their referrals from LME/MCOs. Between January and July 2014, at least 7-8 more providers are in queue for evaluation; most of the providers are serving individuals and their numbers of referrals are increasing. A communication bulletin to LME/MCOs was developed by the Department emphasizing the need to offer employment services to individuals transitioning to community living; LME/MCOs report ensuring providers are ready for fidelity evaluation through training and outreach.

The State has also developed supports to train providers and bring employment supports up to scale with the *NC Employment First Technical Assistance Center*⁶ through Promise Resource Network, Inc. in Charlotte, NC. This center's staff join staff from Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and Division of Vocational Rehabilitation Services to provide statewide technical assistance. Jointly, the team brings years of

⁴ <http://sites.dartmouth.edu/ips/fidelity/fidelity-review-manual/>

⁵ <http://sites.dartmouth.edu/ips/fidelity/>

⁶ <http://www.nceftac.org/>

experience in recovery and employment that will support providers in identifying with this new approach in reaching competitive employment outcomes.

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services has been working very closely with Division of Vocational Rehabilitation Services in this initiative. Both Divisions recognize that traditional SE services have been historically ineffective in serving individuals with SMI, therefore requiring the need for evidence-based approaches to enhance employment success. Together with Division of Vocational Rehabilitation Services, the State provided onsite technical assistance to 7 local Vocational Rehabilitation offices: Pinehurst, Durham, Henderson, Smithfield, Albemarle, Charlotte, and Lumberton. Most recently, Division of Vocational Rehabilitation Services sent out a communication letter to all the vocational rehabilitation local offices supporting joint efforts in the Transitions to Community Living Initiative and encouraging them to engage with their new local providers in this model.

Significant support has been received through North Carolina's grant and collaboration with the, *Dartmouth Psychiatric Research Center*. The State is participating in the international learning collaborative through this 4 year grant that began in July 2013 that will help develop a sustainable infrastructure for this model in partnership with Division of Vocational Rehabilitation Services. The Departments jointly selected 4 sites (out of the 27) as "Dartmouth Research Sites" that will be required to send their outcomes to the Dartmouth Research Center for international research. The sites are: Monarch NC in Lumberton (Eastpointe LME/MCO), UNC CECMH in Carrboro/Pittsboro (Cardinal Innovations LME/MCO), Meridian BH in Sylva (Smoky Mountain LME/MCO), and Easter Seals UCP in Wake (Alliance LME/MCO). Dartmouth national trainer, Sarah Swanson, has been an integral support for our implementation process.

As part of North Carolina's commitment to providing evidence-based Supported Employment, for individuals with mental health and substance use disorders, North Carolina's new "IPS-SE Steering Committee" held its first meeting on April 16, 2014.

An IPS-SE kick-off event was held with over 50 guests from the LME/MCOs, providers, and DVRS, with model developers Dr. Bob Drake and Debbie Becker from Dartmouth. Both described the event as highly successful and commented on their excitement that [paraphrasing] *We are proud that North Carolina is the only state to be implementing IPS-SE with such a strong foundation on recovery and integration with peer support.* They are eager to support us in this implementation and hope to showcase our work with the other states during Dartmouth's annual meeting for international IPS-SE sites, in Kentucky on May 5-6, 2014.

The NC Employment First Technical Assistance Center with the Department is facilitating 2-day onsite training and web-based learning collaborative on our IPS-SE initiative; participants include SE and ACT vocational specialists, LME/MCO Transitions to Community Living staff, peers, and Division of Vocational Rehabilitation Services. To date 113 individuals representing LME/MCOs, Transitions to Community Living, Supported Employment and ACT Teams are registered to attend monthly web-based learning communities that are hosted by the NC Employment First Technical Assistance Center in collaboration with The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services staff.

Starting in July the following trainings have been developed and are being or will be offered:

- 1) *"Foundations of SE and Recovery"* - Nine 2-day sessions with a total of 284 staff trained, 67 agencies represented;
- 2) *"IPS-SE Learning Communities"* – 12 sessions held monthly on various topics such as Job Development, working with Criminal Backgrounds; and understanding Supplemental Security Income and Social Security Disability benefits,

- 3) *“Employment Peer Mentor”* – April 2014, training ~20 peers for the new position within SE-IPS teams
- 4) *“Benefits Counseling for Recovery”* – April 2014, goal to train 80 staff statewide, facilitated by consultant Lyn Lygere from the Transformation Center in Boston.
- 5) *Assistive Technology* - webinar held 12/13/13 with the NC Assistive Technology Center.

Findings from training evaluations tell us that the “employment” conversation and Employment First is a major paradigm shift. Providers clearly need hands-on systematic training and mentor training on site to understand the model and shift agency practices. There is a need for stronger focus on linkage to this service through In-Reach/Transition Coordination, where community integration includes employment and work for everyone. The Department is working on ways to remove barriers such as “readiness thinking” through continuing education and research dissemination; also focusing on improving benefits counseling with individuals and their families, as well as improving job development using the dual customer approach with employers.

Comments from Participants in Training and Learning Communities

"The Supported Employment Foundations and Recovery Principles Training were very helpful. I learned about the elements of model fidelity and also about how to incorporate recovery principles into everything we do."

"The trainers for the SE- Foundations have a wealth of training, education and experience. Especially on job market development. I left this training with practical, actionable ways to engage employers and develop jobs with the individuals our agency supports. I look forward to future trainings from the TAC Center on employment services and I have already signed up for the benefits training and other topics the Employment First TAC is offering. "

"Knowing what my role is as the Peer Employment Specialist was my reason for coming to the training. I felt much better able to perform my role as a Peer on the SE- IPS Team."

"I came to this training to learn about how to do the vocational, supported employment part of my job on the ACT Team. I left understanding what supported employment is and also knowing what I need to do to fill that role for my ACT Team. I am also going to sign up for other trainings the NCEFTAC offers in the future."

"The Learning Communities are informative and worth my time. I learn what other MCOs are doing and also how we can apply ideas to my MCO. The facilitator does a good job with organizing and encouraging discussion and ideas."

It is so unusual for the state to offer these in depth training sessions. It is a refreshing change from "business as usual". I feel supported and impressed that the state cares enough to give us these training opportunities not just at the beginning, but as an ongoing support to staff and providers trying to do these new services."

Tenancy Support Services (TSS)

The State is ensuring that best practice Tenancy Supports services are being provided to individuals transitioning to their own homes. Tenancy Supports are being provided through the Housing Subsidy Administrator, Quadel, and through dedicated Housing Specialists within ACT teams. In some LME/MCOs, the use of a Medicaid funded B3 service called “Individual Supports” is also helping individuals with daily living skill-building in their homes to ensure optimal community success. “Individual Support” is a hands-on service for persons with severe and persistent mental illness. The intent of the service is to teach and assist individuals in carrying out instrumental activities of daily living such as preparing meals, managing medicines, grocery shopping and managing money, so they can live independently in the community.

Beginning July 2013, the Department began work in researching training founded on the philosophy of best practices such as SAMHSA’s Permanent Supportive Housing Evidence-Based Practices Toolkit and Housing First. The Department began work with the Center for Social Innovation’s T3⁷ Training consultants. SAMHSA and other states have contracted with this center around evidence-based practice training such as Motivational Interviewing and Critical Time Intervention. T3 had the right combination of subject matter experts with national experience in housing first practices and supports for our target population. The T3 center had readily developed training on this model and was able to quickly tailor it around our need and overlay principles of other evidence-based practices for motivational interviewing, engagement, retention, and recovery.

Trainings were developed by T3 and four 2-day trainings were held in February and March, 2014 in Raleigh, Wilmington, Greensboro, and Asheville. These trainings will be followed by 3 web-based communities of practice. The trainers are Ken Kraybill, Housing and MINT trainer from the Center for Social Innovation, and Linda Kauffman of the 100,000 homes campaign in DC. The

⁷ <http://www.center4si.com/training/>

target audience includes LME/MCO TCL staff, housing specialists, care coordinators, peer support specialists, ACT teams, and Quadel staff.

The training is titled “*Best Practices in Tenancy Support*” covering the Permanent Supportive Housing and Housing First model, Motivational Interviewing, Working with Landlords, Doing home visits, Responding to Crisis, and the overall basics of a person-centered, housing-focused, trauma-informed, recovery-oriented, peer-integrated approach to tenancy support.

Peer Support Services (PSS)

The State has had a Peer Support certification program for several years and offers peer support services through the LME/MCO provider networks. As mentioned in the Settlement Agreement and in efforts to support an inclusive systems change initiative supporting recovery and evidence-based practice integration, it is a priority to expand and enhance Peer Supports. For this effort, DMHDDSAS convened a workgroup in 2013 of peer specialists and stakeholders to develop a new service definition that aligns with best practices and SAMHSA’s Consumer-Operated Services Evidence-Based Practices Toolkit. The new policy is being reviewed by the Division for implementation through the LME/MCO network. Medicaid funded B3 services include “Peer Support Services” and can support expansion of this service statewide.

Furthermore, Peer Supports Specialists “*introduce and advance communities’ understanding of recovery and community integration as the catalyst for transforming individual lives*”⁸. As such, the State has included peers in the following roles/capacities:

- In-Reach Specialists – must be a certified peer support specialist (CPSS)
- ACT – all teams must have a CPSS
- IPS-Supported Employment – adds “Employment Peer Mentors” (CPSS specialty) as a new staff role

⁸ <http://www.mhrecovery.org/>

- Tenancy Support services – can be provided by CPSS
- Peer Support Service – offered B3 services which eligible individuals can have access to their own peer support staff

Currently, there are 1,172 Certified Peer Support Specialists (CPSS) in the state. The Department and the UNC Behavioral Health Resource Program⁹ have been working to improve the training and workforce development of individuals seeking CPSS certification and working in the field. There are current efforts around revision of the curriculum and standardization process for trainers to ensure quality training and services.

Community Support Team (CST) and other Services

As mentioned in the Settlement Agreement, Community Support Team (CST) is one of the services available to help support individuals transitioning to the community. This service has been available in the state for some time but through stakeholder feedback, it became apparent that there are gaps and time-limits in the current model structure. The Department convened a workgroup in 2013 to review and revise the Community Support Team service definition to ensure that it is recovery-oriented, evidence-based and community-based. The workgroup included LME/MCOs, providers, consultants and peer specialists.

The workgroup supported enhancing Community Support Team to include evidence-based practices such as Critical Time Intervention¹⁰ (CTI) and other evidence based practices. The proposal is to develop Community Support Team into two phases with a short-term and long-term option. Critical Time Intervention is an empirically supported, time-limited (8-9 months) case management model designed to prevent homelessness and other adverse outcomes in people with mental illness following discharge from hospitals, shelters, prisons and other institutions. Therefore,

⁹ <http://pss-sowo.unc.edu/pss>

¹⁰ <http://www.criticaltime.org/>

Critical Time Intervention and other evidence based practices could serve for the 8-9 month duration, and the Community Support Team long-term option should remain for individuals who need some ongoing supports that do not require the frequency and intensity of ACT. The recommendations have been submitted to DMA for review.

Individuals with SMI/SPMI often need long-term and flexible support options to address issues as they arise. The Department is currently considering service options including *Case Management* and other Psychiatric Rehabilitation services within the SAMHSA toolkit array such as *Integrated Dual Disorders Treatment, Wellness Management and Recovery, and Family Psychoeducation* to address gaps in the continuum of care for SMI/SPMI.

The Transitions to Community Living housing supports is a partnership between private sector landlords who rent to Transition to Community Living participants, and the Department, which uses rental assistance to ensure that the tenants can afford to live in the units. In a typical scenario, a tenant signs a lease for a one bedroom apartment with a community landlord, and the tenant pays a portion of his/her income towards rent. Since the portion paid by the tenant is never enough to pay the entire rent, the Department subsidizes the rent with a rental voucher of no more than \$360. If additional funds are needed to meet the rent payment, the tenant will use some of his/her Supplemental Assistance-In Home payment to fulfill the rent payment.

The Department has contracted with Quadel, Inc. to act as the housing subsidy administrator on behalf of the Department. In that capacity, Quadel ensures that participating landlords meet standard legal requirements, that the tenants are being charged a reasonable rent that complies with federal Fair Market Rents, that the units meet federal minimum standards, and that the landlords receive the subsidy payments in a timely manner. The Housing and Homeless Unit, within the Division of Aging and Adult Services, is responsible for monitoring the housing subsidy administrator contract.

Quadel is also tasked with administering the Transition Year Stability Resources (TYSR), a fund of up to \$2000 per person to assist with move-in costs including, but not limited to, deposits, furniture and household goods. In addition, Quadel administers the Community Living Voucher (CLV), a replacement fund for persons moving out of Adult Care Homes who are no longer eligible for Supplemental Assistance-In Home. The availability of Community Living Voucher makes sure that persons who want to move out of an Adult Care Home do not automatically face a drop in income which might limit desire to participate in the community based Initiative. Quadel also provides tenancy supports to all tenants who do not receive the support through ACT services. At this time the Department is preparing a Request for Proposal (RFP) for the housing administrator function and the tenancy support activities.

Crisis Services

Current Crisis Service Array Includes

LME/MCO Access Centers-All LME/MCOs have 24/7 Access Centers that provide screening, triage, referral, and customer service functions. These are also a first line of access to telephone crisis intervention and dispatch or referral to other crisis services.

Mobile Crisis Teams-All 100 NC counties are served by Mobile Crisis Teams, contracted by the LME/MCOs. There are 13 agencies providing Mobile Crisis Management services. By most recent reporting (July – December 2013), a total of 18,849 service events were reported for the 6 month period. There is wide variability in the utilization of this service across the LME/MCOs. The provider in Mecklenburg County reported only 567 events whereas the 5 providers across the Smoky Mountain Center area reported 3997 events.

Walk-in Crisis/Psychiatric Aftercare Centers-83 of 100 counties report having some version of a same day walk-in center. Some are not even open daily, a few have extended evening or weekend hours. Seven of these are true Walk-in Crisis Centers with full staffing to support medical and safety needs of the involuntary commitment population and serve as robust alternatives to emergency departments for individuals in behavioral health crisis.

Facility Based Crisis Services -There are currently 21 DHSR licensed Facility Based Crisis Service units for a total of 196 beds across the state. 10 of these units have also received Department designation to accept patients on involuntary commitment status. The most recent claims based data available (FY12) shows utilization of about 67% for these beds.

Crisis Intervention Team Partnerships-All LME/MCOs actively support law enforcement Crisis Intervention Team programs. As of January 2014, there are 331 participating law enforcement agencies with 5,914 Crisis Intervention Team -trained officers in 85 counties. That is more than 26% of all officers in NC have been Crisis Intervention Team trained.

As noted in the introduction to this report, the Department committed to a systems change approach that will benefit all individuals in need of services rather than developing specialty services or supports that carve out individuals into a “Transitions to Community Living population”.

Consistent with this the Department kicked off a major effort to focus on, review, and redesign (if necessary) the crisis service components of the Mental Health, Developmental Disability, and Substance Abuse Service system in November 2013. This work is the *Crisis Solutions Initiative*.¹¹

Crisis services are essential components of any comprehensive behavioral health system. As is true in many states, North Carolina’s crisis service system has become increasingly stressed over the last decade. This has resulted in an over-reliance on the use of hospital emergency departments for

¹¹ http://www.ncdhhs.gov/pressrel/2013/2013-11-07_mhsas_initiative.htm

behavioral health crisis care, extended emergency department wait times (psychiatric boarding) for individuals in need of inpatient care, and repeat visits to emergency departments.

The work of the Crisis Solutions Initiative is lead by Dave Richard, DHHS Deputy Director of Behavioral Health and Developmental Disabilities Services.

One of the key strategies of this initiative has been the formation of the *Crisis Solutions Coalition*.

The Crisis Solutions Coalition was established to provide a forum for this cross-system partnership.

To date three meetings have been held (Dec 9, 2013, Feb 25, 2014, Mar 31, 2014) and the next is planned for mid-May. Forty-five representatives were invited to the first meeting, but the popularity of these meetings has drawn 65 – 80 attendees each time. The meetings are designed around short presentations on innovative crisis intervention strategies. The presentations offer a springboard for question/answer periods, and robust discussion. Participants contribute solution recommendations from their home communities or organizations. The Coalition is experiencing early success towards its goals.

- Recommend & establish community partnerships to strengthen the continuum of care.
- Promote education & awareness of alternative community resources to the use of emergency departments.
- Make recommendations related to data sharing to help identify who, when and where people in crisis are served, and what the results of those services are.
- Create a repository of evidence-based practices and provide technical assistance to LME/MCOs, providers, & other partners on how to respond to crisis scenarios.

The Department and internal project management team staff are leading and/or supporting the following solution-oriented projects:

- The Department released an updated version of the “Comprehensive Crisis Prevention and Intervention Plan” for implementation by providers on January 1, 2014.¹² This is a section of any person-centered plan that may be pulled out to be free-standing and distributed to any resource the individual allows.

¹²

<http://www.ncdhhs.gov/mhddsas/communicationbulletins/2013/commbulletin139/cb139pcpcomprehensivecrisisplan.pdf>

- In a second effort to address essential crisis prevention strategies, Division of Mental Health, Developmental Disability, and Substance Abuse Service has consulted with Dr. Marvin Swartz at Duke – a leader in the area of Psychiatric Advance Directives (PADs). Dr. Swartz provided a presentation to the Coalition members on PADs and will consult over the next 6 months during a “Promotional Campaign on PADs”.
- A new website¹³ has been developed to support individuals, families, and other crisis responders who are specifically searching for crisis service information. A key feature of the site is a county-by-county listing of which LME/MCO is responsible for the county, the LME/MCO 27/7 Access Center phone number, the name, number and contact information for the Mobile Crisis Team covering the county, and the name, number, website, and operating hours for each county’s identified walk-in crisis site. Other Crisis Solutions Initiative information is also provided on the website for reference.

Of course, the Department’s primary partners in this initiative are the LME/MCOs and their networks of providers. There have been efforts at addressing crisis services gaps over the last decade. Funding was previously allocated toward several initiatives (i.e., Mobile Crisis Management, Walk-In Crisis, and community hospital inpatient beds). Each LME/MCO has a baseline of required services (see CrisisSolutionsNC.org).

The Department and internal project management team staff, in partnership with LME/MCOs and providers, are leading and/or supporting the following service specific projects:

- First Responder requirements: All agencies and Licensed Independent Practitioners who are contracted providers with LME-MCOs have obligations to be available to consumers in crisis, including for after-hours response. Department implemented a new strategy to promote awareness and compliance of these requirements. Beginning March 1st, LME/MCOs began utilizing new routine provider monitoring tools. The overall tool has been streamlined from more than 150 elements to fewer than 20. Newly included among the 20 is the first responder requirement.¹⁴

¹³ <http://crisissolutionsnc.org/>

¹⁴ <http://www.ncdhhs.gov/mhddsas/providers/providermonitoring/index.htm>

- Care Coordination – frequent Emergency Department users: Department staff have drafted new potential contract language around care coordination standard that will include crisis population standards. That draft is currently under review by LME/MCO CEOs.
- Department staff, in partnership with LME/MCOs, began site reviews and will visit each of the 21 facility based crisis/non-hospital detox units across the state over the next 4 months. This is an information gathering survey process to assess the effectiveness of the FBC level of care.

Finally, the Crisis Solutions Initiative has also created opportunities to increase funding and to strategize with partners about appropriate statutory changes.

- The 2013 legislative session resulted in significant appropriations for two established and successful programs which support the crisis intervention continuum. A \$4 million investment over the next two years will expand the use of tele-psychiatry state-wide. Funds to pay for inpatient psychiatric care in community hospital beds – “3-way beds” – have been increased to more than \$38 million, due to the success of this strategy for serving individuals in non-state hospital settings.
- Based on Crisis Solutions Coalition recommendations the following crisis intervention strategies are prioritized for new funding requests:
 - Walk-In Crisis Centers: Enhance 4 – 6 existing walk-in crisis centers to expand hours, operating capability, or facility security updates so the centers may function as viable alternative sites to hospital emergency departments for behavioral health crisis intervention.
 - Addiction Recovery Community Centers: Provide training and start-up funding for 8 peer run/volunteer supported community education and activity centers for people in recovery. Collaborations with public universities will be considered to engage and support young adults in recovery.
 - Critical Time Intervention (CTI): CTI is a time-limited case management service designed to prevent adverse outcomes following discharge from hospitals, shelters, prisons and other institutions. Suitable for the high risk TCL/DOJ population and other high end users of emergency rooms. Will work with DMA to develop new Medicaid service definitions while funding start-up in each LME/MCO.

- Peer Support Respite: Day drop-in and/or overnight short stay programs that are alternatives to emergency department visits for people in crisis. Programs are operated and staffed by certified peer support specialists. There are no current programs in NC, and this funding will support necessary training and start-up of 2 pilot sites. Sites will be expected to have 4 - 6 beds each.
- Community Paramedic Mobile Crisis Management: Provide a payment option for LME/MCOs to contract with EMS departments to assess and transport consumers with MH/SA needs to non-hospital clinics (based on successful Wake County pilot). Fund direct services and "mini-grants" for replication planning. In collaboration with DHSR/OEMS, and with longer term investigation with DMA for Medicaid funding possibilities.
- MH First Aid: Fund a train-the-trainer contract and workbook costs to spread the use of MH First Aid for youth and adults, a strategy for teachers, faith partners and other community lay people to intervene early with individuals in crisis. Deliver 6 - 12 instructor trainings + workbooks for participants
- Group Home Employee Skills Training (GHEST): Developed and piloted by the UNC Center for Excellence in Community Psychiatry in conjunction with NAMI advocates, GHEST is designed to help .5600A group home staff more effectively assist adult residents with mental health crises. Group homes have a disproportionate number of emergency room visits and crisis calls requiring law enforcement involvement. Funds are needed to support 1 workshop (3 days for 25 participants) and an evaluation of the program and then ongoing 2 workshops/year if formal evaluation supports successful outcomes.
- Innovative Technology Tools: Support the development and use of innovative health, assistive, and wellness management technologies that assist consumers to prevent and avoid crisis escalation. Examples include mobile apps, smart home technology, and med monitoring systems.
- The Joint Legislative Oversight Committee on Health and Human Services has just made its final report in preparation for the 2014 General Assembly session.¹⁵ The document includes eight recommendations for Mental Health. All and any of the recommendations have the

15

<http://www.ncleg.net/documentsites/committees/JLOCHHS/Final%20Reports%20to%20the%20NCGA%20from%20Oversight%20Committee/2014%20Joint%20Legislative%20Oversight%20Committee%20on%20HHS%20Report.pdf>

potential to directly and positively impact the Crisis Services components of the North Carolina Mental Health, Developmental Disability and Substance Abuse Services system.

External Quality Reviews

Federal regulation 42 CFR 438 requires state Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with the state and federal requirements. The North Carolina Department of Health and Human Services has contracted with the Carolina's Center for Medical Excellence to monitor the contracted Managed Care Organizations.

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>

As a part of this process the External Quality Review Organization will review documents and interviews with staff to determine the LME/MCO's compliance with the federal regulations and state contract requirements for quality, timeliness of, and access to care and services provided to Medicaid enrollees by the Plan. The EQR includes;

- Three year review--Performed every three years to determine the LME/MCO's compliance with Federal Regulations (CFR 438) and DMA contract requirements
- Desk review--Desk review conducted at CCME of all policies and procedures, program descriptions, committee minutes, manuals, handbooks, and quality data
- Onsite visit--Onsite visit conducted in the health plan's office to review credentialing files, medical records, conduct staff interviews and provide feedback

The functional areas reviewed are as follows:

- Administrative: Organizational structure, Staffing levels, Policies and procedures, Compliance Plan,
- Provider Services: Credentialing/Re-credentialing file review, Adequacy of the Provider Network, Service Access, Provider education, Preventive and clinical practice guidelines
- Member Services: Rights and responsibilities, Preventive health and chronic disease management education, Disenrollment, Grievances and complaints
- Quality Improvement: Activities of the Quality Improvement Committee, Provider involvement in quality activities, Annual evaluation of the quality improvement program
- Utilization Management/Case Management: Program structure and evaluation, Medical necessity determinations (Utilization process, File review of approvals and denials),

Member and provider appeal process; Appeal file review, Case management file review, Evaluation of over and under utilization data

- Delegation: Review of activities and monitoring of contractors and/or agencies performing delegated activities for the LME/MCO
- State Mandated Services: Review of core benefits and follow-up review of identified deficiencies from the previous EQR, if applicable

During the most recent contract cycle for, East Carolina Behavioral Healthcare, Smoky Mountain Center, and the former Western Highlands Network and the Sandhills Centers were reviewed.

Strengths

Some of the strengths of the LME/MCOs performance included the following:

- Overall, the LME/MCOs are generally complying with federal and state requirements.
- All plans had appropriate staffing and clearly demonstrated a desire to serve the Medicaid populations.
- Quality Improvement programs have been established to monitor and evaluate the internal and external services provided to Medicaid members. The plans have strong community education and engagement programs, providing information on topics specific to the population served.
- Case Management programs and services are thorough and demonstrate the ability to meet the needs of the enrollees.
- Based on the submitted materials for the ISCA review, each of three plans maintains a capable and solid IT system.
- All of the plans have set the bar high for their handling and processing of claims, and each is doing a good job of meeting the targets for accuracy and timeliness.
- All plans track demographics and enrollment data regularly. Sandhills LME/MCO has set up accessibility guidelines based on the demographics to ensure that there is sufficient access to providers for all members. This is commendable.
- The documentation received from all three plans showed that the project study question had been appropriately documented.

Areas for Opportunity

Some of the areas for opportunity identified during this contract year's EQR included:

- Areas for Opportunity identified in plan program materials and policies and procedures were due to inconsistent, incorrect, and/or unclear information.
- All of the LMEs/MCOs had issues relating to their credentialing/recredentialing policies and procedures.
- By-laws or committee charters that include information such as the make-up of the committee, voting privileges, and meeting frequency had not been established for each plan's Credentialing Committee.
- Several of the plans had inconsistent and incomplete documentation regarding enrollee rights and responsibilities. Incomplete or incorrect information was provided to new enrollees regarding privacy practices; changes in benefits, services, and providers;

availability of second opinions; and provider information such as alternate languages, addresses, whether the provider is accepting new patients, and qualifications.

- The annual work plan for Quality Improvement activities had not been established or the plan did not include all of the monitoring activities underway.
- The Utilization Management program description and/or policies did not contain all of the requirements and/or were found to be incorrect.
- All of the plans had deficiencies identified in how requests for an appeal are handled.
- The performance improvement project validation found that the plans were not completely documenting numerators and denominators used for the projects.

For the upcoming contract period Alliance, Cardinal Innovations, CenterPoint, CoastalCare,

Eastpointe, and Partners will be reviewed. MeckLINK was scheduled to be reviewed but will be

reviewed as a part of the merger with Cardinal Innovations that occurred April 1, 2014.

Quality of Life Survey

The Department implemented Quality of Life surveys for individuals with SMI who are transitioning out of an adult care home or State psychiatric hospital. The N.C. Community Living Quality of Life (CLQL) Survey is modeled after the Money Follows the Person Quality of Life Survey* and assesses an individual's satisfaction and perceptions related to daily living, services, and community supports.

Prior to implementation of the Quality of Life Survey, the State piloted the instrument with a small number of individuals and developed and provided LME/MCO transition team staff with survey administration training and materials. LME/MCO transition team staff administer the Quality of Life Survey in person with the individual at three points in time:

1. The Initial (Pre-Transition) version of the survey is administered during the individual's transition planning process.
2. Follow-Up Survey I is administered 11 months after the individual has transitioned into the community.
3. Follow-Up Survey II will be administered 24 months after the individual has transitioned.

Participation in the survey is completely voluntary and does not impact the individual's ability to transition. The LME/MCO submits each individual's responses via the State's secure web-based survey tool.

To allow the State to track change over time, the Pre-Transition CLQL includes 38 survey questions that are repeated at both of the follow-up survey contacts. Thus, the Pre-Transition version of the Quality of Life Survey primarily addresses the individual's perceptions related to his or her life prior to transitioning out of an adult care home or State psychiatric hospital. Additional questions on the Pre-Transition Quality of Life Survey address the individual's perceptions and experiences related to Transition Planning; these items are unique to the Pre-Transition Quality of Life survey. Together the Pre-Transition and Follow-Up Quality of Life Survey versions cover the following broad content domains:

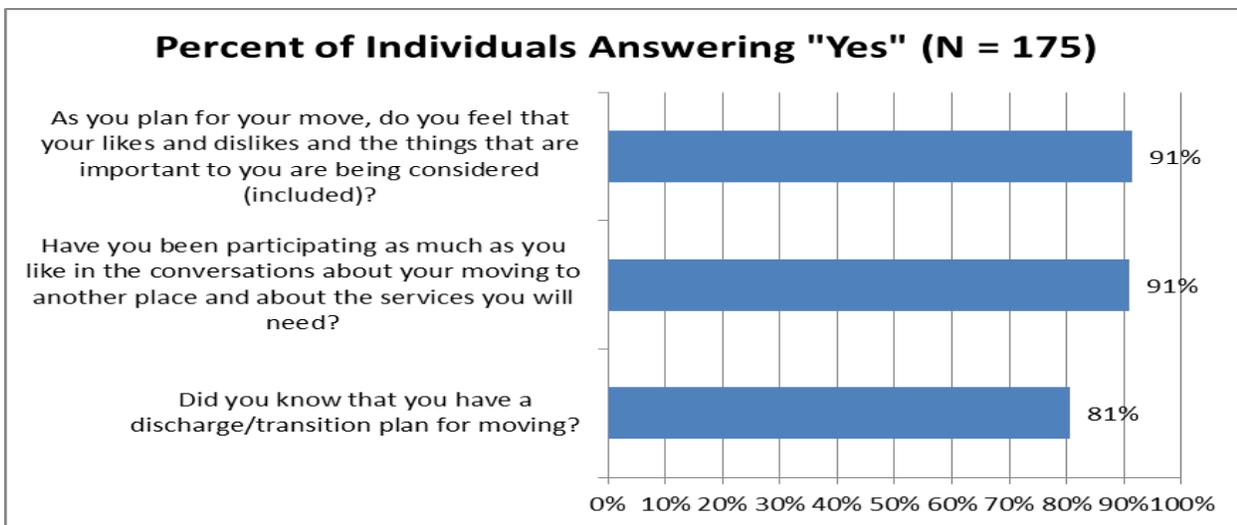
1. The individual's participation in discharge/transition planning,
2. Housing, community, and integration,
3. Individual choice and control of daily activities,
4. Well-being and support for personal development and recovery, and
5. Service access and satisfaction.

Most survey questions include multiple choice type options, and the individual is asked to choose one or more options to indicate his or her response, level of agreement, or degree of satisfaction. Approximately one-quarter of the survey questions are open-ended for the individual's narrative response, or have open-ended follow-up questions.

Collection of responses to the same questions at pre- and post-transition contacts will allow the State to determine if, to what extent, and in which areas individuals who transitioned have experienced improvements in the quality of their daily lives. Survey data also represent one source of information that may help to identify areas in which additional supports are needed.

To date, a sufficient number of individuals have completed the Pre-Transition Quality of Life Survey to derive meaningful aggregate results for the Transition Planning questions that are unique to the Initial Quality of Life survey. Analyses conducted for the 2013 Annual Report indicated that a total of 175 individuals completed the Pre-Transition Quality of Life Survey during calendar year 2013. While substantial percentages of these individuals indicated dissatisfaction with various aspects of their pre-transition living arrangements—ranging from the home’s location and transportation to options for leisure, entertainment, and recreation—the vast majority (91%) reported satisfaction with their participation in transition planning, and with the extent to which their likes and preferences were being considered in the process:

Community Living Quality of Life Survey (CLQL): Transition Planning



The remainder of survey questions with defined (e.g., multiple choice) response options may be most meaningfully analyzed when sufficient numbers of Follow-Up surveys have been submitted to allow for pre-transition vs. post-transition comparison. However, responses to some of the survey’s open-ended questions illustrate individual’s experiences in their pre-transition settings, and their feelings and perceptions related to their upcoming transitions:

Community Living Quality of Life Survey (CLQL): Community, Housing, and Personal Control*

What would you change about your current living situation?

I am ready to move out so we can have more options about the way we live.

...Being independent. Live on my own.

Being able to go out by myself; change how my linens and clothes are cleaned/taken care of; dietary--more fresh vegetables

Have more things to do and go places.

I want to live on my own. I live in an assisted living and sometimes have to have a roommate and sometimes people take my things. I want to live somewhere close to stores and things.

less restricted, more independence, access to transportation

Making changes from ACH to community independent living

My own place, more privacy and more things to do. Better food.

Ready to be closer to family and more independent.

To become more independent

*Illustrative responses

Community Living Quality of Life Survey (CLQL): Personal Development, Well-Being, & Services

Is there anything you would like to add about your life that we have not discussed today?

Can't wait to get out on my own and away from this place.

I am so grateful for this opportunity.

I am tired and just want things to be different. I am working hard to work my program and I see things turning around.

I want to live on my own.

I'm just eager to go (move). The sooner the better.

It is hard living on the street. Thank you.

Nothing. I am happy.

Thank God I'm gone!

*Illustrative responses

The State is currently planning an April 2014 release of Quality of Life Survey revisions based on analysis of the first wave of survey responses. Planned revisions are minor and are expected to more adequately reflect the range of potential and likely response options to multiple choice items that include an "Other" option, while still allowing for comparison of responses from original and revised versions of the survey. (For example, we are expanding the range of response options to capture obstacles to going out into the community when desired to reflect "Other" obstacles individuals reported.)

* Sloan, M., & Irvin, C. Money Follows the Person Quality of Life Survey. Prepared for Centers for Medicare and Medicaid Services (CMS). Washington, D.C.: Mathematical Policy Research, Inc., 2007.

Performance Improvement Initiatives based on Quality Management Indicators

Transitions to Community Living and Person Centered Planning Process

As part of ongoing implementation of the Transitions to Community Living Initiative, the Department of Health and Human Services asked for copies of plans for 55 individuals who transitioned into housing slots in early November. Plans included any relevant documentation but the Department specifically asked for copies of in-reach documentation, transition planning tools, copies of the official state Person Centered Plan for enhanced services and the final transition plan. Based on the review there were some identified areas of opportunities to focus on including meaningful days, ensuring services and supports were detailed in the plan, crisis plans being individualized and timely. Each LME/MCO received feedback on their specific plans to assist in the continued improvement opportunities for the process. Beginning in February, the Department along with partners from CARES/Jordan Institute, conducted onsite training, technical assistance and plan reviews with each LME/MCO to continue the dialogue around planning efforts and ensuring individuals have meaningful activities as well as the services and supports necessary to transition into the community in the most supported and integrated way. These visits have assisted the state in identifying other performance improvement projects such as the need to streamline the Transition to Community living documentation requirements in order to result in one complete person centered recovery plan that is mutually inclusive of the transition to the community as well as the persons treatment needs, other natural or paid supports and meaningful activities; continued training and dialogue with guardians around transitions to community living; and the need for role clarity among providers, LME/MCOs and Tenancy Supports.

In addition, beginning in March 2014 the Department has implemented a collaborative review process around person centered plans to continue to offer technical assistance and better identify

areas where ongoing learning around person centered recovery planning is needed. Housing slots will be provisionally approved upon request but will also require submission of the final plan for state level review before final approval of the housing slot is made. The final plans and all other relevant information will be sent secure to the Department. The review of the plan includes both a review of the documentation provided and a phone conference with the transition coordinator. This process is intended to be short term as the LME/MCO's capacity for internal review grows, and eventually will fold into a small sample review by the state as part of overall quality management and monitoring for the Transitions to Community Living Initiative. Upon mutual agreement of the individuals plan components, the LME/MCO will be able to complete final transition activities.

Screening for Serious Mental Illness (SMI) in Adult Care Homes

The Department has utilized information gathered over the last year to review and assess for opportunities to improve and streamline the screening process. One of the major areas of revision was moving the authority from a temporary rule through Division of Health Service Regulation to authority of the N.C. Division of Medical Assistance (DMA) Clinical Coverage Policy 3L. All Medicaid eligible individuals referred or seeking admission to Adult Care Homes must be screened through the Preadmission Screening and Resident Review (PASRR). Adult Care Home providers will not be able to schedule independent assessments for Personal Care Services without verification of a PASRR number.

Up to 75% of individuals who request admission to an Adult Care Home are in a community or State hospital at the time of the request. State Hospital had individuals who were discharged to an Adult Care home account for 5 % of the overall Discharges for 2013. State Hospitals had a total of 3140 individuals discharged in 2013. Adult Care Homes with 6 beds or more accounted for 82 individuals discharged and Family Care Homes with 6 beds or less

accounted for 85 individuals discharged. to In order to shorten the time between screening and notification to the responsible LME/MCO of the need for diversion activities, the Department is planning on locating a contract agency to take on the responsibility for assessment, community living options counseling and community integration planning as required by the Settlement. This should result in shorter hospital stays and the reduction of referrals to Adult Care Homes by hospitals for the individuals in their care. PASRR numbers will not be issued for individuals who during options counseling and community integration planning choose to transition to the community. This will eliminate admissions for people in the transition process. At the same time, a pilot project with housing finance agency to assist individuals to move into housing for short stays while they are completing the person centered planning process and finding community-based apartments.

Quality Management Information &
Data Summary
2013 Calendar Year

In-Reach, Transition Planning, and Housing Totals: Calendar Year 2013

<i>LME/MCO</i>	<i>In-Reach Planning</i>	<i>Transition Planning</i>	<i>In Housing with Confirmed Lease</i>
Alliance Behavioral Healthcare	255	26	18
Cardinal Innovations	123	9	13
CenterPoint Human Services	116	15	20
Coastal Care	94	15	16
East Carolina Behavioral Health	278	27	9
Eastpointe	140	10	21
MeckLINK Behavioral Healthcare	115	9	12
Partners Behavioral Health Mgmt	209	5	12
Sandhills Center	109	19	22
Smoky Mountain Center	211	23	29
Total	1650	158	172

In-Reach, Transition, and Housing numbers are not duplicative

Population Categories of Housed Individuals: Calendar Year 2013

<i>LME/MCO</i>	<i>Cat 1</i>	<i>Cat 2</i>	<i>Cat 3</i>	<i>Cat 4</i>	<i>Cat 5</i>	<i>Total</i>
Alliance Behavioral Healthcare	0	10	0	2	6	18
Cardinal Innovations	2	4	0	1	6	13
CenterPoint Human Services	15	0	0	0	5	20
Coastal Care	7	5	0	0	4	16
East Carolina Behavioral Health	2	0	1	0	6	9
Eastpointe	0	10	2	4	5	21
MeckLINK Behavioral Healthcare	0	5	0	0	7	12
Partners Behavioral Health Mgmt	4	0	2	2	4	12
Sandhills Center	1	12	2	1	6	22
Smoky Mountain Center	8	3	5	2	11	29
Total	39	49	12	12	60	172

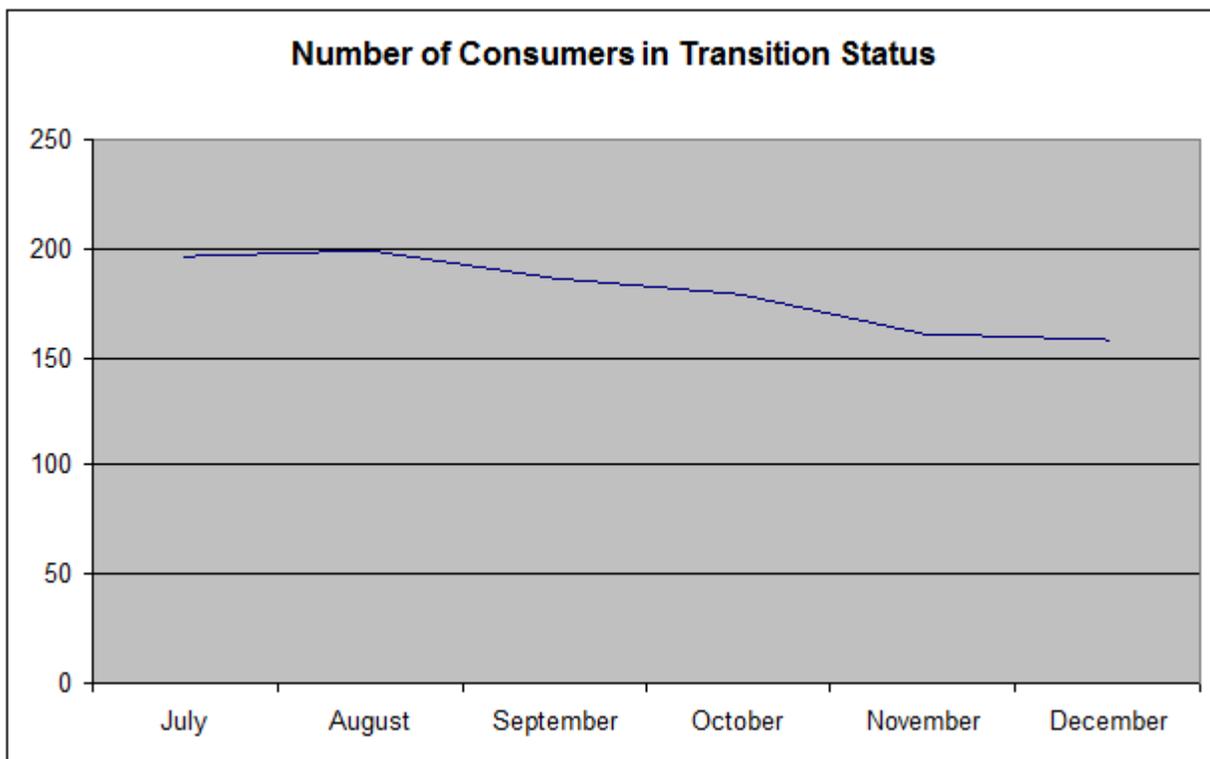
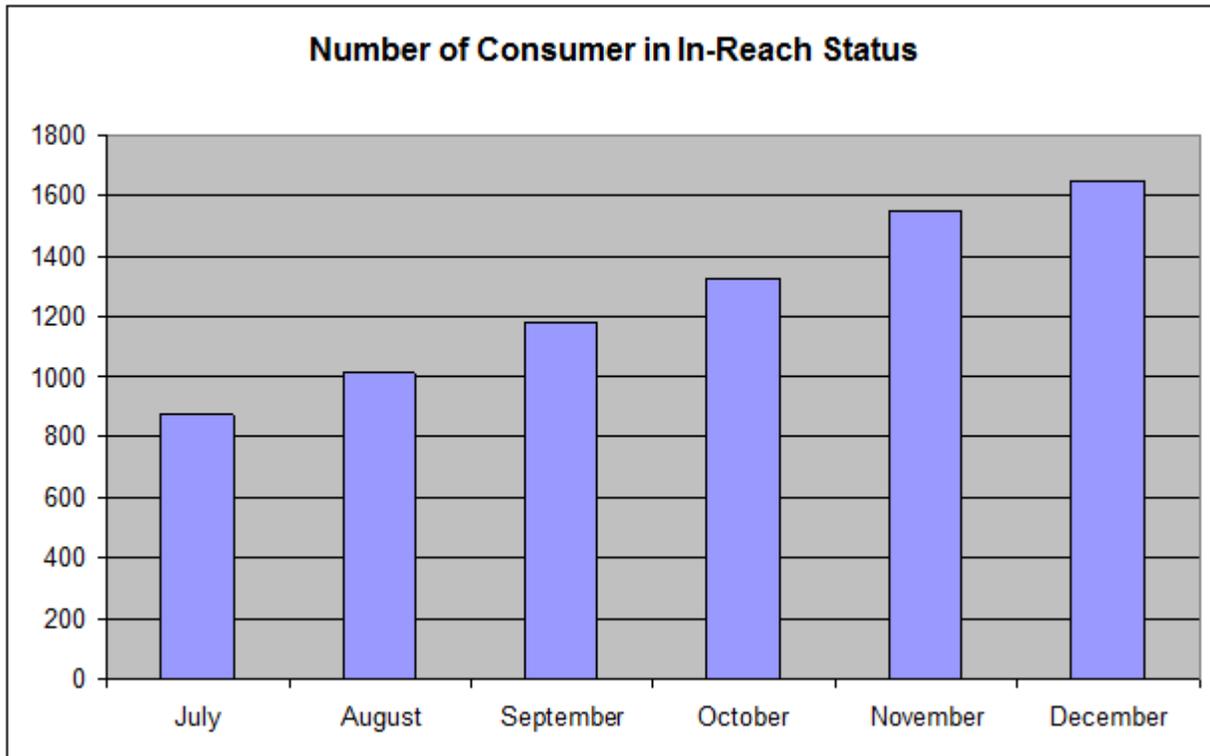
Category 1- Individuals with SMI who reside in an adult care home determined by the State to be an Institution for Mental Disease (“IMD”);

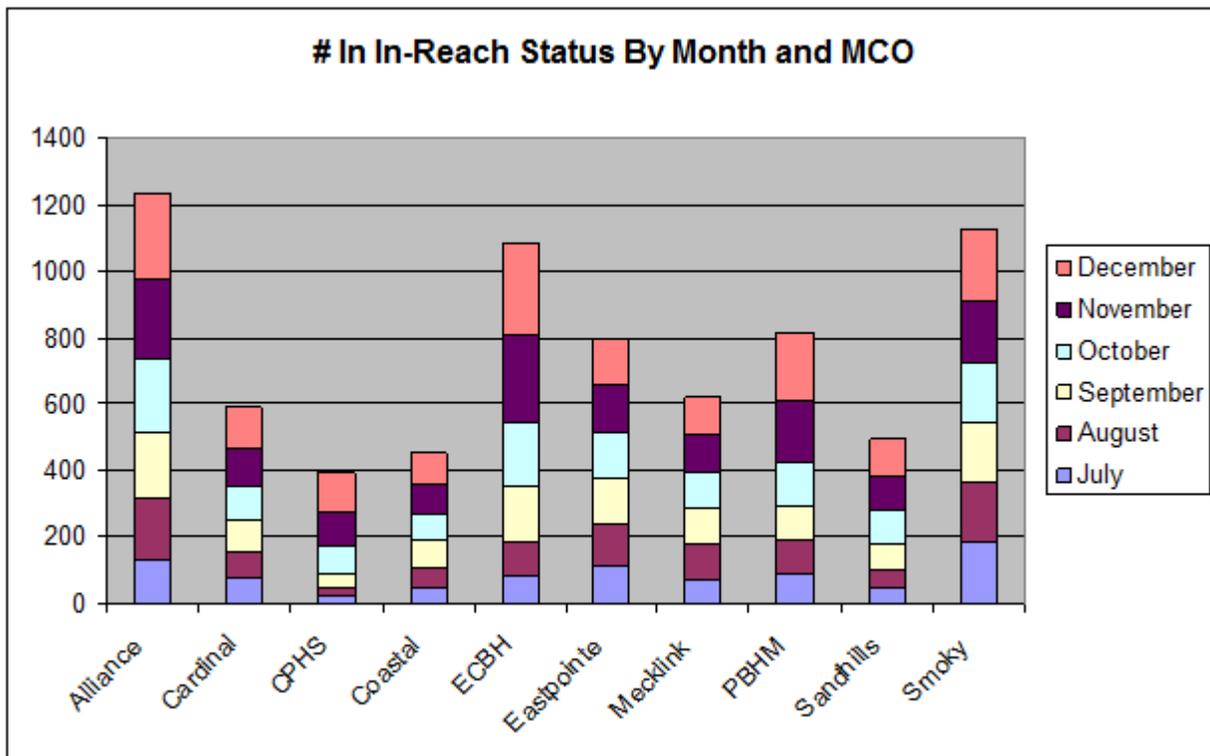
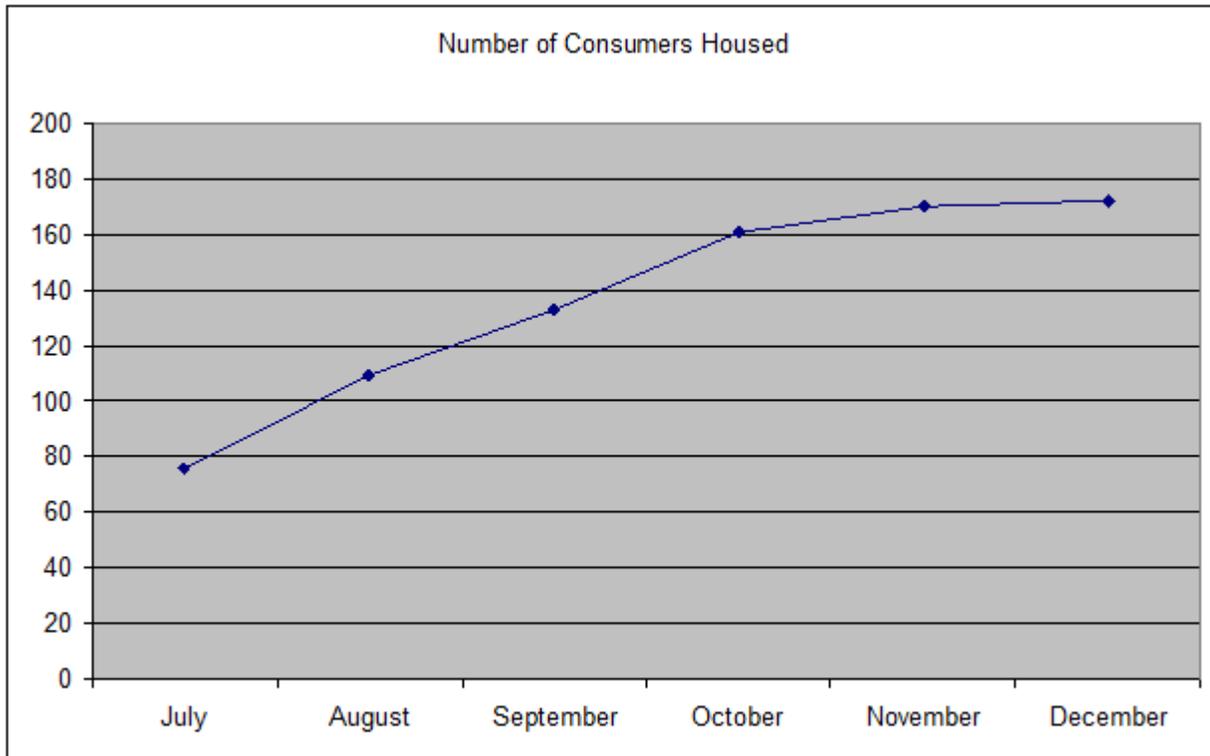
Category 2- Individuals with SPMI who are residing in adult care homes licensed for at least 50 beds and in which 25% or more of the resident population has a mental illness;

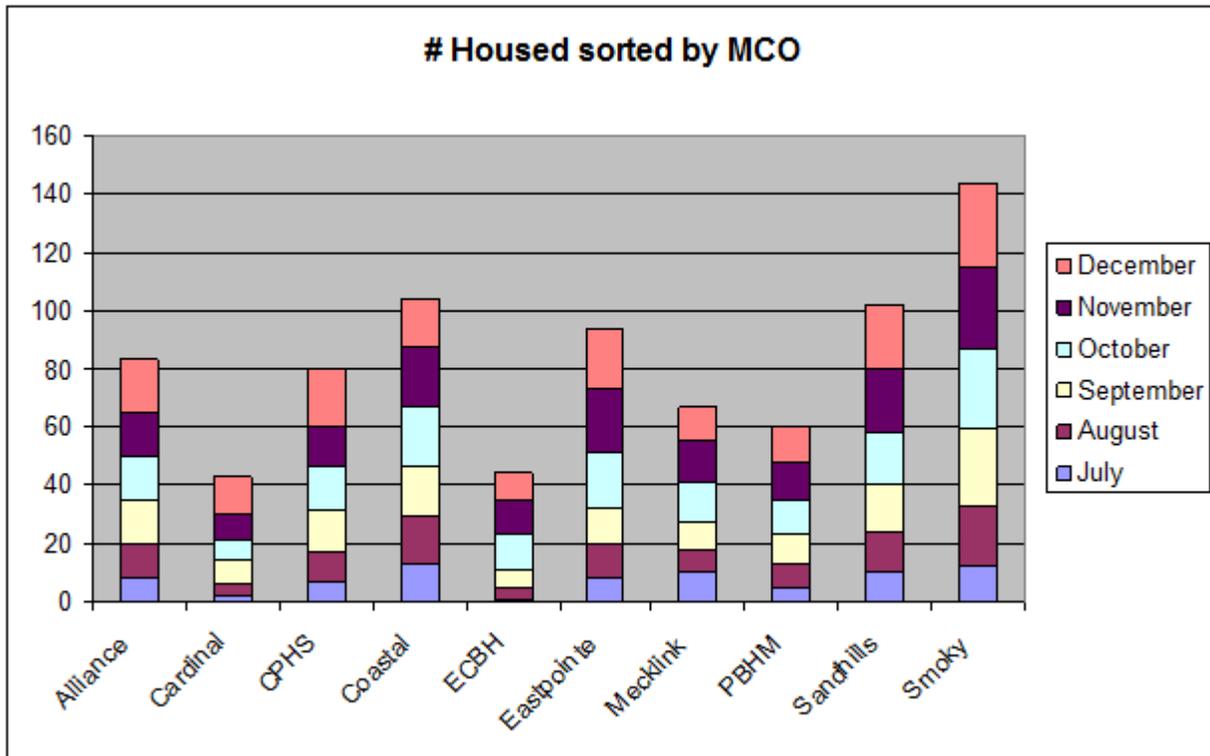
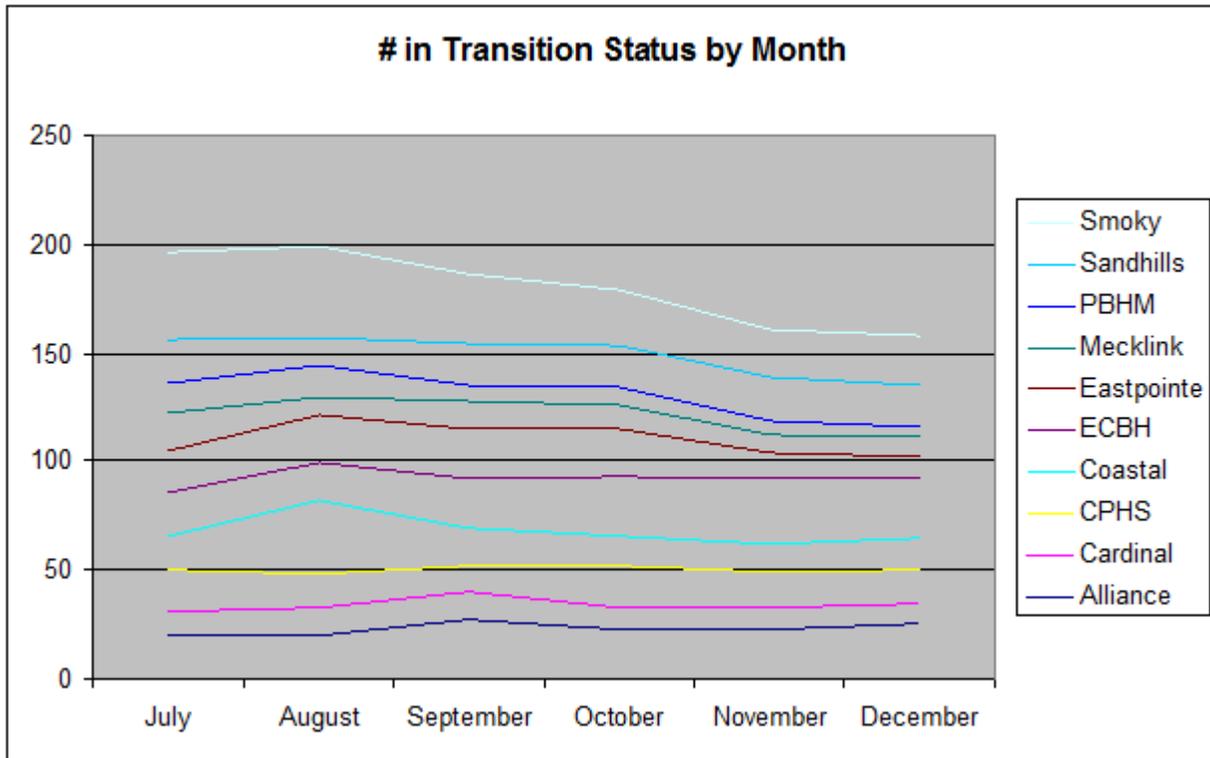
Category 3- Individuals with SPMI who are residing in adult care homes licensed for between 20 and 49 beds and in which 40% or more of the resident population has a mental illness;

Category 4- Individuals with SPMI who are or will be discharged from a State psychiatric hospital and who are homeless or have unstable housing; and

Category 5- Individuals diverted from entry into adult care homes pursuant to the pre-admission screening and diversion provisions.







PASRR Screenings: Calendar Year 2013

<i>Total Level I PASRRs Processed through December 31, 2013</i>	<i>11,127</i>
LME/ MCO Level II PASRRs	
Alliance Behavioral Healthcare	371
Cardinal Innovations	354
CenterPoint Human Services	143
Coastal Care	144
East Carolina Behavioral Health	344
Eastpointe	191
MeckLINK Behavioral Healthcare	189
Partners Behavioral Health Mgmt	269
Sandhills Center	180
Smoky Mountain Center	443
<i>Total Level II PASRRs Processed through December 31, 2013</i>	<i>2,628</i>

Personal Outcomes I: Calendar Year 2013

LME/MCO	# of incidents of harm	# of repeat admissions to State Hospitals	# of repeat admissions to Community Hospitals	# of repeat admissions to Adult Care Homes	# of repeat admissions to Inpatient Psychiatric Facilities	# of repeat Emergency Room visits	# of Crisis Calls
Alliance Behavioral Healthcare	4	0	1	1	2	42	3
Cardinal Innovations	0	0	0	0	0	0	0
CenterPoint Human Services	1	1	6	1	0	10	5
Coastal Care	0	0	0	1	1	1	1
East Carolina Behavioral Health	3	1	10	1	5	9	4
Eastpointe	17	1	1	3	4	9	0
MeckLINK Behavioral Healthcare	0	0	0	0	0	0	0
Partners Behavioral Health Mgmt	3	0	0	3	13	21	5
Sandhills Center	4	0	18	2	2	18	0
Smoky Mountain Center	3	1	13	2	5	15	6
Total Count	35	4	49	14	32	125	24
# of Individuals Affected	16	4	28	13	21	47	14
% of Total Individuals Housed	8.51%	2.13%	14.89%	6.91%	11.17%	25.00%	7.45%

Personal Outcomes II: Calendar Year 2013

LME/MCO	Number of individuals spending time in congregate day programming	Average time spent in congregate day programming	Number of Individuals employed	Number of Individuals attending school	Number of Individuals engaged in community life (as reported by LME/MCO)	Number of Individuals maintaining chosen living arrangement
Alliance Behavioral Healthcare	1	4 days/wk	1	1	14	18
Cardinal Innovations	2	25 hrs/wk	2	0	10	13
CenterPoint Human Services	2	3 days/wk	0	0	22	20
Coastal Care	0	0	0	0	14	16
East Carolina Behavioral Health	5	3 days/wk	1	1	11	9
Eastpointe	0	0	0	1	19	21
MeckLINK Behavioral Healthcare	0	0	0	0	14	12
Partners Behavioral Health Mgmt	2	Not reported	0	0	9	12
Sandhills Center	4	6 hrs/wk	0	0	22	22
Smoky Mountain Center	3	2 hrs/wk	1	1	24	29
# of Individuals Affected	19		5	4	159	172
% of Total Individuals Housed	10.11%		2.66%	2.13%	92.44%	91.49%

*One individual spent 3 days/wk; one individual spent 14 days total.