



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

North Carolina's Olmstead Plan

December 20, 2021

This page intentionally left blank.

Table of Contents

Introduction	5
Acknowledgments	6
<i>Olmstead v. L. C.</i>	7
The Development of North Carolina’s Olmstead Plan	9
North Carolina’s System to Support Individuals with Disabilities	13
Systems Overview	13
System Strengths, Gaps, and Challenges in Supporting Individuals with Disabilities	14
North Carolina’s Olmstead Plan Priorities	17
Priority Area 1: Strengthen Individuals’ and Families’ Choice for Community Inclusion through Increased Access to Home and Community Based Services and Supports	17
Priority Area 2: Address the Direct Support Professional Crisis	21
Priority Area 3: Divert and Transition Individuals from Unnecessary Institutional and Segregated Settings	25
Priority Area 4: Increase Opportunities for Supported Education and Pre-employment Transition Services for Youth with Disabilities, and Competitive Integrated Employment for Adults with Disabilities	31
Priority Area 5: Increase Opportunities for Inclusive Community Living	37
Priority Area 6: Address Gaps in Services	41
Priority Area 7: Explore Alternatives to Full Guardianship	47
Priority Area 8: Address Disparities in Access to Services	50
Priority Area 9: Increase Input from Individuals with Lived Experience	53
Priority Area 10: Reduce Transportation Burdens for Individuals with Disabilities	55
Priority Area 11: Use Data for Quality Improvement	56
Plan Implementation and Oversight	59
Designated Olmstead Staff	59
Ongoing Role of the Olmstead Plan Stakeholder Advisory	59
Making <i>Olmstead</i> Everyone’s Responsibility	60
Conclusion	61
Appendix A: North Carolina’s Additional Efforts to Date in Achieving Olmstead Plan Priorities	63
Appendix B: Olmstead Plan Stakeholder Advisory Membership, Committee Assignments, and Staff Work Group (November 23, 2021)	69
Appendix C: OPSPA Housing Committee Driver Diagram	77
Appendix D: Glossary of Terms	79

Abbreviations Used in this Document

ACH – Adult care home	I/DD – Intellectual and other Developmental Disabilities
ADA – Americans with Disabilities Act	IDM – Informed Decision Making
ADATC – Alcohol and Drug Addiction Treatment Center	IPS/SE – Individual Placement Support - Supported Employment
ADVP – Adult Developmental Vocational Program	LME/MCO – Local Management Entity/Managed Care Organization
CAP/C – Community Alternatives Program for Children	MFP – Money Follows the Person
CAP/DA – Community Alternatives Program for Disabled Adults	MORES – Mobile Outreach Response Engagement Stabilization
CARES Act – Coronavirus Aid, Relief and Economic Security Act	NCCDD – North Carolina Council on Developmental Disabilities
CIE – Competitive Integrated Employment	NC CORE – North Carolina Collaborative for Ongoing Recovery through Employment
CMS – Centers for Medicare and Medicaid Services	NC FIT – North Carolina Formerly Incarcerated Transitions Program
DAAS – Division of Aging and Adult Services	NCI – National Core Indicators®
DHB – Division of Health Benefits	NC PAL – North Carolina Psychiatry Access Line
DHHS – Department of Health and Human Services	NC START – North Carolina Systemic, Therapeutic, Assessment, Resources and Treatment
DMH/DD/SAS – Division of Mental Health, Developmental Disabilities and Substance Abuse Services	OPSA – Olmstead Plan Stakeholder Advisory
DPI – Department of Public Instruction	Pre-ETS – Pre-Employment Transition Services
DSB – Division of Services for the Blind	PROMS – Patient-Reported Outcomes Measures
DSOHF – Division of State Operated Healthcare Facilities	PRTF – Psychiatric Residential Treatment Facility
DSP – Direct Support Professional	RSVP – Referral, Screening, and Verification Process
DSS – Division of Social Services or local Department of Social Services	SAMHSA – U.S. Substance Abuse and Mental Health Services Administration
DVRS – Division of Vocational Rehabilitation Services	SED – Serious Emotional Disturbance
EMS – Emergency Medical Services	SMI – Serious Mental Illness
EPSDT – Early and Periodic Screening, Diagnostic and Treatment	SPMI – Severe and Persistent Mental Illness
FMAP – Federal Medical Assistance Percentage(s)	START – Sobriety Treatment and Recovery Teams
HCBS – Home and Community Based Services	SUD – Substance Use Disorder
HUD – U.S. Department of Housing and Urban Development	TBI – Traumatic Brain Injury
ICF/IID – Intermediate Care Facility for Individuals with Intellectual Disabilities	TCL – Transitions to Community Living
	WIOA – Workforce Investment Opportunity Act



Introduction

In its landmark ruling, *Olmstead v. L.C.*, the United States Supreme Court made “the case for community” on behalf of two people with disabilities, Lois Curtis (L.C.) and Elaine Wilson (E.W.) – and millions of Americans who would follow. The case rested on the foundational “integration mandate” of the Americans with Disabilities Act (ADA) and opened the door for people with disabilities to live the everyday lives that each of us so cherish. Under *Olmstead*, people with disabilities who reside or work in publicly funded, congregate settings – or who are at serious risk of entering such settings – must be given the opportunity to live side-by-side with everyone else, to the fullest extent possible. In this spirit, our state’s Olmstead Plan renews and strengthens our shared commitment to offer North Carolinians the opportunity to receive services and supports in places and in ways that are person-centered and integrated into day-to-day life.

The Olmstead Plan is a cross-population blueprint, addressing the health and well-being of children and families, youth, adults, and elders with disabilities. It reflects the contributions of many and incorporates much of the work we have already done as a state to advance independence, integration, inclusion, and self-determination for those with disabilities. Going forward, this strategic plan, and the work plans that flow from it, will shape policy, practices, and funding decisions.

Realizing the promise of *Olmstead* is not something we can do from the top down, or even from the bottom up. This effort requires all of us. We must coalesce around a common purpose, one that engages people with lived experience and families; advocacy groups; organizations, agencies and associations; regional management entities; and service providers. We are grateful to those already leading the way, including the many people who participated directly in this Plan’s development. Governor Cooper and I are committed, with your continued help, to making the promise of *Olmstead* a reality. Together, we will build partnerships that reach across the Administration, garnering support from the housing community; employers; schools; colleges and universities; transportation systems; the General Assembly; and the general public.

The Olmstead Plan is a living, breathing document. It will guide a changing system of services and supports. Its first phase covers 2022 to 2023; but we will not stop there. We continue the journey, advised each step of the way by those with lived experience, their families, and diverse stakeholders. Today, we celebrate the vision adopted by the Plan’s Stakeholder Advisory: North Carolina champions the right of all people with disabilities to choose to live life fully included in our communities. Tomorrow, I ask that you join us in the work that lies ahead.

Kody H. Kinsley

Secretary of the North Carolina Department of Health and Human Services

Acknowledgments

The development of this initial Olmstead Plan – a plan that applies, across the lifespan, to all people with a disability or behavioral health disorder who are in or at risk of entering publicly-funded, congregate settings – would not have been possible without the contributions of the following people: members of the Olmstead Plan Stakeholder Advisory (OPSA) and its Community Co-Chairs; the staff of the Office of the Senior Advisor on the Americans with Disabilities Act, Office of the Secretary, North Carolina Department of Health and Human Services (DHHS); the leadership and staff of many other DHHS divisions and offices, including the OPSA Departmental Co-Chair; the national experts who graciously volunteered their time and expertise to present during the OPSA's meetings, including Allan Bergman, Amy Hewitt, Leigh Ann Kingsbury, Marti Knisley, Joe Macbeth, Jonathan Martinis, Estelle Richman, Mark Salzer, and Ann Turnbull; members of the eight OPSA committees and their chairs, inclusive of representatives of the North Carolina General Assembly; stakeholders from across North Carolina, among them Local Management Entities/Managed Care Organizations; Area Agencies on Aging; legal professionals; Area Health Education Centers; provider agencies; professional associations; advocacy groups; family members of individuals with lived experience; and, most importantly, people whose lives are at the center of this Plan.

Going forward, we will continue to rely on the ongoing participation and commitment of these individuals, and those who will follow, to assist North Carolina in realizing the vision of *Olmstead* and its capacity for strengthening the vibrancy, health, and well-being of this state's communities and its people.



Olmstead v. L. C.

Within the disability community, the *Olmstead v. L. C.* Supreme Court case¹ is often compared to *Brown v. Board of Education*, and with good reason. Like *Brown*, *Olmstead* is a transformative driver of cultural and systemic change. The *Olmstead* decision, which derives from the Americans with Disabilities Act (ADA), provided our country with a sweeping interpretation of the ADA's "integration mandate." Writing for the court, Justice Ruth Bader Ginsburg stated that "unjustified segregation" of people with disabilities in institutional settings was unlawful discrimination under the ADA. The ruling established that public entities, such as the North Carolina Department of Health and Human Services, must provide community-based services to people with disabilities when: (1) such services are appropriate; (2) the affected person doesn't oppose treatment that takes place in the community; and (3) providing such services can be "reasonably accommodated, taking into account the resources available...and the needs of others who are receiving disability services..."² Since the ruling, implementation of the *Olmstead* decision has brought thousands of people with disabilities into the mainstream of American life.

¹ *Olmstead vs. L.C.*, 1999, 527 U.S. at 600-01. Retrieved October 10, 2021 from <https://supreme.justia.com/cases/federal/us/527/581/>

² *Olmstead vs. L.C.*, 1999, 527 U.S. at 600-01. Retrieved October 10, 2021 from <https://supreme.justia.com/cases/federal/us/527/581/>

This page intentionally left blank.



The Development of North Carolina's Olmstead Plan

In January 2020, the North Carolina Department of Health and Human Services (DHHS) engaged the Technical Assistance Collaborative (TAC), in partnership with the Human Services Research Institute, to assist in the development and implementation of a comprehensive, effectively working plan to support the state's residents with disabilities in the most integrated settings appropriate to their needs, as required under *Olmstead*. Following 15 listening sessions and extensive qualitative and quantitative data review, TAC issued a report that included both an assessment and an analysis of how the systems, funding, services, and housing options of the DHHS and other state agencies function to serve people with disabilities in integrated settings.³ The findings of this report, summarized below, were among many sources of information used in the development of the state's Olmstead Plan. The report also offered information germane to subsequent phases of the initiative, specifically, technical assistance for implementation activities, as deemed necessary, and development and implementation of a system for performance evaluation and outcome measurement.

In the early summer of 2020, the DHHS Secretary announced appointments to the Olmstead Plan Stakeholder Advisory (OPSA), a group of diverse stakeholders from the disability advocacy community, including individuals with lived experience and their families; service providers; managers of provider networks (e.g., the Local Management Entities/Managed Care Organizations or LME/MCOs); professional associations; policymaking leaders within the DHHS; and state legislators from both sides of the aisle. The 2021 OPSA was co-chaired by the recent past chairs of The Coalition and the North Carolina Coalition on Aging. These Community Co-Chairs were joined by a Departmental Co-Chair, the Deputy Secretary for the Division of Health Benefits (NC Medicaid). Please see [Appendix B](#) for the 2021 list of OPSA members and their affiliations.

Shortly after the OPSA's first meeting, the DHHS adopted the following mission statement for the Olmstead initiative:

In collaboration with our partners, the NC DHHS provides essential services to assist people with disabilities to reside in and experience the full benefit of inclusive communities.

³ Technical Assistance Collaborative, Inc. and Human Services Research Institute (2021). [An assessment of the North Carolina Department of Health and Human Services' system of services and supports for individuals with disabilities](https://bit.ly/3uZFBPB) [PDF], Raleigh, NC: North Carolina Department of Health and Human Services, <https://bit.ly/3uZFBPB>

After discussion with its membership, the OPSA also adopted this vision statement:

North Carolina champions the right of all people with disabilities to choose to live life fully included in the community.

The DHHS recognized that while the OPSA would play a key role in advising the Department during plan development, the focused work for development and implementation would require staff and individuals involved in carrying out the day-to-day work. The DHHS subsequently complemented the Advisory with a team of subject matter and data experts from across the Department, along with representatives from LME/MCOs and their provider networks. This OPSA Staff Work Group is led by the Office of the Senior Advisor on the Americans with Disabilities Act (ADA) and the Office of the General Counsel. The DHHS next formed committees from the OPSA's membership, composed of external stakeholders, DHHS leadership, and other DHHS staff members, to develop recommendations and action steps to address plan priorities. The 2021 committees were:

Housing	Employment
Community Capacity Building	Transitions to Community
Children, Youth, and Families	Workforce Development
Older Adults	Quality Assurance and Quality of Life

The Department selected eight OPSA members to chair the committees, and each committee was assigned staff to guide and inform its work. Please see [Appendix B](#) for a list of OPSA committees and membership.

To date, the OPSA has convened six quarterly meetings which have spotlighted key policy innovations; featured presentations from national experts;⁴ provided committee updates; and reviewed progress and provided feedback on Olmstead Plan development. The subcommittees have met regularly, providing meeting minutes and summaries to the Assistant Director for Olmstead Plan Development in the Office of the Senior Advisor on the ADA; these were forwarded to TAC for review.

⁴ In 2020, the OPSA heard from TAC Executive Director Kevin Martone on Olmstead Plan development; Burton Blatt Institute Senior Director for Law and Policy Jonathan Martinis on supported decision-making; and Executive Director of the National Alliance for Direct Support Professionals (NADSP) Joe Macbeth and Director of the Institute for Community Integration (ICI) Amy Hewitt, Ph.D. on workforce development. In 2021, the OPSA hosted expert presentations from the Lewin Group's Leigh Ann Kingsbury on person-centered systems and aging with disabilities; High Impact's Allan I. Bergman on competitive integrated employment; former Secretary of the Pennsylvania Department of Public Welfare and former Senior Advisor to the Secretary of Housing and Urban Development Estelle Richman on effective system change strategies; Mathematica's Jessica Ross and Carey Appold on quality measurement; TAC's Jim Yates on the Center for Medicare and Medicaid's (CMS) Final Home and Community Based Services (HCBS) Settings Rule; and TCL Independent Reviewer Marti Knisley on supported housing. TAC Senior Consultant Sherry Lerch attended all quarterly meetings.

The draft Olmstead Plan was released for public comment from October 12 through November 8, 2021. Comments were submitted by 91 individuals and organizations. The DHHS reviewed and considered all public comments received, contributing to an initial Olmstead Plan that is both comprehensive and achievable.

This page intentionally left blank.



North Carolina's System to Support Individuals with Disabilities

Systems Overview

State Structure

The North Carolina Department of Health and Human Services (DHHS) has 34 divisions and offices covering six broad service areas: Health; Opportunity and Well-Being; Medicaid; Operational Excellence; Policy and Communications; and Health Equity. The DHHS also oversees 14 facilities: developmental centers; neuro-medical treatment centers; psychiatric hospitals; alcohol and substance use disorder treatment centers; and two residential programs for children. These divisions and offices are responsible for the oversight of state and federal funding; program development; establishing and informing statewide policy; providing advocacy and protection for recipients; providing technical assistance on evidence-based and promising practices; and overseeing quality improvement.

The Role of Local Management Entities/Managed Care Organizations, Tailored Plans, and Standard Plans

Since July 1, 2013, Local Management Entities/Managed Care Organizations (LME/MCOs) have been responsible for statewide management and oversight of the public system of mental health, developmental disabilities, and substance use disorder services at the community level. Their role is to coordinate both behavioral health and intellectual and other developmental disabilities (I/DD) services, and payments for those services. This coordination is accomplished through a network of local community service providers which contract with and are monitored by the LME/MCOs. The LME/MCOs receive a monthly payment from the DHHS' Division of Health Benefits (NC Medicaid) based on the number of Medicaid beneficiaries residing in each LME/MCO's catchment area. Medicaid beneficiaries receive mental health, substance use disorder, and I/DD services through the LME/MCO's authorization for services within their network. LME/MCOs are also charged by General Statute to serve people who are uninsured, with funding supplied through U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) block grants that require matching state funds as a "Maintenance of Effort." The state portion of non-Medicaid funding is appropriated by the General Assembly and referred to as "single stream funding."

Prior to July 1, 2021, Medicaid beneficiaries were enrolled in NC Medicaid Direct, administered by the DHHS, for physical health and pharmacy benefits. Effective on that date, most Medicaid beneficiaries were required to enroll in a Medicaid managed care plan run by an insurance

company, referred to as a “Standard Plan.” Standard Plans provide integrated physical health, behavioral health, pharmacy benefits, and long-term services and supports to most Medicaid beneficiaries, as well as programs and services that address unmet health-related resource needs.

Beginning on December 1, 2022, selected LME/MCOs will operate Behavioral Health I/DD Tailored Plans to provide specialized services for individuals with significant behavioral health conditions, I/DD, or traumatic brain injury (TBI). Tailored Plans will include integrated physical health care, pharmacy benefits, and long-term services and supports, as well as programs and services to address unmet health-related resource needs.

NC Medicaid's [“Tailored Plan Information for Providers”](#) [PDF] resource provides more information.

System Strengths, Gaps, and Challenges in Supporting Individuals with Disabilities

Strengths of the System

North Carolina has been engaged for many years in transforming its services and systems to support individuals with disabilities as fully included members of their communities.

The Transitions to Community Living (TCL) effort has resulted in positive outcomes and improved delivery of services for many adults with serious mental illness (SMI) in North Carolina and may act as a framework for serving people with other disabilities. North Carolina leverages numerous federal resources to support individuals with disabilities, including Medicaid Home and Community Based Services (HCBS) waivers, Money Follows the Person (MFP), the Children's System of Care model, and the development of affordable housing. North Carolina has made progress in providing opportunities for competitive integrated employment for individuals with disabilities and Governor Cooper signed Executive Order No. 92, declaring North Carolina an Employment First state. The DHHS promotes evidence-based practices that support children, adults, and older adults with behavioral health disorders; individuals with I/DD; and individuals involved with the criminal justice system. North Carolina's universities have created model programs and provide training and consultation in evidence-based practices. LME/MCOs provide community-based services and supports in addition, or as alternatives to, Medicaid state plan services. Finally, the DHHS has entered into a contract with the Cherokee Indian Hospital Authority to support the Eastern Band of Cherokee Indians in addressing the health needs of American Indian/Alaska Native Medicaid beneficiaries, the first Indian managed care entity of its kind in the nation.⁵

⁵ North Carolina Department of Health and Human Services (2021, October 3). [Eastern Band of Cherokee Indians \(EBCI\) tribal option overview](#). Retrieved October 10, 2021 from <https://bit.ly/3iQTlrb>

Challenges within the System

While progress has been made towards achieving the vision of *Olmstead*, there is more work to do. Not enough community-based service providers have developed the skills necessary to serve individuals with complex needs or challenging behaviors, leaving state-operated facilities and costly, out-of-state psychiatric residential treatment facilities (PRTFs) as the only options for services for these individuals. Gaps in services impede community integration; additional community-based service options and capacity are needed for children, adults, and older adults with disabilities to reduce reliance on institutional and congregate care settings. Yet the growth of service capacity is challenged by the staffing crisis faced by North Carolina and every state across the country. There are not enough staff, including, but not limited to, Direct Support Professionals, to serve individuals with disabilities. Finally, the supply of affordable, accessible housing is limited in locations where services and transportation are readily available for individuals with disabilities.

A number of barriers inhibit both access to the services and supports that do exist and to the development of additional services to support individuals with disabilities as integrated members of their communities. Individuals and families must wait for services and funding. The Registry of Unmet Need ("waiting list") exceeds 15,000 individuals with I/DD, more than the number of Innovations waiver participants. More than one in ten North Carolinians lacks access to health care coverage and must rely on limited and shrinking state funding for community-based services, leading them to turn instead to crisis, emergency department, and state-operated health care services. Finally, the overuse of full guardianship has been identified as a consistent barrier to community inclusion, affecting individuals with all disabilities and of all ages.

No Olmstead Plan can remedy every need and challenge a state faces in serving and supporting its residents with disabilities. This Plan, set forth by the DHHS, is intended to highlight how the Department's current work, future implementation efforts, and use of resources can be viewed through an *Olmstead* lens to achieve the state's vision of community inclusion for individuals with disabilities in North Carolina's publicly funded system of services and supports.

This page intentionally left blank.

North Carolina's Olmstead Plan Priorities

North Carolina's Olmstead Plan envisions all people with disabilities exercising their right to choose a life that is fully included in the community. This Plan is a *strategic plan*; it provides a framework for the system and identifies actions and the allocation of resources to help achieve this vision. Detailed work plans will be developed, as needed, to carry out the strategies within each Goal Area. The Department of Health and Human Services (DHHS) does not have the staffing capacity or the financial resources to address immediately every system gap or challenge; nor can the Department resolve all systemic barriers alone. This Plan sets forth priorities and strategies to continue strengthening the community-based system that we know today. For each priority, initial target measures are identified to assess progress in implementing strategies. We envision that the system will continue to evolve over the next few years; measures will be revised and refined, and new measures developed, as the DHHS enhances its ability to track data and establish baselines. This initial Plan will guide the Department's efforts as follows:

Year One: January 1, 2022 – December 31, 2022

Year Two: January 1, 2023 – December 31, 2023

As noted in the conclusion, the 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 public input, learned experience, or circumstances that are unaccounted for or unforeseen.

Priority Area 1: Strengthen Individuals' and Families' Choice for Community Inclusion through Increased Access to Home and Community Based Services and Supports

What Priority Area 1 Means

Home and Community Based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their homes or in a community-integrated setting rather than in institutions or other isolating settings.

Why Priority Area 1 is Important

North Carolina has four Medicaid waivers that provide federal matching funds for HCBS: the Innovations waiver for individuals with intellectual and other developmental disabilities (I/DD); the Traumatic Brain Injury (TBI) waiver; and, for children and adults who are medically fragile or medically complex, the Community Alternatives Program for Children (CAP/C) waiver and the Community Alternatives Program for Disabled Adults (CAP/DA) waiver, respectively. The Centers for Medicare and Medicaid Services (CMS) issued a Final Rule on the requirements for settings in which residential and employment/day services are provided to HCBS recipients. North Carolina must be fully compliant with the Final Rule by March 23, 2023 or risk losing federal revenue.

There are currently waiting lists for two of North Carolina's four HCBS waivers. Approximately 2,100 people are on the CAP/DA waiver waiting list, and approximately 15,000 people are on the Innovations waiver waiting list (the Registry of Unmet Need).⁶ Although the CAP/C waiver does not have a waiting list, the maximum participant count of 4,000 is reaching its limit. The demand for CAP/DA waiver services will likely increase; over the last ten years, while the North Carolina population saw a 10 percent increase, there was a 41.9 percent increase in the population over 65 years old.⁷ Finally, while the TBI waiver is a "pilot" and does not have a waiting list, eligibility for this waiver is limited to a few counties within the state.

Section 9817 of the American Rescue Plan Act temporarily increases Federal Medical Assistance Percentage (FMAP) rates by 10 percentage points for certain Medicaid HCBS expenditures. This federal funding boost can help states increase community-based options for people with disabilities. The policy of promoting community inclusion comports with Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12131–12134, as interpreted by the Supreme Court in *Olmstead v. L.C.*, 527 U.S. 581 (1999). The ruling requires public entities to administer services to individuals with disabilities in the most integrated setting appropriate to their needs.

North Carolina's Priority Area 1 Efforts to Date

HCBS Transition Plan

- ✓ As of July 8, 2021, the DHHS had validated that 70.29 percent of the 6,000 residential, supported employment, and day supports sites providing HCBS to waiver recipients were in compliance with the Final Settings Rule.⁸
- ✓ The Department of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) is also revising I/DD and TBI state-funded service definitions to include HCBS principles, making these services comparable for recipients.

⁶ Per conversation with North Carolina Division of Health Benefits staff.

⁷ 2019 Population estimates, U.S. Census Bureau.

⁸ Per conversation with North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services staff.

Expanded Opportunities for Community Inclusion and HCBS

- ✓ On July 12, 2021, the DHHS submitted to CMS a proposal and estimated expenditures for a number of initiatives to strengthen HCBS in North Carolina in support of this Olmstead Plan (see strategies below). The DHHS has received a partial approval of the HCBS Transition Plan and, at the request of CMS, is in the process of providing clarification.
- ✓ The North Carolina General Assembly approved funding for additional participants in the Innovations waiver by 1,000 in 2022. The North Carolina legislature also funded 114 additional participants in the CAP/DA waiver.

Please see [Appendix A](#) for additional North Carolina efforts to date.

Proposed Priority Area 1 Strategies

- The DHHS will ensure that all remaining sites providing HCBS that are identified within the transition period are validated and in compliance with the Final HCBS Settings Rule by no later than March 2023.
- The DHHS will continue efforts to promote serving individuals in community-integrated settings and will assess annual expenditures for institutional and community-based services with the intent of further rebalancing state and federal resources to support more individuals with disabilities in the community.
- The Division of Health Benefits (DHB) will add Innovations, CAP/DA, and CAP/C waiver slots using enhanced FMAP, pending CMS approval, and newly appropriated state funds.
- The DHHS will expand eligibility for the TBI waiver by adding counties of residence, reducing the age of eligibility to 18 years old, and increasing the income limit to 300 percent of the federal poverty level.
- The DHB will develop an integrated, state waiting list database of people with I/DD and people with TBI for state-operated and state-funded services, along with Medicaid waiver-funded services. This will provide beneficial information about the demographics of people who require services and who may shift between programs. This database will not replace the Registry of Unmet Need, which will continue to be maintained by the Local Management Entities/Managed Care Organizations (LME/MCOs) and, eventually, the Tailored Plans.
- The DHB will inform families of children on the Registry of Unmet Need that their children may be eligible and should be assessed for services through the CAP/C waiver or Personal Care Services, as covered under the State Plan.
- The DHB is actively developing a Remote Supports service definition, initially for the TBI waiver renewal, followed by the Innovations waiver and, pending CMS approval, will use enhanced FMAP to add remote technology support to the CAP/C and CAP/DA waivers.
- The DHB will expand Home Health services to include persons who are transitioning from institutions to the community and who have three or more chronic conditions of any type. The DHB will also expand Specialized Therapies for the first year for people transferring to the community from institutions.

- The DHB is revising North Carolina's regulations that set the cap on eligibility for 1915(c) waiver benefits for individuals transitioning from institutional care, to reduce/eliminate the deductible for community-based services, thereby increasing access to HCBS for these individuals.

Baseline Data/Targeted Measures for Priority Area 1

Baseline Data for Priority Area 1⁹

As of May 1, 2021, there were 13,138 individuals with I/DD supported by the Innovations waiver, and more than 15,000 individuals on the Registry of Unmet Need.

In Fiscal Year 2019, there were 11,534 adults with physical disabilities supported by the CAP/DA waiver and 2,650 children with complex medical conditions supported by the CAP/C waiver.

The TBI waiver, which is not yet statewide, currently supports 41 individuals but has a capacity of 107 slots.

Targeted Measures for Priority Area 1

- By March 2023, 100 percent of HCBS settings will comply with the Final HCBS Settings Rule.

As noted in Table 1 below, the DHHS will provide more than 2,300 additional participants with access to HCBS waivers by December 31, 2023.

Table 1: Planned Increases to HCBS Waiver Participation in North Carolina

Waiver Type	Calendar Year 2022	Calendar Year 2023
Innovations	Increase by 1,000	Increase by 1,000
CAP/DA	Increase by 114	Increase by 200
CAP/C	Expand to 5,000	Increase if needed

Resource Requirements for Priority Area 1

HCBS Transition Plan

The DMH/DD/SAS will cover the cost to apply the Final HCBS Settings Rule requirements to state-funded HCBS services within the existing state appropriation.

⁹ Except where otherwise noted, baseline data for all Priority Areas was provided to TAC by DHHS staff.

Expanded HCBS Opportunities

The cost of additional waiver slots will be covered through federal Medicaid revenues and increased state appropriations as approved by the North Carolina General Assembly.

The estimated state share of the cost of HCBS policy proposals will be covered through State Fiscal Year 2023 using a portion of the enhanced FMAP for HCBS.

Priority Area 2: Address the Direct Support Professional Crisis

What Priority Area 2 Means

Direct Support Professionals (DSPs) are individuals who are employed to “provide a wide range of supportive services to individuals...on a day-to-day basis, including habilitation, health needs, personal care and hygiene, employment, transportation, recreation, housekeeping and other supports, so that these individuals can live, work and participate in their communities” and “lead self-directed, community and social lives.”¹⁰ DSPs support activities of daily living to the extent needed and provide support and advocacy for individuals to be fully included in their communities. DSPs may work in community-based facilities or provide services to a Medicaid waiver participant in the person’s workplace or in their own home or that of the family.

Why Priority Area 2 is Important

The quality of support provided by DSPs to individuals with physical disabilities, I/DD, mental health needs, and substance use disorders has a profound influence on their satisfaction with services and supports paid for by the State of North Carolina. Specific factors that can have a significant impact on the quality of life for these individuals include the competence, stability, and satisfaction of DSPs, as well as turnover rates and vacancies.

The success of HCBS and other community-based services depends on having a workforce, inclusive of professional caregivers and, in some cases, family members who can meet the needs of individuals with disabilities living in the community. This is not only a matter of hiring enough qualified individuals, but of retaining them as well. While raising the hourly rate they receive is viewed as the priority solution to increase hiring of DSPs, requiring competency-based training is essential to improving the quality of services provided.

¹⁰ Congressional Record, November 4, 2003, p. H10301 as cited in Report to the President 2017, *America’s direct support workforce crisis: Effects on people with intellectual disabilities, families, communities and the U.S. economy*, President’s Committee for People with Intellectual Disabilities. The term “Direct Support Professionals” is increasingly used for the frontline workforce within other populations of people with disabilities.

North Carolina has more than 123,000 direct service workers,¹¹ including DSPs for the Olmstead population, and the need for these workers is projected to increase by at least 20,000 jobs by 2028.¹² However, the direct service workforce has high rates of turnover and lower rates of employee retention; 53 percent of the state's direct service workforce live at or near poverty level.¹³ Adequate rates of pay must be established, and competency-based training made available.

Currently, there is a gap between the HCBS services authorized and the services delivered by providers, attributed in large part to the lack of DSPs and in-home nurses. This gap will only widen as the DHHS is proposing to increase the number of participants for the Innovations, CAP/C, CAP/DA, and TBI waivers. Adding waiver slots without also addressing the shortage of DSPs may create an environment where people have more difficulty accessing services.

Raising DSP wages will go a long way in stabilizing the workforce, however additional efforts will also be necessary to maximize the available workforce. The expanded use of assistive technology is emerging as a strategy to relieve the overwhelming demand for DSPs. For example, "smart homes" support individuals with I/DD, TBI, and physical disabilities to live independently. The technology and supports are designed to anticipate challenges and threats to safety and resolve them before they happen, allowing staff to intervene only when needed rather than being present 24/7. While not the solution for everyone, technology can empower individuals with disabilities with greater independence and expand access to HCBS support.¹⁴

North Carolina's Priority Area 2 Efforts to Date

- ✓ In November 2021, the General Assembly approved budget included a rate increase for direct service workers employed by Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) and HCBS providers.
- ✓ The approved budget also included a rate increase for private duty nurses.
- ✓ The DHB developed and implemented a pilot program to expend \$1.6 million by June 30, 2021 to provide communication access services for deaf, deaf-blind and hard-of-hearing Medicaid beneficiaries.
- ✓ By December 2021 the Division of Aging and Adult Services (DAAS), in collaboration with the NC Assistive Technology Project, will have accessed funds awarded via a COVID Aging and Disability Resource Center grant. These funds will support the initiation of specific services to

¹¹ Goldsmith, T. (2018, November 29). [Demand for NC direct care workers. mount. but wages decline. North Carolina Health News](https://bit.ly/2YFDsMT), <https://bit.ly/2YFDsMT>

¹² Goldsmith, T. (2021, February 17). [As the long-term care industry shifts, COVID-19 shortchanges NC's frontline workers](https://bit.ly/3mHiCp1), North Carolina Health News, <https://bit.ly/3mHiCp1>

¹³ Robins, A. (2020, October 6). [Essential jobs, essential care: A conversation with North Carolina](https://bit.ly/3mIGrN5), PHI National, <https://bit.ly/3mIGrN5>

¹⁴ LADD, Inc. (n.d.) [Smart living](https://laddinc.org/program/smart-living/), Retrieved October 10, 2021 from <https://laddinc.org/program/smart-living/>

assist seniors with disabilities to learn about and use assistive technology for communication and safety.

- ✓ Self-direction is an option under the Innovations, CAP/DA, and CAP/C waivers.

Please see [Appendix A](#) for additional North Carolina efforts to date.

Proposed Strategies for Priority Area 2

- The DHB will allocate enhanced FMAP funds to increase DSP wages, to be sustained on an ongoing basis as a result of additional funds appropriated by the General Assembly.
- Beginning in March 2022, the DHB will conduct an annual survey of direct care workers/ Direct Support Professionals who serve Innovations waiver recipients, to assess whether the wages of licensed direct care workers, non-licensed direct care workers, or both need to be increased. If the DHB determines that there is a need for an increase in wages, the DHB will develop a plan, or update to a previously submitted plan as applicable, to implement the increase.
- The DHB will, pending CMS approval, allocate enhanced FMAP for the recruitment and training of DSPs.
 - The DHHS will consult with qualified individuals to determine the competency-based curricula for training DSPs across sectors.
- The DHHS will establish a certification process for DSPs that recognizes lived experience.
- The DHHS will establish a DSP credential that is portable among geographic regions of the state and will identify a credentialing association/board/entity to develop and manage the credentialing process; advocate for the credential; and manage grievances.
- The DHB will assess the impact of the rate increase for private duty nurses, approved by the General Assembly, on the ability of families to receive authorized services for their medically complex children, given the shortage of in-home nurses.
- The DHHS Individual Placement and Support Statewide Steering Committee meetings will include, as a recurring agenda item, review of challenges impacting the ability to hire new staff, in order to assist in the removal of barriers to obtaining and retaining quality trained staff.
- The Division of Services for the Blind (DSB) will provide virtual instruction to enable 50 individuals with visual impairment to successfully utilize assistive technology and adaptive devices to enhance their independent functioning in the home, family, community, and employment.
- The DMH/DD/SAS will work with the Standard Plans and LME/MCO Tailored Plans to increase the use of “smart home” technologies that support independent living.

Baseline Data / Targeted Measures for Priority Area 2

Baseline Data for Priority Area 2

The average starting wage for a DSP in North Carolina is \$10.88/hour; the average wage paid ongoing is \$11.95/hour.¹⁵

In Fiscal Year 2019, the penetration rate for assistive technology among Innovations waiver recipients was 7.9 percent.¹⁶

In Fiscal Year 2020, the Division of Vocational Rehabilitation Services (DVRS) provided assistive technology services including assessments, provision of adaptive equipment, and training for 700+ consumers.

Between April 2020 and August 2021, the DAAS Assistive Technology Project served 6,404 individuals. Of those served, 2,147 have a disability and 1,299 are age 60 or older.

In Fiscal Year 2019, the penetration rate for the self-directed Community Navigator service among individuals on the Innovations waiver was 24.8 percent;¹⁷ self-direction was selected by 23 percent of CAP/DA participants and 38 percent of CAP/C participants.

Targeted Measures for Priority Area 2

- Effective the first quarter of 2022, DSPs will be eligible to receive a wage increase of up to \$15.00/hour.
- By December 31, 2023, an additional 100 individuals will receive assistive technology, including “smart homes” technology, through Standard Plans and LME/MCO Tailored Plans.
- By December 31, 2023, 20 percent more seniors will have increased access to assistive technology through the Aging and Disability Resource Center DAAS Assistive Technology Project.
- By December 31, 2023, an additional five percent of individuals on the CAP/DA, CAP/C, and Innovations waivers will choose to self-direct their services.

Resource Requirements for Priority Area 2

The DSP wage increase will be covered via enhanced FMAP and a budget increase approved by the General Assembly through State Fiscal Year 2023.

¹⁵ National Core Indicators (2020). [National Core Indicators 2019 staff stability survey report](https://bit.ly/3aoa1ld) [PDF].
<https://bit.ly/3aoa1ld>

¹⁶ Technical Assistance Collaborative, Inc. and Human Services Research Institute (2021). [An assessment of the North Carolina Department of Health and Human Services' system of services and supports for individuals with disabilities](https://bit.ly/3uZFBPB) [PDF]. Raleigh, NC: North Carolina Department of Health and Human Services, <https://bit.ly/3uZFBPB>

¹⁷ DHHS Medicaid Claims Data.

Priority Area 3: Divert and Transition Individuals from Unnecessary Institutional and Segregated Settings

What Priority Area 3 Means

Diversion services provide individuals with disabilities the supports needed to remain at home, alleviating the need for institutional or congregate living. Many individuals with disabilities want to remain in their homes, but they or their families lack the resources or assistance they need to do so safely. More individuals could be supported in community-based settings of their choice if they and their families could easily access information about services to support greater independence.

Transition services and supports assist people to integrate into the community after leaving institutions or settings that hindered community inclusion. Individuals with disabilities can languish in such settings if they do not have either the resources to cover transition costs, such as first-month's rent or move-in expenses, and the ongoing tenancy supports to successfully maintain their housing.

Why Priority Area 3 is Important

Children and youth are negatively impacted by out-of-home placements, through reduced contact with their families, homes, communities, pets, friends, possessions, routines, and school settings. These changes can be traumatic, having a detrimental effect on children's brain development and neurological function. Adults also experience negative impacts when removed from their homes, resulting in loss of independent living skills and social supports. The longer an individual with a disability is in a more restrictive setting, the more challenging it is for them to return to independent living.

In addition to the individual benefits of diversion and transition services, there are cost savings that can be invested into serving more people in the community. For example, Money Follows the Person (MFP) offers individuals the opportunity to transition to the community where they can receive home- and community-based services; on average, North Carolina saves \$2,600 per person per month in its MFP program compared to the cost of institutional care.

Finally, diverting and transitioning individuals with mental health disorders from state psychiatric hospitals, adult care homes (ACHs), and homelessness are requirements of the Transitions to Community Living (TCL) settlement agreement with the U.S. Department of Justice.¹⁸ Over the last two years, North Carolina has been hampered in its ability to move individuals from ACHs

¹⁸ North Carolina Department of Health and Human Services (n.d.). [Transitions to community living](https://bit.ly/3FxEwU8). Retrieved October 10, 2021 from <https://bit.ly/3FxEwU8>

as a result of the COVID-19 pandemic. The state fell just short of its benchmark to have 3,000 persons in housing by June of 2021. Per the TCL independent reviewer's 2020 report, North Carolina is not on track to transition 2,000 individuals from adult care homes to supported housing slots, which is one of the main sub-requirements in the settlement agreement and the issue at the heart of the alleged *Olmstead* violations leading to the agreement.

North Carolina's Priority Area 3 Efforts to Date

Diversion

- ✓ The DHHS created the Referral, Screening, and Verification Process (RSVP)¹⁹ to identify when a person with a serious and persistent mental illness (SPMI) is referred to an ACH. An "Independent Reviewer" then screens them for eligibility to TCL, to potentially divert the admission to an ACH.
- ✓ The LME/MCOs are currently conducting in-reach with 1,241 adults with serious mental illness (SMI) and SPMI in state psychiatric hospitals, and with 3,852 individuals residing in ACHs, to engage and inform them about community mental health services and supportive housing options.²⁰
- ✓ The DHHS is proposing to use a portion of the American Rescue Plan Act five-percent set-aside, as well as Duke Endowment funds, to expand the availability of mobile crisis services to children. Use of the Mobile Outreach Response Engagement Stabilization (MORES) model, including training staff in the provision of crisis services to children and a family peer support component, will divert inpatient admissions and out-of-home placements for treatment.
- ✓ Supported with Governor's Task Force funds, the Division of Mental Health, the DMH/DD/SAS, the Vaya Health LME/MCO, and Mission Hospital have piloted the Resource Intensive Comprehensive Case Management model. The model focuses on diverting adults with SMI from unnecessary hospital emergency department admissions, instead linking them to intensive community supports.
- ✓ The Promise Resource Network, a nationally recognized peer-run organization in Charlotte, and the Sunrise Community for Recovery and Wellness in Asheville, operate peer-run respite centers that offer an alternative to emergency department visits, inpatient mental health services, and involuntary commitments through a non-forced, voluntary, and unlocked healing alternative.

¹⁹ North Carolina Department of Health and Human Services (n.d.). [Transitions to Community Living - Referral Screening Verification Process \(RSVP\)](#) [PDF].

²⁰ North Carolina Department of Health and Human Services (n.d.). [Transitions to Community Living - Referral Screening Verification Process \(RSVP\)](#) [PDF].

Transitions

- ✓ Since 2009, North Carolina has used the MFP program to transition more than 1,400 individuals from institutional settings to community-based living.
- ✓ Since 2013, the TCL effort has transitioned more than 5,000 individuals with serious and persistent mental illness from state psychiatric hospitals and ACHs, with nearly 3,000 to date occupying their own permanent supported housing and only 28 readmissions to a state psychiatric hospital.²¹
- ✓ The DMH/DD/SAS is engaged in Children's Residential Redesign, an effort focusing on family support partners to increase families' voice and choice; active decision-making; and appropriate transitions from placement to services and supports within the community.
- ✓ In 2021, the Green Tree Peer Center opened a peer-run crisis respite program to transition individuals from emergency departments by continuing to offer crisis support and a quiet space for up to 24 hours.
- ✓ In August 2021, the DMH/DD/SAS submitted a budget amendment under the Emergency COVID Grant to help no fewer than 200 individuals from impacted counties transition from incarceration into a North Carolina Oxford House.
- ✓ NC FIT (Formerly Incarcerated Transitions) program – a partnership among UNC Family Medicine, the North Carolina Department of Public Safety, The North Carolina Community Health Center Association, Federally Qualified Health Centers, county departments of public health, community-based reentry organizations, and local reentry councils – established patient-centered primary care medical homes for inmates returning to the community who have chronic medical conditions, mental illness and/or substance use disorders. The FIT program provides vouchers to cover office visits and medication costs for uninsured patients. It utilizes specially trained community health workers with a personal history of incarceration to establish rapport and trust and to act as peer navigators in all aspects of reentry.

Please see [Appendix A](#) for additional North Carolina efforts to date.

Proposed Strategies for Priority Area 3

- The DHHS has embarked on Child Welfare redesign to identify children and families served by the Division of Social Services (DSS), the DHB, and the DMH/DD/SAS, and to establish shared outcomes to reduce out-of-home placements.
- The DHHS will build, going forward, on lessons learned from the Child Welfare Transformation Work Group to reduce involvement of youth with disabilities in the juvenile justice system.
- The DMH/DD/SAS will implement new mobile crisis services teams for children.

²¹ Represents fewer than 28 individuals; some had more than one state psychiatric hospital readmission.

- LME/MCOs will seek to initiate in-reach with their members within seven days of admission to a state psychiatric hospital or ACH and will continue to provide frequent education about transition services and supports to members. The DHHS commits to establishing a process that ensures that people seeking Intermediate Care Facility admission will have an opportunity to hear about the community options that are available to them so that they can make an informed decision about where they want to live, work, and receive services.
- The DHB will use a portion of the enhanced FMAP under the American Rescue Plan Act of 2021 to expand Healthy Options Care Needs screening to HCBS beneficiaries.²²
- Pending CMS approval, the DHB will use a portion of the enhanced FMAP for bridge funding to cover transition support for individuals moving from institutional and congregate care settings into independent living.
- The Division of State Operated Healthcare Facilities (DSOHF) will continue to articulate specific stabilization goals, timeframes, and expectations for an individual's transition back to the community via the State Developmental Centers' Memorandum of Agreement with the individual and their family or guardian.
- The DSOHF is seeking and will incorporate stakeholder input as an initial step to developing a new strategic plan, to be completed by December 31, 2022, for the State Developmental Centers.
- The State Developmental Centers will establish Centers of Excellence for testing service models and approaches to support individuals with I/DD in the community. These will provide training, technical assistance, and consultation for community providers to build their expertise in supporting individuals with challenging and complex needs, thereby reducing reliance on future admissions to the Centers.
- The DHHS will develop an on-demand, Informed Decision Making (IDM) webinar for the LME/MCO staff and local DSS guardians.
- The DHHS will expand and monitor the use of Consumer Engagement IDM tool beyond TCL.
- The DHHS will expand the Barriers Committee, which helps to resolve barriers to community living for the TCL population, to all *Olmstead* populations.
- The DAAS will expand to statewide the use of the Screening and Priority Services tool, or an alternative tool, for prioritization of services.
- The DHHS will collect data on ambulance transports to locations other than emergency departments to assist in quantifying the need for expanded peer-run respite services.
- The DHHS will develop steps in its Strategic Housing Plan to bridge transitions between institutional settings and permanent housing. Efforts will encompass individuals discharged

²² North Carolina Department of Health and Human Services, Division of Health Benefits (2021). [North Carolina spending plan for the implementation of the American Rescue Plan Act of 2021, Section 9817 10% FMAP increase for Home and Community-Based Services](https://medicaid.ncdhhs.gov/media/9910/open) [PDF]. <https://medicaid.ncdhhs.gov/media/9910/open>

from, or at risk of entering, institutional settings, including jails and prisons. Additional focus on access to housing and community-based supportive services will facilitate successful reentry to the community.

Baseline Data/Targeted Measures for Priority Area 3

Baseline Data for Priority Area 3

Since the program was launched in 2009, NC Medicaid's MFP program has transitioned 395 older adults, 442 people with physical disabilities (under the age of 65) and 636 individuals with I/DD from nursing facilities, hospitals, ICF/IIDs, and psychiatric residential treatment facilities (PRTFs).

In State Fiscal Year 2020, the number of individuals discharged from state psychiatric hospitals to TCL and supported housing increased by 28 percent from fiscal year 2019, and the number of individuals with SMI referred to ACHs decreased by 33 percent.²³

In State Fiscal Year 2020, specially trained emergency medical services (EMS) workers in five counties in North Carolina (Forsyth, Orange, Stokes, McDowell, and Onslow) responded to behavioral health emergencies, reporting 1,565 community behavioral health paramedicine encounters. Of those encounters, 380 were treated on the scene and required no transport to a higher level of emergency response; another 159 encounters resulted in the individuals being transported to alternative emergency response facilities (e.g., behavioral health urgent care centers or facility-based care centers) instead of to hospital emergency departments.

As of July 2021, ten providers in five of the sixteen Area Agencies on Aging reported using the Screening and Priority Services Tool. Four Area Agencies on Aging had offered training on use of the tool.²⁴

Peer-run crisis centers have diverted 380 individuals (24%) from inpatient admissions and transitioned 159 individuals (10%) from emergency department stays.

In State Fiscal Year 2021, 240 individuals in recovery from substance use disorders, including opioid use disorder, were mentored and transitioned from incarceration into a North Carolina Oxford House.

²³ North Carolina Department of Health and Human Services (2021). [2019-2020 annual report of the North Carolina Transitions to Community Living Initiative](#) [PDF]. Report to the Joint Legislative Oversight Committee on Health and Human Services, <https://www.ncdhhs.gov/media/10458/open>

²⁴ North Carolina Department of Health and Human Services (2018, November 18). [NC Area Agencies on Aging locations](#) [PDF].

In calendar Year 2021, RSVP received 1,335 valid referrals for TCL's population 5 category²⁵; 827 individuals within population 5 were screened as TCL-eligible and did not go to an ACH.²⁶

In Fiscal Year 2021, 111 individuals with SMI, or co-occurring mental illness and substance use disorder, who were homeless or at risk of homelessness received Projects for Assistance in Transition from Homelessness (PATH) services.

Targeted Measures for Priority Area 3

- In each of Fiscal Years 2022 and 2023, MFP will support 68 transitions to the Innovations waiver and 3 transitions to the TBI waiver.
- By December 31, 2023, the DHHS will transition 750 individuals from ACHs.
- By December 31, 2023, 400 individuals will receive bridge funding to transition from institutional and congregate care settings to independent living.
- By June 30, 2023, at least eight Area Agencies on Aging and 30 providers will be using the Screening and Priority Services Tool.
- The North Carolina Council on Developmental Disabilities' reentry initiative will assist in the transitions of 100 individuals with I/DD in 2022 and 60 more in the first six months of 2023 from certain jails and prisons into the community, supporting these individuals to access necessary supports and services, thereby reducing recidivism.²⁷

Priority Area 3 Resource Requirements

The cost of these initiatives will be covered by enhanced FMAP under the American Rescue Plan Act of 2021, pending CMS approval, and by Mental Health Block Grant set-aside funds; other federal funds; LME/MCO and Tailored Plan contracts; and existing state funds. Additional state funds may be requested as needed from the North Carolina General Assembly.

²⁵ TCL's category 5 is comprised of individuals diverted from entry into adult care homes pursuant to the preadmission screening and diversion provisions of the settlement agreement.

²⁶ Individuals diverted from entry into an adult care home pursuant to the preadmission screening and diversion provisions established by the state.

²⁷ North Carolina Council on Developmental Disabilities (2020). [Justice: Release, reentry and reintegration](https://bit.ly/3oUAGy8) [PDF]. <https://bit.ly/3oUAGy8>

Priority Area 4: Increase Opportunities for Supported Education and Pre-employment Transition Services for Youth with Disabilities, and Competitive Integrated Employment for Adults with Disabilities

What Priority Area 4 Means

Supported education is a person-centered approach that provides students with I/DD and mental health disorders the opportunity to pursue post-secondary education options. Pre-employment transition services (Pre-ETS) are described in the Workforce Investment Opportunity Act (WIOA). The DVRS is required to provide these services to students with disabilities, 14 to 21 years of age, in collaboration with Local Education Agencies for all eligible and potentially eligible students with disabilities. The DVRS also continues to provide vocational rehabilitation services to youth and adults with disabilities, 14 years of age and older, to assist them in reaching their goal of competitive, integrated employment (CIE).

Why Priority Area 4 is Important

Supported education assists individuals with mental health disorders in gaining access to the types of employment that meet their interests and abilities and increases their ability to be self-sufficient by earning above minimum wage, through post-secondary education. Pre-ETS provides students with job exploration counseling, work-based learning experience, counseling on employment options, workplace readiness training, and instruction in self-advocacy. CIE assists individuals with disabilities to increase their dignity, self-sufficiency, and quality of life, resulting in more positive outcomes than sheltered employment.

Participation in supported employment is a requirement in the U.S. Department of Justice TCL settlement agreement; 2,500 covered individuals are to be receiving supported employment services to meet the agreement's requirement of "substantial compliance" with respect to employment. However, according to the 2019 report of the Independent Reviewer designated by the Department of Justice to monitor North Carolina's compliance with the TCL settlement agreement, "the number of individuals in the TCL target population receiving Individual Placement and Support - Supported Employment (IPS/SE) remains low and IPS/SE teams struggle to improve their performance. Data supports that there are many more individuals in the TCL population who want the opportunity to go to work or back to work." In State Fiscal Year 2021, Access to Supported Employment had the lowest mean score of 22 Transitions to Community Living (TCL) performance indicators.

North Carolina's Priority Area 4 Efforts to Date

Supported Education/Pre-employment Transition Services for Youth

- ✓ The DVRS has 84 third-party cooperative agreements with school systems across the state in which the school systems contribute to the cost of dedicated vocational rehabilitation staff serving students with disabilities who express interest in CIE.
- ✓ The DMH/DD/SAS was awarded a U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) Healthy Transitions grant, targeted for transition-age youth and young adults²⁸; the grant focuses on screening, assessment, referral, and coordination of services, including access to employment and education services and supports.
- ✓ With the DVRS's active participation on the State Transition Team, joint trainings for Local Education Agencies and local vocational rehabilitation transition staff, developed in partnership with Department of Public Instruction, resulted in an analysis of local needs and goal-setting to address gaps in areas related to CIE.

Competitive, Integrated Employment

- ✓ In March 2019, the Cooper administration declared North Carolina an Employment First state under Executive Order No. 92, affirming that individuals with disabilities can and should be valued members of the competitive work force.²⁹
- ✓ The DHHS supports CIE for individuals with serious mental illness using the evidence-based practice of IPS/SE. This service is an entitlement for Medicaid beneficiaries and is available as funds allow for individuals supported with state funding.
- ✓ Supported employment is a covered service for participants in the Innovations waiver, TBI waiver, and available via (b)(3) services, as well as state-funded services.
- ✓ North Carolina's first episode psychosis program consists of three pilot sites³⁰; each site has a Supported Employment and Education specialist.
- ✓ In partnership with the North Carolina Business Committee on Education, the DVRS, North Carolina State University, and Wake Technical Community College, targeted community rehabilitation providers have developed Science, Technology, Engineering, and Math, including Computer Science (STEM/CS) internships for neuro-diverse individuals resulting in an 80-percent rate of hire.

²⁸ A student with a disability, age 14 to 22, is eligible for transition services as part of their Individualized Education Plan (IEP), so long as that student is enrolled in a public school, which includes charter schools.

²⁹ [North Carolina Executive Order No. 92: Employment First for North Carolinians with disabilities](#) (March 28, 2019).

³⁰ Mental Health Services - First Psychotic Symptom Treatment Session Law, 2018-5, Section 11L.1(x), [Report to the House Appropriations Committee on Health and Human Services And Senate Appropriations Committee on Health and Human Services And Fiscal Research Division](#) by North Carolina Department of Health and Human Services December 23, 2019. Retrieved 11/05/21 from <https://www.ncdhhs.gov/media/9295/download>

- ✓ Effective October 1, 2021, DVRS-funded work adjustment training must be provided in an integrated location, offer a choice of three, broad, occupational categories, and pay at least minimum wage for work performed.
- ✓ The DMH/DD/SAS directly provided or supports numerous trainings to increase referrals to IPS/SE:
 - An IPS/Employment and Recovery training provided to all six LME/MCOs gave LME/MCO staff responsible for In-reach, Utilization Management, Transition and Network Management a better understanding of the intersection of employment and recovery.
 - An 'In or At Risk' training, provided on 10/28/21, reviewed the In or At-Risk checklist data, and state expectations for improvement, along with recommendations, strategies, and plans for improvement.
 - The University of North Carolina Institute for Best Practices offers six IPS trainings quarterly.
- ✓ The Vaya, Trillium, and Alliance LME/MCOs have added an Employment Collaborative to include IPS/SE, Community Support Teams, Assertive Community Treatment (ACT), and Transition Management Services providers and service members to join forces, develop relationships, and learn about IPS/SE and how to refer eligible individuals to the service.

Please see [Appendix A](#) for additional North Carolina efforts to date.

Proposed Strategies for Priority Area 4

- The DHHS will work with the Department of Public Instruction to promote the inclusion of employment in every Individualized Education Plan (IEP).³¹
- The DHHS will strengthen efforts to coordinate employment services across agencies and systems to decrease reliance on segregated employment settings for youth, post-graduation.
- The DHHS is committed to expanding integrated, supported education and employment, including CIE and other meaningful day opportunities, for all individuals with disabilities, based upon each individual's informed choice and their unique circumstances and needs. The Department will continue its ongoing cross-division undertaking to improve supported employment opportunities for individuals with I/DD, including customized employment, and to align Medicaid- and state-funded supported employment services for these individuals with the Department's vision for integrated employment as part of Tailored Plan care management. The DHHS will expand a model in which services and supports will be provided to persons with I/DD to enable their employment in integrated community settings. These efforts will include helping individuals with I/DD prepare for and transition to CIE, following an individual's informed choice to explore and pursue CIE.

³¹ U.S. Department of Education (July 12, 2017). [Individuals with Disabilities Education Act: Sec. 300.320 Definition of individualized education program - Individuals with Disabilities Education Act](https://bit.ly/3ap1a2y), <https://bit.ly/3ap1a2y>

- The DSOHF will eliminate all State Developmental Center use of subminimum wage and will add programmatic offerings to allow for experiential, informed decision-making and better prepare individuals with skills to pursue CIE when they transition to a community setting.
- The DHHS will draw upon the experience of providers (e.g., Watauga Opportunities, Inc.) that have transitioned successfully from Adult Developmental Vocational Programs (ADVPs) to supported employment.
- The DHHS will solidify Medicaid coverage for supported employment through submission of a 1915(i) Medicaid State Plan Amendment and alignment of the supported employment service definition across funding streams.
- TCL program staff will monitor the LME/MCOs to improve their monitoring of and education for behavioral health service providers to increase IPS/SE referrals for TCL participants and other individuals with SMI/SPMI.
- The DHHS will provide trainings to DVRS, DMH/DD/SAS, and DHB employment provider agencies in evidence-based practices that support individuals to achieve CIE. Trainings will be conducted for two cohorts of 35 providers by the end of Fiscal Year 2022. The DHHS will provide two additional trainings, open to any service provider, outlining best practices in CIE (e.g., customized employment) for an additional 35 providers each. This statewide training effort will equip service providers to better assist all persons with disabilities in the pursuit of CIE at competitive wages, according to their informed choice.
- LME/MCO Tailored Plan staff will enhance assertive engagement in employment and education, along with strategies to address common barriers and obstacles, for members during In-Reach, transition planning, and after transitioning to supportive housing.
- The DMH/DD/SAS will continue transitioning reimbursement for IPS/SE for individuals with SMI/SPMI from fee-for-service to milestone payments. The DVRS anticipates establishing a milestone rate for work adjustment training in November 2022.
- The DAAS will continue to promote the Senior Community Service Employment Program (SCSEP), empowering low-income, older workers with disabilities to achieve economic independence while receiving training in community service activities that will assist them in gaining the marketable skills necessary to reenter the workforce.

Baseline Data/Targeted Measures for Priority Area 4

Baseline Data for Priority Area 4

In the 2018-19 In-Person Survey, National Core Indicators® (NCI)³² respondents in North Carolina were significantly below the NCI® national average in likelihood of having a paid

³² [National Core Indicators](#) (NCI) is a voluntary effort by public developmental disabilities agencies to measure and track their own performance. North Carolina participates in the NCI.

community job (12% vs. 19%), and significantly above the NCI® national average in not having a paid community job despite wanting one (58% vs. 44%).³³

In State Fiscal Year 2019, 4,817 individuals with a disability successfully exited the DVRS vocational rehabilitation program into CIE.

- ▶ 34 percent were transition-age youth.
- ▶ 34 percent were individuals with cognitive disabilities.
- ▶ 38 percent were individuals with a psychosocial disability.

In fiscal year 2019, 27.7 percent of individuals receiving state-funded developmental disability services authorized by the LME/MCOs received ADVP services, while only 1.1 percent received supported employment.

In federal Fiscal Year 2019, DSB vocational rehabilitation services were provided to 3,085 individuals with blindness or low vision.

From October 1, 2020 through August 30, 2021, the DVRS provided employment services to over 29,000 North Carolinians with disabilities and has provided pre-employment transition services in all 100 counties of the state, serving over 3,000 students with disabilities at a cost of \$8,678,871.

In Fiscal Year 2021, the DVRS purchased the following services for persons with disabilities in addition to directly provided services:

- | | |
|--|--|
| ▶ Job Placement and Supports for \$16.67M | ▶ Assessment for \$2.30M |
| ▶ Training for \$5.56M | ▶ Treatment for \$2.22M |
| ▶ Transportation and Maintenance for \$4.39M | ▶ Rehabilitation Technology for \$1.40M |
| ▶ Pre-Employment Transition Services for \$7.37M | ▶ Auxiliary and Other Services for \$1.61M |

In State Fiscal Year 2021, more than 3,150 individuals achieved goals for CIE after working with the DVRS.

In State Fiscal Year 2021, Employment First efforts by the DHHS and the Office of State Human Resources touched over 1,400 North Carolinians to further the goals of Governor's Executive Order 92.

³³ National Core Indicators – The National Association of State Directors of Developmental Disabilities Services and the Human Services Research Institute (2020). [In person survey \(IPS\) state report 2018-19, North Carolina report \[PDF\]. https://bit.ly/2YHKNfh](https://bit.ly/2YHKNfh)

North Carolina's Coordinated Specialty Care First Episode Psychosis programs reported that participants exceeded the national averages for "any time spent in work or school" and for "any time spent in work" by 12 months and 24 months, respectively.

The TCL rate for CIE is 39 percent.

Targeted Measures for Priority Area 4

- By December 31, 2022, the DVRS is committed to increasing by five percent the number of students with disabilities who are provided pre-employment transition services.
- By December 31, 2023, the DVRS will increase by five percent the number of vocational rehabilitation participants achieving CIE after having been provided supported employment or other on-the-job supports.
- North Carolina CSC FEP programs will report a two-percent increase above the national averages for "any time spent in work or school" by 12 months and 24 months, and for "any time spent in work" by 12 months and 24 months.
- By the end of Fiscal Year 2022, the DHHS will conduct training with two cohorts of 35 DVRS, DMH/DD/SAS, and DHB employment provider agencies on evidence-based practices that support individuals to achieve CIE. The DHHS will provide two additional trainings, open to any service provider, outlining best practices in CIE (e.g., customized employment) for an additional 35 providers each.
- By December 31, 2023, increase by five percent the number of individuals receiving state-funded and Medicaid funded supported employment services authorized by the LME/MCOs for individuals with an I/DD.
- By December 31, 2022, increase by three percent over the previous calendar year the number of participants who exit the DSB vocational rehabilitation program in unsubsidized CIE.
- The DVRS has committed to ensuring that at least 34 percent of career training program participants will receive a measurable skill gain to help them achieve their employment goal.
- By June 30, 2023, increase by 16 percent IPS/SE service (through IPS/SE or ACT) to TCL members and/or CIE rates.

Resource Requirements for Priority Area 4

The cost of these initiatives will be covered using federal vocational rehabilitation awards, educational funds, aging funds, LME/MCO Tailored Plan contracts, and existing state funds. Additional state funds may be requested as needed from the General Assembly. These goals are set by the DHHS and the listed divisions; funds will be expended as made available, according to funding guidelines.

Priority Area 5: Increase Opportunities for Inclusive Community Living

What Priority Area 5 Means

Inclusive community living requires access to safe, decent, and affordable housing and individualized services and supports. People with disabilities are able to live in homes, apartments, and communities of their choice – and contribute to the communities – when they have access to the services and supports they may need. Affordable, accessible housing paired with individualized services and supports helps to ensure individual well-being.

Why Priority Area 5 is Important

Housing is one of the most researched social determinants of health. Selected housing interventions have been found to improve health outcomes and decrease health care costs.³⁴ People who are chronically homeless face substantially higher morbidity associated with both physical and mental health conditions and increased mortality. People who are not chronically homeless, but face housing instability (in the form of moving frequently, falling behind on rent, or couch surfing), are more likely to experience poor health in comparison to their stably housed peers.³⁵ Residential instability is associated with health problems among youth, including increased risks of teen pregnancy, early drug use, and depression.³⁶

Conversely, research shows that providing safe, decent, and affordable housing with voluntary individualized services and supports is more cost-effective than institutional or congregate housing options; is better aligned with individual housing preferences; and demonstrates positive outcomes such as reduced hospitalizations and homelessness, increased housing stability, and improved behavioral and physical health.³⁷ Permanent supportive housing (PSH) combines lease-based, permanent affordable housing in the community with voluntary, flexible, and individualized services to support successful tenancies, and is an evidence-based practice for individuals with serious mental illness and/or substance use disorders and for individuals who are homeless or are at risk of becoming homeless. Supported living is the more commonly used term in the context of individuals with I/DD or a traumatic brain injury and is a covered service within the Innovations waiver.

Research has also established the correlation between environmental factors within homes, such as lead exposure, mold, pest infestation and over-crowded living conditions, and poor

³⁴ Taylor, L. (2018, June 7). [Housing and health: An overview of the literature](https://bit.ly/3Bzdidp), *Health Affairs*, <https://bit.ly/3Bzdidp>

³⁵ Taylor, L. (2018, June 7). [Housing and health: An overview of the literature](https://bit.ly/3Bzdidp), *Health Affairs*, <https://bit.ly/3Bzdidp>

³⁶ Taylor, L. (2018, June 7). [Housing and health: An overview of the literature](https://bit.ly/3Bzdidp), *Health Affairs*, <https://bit.ly/3Bzdidp>

³⁷ Taylor, L. (2018, June 7). [Housing and health: An overview of the literature](https://bit.ly/3Bzdidp), *Health Affairs*, <https://bit.ly/3Bzdidp>

health outcomes.³⁸ Many studies focusing on improving health have demonstrated positive results through improved housing quality and safety.³⁹

There is an affordable housing crisis in North Carolina (and nationally). While the cost of housing varies geographically, a person with a disability receiving Supplemental Security Income (SSI) in North Carolina would have to pay 99 percent of their monthly income to rent an efficiency unit and 102 percent of their monthly income for a one-bedroom unit, making independent living unaffordable without rental assistance. Key Rental Assistance is the only state-funded subsidy program that is “disability neutral,” that is, not targeted to any particular group of people with disabilities.

Housing is a requirement within the TCL settlement agreement with the U.S. Department of Justice.

North Carolina's Priority 5 Efforts to Date

Access to Safe, Decent, and Affordable Housing

- ✓ The DHHS has contracted for the development of a Strategic Housing Plan that will serve as a roadmap for the expansion of affordable housing capacity for North Carolinians with disabilities. A Housing Leadership Committee was established to assist with plan development and includes representatives from state and local housing partner agencies, housing and service providers, people with lived experience, family members, advocates, and others.
- ✓ Per North Carolina's Consolidated Plan, 200 Low Income Housing Tax Credit units are set aside each year for individuals with disabilities; 10 percent of the units must be accessible.⁴⁰
- ✓ In 2020, the North Carolina Housing Finance Agency applied for and was awarded \$7,000,000 for U.S. Department of Housing and Urban Development (HUD) Section 811⁴¹ Project Rental Assistance units with about 188 apartments targeted for individuals with disabilities transitioning from or at risk for institutionalization.
- ✓ North Carolina sought and received HUD approval for a remedial preference for individuals with SMI/SPMI who are living in an ACH or who are at risk of entry into an ACH. This preference enables individuals with SMI/SPMI who are being diverted or discharged from an ACH to have priority access to a number of newly created housing units.

³⁸ Taylor, L. (2018, June 7). [Housing and health: An overview of the literature](https://bit.ly/3Bzdidp), *Health Affairs*, <https://bit.ly/3Bzdidp>

³⁹ Taylor, L. (2018, June 7). [Housing and health: An overview of the literature](https://bit.ly/3Bzdidp), *Health Affairs*, <https://bit.ly/3Bzdidp>

⁴⁰ North Carolina Housing Finance Agency (n.d.). [Low-Income Housing Tax Credits](https://bit.ly/3ApwGrP), Retrieved October 10, 2021 from <https://bit.ly/3ApwGrP>

⁴¹ Schaak, G., and Sloane, L. (2015). [Section 811 Supportive Housing for Persons with Disabilities program](https://bit.ly/3mXL0n1) [PDF]. *Advocates' Guide 2015*. Washington, D.C.: National Low-Income Housing Coalition. <https://bit.ly/3mXL0n1>

Access to Housing-Related Services and Supports

- ✓ In 2016, the DHHS established a service definition for supported living.⁴² Supported living enables people with significant disabilities to live in their own homes. A person who experiences a disability partners with an organization, family, friends, and community resources to experience life in a way that results in:
 - A safe and decent home of one's own
 - Personalized assistance
 - Choice
 - Support from others who care about and respect the person
- ✓ The North Carolina Council on Developmental Disabilities (NCCDD), with support from the state's MFP program, funded a three-year grant to the Vaya Health LME/MCO to launch and expand supported living services across the state. The NCCDD also produced a resource web page on the topic.⁴³
- ✓ In 2020, the DHHS amended the Innovations waiver to allow individuals receiving Supported Living Level 3 to exceed the \$135,000 cap.
- ✓ 2,957 individuals are currently in supportive housing through TCL, and 4,573 have been housed over the life of the program.⁴⁴
- ✓ The DHHS embedded housing-related services and supports into Medicaid policy and the state-funded Community Support Team service definition to support and sustain reimbursement.
- ✓ A state-funded program unique to North Carolina, DVRS's Independent Living Rehabilitation Program (ILRP), helps individuals with disabilities integrate into the community. The ILRP prioritizes people in institutional settings; people who can be diverted from institutionalization; and individuals who need support to maintain community-based living.
- ✓ The General Assembly approved an increase to \$1,228 per month for state-county Special Assistance/In-Home program participants.

Please see [Appendix A](#) for additional North Carolina efforts to date.

⁴² North Carolina Council on Developmental Disabilities (2020). [Justice: Release, reentry and reintegration](https://bit.ly/3oUAGy8) [PDF]. <https://bit.ly/3oUAGy8>

⁴³ North Carolina Council on Developmental Disabilities (n.d.). [Supported living guidebook/resource manual](https://bit.ly/3AFXu7D). Retrieved October 10, 2021 from <https://bit.ly/3AFXu7D>

⁴⁴ North Carolina Department of Health and Human Services (2021). [2019-2020 annual report of the North Carolina Transitions to Community Living Initiative](https://www.ncdhhs.gov/media/10458/open) [PDF]. Report to the Joint Legislative Oversight Committee on Health and Human Services. <https://www.ncdhhs.gov/media/10458/open>

Proposed Strategies for Priority Area 5

Increase Access to Safe, Decent and Affordable Housing

- The DHHS will issue a Strategic Housing Plan for Individuals with Disabilities in the spring/summer of 2022. The Strategic Housing Plan will be based on the Olmstead Plan Stakeholder Advisory (OPSA) Housing Committee's Driver Diagram (See [Appendix C](#)).
- The DHHS will support HUD housing providers, for example The Arc of NC, in their efforts to gain more flexibility in the use of existing housing and vouchers.

Increase Access to Housing-Related Services and Supports

- The DHB will issue clarification about the criteria that allows individuals receiving Supported Living Level 3 to exceed the \$135,000 cap.
- The DHHS will encourage the LME/MCOs and subsequently their Tailored Plans to utilize "In Lieu Of" services to offer the individualized services and supports necessary to provide their members with community-based alternatives to institutional and congregate care settings.
- The DHHS will expand Community Inclusion pilots, beyond Eastpointe and Alliance LME/MCOs, to enhance promotion of successful tenancy and housing retention for the TCL population.
- The DSOHF State Developmental Centers will provide opportunities for individuals receiving services at the State Centers to learn about supported living and to meet with individuals with I/DD who are living in the community with supported living services and supports.
- The DHHS and system partners will promote the NCCDD's Supported Living Guidebook/Resource Manual for Individuals with I/DD.⁴⁵
- The DHB will include performance measurements related to housing stability in Tailored Plans, with incentives for high performance.
- The DVRS will expand efforts towards a comprehensive array of services and service delivery, and access to assistive technology, mobility, and transportation to support individuals in independent living.

Baseline Data/Targeted Measures for Priority Area 5

Baseline Data for Priority Area 5

In 2019, the DSB served 1,109 eligible individuals (365 through Independent Living Rehabilitation and 744 through Independent Living Older Blind). The DSB also held 33 daily living skills classes, attended by 380 eligible individuals.

⁴⁵ North Carolina Council on Developmental Disabilities (n.d.). [Supported living guidebook/resource manual](#). Retrieved October 10, 2021 from <https://bit.ly/3AFXu7D>

As of December 2020, 114 individuals supported by the Innovations waiver resided in Supported Living Level 1; 126 individuals resided in Supported Living Level 2; and 85 individuals resided in Supported Living Level 3 – for a total of 325.

Targeted Measures for Priority Area 5

- Measures for increasing access to safe, decent affordable housing are deferred, pending release of the Strategic Housing Plan in 2022.
- By June 30, 2022, the DHHS will house 750 additional TCL participants, including 450 from ACHs.
- By December 31, 2023, the DHHS will attain a 12 percent increase in the number of Innovations beneficiaries with I/DD utilizing Supported Living levels 2 and 3 to assist with living in their own home in the community.
- By December 31, 2023, the DHHS in partnership with the LME/MCOs will increase by five percent the number of individuals with TBI receiving Supported Living services to support greater independence in the community.
- By December 31, 2023 all LME/MCO Tailored Plans will implement Community Inclusion pilots.
- By December 31, 2023, 80 percent or more of ILRP participants will achieve their goal of living independently in their homes and communities.

Additional measures are deferred pending release of the NC Strategic Housing Plan in late spring 2022.

Resource Requirements for Priority Area 5

Upon release of the Strategic Housing Plan, the DHHS will work with the North Carolina Housing Finance Agency and other partners to maximize the use of federal, state, local, and private resources to develop accessible housing and to make housing affordable for individuals with disabilities. The LME/MCOs, and subsequently the Tailored Plans, are expected to fund Supported Living and “In Lieu Of” services.

Priority Area 6: Address Gaps in Services

What Priority Area 6 Means

Gaps in services occur when a service doesn't exist in the array, or when there is insufficient service capacity to meet the needs of individuals assessed as needing the service.

Why Priority Area 6 is Important

The lack of adequate community-based services and insufficient access to existing services are primary factors contributing to the admission to, and extended stay in, institutional settings for

individuals with disabilities. There is considerable variability in service penetration rates among disability populations across the different LME/MCOs.⁴⁶

Children

While overall numbers for psychiatric residential treatment facility utilization have been trending slightly downward, the proportion of children going out of state is increasing.⁴⁷ This is often due to lack of bed availability and lack of in-state provider specialization/training in the populations needing services. As a result of the COVID-19 pandemic, by December 2020, the rate of hospital emergency department discharges for pediatric patients with a behavioral health condition had increased by 70 percent over the prior year, according to the North Carolina Healthcare Association's patient data system.⁴⁸ Emergency department visits are also often the result of an inadequate array of community-based services or of inadequate access to the services that exist.

Adults

The DHHS has made progress in reaching milestones established for the TCL settlement agreement with the Department of Justice but continues to be challenged with supporting individuals outside of segregated settings. In June 2021, 63 of the nearly 3,000 TCL members who were housed did not remain stably housed in the community. Several of these TCL members expressed their desire to return to the congregate ACH setting as a result of isolation and feelings of loneliness that were amplified by the COVID-19 pandemic.

Older Adults

One in three North Carolina residents who is age 65 or older has at least one disability.⁴⁹ The presence of a disability often contributes to social isolation and increases the likelihood of depression, substance use disorders, and poor health care outcomes. A nationwide survey conducted by Cigna Healthcare reported that three in five adults now struggle with feelings of loneliness.⁵⁰ This figure has increased by 13 percent since 2018.

North Carolina's Priority 6 Efforts to Date

- ✓ The DHHS established the Division of Child and Family Welfare, which will focus on supporting whole child and family health for North Carolinians, including all child nutrition programs (the Special Supplemental Nutrition Program for Women, Infants, and Children [WIC], the Supplemental Nutrition Assistance Program [SNAP], and the Child and Adult

⁴⁶ The service penetration rate is based on the number of unduplicated eligible individuals and consumers who have received at least one billable service during the fiscal year.

⁴⁷ Per conversation with DMH/DD/SAS staff.

⁴⁸ Strickland, S. (2021, June 14). [Letter: Behavioral health crisis across North Carolina has reached a state of emergency](https://bit.ly/3ByL2b0). North Carolina Healthcare Association. <https://bit.ly/3ByL2b0>

⁴⁹ U.S. Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities (n.d.). [Disability impacts North Carolina](https://bit.ly/3oWLPzV) [PDF], <https://bit.ly/3oWLPzV>

⁵⁰ Cigna Newsroom (n.d.). [Loneliness is at epidemic levels in America](https://bit.ly/3j8SLW7). Retrieved September 10, 2021 from <https://bit.ly/3j8SLW7>

Care Food Program [CACFP]); the full range of prevention services for children beginning at birth; children's mental health services; and early intervention programs.

- ✓ All LME/MCOs support high fidelity wraparound as an "In Lieu Of" service. The DHHS is piloting the use of youth peers, embedded in high fidelity wraparound teams with a case manager and a family partner.
- ✓ The Rapid Response Team for Crisis Care Management was created in December 2020 to address the immediate needs of DSS-involved children in emergency departments, local Departments of Social Services, or other inappropriate settings. The team meets regularly to respond to referrals from local DSS or LME/MCOs when crises exist, and takes swift action to address the immediate need.
- ✓ The DHHS was awarded a SAMHSA grant to support crisis system redesign.
- ✓ The DHHS' TBI waiver renewal application will expand the waiver and supported living services to an additional catchment area, allowing more individuals with TBI to live at home with supports.
- ✓ The DSOHF has implemented outpatient programs at the Alcohol and Drug Abuse Treatment Centers (ADATCs) to enhance the array of services available to support individuals with substance use disorders and co-occurring mental health disorders.
- ✓ The General Assembly approved an extension of Medicaid coverage for 12 months postpartum for pregnant women with incomes equal to or less than 196 percent of the federal poverty level.

Proposed Strategies for Priority Area 6

North Carolina will fill gaps in services by identifying and applying population-specific, evidence-based, best and promising practices to support individuals with disabilities.

Strategies for Children

- The DHHS will seek approval from CMS to allow a parent to retain Medicaid eligibility when the child is being served temporarily by the foster care system, regardless of the type of out-of-home placement, and the parent is making reasonable efforts to comply with a court-ordered plan of reunification.
- The DHHS will expedite efforts to enhance the array of high-quality, community-based services and supports to address the needs of children and families, thereby reducing the number of children and youth admitted to in-state and out-of-state PRTFs:
 - Expand the availability of mobile crisis services to children using the MORES model, including training staff in the provision of crisis services to children and a family peer support component, to divert inpatient admissions and out-of-home placements for treatment.

- Implement Sobriety Treatment and Recovery Teams (START), a specialized child welfare service delivery model that has been shown, when implemented with fidelity, to improve outcomes for children and families affected by parental substance use and child maltreatment.
- Promote use of the North Carolina Psychiatry Access Line (NC PAL), telephone consultation to connect pediatricians and primary care physicians with child psychiatrists to improve diagnoses and to reduce polypharmacy for children.
- Scale the reach of high-fidelity wraparound services from 33 counties to availability statewide.
- Implement facility-based and in-home respite service pilots for foster parents, birth parents, and adoptive families caring for children with behavioral health needs.
- Per Session Law 2021-132 (Senate Bill 693), “develop a plan to increase the supply of appropriate treatment and residential settings for minors in need of behavioral and mental health services.”
- Refine the Rapid Response Team process to improve timeliness of response and outcomes.
- Expedite licensure for time-sensitive services/programs to allow children prompt access to services in the community.
- The DHHS will enhance access to children’s mental health services by expanding mental health services in primary care, schools, and specialty care.
- The DHB will work with Standard Plans and LME/MCO Tailored Plans to continue to promote children’s access to personal care services via Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and its coverage of Health Check.
- LME/MCOs, and eventually Tailored Plans, will increase the availability of high-fidelity wraparound services, care coordination, and therapeutic foster care families.
- The DHHS, in partnership with the LME/MCOS, will increase the supply of outpatient therapists trained to treat children with co-occurring mental health disorders and I/DD.

Strategies for Adults

- The DHHS will continue advocating for Medicaid expansion, which would provide an estimated 600,000 North Carolinians with health care coverage for chronic conditions, reducing opioid-related complications and improving mental health.⁵¹
- The DHB will submit a 1915(i) state plan amendment to transition Medicaid coverage for selected (b)(3) services for children and adults.

⁵¹ Per communication with DHHS staff.

- The DMH/DD/SAS will enhance crisis response services and increase access to them using American Rescue Plan Act funds.
- The DMH/DD/SAS will work with peer-run organizations to quantify existing, peer-run services and to determine meaningful targets for future DHHS support of peer-run services.
- The DHHS will expand research-based, behavioral health treatment services for adults with autism.
- The DHHS will expand core, community-based services for individuals with TBI, including cognitive rehabilitation, life skills training, and neuro-behavioral programming.

Strategies for Older Adults

- The DAAS, in partnership with Centers for Independent Living and others, will organize a cross-departmental effort to address senior social isolation.
- Issue one-time payments focused on social drivers of health to strengthen services to this vulnerable population incident to the heightened challenges caused by COVID-19.
- Make Senior Centers more welcoming to individuals with I/DD, TBI, and SMI.

Baseline Data/Targeted Measures for Priority Area 6

Baseline Data for Priority Area 6

Among all individuals with SMI or Serious Emotional Disturbance (SED) served in community mental health programs in North Carolina, only 2.5 percent are ages 0-12 compared to 29.3 percent in this age group nationally.⁵²

As of March 31, 2021, 410 North Carolina children with Medicaid were placed in an in-state PRTF.

As of March 31, 2021, 248 North Carolina children with Medicaid were placed in an out-of-state PRTF.⁵³

In federal Fiscal Year 2018, 22 counties in North Carolina had no child psychiatric providers, and six counties had only one provider per 10,000 Medicaid-enrolled youth; eight counties did not have any pediatric provider.⁵⁴

In 2019, two Children's Mobile Crisis Teams were implemented.

⁵² U.S. Substance Abuse and Mental Health Services Administration (2020). [North Carolina 2019 Mental Health National Outcome Measures \(NOMS\): SAMHSA Uniform Reporting System \(URS\)](https://bit.ly/3Byvgww) [PDF]. Page 5. <https://bit.ly/3Byvgww>

⁵³ An out-of-state facility may be the closest facility to the child's home depending on where the child lives.

⁵⁴ NC-PAL (n.d.). [North Carolina – Psychiatry Access Line](https://ncpal.org/node/3). Retrieved August 24, 2021 from <https://ncpal.org/node/3>

In North Carolina's 2019 report to SAMHSA, community mental health services utilization per 1,000 people was 9.16 percent, well below the national average of 23.88 percent.⁵⁵

63 of nearly 3,000 individuals housed by TCL did not remain stably housed due to the lack of social connectedness.

As of August 2021, there were 3,945 individuals receiving Special Assistance/In-Home. This includes 1,017 individuals served through TCL.

In Fiscal Year 2018, of the 36,068 individuals with TBI who received one or more behavioral health services, 6,450 received crisis services; 1,280 lived in a skilled nursing facility; and 910 lived in a congregate care setting other than a skilled nursing facility.

Targeted Measures for Priority Area 6

- Children at risk of out-of-home placement will receive the evidence-based practice of high fidelity wraparound services when appropriate to divert such placements.
- By December 31, 2023, the DHHS will reduce by 10 percent the number of children placed in North Carolina-based PRTFs.
- By December 31, 2023, the DHHS will reduce by 50 percent the number of children placed in out-of-state PRTFs.
- By July 2022, five additional Children's Mobile Crisis Teams will be operational.
- By December 31, 2022, fifty adults over age 21 with Autism Spectrum Disorder will receive research-based, behavioral health treatment.
- The DMH/DD/SAS will provide a minimum of five, TBI-specific trainings to community-based providers, statewide, through in-person, webinar, or online training module formats.
- The state-county Special Assistance/In-Home standard monthly payment will increase for adult participants.

Resource Requirements for Priority Area 6

The DHHS will access Coronavirus Aid, Relief, and Economic Security (CARES) Act funding; American Rescue Plan Act funding, including enhanced FMAP; federal Medicaid revenue ongoing; federal block grant funds; and existing state funds.

⁵⁵ U.S. Substance Abuse and Mental Health Services Administration (2020). [North Carolina 2019 Mental Health National Outcome Measures \(NOMS\): SAMHSA Uniform Reporting System \(URS\)](https://bit.ly/3Byvgww) [PDF]. <https://bit.ly/3Byvgww>

Priority Area 7: Explore Alternatives to Full Guardianship

What Does Priority Area 7 Mean?

Guardianship is a legal process utilized when a person cannot make or communicate safe or sound decisions about their person and/or property as a result of incapacity, or when they have become susceptible to fraud or undue influence. Most individuals with disabilities are capable of making responsible decisions about many areas of their lives and need only limited decision-making supports, if any. The courts, however, may lack awareness of the tools available to assist individuals with disabilities to make informed decisions about their lives, and may order full guardianship, restricting the individual's rights beyond what is needed. Supported decision-making is an alternative to guardianship. In this approach, individuals with disabilities whose decision-making autonomy might otherwise be limited or removed make and communicate their own decisions, with informal support from trusted family and friends.⁵⁶

Why Priority Area 7 is Important

Guardianship can be a barrier to realizing the intent of *Olmstead*. Nationally, people with I/DD who do *not* have a guardian are more likely to:⁵⁷

- ▶ Have a paid job
- ▶ Live independently
- ▶ Have friends other than staff or family
- ▶ Go on dates and socialize in the community
- ▶ Practice the religion of their choice

Full guardianship is the most restrictive option for legal substitute decision-making; it continues to increase in North Carolina, specifically for younger adults with disabilities.⁵⁸

The MFP staff report that guardianship can impede the ability of some eligible individuals to benefit from the MFP program by keeping them in an institutional setting. Guardians can oppose an individual's transition from institutional care to the community, overriding the individual's desire to transition. The DHHS is working with public guardians and the LME/MCOs to identify individuals living in ACHs and foster care or group homes who don't have the opportunity to live

⁵⁶ [National Resource for Supported Decision-Making](http://www.supporteddecisionmaking.org). <http://www.supporteddecisionmaking.org>

⁵⁷ Nye-Lengerman, K., Narby, C., & Pettingell, S. (2017). *How is guardianship status related to employment status for people with IDD? Findings from the National Core Indicators Adult Consumer Survey*. ThinkWork! Institute for Community Inclusion, University of Massachusetts Boston. <https://bit.ly/3ItYjvD>

⁵⁸ North Carolina Council on Developmental Disabilities (n.d.). *Rethinking guardianship: Building a case for less restrictive alternatives*. Retrieved October 10, 2021 from <https://nccdd.org/guardianship.html>

in an integrated setting because of guardian objections. County Clerks of Court, who make guardianship decisions, rely on varying and sometimes inconsistent sources of information to make their determination.⁵⁹

North Carolina's Priority Area 7 Efforts to Date

- ✓ Session Law 2014-100 directed the DAAS to develop a plan to evaluate complaints pertaining to wards under the care of publicly-funded guardians. The plan promotes guardians' understanding of law and policy and supports guardians to act in the best interest of the individual.
- ✓ The Rethinking Guardianship North Carolina Statewide Workgroup has been in place since 2015, with the goals of promoting less restrictive alternatives to full guardianship and creating long-term changes in the state's guardianship system.
- ✓ TCL adopted the Informed Decision-Making (IDM) tool in 2020; the DHHS presented information on the tool to all 100 counties in North Carolina, targeting county DSS guardians.

Proposed Strategies for Priority Area 7

- Educate the community at large about supported decision-making and other alternatives to guardianship.
- Work with public and private guardianship agencies on supportive decision-making and other alternatives to guardianship.
- Meet with individuals and their guardians to identify barriers to transition and the lack of opportunities to make informed choices about community-based services.
- Work with the North Carolina General Assembly to develop a Bill of Rights for individuals subject to guardianship.
- Educate individuals subject to guardianship about the process for full or partial restoration of their rights.⁶⁰
- The DSOHF will provide educational resources and peer learning opportunities for individuals with I/DD to promote better understanding of self-advocates' rights and to strengthen self-advocates' abilities to advocate for themselves.
- The DAAS will support county DSS and the Corporation of Guardianship to expand competency restoration efforts using continuous quality improvement reviews, training, and consultation.

⁵⁹ Kendall Fields, L., Salmon, M. A., Marsh, S., Climo, A., Norris, T., & Nelson, G. (2018). *Rethinking guardianship: Building a case for less restrictive alternatives – final report*. Chapel Hill, NC: Jordan Institute for Families, School of Social Work, University of North Carolina. <https://bit.ly/3mJ9m3p>

⁶⁰ See, e.g., Wood, E. & Pogach, D. (2018). *Guardianship termination and restoration of rights* [PDF]. Washington, D.C.: National Center on Law and Elder Rights, <https://bit.ly/3mDF9Tr>

- The DHHS will propose reforms to General Statute 35A to provide a description of rights for respondents and adults subject to guardianship; improve access to legal counsel; eliminate the presumption of guardianship permanence through regular reviews; and encourage the use of supported decision-making and other less restrictive options to guardianship.

Baseline Data/Targeted Measures for Priority Area 7

Baseline Data for Priority Area 7

In State Fiscal Year 2021, out of more than 6,611 adults served by a public guardian in North Carolina, 4,137 (63%) were younger adults, age 18 to 59 years old; 2,561 (75%) of these younger adults have a primary diagnosis of I/DD or mental illness.

In State Fiscal Year 2021, 37 percent of the adults served by public guardians in North Carolina were older adults; 25 percent had a primary diagnosis of I/DD or mental illness.

Between July 1, 2012 and December 31, 2015, data from the Administrative Office of the Court shows that only three percent of individuals under guardianship sought to have competency restored, but that 70 percent of these were successful in receiving restoration.⁶¹

In State Fiscal Year 2021, 27 individuals had their competency restored.

Targeted Measures for Priority Area 7

- In 2022 and 2023, the DMH/DD/SAS will educate 100 individuals with I/DD and their families each year about the benefits of supported decision-making.
- By December 31, 2023, a total of 800 individuals with SMI/SPMI will use the IDM tool.
- By December 31, 2023, there will be a five-percent increase in individuals who seek to have competency restored.

Resource Requirements for Priority Area 7

The DHHS will utilize existing federal and state funds to cover the costs of these strategies and will request additional funds from the General Assembly if necessary.

⁶¹ Conversation with Linda Kendall Fields, October 5, 2021.

Priority Area 8: Address Disparities in Access to Services

What Priority Area 8 Means

In North Carolina, there are measurable differences in access to health care and services between white people with disabilities and people of color with disabilities. Access to health care and services also varies among geographical areas of the state.

Why Priority Area 8 is Important

These differences in access contribute to the overrepresentation of people of color with disabilities in more restrictive settings. Such settings separate these individuals, especially in rural areas, from the benefits of community inclusion, as well as from opportunities to achieve their full potential.

Whites compose 62 percent of North Carolina's population, African-Americans compose 20.5 percent of the state's population, Latinx/Hispanics compose 11.3 percent of the population, and American Indians and Alaska Natives compose 1.2 percent.⁶² However, the distribution of these groups varies within the population served by publicly funded services, and intentional efforts to address these differences are warranted.⁶³ The Centers for Disease Control and Prevention (CDC) acknowledges that social and economic differences often create health differences in communities of color, and that public health emergencies can isolate communities of colors from necessary resources.⁶⁴

Regarding geographic disparities, the percentage of individuals with a behavioral health diagnosis who received at least one service intended to be responsive to that diagnosis, relative to the estimated prevalence of behavioral health disorders, is different from county to county.

⁶² U.S. Census Bureau. [CEDSCI Profile: North Carolina](https://bit.ly/321RKt4). Retrieved March 25, 2021 from <https://bit.ly/321RKt4>

⁶³ Technical Assistance Collaborative, Inc. and Human Services Research Institute (2021). [An assessment of the North Carolina Department of Health and Human Services' system of services and supports for individuals with disabilities](https://bit.ly/3uZFBPB) [PDF]. Raleigh, NC: North Carolina Department of Health and Human Services, <https://bit.ly/3uZFBPB>

⁶⁴ U.S. Centers for Disease Control and Prevention (n.d.). [Racism and health](https://bit.ly/3aFLDvL), Retrieved October 10, 2021 from <https://bit.ly/3aFLDvL>

North Carolina's Priority Area 8 Efforts to Date

- ✓ The DHHS hired a Chief Equity Officer, responsible for developing, implementing, facilitating, and embedding health equity strategic initiatives into DHHS programs, services, actions, outcomes, and internal employee culture.
- ✓ The DHHS and the Cherokee Indian Hospital Authority have entered into a contract to support the Eastern Band of Cherokee Indians in addressing the health needs of American Indian/Alaska Native Medicaid beneficiaries.⁶⁵ This Indian Managed Care Entity, the first of its kind in the nation, will reflect tribal principles providing care coordination services in a culturally congruent system.
- ✓ The DHHS 2021-2023 Strategic Plan includes the goal to “Advance health equity by reducing disparities in opportunity and outcomes for historically marginalized populations within the DHHS and across the state.”⁶⁶
- ✓ Since the spring of 2020, opportunities to use telehealth have expanded significantly, increasing access to treatment and case management services for individuals residing in rural communities.

Please see [Appendix A](#) for additional North Carolina efforts to date.

Proposed Strategies for Priority Area 8

- The DHHS will provide training and technical support to increase the number of highly qualified contracted providers from historically marginalized populations.
- The DHHS will require LME/MCOs to have a Diversity, Equity and Inclusion Committee to proactively address issues related to disparities and to collect and analyze race and ethnicity data on their members and service recipients, including individuals on the Registry of Unmet Need.
- The DHHS will require Tailored Plans and Standard Plans to collect and report quality data on race and ethnicity to assist the Department in assessing disparities.
- The DHHS will identify a vendor to provide quality translation of information/materials into the foreign languages most commonly spoken in North Carolina⁶⁷, and in alternative formats that are readily accessible for individuals with disabilities.
- The DHB is actively developing a Remote Supports definition, initially for the TBI waiver renewal, followed by the Innovations waiver. Pending CMS approval, the DHB will use

⁶⁵ North Carolina Department of Health and Human Services (October 3, 2021). [Eastern Band of Cherokee Indians \(EBCI\) tribal option overview](#). Retrieved October 10, 2021 from <https://bit.ly/3iQTIrb>

⁶⁶ North Carolina Department of Health and Human Services (2021). [NC Department of Health and Human Services 2021-2023 strategic plan](#) [PDF]. <https://bit.ly/3FCpb4A>

⁶⁷ Jensen, S. (2021, August 27). [The most commonly spoken languages in the Carolinas](#). CharlotteStories.com. <https://bit.ly/3DrCkVA>

enhanced FMAP to add remote technology support to the CAP/C and CAP/DA waivers to increase access to services for individuals living in rural areas of the state.

- The Office of Rural Health will support a robust network of community health workers to connect individuals to human services in historically underserved communities.
- The DMH/DD/SAS will focus efforts to address underserved populations, for example, individuals living in rural communities.

Baseline Data/Targeted Measures for Priority Area 8

Baseline Data for Priority Area 8

Black North Carolinians utilize 27 percent of community-based mental health services funded by the DMH/DD/SAS and 32.4 percent of those funded by Medicaid but represent 50.6 percent of all state psychiatric hospitalizations.

Black North Carolinians are disproportionately represented in the utilization of crisis services, representing 30 percent of the population in some communities but 50 percent of all crisis contacts.⁶⁸

Three of seven LME/MCOs do not track the race and ethnicity of individuals who are on the Registry of Unmet Needs; one LME/MCO collects the demographic information but does not analyze or report it.⁶⁹

Among the adult substance use disorder population, Duplin County had the lowest service penetration rate, at 12 percent, while Haywood County had the highest service penetration rate, at 58 percent, nearly five times higher.⁷⁰

Targeted Measures for Priority Area 8

- The DHHS will provide up to two webinars in calendar year 2022, and again in calendar year 2023, to increase the number of highly qualified, contracted providers from historically marginalized populations.
- The DHHS will increase by five percent the number of Black North Carolinians utilizing community-based mental health services, funded by the DMH/DD/SAS and Medicaid, to reduce overrepresentation among this population in the use of crisis services and state psychiatric hospital admissions.

⁶⁸ RI International, data presented on March 17, 2021 on a national stakeholders call for crisis services.

⁶⁹ Dupuch, C., Pfau, S., & Franklin, M. (2021). [Research findings and policy solutions to address the North Carolina Registry of Unmet Needs](#) [PowerPoint slides]. Downloaded October 10, 2021 from <https://bit.ly/3mGDBbl>

⁷⁰ North Carolina Department of Health and Human Services (2018). [Strategic plan for improvement of behavioral health services: Session Law 2016-94, Section 12F.10.\(a-d\); Session Law 2017-57, Section 11F.6.\(a-b\)](#), Retrieved March 25, 2021 from <https://bit.ly/3DYqKYK>

- All LME/MCOs will collect and analyze race, ethnicity, and gender data on their members, including individuals on the Registry of Unmet Need.

Resource Requirements for Priority Area 8

LME/MCO and Tailored Plan rates have been determined to be actuarially sound to cover the administrative costs and provide the services necessary to meet the contractual requirements for members. The DHHS will seek additional state funds from the General Assembly to cover costs outside the LME/MCO Tailored Plan contracts, if necessary.

Priority Area 9: Increase Input from Individuals with Lived Experience

What Priority Area 9 Means

Individuals with lived experience have firsthand knowledge about services and supports and the systems that provide these. Individuals are able to share a point of view and to provide vital information that those who represent or seek to respond to their interests may overlook or ignore.

Why Priority Area 9 is Important

Organizations that incorporate individuals with firsthand experience in developing, designing, and delivering services are better able to deliver services that are appropriately targeted, efficient, fully integrated, culturally appropriate, and sustainable. Individuals are less likely to participate in services that do not reflect their needs and interests.

Of all stakeholders participating in the Technical Assistance Collaborative's (TAC) Services and Systems Assessment listening sessions and online survey, the individuals most directly impacted by the service system were least represented, despite efforts to solicit their participation.⁷¹

North Carolina's Priority Area 9 Efforts to Date

- ✓ The MFP program has four stakeholder engagement meetings per year, each averaging an attendance of 200 or more. In addition, the program funds the facilitation of Supported Living Levels 2 and 3 stakeholder meetings and workgroups.
- ✓ In the fall of 2021, the NCCDD issued its federally required Five-Year Plan for FY 2022–2027, based on input received from over 500 individuals and families of individuals with I/DD.

⁷¹ Technical Assistance Collaborative, Inc. & Human Services Research Institute (2021). [An assessment of the North Carolina Department of Health and Human Services' system of services and supports for individuals with disabilities](https://bit.ly/3uZFBPB) [PDF]. Raleigh, NC: North Carolina Department of Health and Human Services. <https://bit.ly/3uZFBPB>

- ✓ In 2020, leaders from the DMH/DD/SAS held virtual Town Hall meetings throughout North Carolina to hear from consumers, families, and advocates about how the behavioral health and I/DD system was working and how the DHHS can advance a system that fosters independence, improves health, and promotes well-being for all North Carolinians.
- ✓ The DHHS has included meaningful representation of individuals with lived experience on the OPSA.
- ✓ Peer Voice of North Carolina is a SAMHSA-funded, grassroots nonprofit in Mecklenburg County. Peer Voices uses the voices, experiences, and resilience of people who have overcome trauma, mental health and substance use disorders, and related barriers to elevate recovery and wellness by providing a forum for individuals to participate actively in and influence mental health reform.

Please see [Appendix A](#) for additional North Carolina efforts to date.

Proposed Strategies for Priority Area 9

- The DHHS will continue to seek active participation in the OPSA by individuals with lived experience.
- The DHHS will explore ways to recognize financial costs associated with the time that people with lived experience contribute as members of DHHS workgroups and committees.
- The DHHS will explore opportunities to fund initiatives that give voice to and empower advocacy efforts of individuals with lived experience of behavioral health disorders, I/DD, TBI, and other disabilities.
- The NCCDD will make peer support training available for people with lived I/DD experience.
- The DHHS will continue to conduct My Individual Experience surveys of HCBS recipients.⁷²
- The DHHS will increase support of consumer-operated services.
- Introduce the option for state funds to support consumer-run services.
- The DHHS will promote and educate individuals about self-direction⁷³ during annual renewals of Individual Support Plans and for individuals receiving Medicaid-funded services for the first time.

Baseline Data/Targeted Measures for Priority Area 9

Baseline Data for Priority Area 9

Thirty-one percent of the 45 members of the 2021 OPSA are people with lived experience.

⁷² North Carolina Department of Health and Human Services (n.d.). [My individual experience survey](https://hcbsinfo.ncdhhs.gov/Home/myexperience). Retrieved December 9, 2021 from <https://hcbsinfo.ncdhhs.gov/Home/myexperience>.

⁷³ Centers for Medicare and Medicaid Services (n.d.). [Self-directed services](https://bit.ly/3m54UNd). Retrieved 11/5/21 from <https://bit.ly/3m54UNd>.

The DHHS will establish baseline data on consumer-operated services that support individuals with SMI, I/DD, and TBI.

Targeted Measures for Priority Area 9

- The DHHS will increase support for organized advocacy groups led by families and individuals with lived experience.
- After establishing baseline data, the DHHS will establish a target to increase support for consumer-operated services.

Resource Requirements for Priority Area 9

The DHHS will utilize existing federal and state funds, as well as LME/MCO Tailored Plan contracts, to cover the costs of these strategies.

Priority Area 10: Reduce Transportation Burdens for Individuals with Disabilities

What Priority Area 10 Means

Individuals with disabilities and older adults often lack the financial resources to own a vehicle or to afford public transportation when it exists. Many parts of North Carolina do not have public transportation such as buses, cabs, or ride-share drivers.

Why Priority Area 10 is Important

With limited or no transportation options, individuals with disabilities are unable to visit with family and friends and to access food and clothing stores, health care providers, recreation centers, and social activities – in other words, to become integrated members of their communities. A robust service array is of little benefit if individuals are not able to access the opportunities due to the lack of transportation.

North Carolina's Priority Area 10 Efforts to Date

- ✓ The DHHS obtained CMS approval to allocate up to \$650 million in state and federal Medicaid funding. Funding will cover the cost of providing select, Healthy Opportunities Pilot services related to housing, food, transportation, and interpersonal safety. These services directly impact the health outcomes and health care costs of Medicaid members.

Proposed Strategies for Priority Area 10

- Pending CMS approval, the DHB is proposing to add remote technology support to CAP/C and CAP/DA waivers.

- The DHHS will continue to expand telehealth and scope of practice flexibilities to reduce transportation burdens.
- The DHHS will work with Standard Plans, LME/MCOs and, subsequently, Tailored Plans to enhance Medicaid coverage for Non-Emergency Medical Transportation⁷⁴ in compliance with the Consolidated Appropriations Act of 2021.⁷⁵
- The DHHS will evaluate the impact of Healthy Opportunities Pilots' investment in transportation beyond medical services to support and facilitate community inclusion for Medicaid beneficiaries.
- The DHHS will promote opportunities for Peer Support Specialists and individuals with disabilities to establish ride-share arrangements.

Baseline Data/Targeted Measures for Priority Area 10

Baseline Data for Priority Area 10

The DHHS will seek to establish baseline data on the number of individuals in rural and underserved ZIP codes served through telehealth services.

Targeted Measures for Priority Area 10

- After establishing baseline data, the DHHS will set a target for increasing the number of people served through telehealth services in rural and underserved ZIP codes.

Resource Requirements for Priority Area 10

The DHHS will utilize, pending CMS approval, enhanced FMAP for HCBS; existing federal and state funds; and LME/MCO Tailored Plan contracts to cover the costs of these strategies.

Priority Area 11: Use Data for Quality Improvement

What Priority Area 11 Means

Regularly collecting and reporting data allows for objective assessment of the provision of services and progress towards achieving identified goals and measurement of outcomes, as

⁷⁴ North Carolina Department of Health and Human Services (2021, July 20). [Non-emergency transportation for NC Medicaid Managed Care](https://bit.ly/3mJcVXI). Retrieved September 30, 2021 from <https://bit.ly/3mJcVXI>

⁷⁵ Center for Medicaid and CHIP Services Informational Bulletin (July 12, 2021). [Medicaid coverage of certain medical transportation under the Consolidated Appropriations Act, 2021 \(Public Law 116-260\)](https://bit.ly/3FAGWpN) [PDF], <https://bit.ly/3FAGWpN>

opposed to strictly determining the number of services delivered. Data should be used in determining areas of service provision that need to be improved.

Why Priority Area 11 is Important

Data is essential for validating or refuting popular beliefs that, left unchecked, can create a false sense of reality, either positive or negative. However, data collection must serve a purpose. DHHS staff have reported that, in spite of ample data, they still have an incomplete picture of the quality of the services being delivered, and of the impact those services are having on recipients' lives.

There are numerous evidence-based and promising practices that demonstrate positive results. However, providers may elect not to transition to these practices absent incentives to do so. As stewards of federal and limited state funds, the DHHS should be driving service system transformation by requiring its contractors, LME/MCOs, and eventually the Tailored Plans to prioritize the expenditure of funding to develop a data-driven, service delivery system.

Finally, data analysis will be essential to determine the extent to which North Carolina is achieving its Olmstead Plan priorities.

North Carolina's Priority Area 11 Efforts to Date

- ✓ Behavioral Health I/DD Tailored Plans will be required to:
 - Develop quality management and improvement programs; quality assessment and performance improvement plans; and at least three performance improvement projects.
 - Achieve National Committee for Quality Assurance health plan accreditation with the Long-Term Services and Support Distinction for Health Plans by the end of Contract Year 3.
 - Report a wide range of quality metrics, including outcome metrics, with variations depending on whether the enrollee is receiving Medicaid- or state-funded services.
- ✓ DHHS staff are working with Manatt to develop a set of patient-reported outcomes measures (PROMs) for both Standard and Tailored Plans, intended to cover health-related quality of life, symptoms, consumer experiences, and health behaviors.
- ✓ DHHS staff are working with Mathematica to enhance TCL data quality and integration, performance measurement, and use of program data for evaluation and decision-making, and to establish a framework that can potentially assist in developing a quality assurance structure for the state's Olmstead Plan.
- ✓ The DHHS is developing a score card for LME/MCOs which will reflect data-driven performance on selected measures.
- ✓ The DMH/DD/SAS is expanding the data collected from providers who serve individuals under involuntary commitment to assess whether the commitment was necessary and appropriate.

- ✓ The DMH/DD/SAS is conducting performance audits of the LME/MCOs, targeting reviews of specific services to determine whether they are meeting service definition requirements.
- ✓ The DMH/DD/SAS is aligning financial incentives to support the delivery of research-based behavioral health services.

Proposed Strategies for Priority Area 11

- The DHHS will expand its capacity to utilize key data points, performance measures, and indicators to assess progress towards achieving Olmstead Plan priorities and revising priorities, strategies, and measures as necessary.
- The DHHS will invest in the technology needed to support more seamless data storage, integration, retrieval, and visualization across the Department.
- The DHHS will finalize a Master Patient Index to link service recipients' records across multiple datasets for more robust analyses.
- The DHHS will create a professional development series on available data resources to help staff understand the data that is available across the Department; the benefits and limitations of different data resources; how to request data from other divisions; and how to leverage data assets to inform decision-making.
- The DHHS will work with Mathematica to expand and enhance its quality assurance framework and strategies; these may apply across initiatives impacting individuals with a variety of disabilities.
- The DHHS Division of Budget and Analysis and the DHHS Office of the Controller will create a set of financial performance dashboards to promote stewardship of key funding resources, including division budgets, CARES Act funding, American Rescue Plan Act funding, and block grants, and to support management in making timely informed decisions.

Resource Requirements for Priority Area 11

The DHHS will utilize existing federal and state funds to cover the costs of these strategies. The DHHS will seek additional state funds from the General Assembly if necessary.



Plan Implementation and Oversight

Designated Olmstead Staff

While this initial Olmstead Plan reinforces North Carolina's vision for transitioning its services and systems to support individuals with disabilities in choosing integrated and inclusive community settings that meet their needs, the Department of Health and Human Services (DHHS) recognizes that effective and regular oversight will be necessary to facilitate implementation of the Plan. Therefore, the DHHS is proposing:

- To establish an Office of Olmstead Plan Implementation that will be led by the Senior Advisor on the Americans with Disabilities Act (ADA). The Senior Advisor reports directly to the Deputy Secretary for Medicaid within the DHHS. The Office will be staffed sufficiently to carry out the duties necessary to provide continued leadership and education; to monitor the implementation of Plan strategies; to assess progress towards measures; and to assist in resolving barriers and challenges that might impede implementation.
- To create an Olmstead Steering Committee, consisting of representatives from DHHS divisions and essential sister agencies, to guide and monitor North Carolina's progress in achieving the Olmstead Plan priorities.
- To appoint and staff a second iteration of the Olmstead Plan Stakeholder Advisory (OPSA) to advise the state regarding its Olmstead Plan.

Ongoing Role of the Olmstead Plan Stakeholder Advisory

In addition to its internal structure of the Olmstead Steering Committee, North Carolina is committed to achieving this Olmstead Plan's goals. The state recognizes that ongoing external stakeholder participation is key to achieving these goals and to transparency. The DHHS will continue to convene the OPSA and to seek the Advisory's regular input and feedback regarding progress in implementing the Olmstead Plan and future Plan revisions.

Making *Olmstead* Everyone's Responsibility

As the Department continues to incorporate compliance with *Olmstead* into its day-to-day operations, the ongoing assessment of progress and need for Plan modifications must become the responsibility of every division. Review of the Plan should be incorporated into the role of all relevant committees, boards, commissions, task forces, and councils. Progress must be captured in evaluation and reports, while action steps and requested resources must be included in departmental strategic plans.

In addition, the Local Management Entities/Managed Care Organizations (LME/MCOs) Tailored Plans and Standard Plans play a key role in Plan implementation and must embrace implementation of the Olmstead Plan as a shared responsibility.

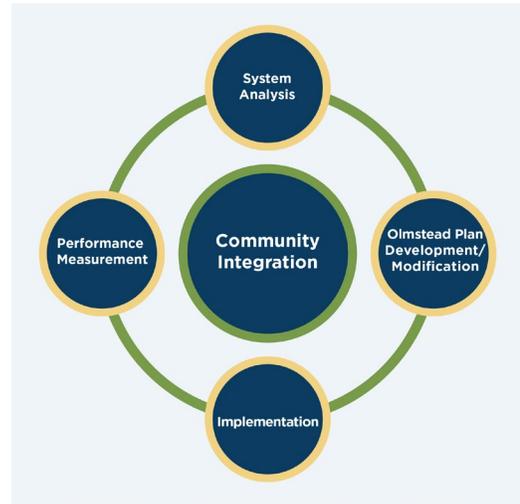


Figure 1. Cycle of Olmstead Planning, TAC 2019



Conclusion

North Carolina intends for the Olmstead Plan to be a living plan and a lens through which policy, practice, and funding decisions are made. The Department of Health and Human Services (DHHS) anticipates that goals, strategies, and measures will need to be adjusted and refined as implementation proceeds. The DHHS anticipates that this plan will result in rebalancing of federal and state funds in favor of community-based services and supports. Moreover, the Plan will enhance community inclusion for people with disabilities and their families. The ability to achieve some of the plan's goals and to implement certain of its strategies will depend, in part, on the availability of additional federal and state funds. The DHHS will work closely with, and will need the full support of, its stakeholders, its sister agencies, and the North Carolina General Assembly to secure the Plan's success.

This page intentionally left blank.

Appendix A: North Carolina's Additional Efforts to Date in Achieving Olmstead Plan Priorities

Priority Area 1:

Strengthen Individuals' and Families' Choice for Community Inclusion through Increased Access to Home and Community-Based Services and Supports

- ✓ The North Carolina State Treasurer's Office administers [Achieving a Better Life Experience \(ABLE\) accounts](#), providing North Carolinians with disabilities – including physical, developmental, and mental health or other conditions – the opportunity to save money, while preserving their Supplemental Security Income (SSI) and Medicaid income.

Priority Area 2:

Address the Direct Support Professional Crisis

- ✓ In April 2021, the North Carolina General Assembly introduced HB 665, an act to address the staffing crisis impacting intermediate care facilities for individuals with intellectual disabilities.
- ✓ The Trillium Local Management Entity/Managed Care Organization (LME/MCO) *Choose Independence* Initiative offers funds to assist with purchases of Smart Home technology applications.

Priority Area 3: Divert and Transition Individuals from Unnecessary Institutional and Segregated Settings

Diversion

- ✓ The General Assembly has appropriated funding from the sale of the Dorothea Dix State Hospital property to the Department of Health and Human Services (DHHS) to establish state psychiatric hospital diversion services.¹ Funds have been allocated to convert existing, licensed, acute medical inpatient beds into licensed psychiatric or substance use inpatient beds or to create new licensed psychiatric or substance use inpatient beds, including in rural communities. In addition, funding was allocated to create new beds in a facility-based crisis program.
- ✓ Medicaid-eligible individuals on the waitlist for waiver services may qualify for (b)(3) Medicaid services and State Plan personal care, additional services focused on helping individuals remain in their homes or communities and avoid institutionalization or hospitalization.
- ✓ The Special Assistance/In-Home program provides cash supplements to support low-income individuals to live in the community as an alternative to institutions such as nursing facilities.
- ✓ North Carolina Systemic, Therapeutic, Assessment, Resources and Treatment (NC START) is a statewide community crisis prevention and intervention program for individuals, age six and above, with intellectual and other developmental disabilities (I/DD) and co-occurring complex behavioral and/or mental health needs. NC START crisis prevention and intervention services are provided through clinical systemic consultation, training, education, therapeutic respite, crisis response and therapeutic coaching.
- ✓ The DHHS implemented community behavioral health paramedicine pilots that use specially trained emergency medical services (EMS) staff to intervene with patients experiencing behavioral health crises. The pilots also provide incentives for the participating EMS to either treat on-scene or route those patients not needing medical treatment to lower cost alternatives instead of hospital emergency departments.²

¹ North Carolina Department of Health and Human Services (2020). [Funds for local inpatient psychiatric beds or bed days purchased in state fiscal year 2019-2020 and other department initiatives to reduce state psychiatric hospital use. Session Law 2020-78, Part IV-E, Section 4E.1](https://files.nc.gov/ncdhhs/SL-2020-78-Section-4E.1-Funds-for-Local-Inpatient-Psychiatric-Beds-or-Bed-Days--Final-.pdf). Report to the Joint Legislative Oversight Committee on Health and Human Services and Fiscal Research Division, December 21, 2020. Retrieved April 26, 2021 from <https://files.nc.gov/ncdhhs/SL-2020-78-Section-4E.1-Funds-for-Local-Inpatient-Psychiatric-Beds-or-Bed-Days--Final-.pdf>

² North Carolina Department of Health and Human Services (2016). [Final report on the Community Paramedic Mobile Crisis Management Pilot Program, Session Law 2015-241, Section 12F.8.\(d\)](#) [PDF]. Report to the Joint Legislative Oversight Committee for Health and Human Services and the Fiscal Research Division, November 1, 2016.

Transitions

- ✓ The DHHS contracts require the Behavioral Health I/DD Tailored Plans “to identify members who are receiving care in an institutional setting and help transition them to the community, if their needs can be met safely in the community.”³
- ✓ The Division of Aging and Adult Services (DAAS) has developed and piloted a Screening and Priority Services tool to be used for older adults and individuals with disabilities and their caregivers to assess their level of functioning, need for services and access to resources to establish their prioritization for services.

Priority Area 4:

Increase Opportunities for Supported Education and Pre-employment Transition Services for Youth with Disabilities, and Competitive Integrated Employment for Adults with Disabilities

Supported Education/Pre-employment Transition Services for Youth

- ✓ The Division of Vocational Rehabilitation Services (DVRS) provides pre-employment transition services and/or vocational rehabilitation services to all youth and students with disabilities to assist them in reaching their competitive integrated employment goals.
- ✓ The DVRS partners with the Youth Development Centers for adjudicated youth to provide Pre-Employment Transition Services and fosters connection to the local Vocational Rehabilitation office when returning to the home community.
- ✓ The DVRS has 113 dedicated transition positions and serves students with disabilities in all 100 North Carolina counties.
- ✓ The DVRS has recently revised its policy on supports provided for students and youth with disabilities who participate in comprehensive transition and post-secondary programs, allowing additional funding for those that meet the established criteria.

Competitive Integrated Employment

- ✓ The DVRS has funded traditional supported employment services for people with I/DD under a milestone funding structure since 2013, incentivizing outcomes over delivery of units of services.
- ✓ In 2019, the DHHS and Vaya Health developed the North Carolina Collaborative for Ongoing Recovery through Employment (NC CORE), a pilot project in which fee-for-service Medicaid reimbursement and state funding was replaced with a shared funding model. Both

³ Department of Health and Human Services Request for Applications #: 30-2020-052-DHB BH I/DD Tailored Plan, November 13, 2020.

Vaya Health and DVRS fund the achievement of milestones for the provision of Individual Placement Support – Supported Employment (IPS/SE). The Alliance LME/MCO is in the process of implementing the approach, and the Partners, Trillium, and Sand Hills LME/MCOs are engaged in planning.

- ✓ The DVRS, the Division of Health Benefits (DHB) and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) are strengthening their partnerships to support competitive, integrated employment (CIE) opportunities for North Carolinians with disabilities.
- ✓ [NC Careers.org](https://www.nccareers.org) represents a collaborative effort to produce an accessible online resource for employment training, supports, and resources available to all North Carolinians, including those with disabilities. This effort is supported by the DHHS, the Department of Commerce, the Department of Public Instruction, and the University of North Carolina.
- ✓ The DVRS has added fee-for-service benefits counseling with approved vendors to increase access to benefits counseling for vocational rehabilitation clients.
- ✓ The DMH/DD/SAS has provided funding to sponsor Individual Placement and Support – Supported Employment staff in receiving benefits counseling training through Cornell University, and has increased the state-funded IPS/SE rate for providers with a benefits counselor on the team.

Priority Area 5: Increase Opportunities for Inclusive Community Living

- ✓ In 2020, a group of advocates, assisted by the DHHS, formed the Innovations Supported Living Stakeholders Levels 2 and 3 workgroup to advance strategies that offer greater access to, and sustainability of, supported living for individuals with significant disabilities.
- ✓ In Fiscal Year 2019, the DHHS partnered with the North Carolina Housing Finance Agency to develop the Integrated Supportive Housing Program, which provides interest-free loans to community developments where up to 20 percent of the units are integrated and set aside for households participating in the Transitions to Community Living (TCL) program.⁴
- ✓ The DHHS established LME/MCO contract requirements for Housing Specialists.
- ✓ North Carolina has 3,847 federal housing vouchers targeted exclusively to people with disabilities.

⁴ The Integrated Supportive Housing Program fosters a collaboration between a local housing developer, DHHS, and the LME/MCO to increase the supply of integrated, affordable rental housing. This housing consists of independent rental units where no more than 20% of the units are required to be set aside for persons with a disabling condition. Prospective tenants will be referred by the DHHS and are anticipated to come with rental assistance and connection to supportive services. See [Integrated Supportive Housing Program: Program Guidelines \[PDF\]](#).

- ✓ Key Rental Assistance is funded in the amount of approximately \$5.5 million annually.
- ✓ Proposed Special Provisions for SL 2021-180 (Senate Bill 105), 2021 Appropriations Act, include eliminating the cap on the number of allowable state-county Special Assistance/In-Home payments.

Priority Area 6: Address Gaps in Services

- ✓ Since 2019, the DHB has provided research-based, behavioral health treatment as a Medicaid state plan service for individuals under the age of 21.
- ✓ The North Carolina General Assembly recently approved legislation allowing licensure of Board Certified Behavior Analysts.
- ✓ The DHHS has engaged the Alliance of Disability Advocates North Carolina to provide community inclusion supports and benefits counseling to TCL recipients in the Alliance and Eastpointe catchment area.
- ✓ The DHHS recently reallocated Single Stream Funding based on data-driven measures, successfully redistributing this state-only funding to the LME/MCOs with substantiated need.

Priority Area 8: Address Disparities in Access to Services

- ✓ The DHHS has been meeting regularly with the Latino Congress to discuss strategies for improving communication about DHHS benefits and services to the Latinx community.
- ✓ On June 1, 2021, the DMH/DD/SAS held an open dialogue to create a safe space for individuals to share their perceptions about diversity, equity, and inclusion.⁵

⁵ See also North Carolina Department of Health and Human Services (n.d.). [Diversity and inclusion](https://bit.ly/3mM4E4W). Retrieved September 30, 2021 from <https://bit.ly/3mM4E4W>

Priority Area 9: Increase Input from Individuals with Lived Experience

- ✓ TCL includes consumer satisfaction surveys as a tool for assessing the quality of services and overall success of the initiative.
- ✓ As part of its five-year plan process, in September 2020, the North Carolina Council on Developmental Disabilities (NCCDD) held statewide input sessions for adult and youth (age 30 and under) self-advocates to identify the issues that matter to them and the initiatives that the NCCDD should work on to make North Carolina a more inclusive state for people with I/DD.
- ✓ In 2019, the DHHS held numerous statewide listening sessions to obtain input from a broad range of stakeholders, including Medicaid beneficiaries, to design initiatives under Medicaid Transformation.

Appendix B: Olmstead Plan Stakeholder Advisory Membership, Committee Assignments, and Staff Work Group (November 23, 2021)

NC DHHS Mission: In collaboration with our partners, the North Carolina Department of Health and Human Services provides essential services to assist people with disabilities to reside in and experience the full benefit of inclusive communities.

Olmstead Plan Stakeholder Advisory (OPSA) Vision Statement: North Carolina champions the right of all people with disabilities to choose to live life fully included in the community.

OPSA Leadership

OPSA Community Co-Chairs:

Betsy MacMichael, BetsyM@fifnc.org

Charmaine Fuller Cooper, cfcooper@aarp.org

OPSA Departmental Co-Chair:

Dave Richard (Deputy Secretary for NC Medicaid), Dave.Richard@dhhs.nc.gov

OPSA Membership

DHHS Divisions/Offices

1. Office of the Secretary:

Secretary Kody Kinsley, Kody.Kinsley@dhhs.nc.gov

Deputy Secretary Dave Richard, Dave.Richard@dhhs.nc.gov

Sr. Advisor for the ADA, Sandra K. (Sam) Hedrick, Sam.Hedrick@dhhs.nc.gov

Sr. Director Chris Egan, Chris.Egan@dhhs.nc.gov

2. NC Medicaid:

Sandy Terrell, Sandra.Terrell@dhhs.gov

Deb Goda (alt.), Deborah.Goda@dhhs.nc.gov

3. Division of Mental Health, Developmental Disabilities and Substance Abuse Services:

Deepa Avula, Deepa.Avula@dhhs.nc.gov

Michelle Laws (alt.), Michelle.Laws@dhhs.nc.gov

4. Division of State Operated Healthcare Facilities:

Karen Burkes, Karen.Burkes@dhhs.nc.gov

Niki Ashmont (alt.), Niki.Ashmont@dhhs.nc.gov
Laura White (alt.), Laura.White@dhhs.nc.gov

5. **Division of Vocation Rehabilitation:**

Kathie Trotter, Kathie.Trotter@dhhs.nc.gov
Kenny Gibbs (alt.), Kenny.Gibbs@dhhs.nc.gov

6. **Division of Social Services:**

Susan Osborne, Susan.Osborne@dhhs.nc.gov
Lisa Cauley (alt.), Lisa.Cauley@dhhs.nc.gov

7. **Division of Aging and Adult Services:**

Joyce Massey-Smith, Joyce.Massey-Smith@dhhs.nc.gov
Karey Perez (alt.), Karey.Perez@dhhs.nc.gov

Consumer, Family and Advocacy Group Representatives

8. **NC Council on Developmental Disabilities** – Kerri Bennett Eaker, Chair,
Kerri.Eaker@hcahealthcare.com
9. **Alcohol and Drug Council of NC** – Kurtis Taylor, Executive Director,
KTaylor@alcoholdrughelp.org
10. **National Alliance for People with Mental Illness/NC** – Judy Jenkins, Board President,
judy.jenkins@me.com
11. **Brain Injury Advisory Council of NC** – David Forsythe, Chair,
David.Forsythe@pcqhinc.org
12. **State Consumer and Family Advisory Committee** – Jean Andersen, Committee Member,
tbiadvocate@windstream.net
13. **Disability Rights North Carolina** – Bryan Dooley, Chair,
Dooleybg@guilford.edu
14. **Statewide Independent Living Council** – Eva Reynolds, Chair,
ereynolds@disabilitypartners.org
15. **First in Families** – Betsy MacMichael, Executive Director,
Betsym@fifnc.org
16. **Arc of NC** – Jeff Smith, Board Member,
Supersmitty100@gmail.com
17. **Coalition on Aging** – Charmaine Fuller Cooper, Chair,
Cfcooper@aarp.org
18. **Dementia Alliance of North Carolina** – Lanier Cansler, Chair,
Lcansler@canslermail.com
19. **NC Child** – Jenny Hobbs, Parent Advisory Council,
jhobbsfamily6@gmail.com

20. **NC Empowerment Network** – Matthew Potter, Board Member,
Pottmm5@gmail.com
21. **NC Mental Health Planning and Advisory Committee** – Lacy Flintall, Board Chair,
LFlintall@NCFamiliesUnited.org
22. **Promise Resource Network** – Cherene Allen-Caraco, CEO,
ccaraco@promiseresourcenetwork.org
23. **Disability Rights North Carolina** – Corye Dunn, Policy Director,
corye.dunn@disabilityrightsncc.org
24. **At-Large Member** – Matty Lazo-Chadderton,
lazomatty@gmail.com
25. **Center for Family and Community Engagement, NCSU** – Glenda Clare, Family Partner Specialist, gsclare@ncsu.edu
26. **Strong Able Youth Speaking Out (SaySo)** – Carmelita Coleman, Executive Director,
ccoleman@chsnc.org
27. **Housing Options for Person with Exceptionalities (HOPE)** – Dotty Foley, Co-Founder,
dotty@dottyfoley.com

Professional Organizations, Agencies and Associations

28. **NC Housing Finance Agency** – Paul Kimball, Director of Community Living,
pekimball@nchfa.com
29. **NC Association for Persons in Supported Employment** – Bridget Hassan, Board President,
bridget.hassan@eastersealsucp.com
30. **NC Providers Council** – Wilson Raynor, Board Member,
wraynor@lifeincorporated.com
31. **Benchmarks** – Karen McLeod, CEO,
kmcleod@benchmarksnc.org
32. **LME/MCOs** – Leza Wainwright, CEO, Trillium Health,
leza.wainwright@trilliumnc.org
33. **LME/MCOs** – Mike Bridges, Director, Transitions to Community Living, Cardinal Innovations Healthcare, mike.bridges@cardinalinnovations.org
34. **NC Senior Living Association** – Jeff Horton, Executive Director,
jeff@ncseniorliving.org
35. **Addiction Professionals of NC** - Sarah Potter, Executive Director,
spotter@apnc.org
36. **Developmental Disabilities Facilities Association** – Peyton Maynard, CEO,
pmaynard@bellsouth.net

37. **Association for Home and Hospice Care of North Carolina** – Tim Rogers, CEO,
tim@ahhcnc.org
38. **NC Health Care Facilities Association** – Adam Sholar, CEO,
adams@nchcfa.org
39. **Marketing Association of Rehabilitation Centers** – Michael Maybee, President,
mmaybee@woiworks.org

North Carolina General Assembly

40. Representative Carla Cunningham,
Carla.Cunningham@ncleg.net
41. Senator Joyce Krawiec,
Joyce.Krawiec@ncleg.net
42. Senator Gladys Robinson,
Gladys.Robinson@ncleg.net
43. Representative Donna White,
Donna.White@ncleg.net

OPSA Committees

Housing

Chair: Mike Bridges, Mike.Bridges@cardinalinnovations.org

Staff: Stephanie Williams, stephanie.williams@dhhs.nc.gov; Ken Edminster,
ken.edminster@dhhs.nc.gov; Pam Lloyd, pamela.lloyd@dhhs.nc.gov

- Paul Kimball
- Peyton Maynard
- David Forsythe
- Sen. Joyce Krawiec
- Kody Kinsley

Employment

Chair: Bridget Hassan, bridget.hassan@eastersealsucp.org

Staff: Julie Bloomingdale, Julie.bloomingdale@dhhs.nc.gov; Jeff Stevens,
jeff.stevens@dhhs.nc.gov

- Kathie Trotter/Kenny Gibbs (alt.)
- Matty Lazo-Chadderton
- Bryan Dooley
- Wilson Raynor
- Michael Maybee
- Chris Egan

Community Capacity Building

Chair: Dotty Foley, dotty@dottyfoley.com

Staff: Tamara Smith, tamara.smith@dhhs.nc.gov; Mya Lewis, Mya.Lewis@dhhs.nc.gov;
Kenneth Bausell, kenneth.bausell@dhhs.nc.gov; Pam Shipman,
Pam.Shipman@monarchnc.org

- Deepa Avula/Michelle Laws (alt.)
- Sandy Terrell/Deb Goda (alt.)
- Jeff Smith
- Eva Reynolds

Transition to Community

Chair: Kerri Eaker, kerri.eaker@msj.org;

Staff: Monica Harrelson, Monica.Harrelson@dhhs.nc.gov ; Talley Wells,
talley.wells@dhhs.nc.gov; Katie Visconti, katie.visconti@dhhs.nc.gov; Brad Owen,
Brad.Owen@dhhs.nc.gov

- Corye Dunn
- Adam Sholar
- Dave Richard
- Karen Burkes/Niki Ashmont and Laura White (alt.)

Children, Youth and Families

Chair: Jenny Hobbs, jhobbsfamily6@gmail.com

Staff: Petra Mozzetti, petra.mozzetti@dhhs.nc.gov / Kristin Jerger, Kristin.Jerger@dhhs.nc.gov;
Teresa Strom, Teresa.Strom@dhhs.nc.gov; Shauna Shaw, shauna.shaw@dhhs.nc.gov;
Rob Morrell, Rob.Morrell@dhhs.nc.gov

- Susan Osborne/Lisa Cauley (alt.)
- Judy Jenkins
- Glenda Clare
- Carmelita Coleman

Workforce Development

Chair: Karen McLeod, kmcleod@benchmarksnc.org

Staff: Jesse Smathers, Jesse.Smathers@vayahealth.com / Celeste Ordiway,
Celeste.Ordiway@vayahealth.com; Janie Shivar, Janie.Shivar@dhhs.nc.gov

- Jean Andersen
- Cherene Caraco
- Matthew Potter
- Kurtis Taylor
- Sen. Gladys Robinson

Older Adults

Chair: Lanier Cansler, Lcansler@canslermail.com

Staff: Hank Bowers, hank.n.bowers@dhhs.nc.gov; Steve Strom, steve.strom@dhhs.nc.gov

- Joyce Massey-Smith/Karey Perez (alt.)
- Jeff Horton
- Tim Rogers
- Rep. Donna White

Quality Assurance and Quality of Life

Chair: Leza Wainwright, Leza.Wainwright@trilliumnc.org

Staff: Karen Feasel, karen.feasel@dhhs.nc.gov; Drew Kristel, drew.kristel@dhhs.nc.gov

- Rep. Carla Cunningham
- Sam Hedrick
- Lacy Flintall
- Sarah Potter

Olmstead Plan Stakeholder Advisory Staff Work Group

Staff Work Group Co-Conveners: Holly Riddle, Office of the Sr. Advisor on the ADA, Holly.Riddle@dhhs.nc.gov and Lisa Corbett, General Counsel, NCDHHS, Lisa.Corbett@dhhs.nc.gov; Pam Scott, Pam.Scott@dhhs.nc.gov

Olmstead Program Manager, Office of the Sr. Advisor on the ADA:

Vickie Callair (Olmstead Program Manager), Vickie.Callair@dhhs.nc.gov;

Amber Kimball Hsu (Intern), Amber.R.Kimball@gmail.com

Lead Subject Matter Experts

1. **NC Medicaid** – Kenneth Bausell, kenneth.bausell@dhhs.nc.gov
2. **DMH/DD/SAS** – Tamara Smith, tamara.smith@dhhs.nc.gov; Mya Lewis, mya.lewis@dhhs.nc.gov; Kristin Jerger, kristin.jerger@dhhs.nc.gov; Ken Edminster, Ken.Edminster@dhhs.nc.gov
3. **DSOHF** – Katie Visconti, katie.visconti@dhhs.nc.gov; Cindy Koempel, cindy.koempel@dhhs.nc.gov
4. **DVR** – Pamela Lloyd, pamela.lloyd@dhhs.nc.gov; Julie Bloomingdale, Julie.Bloomingdale@dhhs.nc.gov
5. **DAAS** – Hank Bowers, hank.n.bowers@dhhs.nc.gov
6. **DSS** – Teresa Strom, teresa.strom@dhhs.nc.gov
7. **Office of the Secretary/NC Council on Developmental Disabilities** – Talley Wells, talley.wells@dhhs.nc.gov

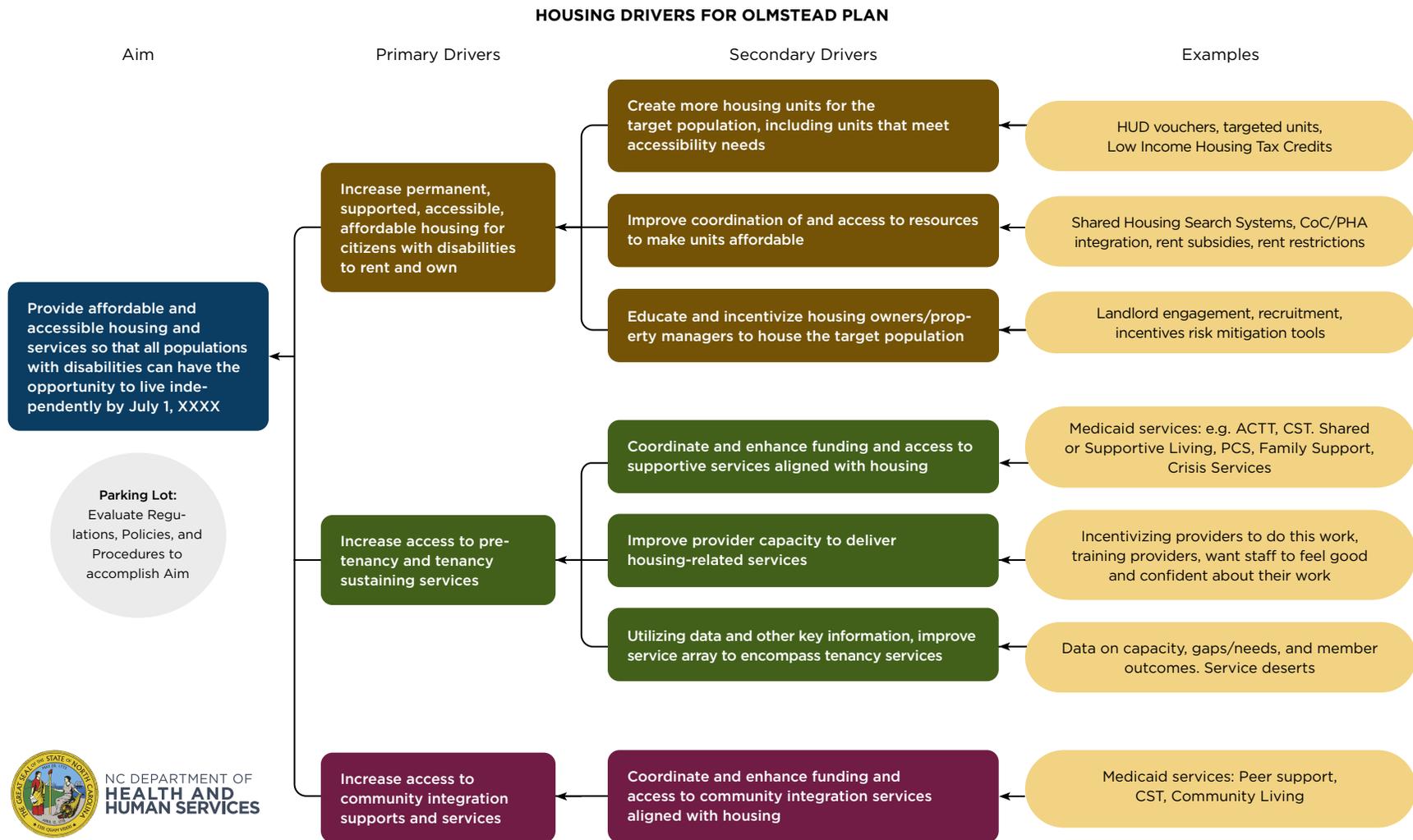
8. **NC Medicaid/Money Follows the Person** – Steve Strom, steve.strom@dhhs.nc.gov
9. **LME/MCOs or Provider Networks** – Pam Shipman, pam.shipman@monarchnc.org; Celeste Ordiway, Celeste.Ordiway@vayahealth.com
10. **Office of the Sr. Advisor on the ADA** – Janie Shivar, Janie.Shivar@dhhs.nc.gov; Stephanie Williams, stephanie.williams@dhhs.nc.gov; Brad Owen, brad.owen@dhhs.nc.gov

Lead Data Experts

11. **NC Medicaid** – Deb Goda, deborah.goda@dhhs.nc.gov
12. **DMH/DD/SAS** – Karen Feasel, karen.feasel@dhhs.nc.gov
13. **DSOHF** – Niki Ashmont, niki.ashmont@dhhs.nc.gov
14. **DVR** – Jeff Stevens, jeff.stevens@dhhs.nc.gov
15. **DAAS** – Hank Bowers, hank.n.bowers@dhhs.nc.gov
16. **DSS** – Shauna Shaw, shauna.shaw@dhhs.nc.gov; Rob Morrell, rob.morrell@dhhs.nc.gov
17. **Office of the Sr. Advisor on the ADA** – Drew Kristel, drew.kristel@dhhs.nc.gov

This page intentionally left blank.

Appendix C: OPSA Housing Committee Driver Diagram



This page intentionally left blank.

Appendix D: Glossary of Terms

(b)(3) Services – Additional supports for people who have Medicaid insurance. They are offered in addition to the services in the North Carolina Medicaid State Plan. These services focus on helping people remain in their homes and communities and avoid higher levels of care, such as hospitals. North Carolina's Local Management Entities/Managed Care Organizations (LME/MCOs) can offer these additional services as a result of savings from the Medicaid waivers. The term "(b)(3)" refers to the section of the federal Social Security Act that allows states to offer these services under a Medicaid waiver.

811 Mainstream Program – Allows persons with disabilities to live as independently as possible in the community by subsidizing rental housing opportunities which provide access to appropriate supportive services. The U.S. Department of Housing and Urban Development (HUD) Section 811 program is authorized to operate in two ways: by providing interest-free capital advances and operating subsidies to nonprofit developers of affordable housing for persons with disabilities, and by providing project rental assistance to state housing agencies.

1915(i) State Plan Option – Allows the state to provide Medicaid coverage for certain home and community-based services (HCBS) to people with disabilities who do not meet the criteria for an institutional level of care and who have incomes lower than 150 percent of the federal poverty level.

ABLE ACT and Accounts – The North Carolina State Treasurer's Office administers the Achieving a Better Life Experience (ABLE) Act, a federal law signed in December of 2014, that allows individuals with disabilities and their families to save for the future and fund essential expenses like medical and dental care, education, community-based supports, employment training, assistive technology, housing, and transportation. ABLE accounts are tax-exempt savings accounts for qualified disability expenses.

Adult Developmental Vocational Program (ADVP) – A day/night service which provides organized developmental activities for individuals with intellectual and other developmental disabilities to prepare them to live and work as independently as possible. ADVP services may only be provided in a licensed or Vocational Rehabilitation approved facility.

American Rescue Plan Act – A \$1.9 trillion economic [stimulus bill](#) passed signed into law on March 11, 2021, building upon many of the measures in the CARES Act from March 2020.

Assertive Community Treatment – An evidence-based practice that provides community-based, multidisciplinary mental health *treatment* for individuals with severe and persistent mental illness.

Assistive Technology – Comprises both devices and services:

- Assistive technology as a device can be any item or piece of equipment that helps a person with a disability to increase, maintain, or improve their ability to function. Assistive technology as a device can range from low-tech devices, such as a cane or wheelchair, to high-tech devices, such as a software program on a computer, or screen readers. Note: Medical devices that are surgically implanted are not considered assistive technology.
- Assistive technology as a service can involve any combination of the following:
 - Evaluation of an individual's needs
 - Acquisition of assistive technology devices (e.g., purchasing, leasing, or loaner programs).
 - Selection, fitting, or repairing of a device.
 - Training an individual with a disability or their caregiver on how to use assistive technology.

Behavioral Health Disorders – Mental health disorders, substance use disorders, or co-occurring mental health and substance use disorders.

Behavioral Health I/DD Tailored Plans – North Carolina will launch the Behavioral Health and Intellectual/Developmental Disabilities Tailored Plan on December 1, 2022. This plan is an integrated health plan designed for individuals with significant behavioral health needs and intellectual and other developmental disabilities (I/DDs). The Behavioral Health I/DD Tailored Plan will also serve other special populations, including Innovations and Traumatic Brain Injury (TBI) waiver enrollees and waitlist members, and will be responsible for managing the state's non-Medicaid behavioral health, developmental disabilities, and TBI services for uninsured and underinsured North Carolinians.

CAP/C Waiver – A 1915(c) Home and Community Based Services waiver that provides services for medically fragile children under 21 who are at risk of institutional care. By providing in-home nursing care, case management, and other supports, CAP/C can help these children stay at home with their families.

CAP/DA Waiver – This waiver program provides a cost-effective alternative to institutionalization for a Medicaid beneficiary who is medically fragile and at risk for institutionalization if the Home and Community Based services approved in the CAP/DA waiver were not available. These services allow the beneficiary to remain in or return to a home- and community-based setting.

Children's Residential Redesign – An initiative to redesign the state's psychiatric residential treatment facilities to improve treatment and agency outcomes.

The Coalition – [The Coalition](#) is a group of statewide organizations in North Carolina that are committed to assuring the availability of services and supports for individuals who experience addictive diseases, mental illness, and developmental disabilities.

Coalition on Aging – A coalition whose mission is to improve the quality of life for older adults through collective advocacy, education, and public policy work. This group works to develop programs for children with autism, advocate and help families navigate services, and educate state policy makers on the needs of children with autism.

Coronavirus Aid, Relief, and Economic Security (CARES) Act – Signed into law March 27, 2020, this act provides over \$2 trillion of economic relief to workers, families, small businesses, industry sectors, and other levels of government that were hit hard by the public health crisis created by COVID-19.

Competitive Integrated Employment – Defined by the Rehabilitation Act as work that is performed on a full-time or part-time basis for which an individual is: (a) compensated at or above minimum wage and comparable to the customary rate paid by the employer to employees without disabilities performing similar duties and with similar training and experience; (b) receiving the same level of benefits provided to other employees without disabilities in similar positions; (c) at a location where the employee interacts with other individuals without disabilities; and (d) presented opportunities for advancement similar to other employees without disabilities in similar positions.

Comprehensive Transition and Postsecondary (CTP) Program – Under the Higher Education Opportunity Act of 2008 (HEOA), this is a college program created specifically for students with intellectual disabilities. The Act defined the key requirements that all CTP programs must provide to students, gave a definition of “student with an intellectual disability,” and opened up access to federal student aid for students with an intellectual disability attending an approved CTP program. Students in CTP programs do not have a standard high school diploma or matriculate towards a degree.

Coordinated Specialty Care – A team-based, collaborative, recovery-oriented, treatment team approach involving individuals who are experiencing first episode psychosis.

Consumer-Operated Services – Services that are fully independent, separate, and autonomous from other mental health agencies, with the authority and responsibility for all oversight and decision-making on governance, financial, personnel, policy, and program issues. Services are predominantly staffed by individuals with lived experience.

Direct Support Professional – Staff who work one-on-one with individuals with disabilities with the aim of assisting them to become integrated into the community or the least restrictive environment.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) – Provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services and covers a program of regular wellness visits called Health Check.

Federal Medical Assistance Percentages – The percentage rates used to determine the matching funds rate allocated annually to certain medical and social service programs in the United States.

Healthy Opportunities – An NCDHHS initiative designed to test and evaluate the impact of providing select, evidence-based, non-medical interventions related to housing, food, transportation, and interpersonal safety to high-needs Medicaid enrollees.

High Fidelity Wraparound – An evidence-informed and standardized supportive care coordination service for youth (3-20 years old) with serious emotional disturbance and youth with serious emotional disturbance plus a co-occurring substance use disorder or intellectual and other developmental disability. “In Lieu Of” service definitions have been developed to promote the use of high fidelity wraparound services across the state.

Home and Community Based Services – Health and human services that address the needs of people with functional limitations who need assistance with everyday activities, like getting dressed or bathing. HCBS are often designed to enable people to stay in their homes, rather than moving to a facility for care. Medicaid funds Home and Community Based Services through its waivers.

Housing Choice Vouchers – These vouchers assist very low-income families to afford decent, safe, and sanitary housing. Housing can include single-family homes, townhouses, and apartments and is not limited to units located in subsidized housing projects. Housing choice vouchers are administered locally by public housing agencies (PHAs). A family that is issued a housing voucher is responsible for finding a suitable housing unit whose owner agrees to rent under the program. A housing subsidy is paid to the landlord directly by the PHA on behalf of the participating family. The family then pays the difference between the amount subsidized by the program and the actual rent charged by the landlord.

Housing and Community Based Services (HCBS) Final Rule – The final HCBS regulations set forth new requirements for several Medicaid authorities (e.g., waivers) under which states may provide home and community-based long-term services and supports. The regulations enhance the quality of HCBS and provide additional protections to individuals who receive services under these Medicaid authorities. Learn more at [Home and Community Based Services Final Regulation](#).

Independent Living Rehabilitation Program – The [Independent Living Rehabilitation program](#) provides an alternative to living in a nursing home or other facility for eligible individuals. Services are person-centered and may be provided directly, purchased or coordinated through other community resources.

Individual Placement and Support / Supported Employment (IPS/SE) – An evidence-based practice that assists individuals with severe mental illness and other debilitating disorders to find competitive, integrated community employment and provides ongoing, individualized services with a focus on employment.

“In Lieu Of” Services – Alternative mental health, substance use disorder, or intellectual and other developmental disability services that are not included in the state Medicaid plan or managed care contract but that are clinically appropriate, cost-effective alternatives to State Plan services. These services are not required and are provided at the discretion of Local Management Entities/Managed Care Organizations.

Innovations Waiver – This Medicaid waiver supports children and adults with intellectual and other developmental disabilities (I/DD) who meet Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care criteria or are a risk of being placed in an ICF/IID, to live in the community.

Key Rental Assistance – This [rental assistance program](#) [PDF] is administered by the North Carolina Housing Finance Agency to make Targeting Program units/housing affordable to very low income households.

Milestone Payments – A method of payment for a service that achieves a defined stage in the client’s progression towards exiting vocational rehabilitation to Competitive Integrated Employment. This payment model is a change from paying for services at an hourly rate, regardless of the whether the client progresses towards their vocational goal.

Mobile Response and Stabilization Services – An enhanced mobile intervention targeting families and children, ages 3-21, who are experiencing escalating emotional or behavioral symptoms or traumatic circumstances that have compromised the child’s ability to function at their baseline within the family, living situation, school or community environments. This program will support the enhancement of the current mobile crisis response to be more child- and family-focused in meeting behavioral health crisis needs.

Money Follows the Person (MFP) – The MFP program helps Medicaid-eligible North Carolinians who live in inpatient facilities to move into their own homes and communities with supports. North Carolina was awarded its initial MFP grant from the Centers for Medicare and Medicaid Services (CMS) in May 2007 and began supporting individuals to transition in 2009.

North Carolina Collaborative for Ongoing Recovery through Employment (NC CORE) – The NC CORE initiative is an innovative payment structure that addresses the discrepancy between fee-for-service (FFS) and milestone payments by switching both the state and Medicaid FFS payments to milestones for supported employment services.

North Carolina – Psychiatry Access Line (NC PAL) – [NC-PAL](#) is a free telephone consultation and education program to help health care providers address the behavioral health needs of their patients.

Olmstead v. L.C – The *Olmstead* decision was the result of a United States Supreme Court case concerning discrimination against people with disabilities. The court held that under the [Americans with Disabilities Act](#), individuals with disabilities have the right to live in the community rather than in institutions if “the State’s treatment professionals have determined that community placement is

appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others” with disabilities.

Oxford House – A housing program that is designed to support people committed to a sober lifestyle, that does not include paid staff, and that is self-run by the people who live there.

Penetration Rate – The number of unduplicated eligible individuals and consumers who have received at least one billable service during the fiscal year.

Projects for Assistance in Transition from Homelessness (PATH) – Federal grant program that provides assistance to individuals who are homeless or at risk of homelessness and who have serious mental illness. PATH funds are distributed to states/territories, which contract in turn with local public or nonprofit organizations to fund a variety of services to homeless individuals, including outreach, treatment, case management, and housing supports.

Remote Supports (Remote Technology) – Utilizes two-way communication in real time, through sensors, cameras, or other devices to provide direct service by monitoring and providing supervision assistance remotely. In general, remote supports are an emerging service that combines technology and direct support for people with disabilities, including individuals with developmental disabilities, using a design approach that avoids intrusiveness.

Rethinking Guardianship – [Rethinking Guardianship](#) is a collaborative effort of the North Carolina Council on Developmental Disabilities and the University of North Carolina-Chapel Hill School of Social Work's Jordan Institute for Families. The initiative is committed to improving life for people who are experiencing guardianship or who could benefit from alternatives to guardianship that preserve more of their rights.

Substance Abuse and Mental Health Services Administration – A branch of the U.S. Department of Health and Human Services charged with improving the quality and availability of treatment and rehabilitative services to reduce illness, death, disability, and the cost to society resulting from substance use disorders and mental illnesses.

Senior Community Service Employment Program (SCSEP) – This program places individuals, 55 and older, who are economically disadvantaged into part-time community service assignments, while helping them transition into unsubsidized employment. SCSEP empowers low-income older workers to achieve economic independence. Training in community service activities assist participants in gaining marketable skills to re-enter the workforce. The Division of Aging and Adult Services and four national contractors administer SCSEP in the state.

Serious Emotional Disorders – Conditions experienced by children, birth to 18 years old, determined by DSM-IV Diagnosis and moderate to severe impairment in functioning. Also referred to as [Serious Emotional Disturbance](#).

Serious Emotional Disturbance – See “Serious Emotional Disorders.”

Serious and Persistent Mental Illness – A mental illness or disorder (but not a primary diagnosis of Alzheimer's disease, dementia, or acquired brain injury) experienced by a person, 18 years of age or older, that is so severe and chronic that it prevents or erodes development of functional capacities in primary aspects of daily life, such as personal hygiene and self-care, decision-making, interpersonal relationships, social transactions, learning and recreational activities; or satisfies eligibility for Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) due to mental illness.

Sheltered Employment – A wide range of segregated vocational and nonvocational programs for individuals with disabilities, such as sheltered workshops, adult activity centers, work activity centers, and day treatment centers. These programs differ extensively in terms of their mission, services provided, and funding sources.

Single Stream Funding – Flexible funds, appropriated by the North Carolina General Assembly, to pay for services for individuals who have a diagnosis of mental illness, a developmental disability, or a substance use disorder issue, or a combination of these, but who are not eligible for Medicaid coverage. Services are delivered by providers contracted with Local Management Entities/Managed Care Organizations (LME/MCOs) which are paid via a non-Unit Cost Reimbursement (non-UCR) fee structure. LME/MCOs are required to submit claims for services rendered and the value of these claims are considered in settlement of the single stream funding account.

Smart Technology – Refers to the vast array of interconnected devices that are still designed to perform the normal functions of device usage with a greater degree of autonomy than their “non-smart” equivalents. Smart options devices generally permit decision-making through software, connect via the internet, and tend to have applications (or apps) for enhanced access or control. Smart technologies are universal devices that tend to make life easier for people without disabilities and allow increase access for individuals with disabilities. Likewise, smart houses are homes designed with multiple smart technologies built in or added to work in tandem to provide the advantage of convenience and other benefits.

Social Determinants of Health – Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of social determinants include safe housing, access to transportation, access to nutritious foods, and air quality.

Special Assistance / In Home Program – [The Special Assistance In-Home \(SA/IH\) program](#) provides low-income North Carolina residents who are eligible for Medicaid with a monthly cash benefit to help them remain living in their homes.

State Transition Team – This team consists of members from the Division of Vocational Rehabilitation Services, Department of Public Instruction representatives, college/university representatives, parents, students, and various community and advocacy organizations with a focus on the transition of students with disabilities from school to employment or post-secondary education.

Subminimum Wage – Section 14(c) of the Fair Labor Standards Act authorizes employers, after receiving a certificate from the Wage and Hour Division, to pay special minimum wages – wages lower than the federal minimum wage – to workers whose capacities for the work being performed are impaired by a physical or mental disability.

Supplemental Security Income – A federal income supplement program funded by general tax revenues to help people who are elderly, blind, or have disabilities, and who have little or no income. It provides cash to meet basic needs for food, clothing and shelter.

Supported Decision-Making – Supported Decision-Making allows individuals with disabilities to make choices about their own lives with support from a team of people they choose. In this approach, people with disabilities choose people they know and trust to be part of a support network to help with day-to-day decision-making.

Supportive Housing – Provides rental assistance and access to services that assist individuals with a disability to live independently.

Supported Living – The North Carolina Innovations waiver includes a [Supported Living service definition](#) that enables people with significant disabilities the opportunity to live in their own homes.

Systems of Care (SOC) – A philosophy supported in North Carolina in which providers work together in coordinated networks of community services and supports that are organized to meet challenges of persons with disabilities.

Targeting Program – A partnership between the North Carolina Housing Finance Agency and the North Carolina Department of Health and Human Services to provide access to affordable housing for low-income people with disabilities and/or those experiencing homelessness.

Transitions to Community Living (TCL) – The State of North Carolina entered into the TCL settlement agreement with the United States Department of Justice in 2012. The purpose of this agreement was to make sure that eligible adults with serious mental illness can live in their communities in the least restrictive settings of their choice. The DHHS has worked to develop in-reach, transition, diversion, and community-based services to support those who are in the TCL target population to remain in the community or transition from facilities to the community.

Workforce Innovation and Opportunity Act (WIOA) – Signed into law on July 22, 2014, WIOA is designed to help job seekers access employment, education, training, and support services to succeed in the labor market and to match employers with the skilled workers they need to compete in the global economy. Under the Act, each U.S. state and territory submits a Unified or Combined State Plan to the U.S. Department of Labor and Department of Education that outlines its workforce development system's four-year strategy, and updates the plan as required after two years. WIOA empowers North Carolina to train its workforce and guides how the NCWorks initiative connects job seekers to employers.



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

www.ncdhhs.gov • The Department of Health and Human Services does not discriminate on the basis of race, color, national origin, sex, religion, age or disability in employment or the provision of services • December/2021



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**