



National Association of State Mental Health Program Directors

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NASMHPD

January 12, 2018

The Honorable Seema Verma
Administrator
Center for Medicare and Medicaid Services
Room 314G-01
200 Independence Avenue
Washington, D.C. 20201

Seema.Verma@cms.hhs.gov

Re: Coverage of Inpatient Mental Health Transitions as Part of the Continuum of Care

Dear Administrator Verma:

The National Association of State Mental Health Program Directors (NASMHPD), and in particular its Financing and Policy Division, noted the announcement by Centers for Medicare and Medicaid Services (CMS) Deputy Administrator Brian Neale at the November 2017 annual meeting of the National Association of Medicaid Directors that CMS would be considering ways to cover some types of inpatient mental health services under Medicaid as part of a continuum of care for individuals with mental illness, similar to the approach outlined for § 1115 substance use disorder waivers under State Medicaid Director Letters 15-003 and 17-003.

The members of NASMHPD—the state executives responsible for the \$41 billion public mental health service delivery systems serving 7.5 million people annually in 50 states, 4 territories, and the District of Columbia—derive, on average, about 29 percent of their funding for services from the Federal Medicaid program through State Medicaid Agencies, and we believe developing such an approach should be collaborative with the State Mental Health Agencies and the Substance Abuse and Mental Health Services Administration (SAMHSA) which helps direct those agencies in their mission.

To initiate that collaboration, we would like to suggest that the proposed initiative consider covering services provided within inpatient treatment facilities that are designed to facilitate the individual's transition back into the community and to help sustain recovery in the community once the move is made. These services, which could be provided by peer specialists or by interdisciplinary teams of health care providers providing patient-centered care that include peer specialists, have been offered and delivered:

- in Kentucky under a SAMHSA-funded Transformation Transfer Initiative grant which provided peer support services young adults under age 30 who are discharged from any of the four state-operated psychiatric hospitals, with the priority population those who have been admitted due to a first episode of psychosis;

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- in Tennessee under:
 - the Tennessee Move Initiative, a program to transition individuals from long-term units to community based housing with services based on intensive, customized care coordination;
 - the East Tennessee Inpatient Targeted Transitional Support program, which provides funding for housing, transportation, and dental and vision services to help adults who have received inpatient treatment or Crisis Stabilization Unit (CSU) services for a mental illness or co-occurring disorders achieve recovery in the community; and
 - the Regional Mental Health Initiative Peer Engagement program, which provides Certified Peer Recovery Specialists in Regional Mental Health Institutes (RMHIs) to engage patients in their own recovery;
- in New York, through:
 - the state's interdisciplinary Mobile Transition Teams of social workers, community mental health nurses, registered nurses, licensed nurse practitioners, rehabilitation counselors, and peer specialists, which support the transition of individuals with long inpatient stays into the community; and
 - New York City's multi-disciplinary Pathway Home Program, a collaboration between the New York State Office of Mental Health, Coordinated Behavioral Care, Inc. (a nonprofit Health Home provider launched in 2011 by over 50 NYC health and human service organizations), and a network comprised of hundreds of outpatient programs, which focuses on facilitating a seamless transition from hospital to home for individuals with serious mental illness.; and
- in Georgia, under:
 - its Community Transition Forensic Peer Supports (Peer Mentor) Service for individuals with behavioral health disorders who are preparing for release from incarceration; and
 - its Community Transition Peer Supports (Peer Mentor) Service, which supports the integration of individuals leaving psychiatric inpatient settings back into their communities.
- in Texas, under:
 - A state-funded pilot program, which employed services proven effective in the state's Money Follows the Person Behavioral Health Pilot to help individuals who had been institutionalized for extended periods transition from a state psychiatric institution. Services included Cognitive Adaptation Training (a mental health rehabilitative service), substance use counseling and transition assistance (locating and establishing residence).

Each of these programs are described in the documents which follow this letter.

In addition to the state programs listed above, we are also aware of a successful transitions

program operated by UnitedHealth Care's Optum Behavioral Health subsidiary in New York State in 2009 which resulted in a 71 percent reduction in hospitalizations among its 229 older adult Medicare-enrolled members receiving peer support services through that organization's Peer Bridger Project.

Additionally, psychiatric institutions can be a significant source of nursing facility admissions. IMD residents without community living skills who meet level of care criteria may be routinely transferred to nursing facilities (NFs). Intervention in the IMD setting including transitional mental health, substance abuse and home and community-based services as part of a defined discharge plan could potentially avert NF placement, enabling these individuals to return to the community and remain there, saving Medicaid dollars.

Allowing Medicaid funding to be used for transition services of a defined duration which facilitate effective transition from IMDs to integrated community settings is consistent with one of the original purposes of the IMD exclusion, *i.e.*, to avoid the long-term warehousing of individuals with mental illness within psychiatric hospitals and other related inpatient facilities and instead ensure that treatment and a sustained recovery occurs in integrated community settings. It is also consistent with the intent of the Americans with Disabilities Act and related interpretations, such as the Olmstead decision.

Thank you for your consideration of this suggestion. We hope you find it helpful in moving to provide coverage for an integrated continuum of care for mental health services.

If you have any questions about this correspondence, please do not hesitate to contact NASMHPD's Director of Policy and Communications, Stuart Yael Gordon, by [email](#) or at 703-682-7552.

Sincerely,

A handwritten signature in black ink that reads "Brian Hepburn". The signature is fluid and cursive, with the first name "Brian" and last name "Hepburn" clearly legible.

Brian Hepburn, M.D.

Executive Director

National Association of State Mental Health Program Directors (NASMHPD)

cc: Kirsten Beronio
Brian Neale
Dena Stoner
Christy Malik

NASMHPD Letter to Administrator Verma on Coverage of Inpatient Mental Health Transitions

State: Georgia

Program

Name: Community Transition Forensic Peer Supports (Peer Mentor) Service

Background: Individuals with behavioral health disorders returning to their communities following incarceration face enormous obstacles as they prepare to leave the confines of the criminal justice system and attempt to reintegrate into society. According to U.S. Department of Justice reports, around 16 percent of the population in jails or prisons has a mental health and/or substance use disorder, and a high rate of re-incarceration. Georgia is investing in innovative tools to help individuals rebuild their lives and address the underlying issues that may have led to incarceration.

Program Description: In 2014, the state implemented the Forensic Peer Supports (Peer Mentor) Service, which offers peer support services to individuals with behavioral health disorders who are preparing for release from incarceration. Services begin prior to an individual's release, and continue both during and after the individual's transition back into the community. Program services are delivered by individuals who are specially trained Certified Peer Specialists (CPS) and who have had past involvement with the criminal justice system. The service is a partnership between the Georgia Department of Behavioral Health and Developmental Disabilities, the Georgia Department of Corrections (GDC), the Georgia Department of Community Supervision, and the Georgia Mental Health Consumer Network (a consumer-run nonprofit organization). There are currently 27 trained CPSs working across the state in five state prisons, six day-reporting centers, three mental health courts, and two state psychiatric hospital forensic units.

Program Outcomes

Timeframe	Number of Individuals Served	Psychiatric Hospitalizations	Criminal Justice System Recidivism
April 2015 thru May 2016	n = 211*	0.0% (n=0)	0.0% (n=3)
July 2016 thru June 2017	n = 283*	0.0% (n=3)	0.0% (n=3)

* only individuals enrolled in day reporting centers or who were released from prison back into the community during the reporting period. Does not include those served in state psychiatric hospital forensic units (n=5 for 2015-2016 and n=19 for 2016-2017). Includes those

Individual Successes:

- A 30-year-old male obtained a court ruling in his favor allowing him to keep his infant child overnight; states that the CPS was the only person who believed in him and actually stood up on his behalf by sharing with the judge the recovery skills he had gained.
- A 26-year-old female went on her first ever job interview; states that she was prepared due to the help of the CPS assisting her with filling out job applications, creating a resume, and role-playing mock interviews.
- A 45 year-old. female was able to develop a monthly budget and saved enough to reinstate her driver's license; has not had her DL in 10 years; now creating a budget to save for a used car.

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State: Georgia

Program

Name: Community Transition Peer Supports (Peer Mentor) Service

Background: The purpose of the service is to support the integration of individuals leaving psychiatric inpatient settings back into their communities. The service focuses on individuals who have lengthy hospital stays (60+ days) and/or frequent readmissions. The service began in 2005 as a collaboration between the Georgia Department of Behavior Health and Developmental Disabilities (DBHDD) and the Georgia Mental Health Consumer Network (a consumer-run nonprofit organization).

Program Description: The service is delivered by Certified Peer Specialists (CPS), who are people with behavioral health diagnoses in recovery, and who have lived experience with navigating a public behavioral health system. The service provides interventions that promote recovery, wellness, independence, self-advocacy, and the development of natural supports among individuals transitioning to community-based service settings. The goal of the service is to foster a positive and intentionally mutual relationship between a Certified Peer Specialist (CPS) and a hospitalized individual to support his/her transition to the community and in regaining control over his/her own life and recovery process. Utilizing their unique lived experience, CPSs role model the recovery journey, assist their peers in recognizing, understanding and relating their own recovery stories, support their peers in developing their own recovery goals and self-directed recovery processes, promote a successful life of meaning and purpose in the community of the individual's choice, support individuals in preparing for their return to the community, and continue to support them during and after discharge.

Program Outcomes: Annual Peer Mentor Survey – Completed by individuals in service.

* The
of

Timeframe	Number of Individuals Surveyed	Experienced a Psychiatric Re-hospitalization	Role of Service/CPS in Improving My Quality of Life
2014-2015	n = 92*	28% (n=25 of 89)	78% (score of 6 to 7 on a 7-point Likert scale) (n=68 of 87)
2015-2016	n = 81*	22% (n=18 of 80)	86% (n=68 of 79)
2016-2017	n = 74*	21% (n=15 of 70)	80% (n=57 of 71)

number
surveyed

individuals is lower than the total number served. Also, some respondents did not answer all questions, which lowers the total n denominator for skipped questions.

Select Annual Peer Mentor Survey Responses to Open Ended Questions:

- “She [CPS/Peer Mentor] has made a plan with me to have an exact plan to stop another hospital admission.”
- “My mentor has really helped me to think positive & to take my medicine like I should & that’s how I stay in my apartment & not in a hospital setting.”
- “By listening and supporting talk, and encourage [ing] me to stay away from drugs, use coping skills.”

State Fiscal Year Annual Reporting from the Georgia Mental Health Consumer Network

Timeframe	Number of Individuals Served in the Community	Number of Individuals Remaining in Community >90 Days <u>Without</u> Re-hospitalization
July 2014 thru June 2015*	n = 2019	62.8% (n=1268)

* This data is intended to be a snapshot at one point in time. Subsequent annual data is available, but many individuals’ enrollment in the program spans across annual reporting timeframes, resulting in a somewhat duplicated count.

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State: New York

Program

Name: Mobile Integration Teams (MIT)

Background: The focus of the New York State funded Mobile Integration Teams (19 teams) is to prevent individuals from long stays in a psychiatric hospital and support the transition of individuals with long inpatient stays into the community.

Program The goal of the program is to support efforts to maintain the person in his or her environment, **Description:** provide immediate access to treatment services designed to stabilize crisis situations, reduce environmental and social stressors, and effectively reduce demand on emergency departments and inpatient hospital services. MIT provides an intensive level of care that is fully community-based, and occurs in the individual's home environment or another preferred community setting. It addresses individualized emotional, behavioral and mental health needs, and also provides resource-linkage to connect individuals to needed services in the community. MIT services are intended to enhance the existing system of care, to fill in service gaps, and to focus on activities needed to prevent psychiatric hospital admissions and emergency department use.

The MITs are comprised of a multidisciplinary team, including Social Workers, Community Mental Health Nurses, Registered Nurses, Licensed Nurse Practitioners, Rehabilitation Counselors, and Peer Specialists, with the availability to consult with facility psychiatrists. The team brings clinical and recovery services to an individual with SMI and their family, working together to evaluate the individual's needs while adapting their roles to meet those needs.

Program Since its inception, MIT has helped 1,295 individuals transition to the community and spend less
Outcomes: than a year at a state psychiatric center. These were individuals who were likely to remain in the hospital in the absence of these services (114 of these individuals had been in a state psychiatric hospital for more than a year, 62 others had two to five years in a state hospital, five more had five to ten years, and 24 had ten years or longer).

During 2015, 7 MITs served 2,150 individuals. Of these, 13% had a psychiatric hospitalization and 8.1% had an ER visit without hospitalization.

In 2016, 15 MITs served 4,270 individuals. Of these, 10.4% had a psychiatric hospitalization and 8.5% had an ER visit without hospitalization.

From January 2017 through November 2017, 19 MIT teams served 5,272 individuals. Of these, 6.4% had a psychiatric hospitalization and 5.6% had an ER visit without hospitalization.

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State: New York

Program

Name: Pathway Home – A Program of Coordinated Behavioral Care, Inc.

Background: The Pathway Home program, located in New York City, is a collaboration between the New York State Office of Mental Health, Coordinated Behavioral Care, Inc. (a nonprofit Health Home provider launched in 2011 by over 50 NYC health and human service organizations), and a network comprised of hundreds of outpatient programs (e.g. clinics, ACT, PROS), thousands of supportive housing units and supportive services (e.g. clubhouses, employment services, HCBS), as well as linkages to health home care management. The focus of the program is to facilitate a seamless transition from hospital to home for individuals with serious mental illness.

Program Description: The Pathway Home programmatic approach is informed by Herman et al.'s (2007) Critical Time Intervention (CTI) Model, and seeks to: "Build Relationships Early and Often" - Address barriers and deliver services through building relationships between participants and their communities; "Step in and Step Back" - Let individuals try to manage routine activity and potential crisis events while remaining accessible and ready to step in for needed support, crisis response, and reminders of appointments and medication; and to "See Health as More Than the Absence of Disease" - Provide supports and activities such as trauma-informed yoga, art classes, and lunches to facilitate socialization.

The program offers mobile, time limited services in NYC for adults with serious mental illness transitioning from the hospital to the community. It utilizes a multidisciplinary team approach, a rapid referral and enrollment process (approximately 2 days), community-based mobility and flexibility, engagement while an individual is still in the hospital, small and flexible caseloads, and wrap-around funding that addresses both immediate needs and innovative recovery promoting expenses. Program activities are driven by several guiding principles: 1) Pre-discharge engagement and discharge planning; 2) Engaging in meaningful activities, and in family and social networks; 3) Accompanying the individual home upon discharge, and to initial as well as follow-up BH and PCP appointments; 4) Linkage to community providers and natural support systems; and 5) Fostering self-efficacy by encouraging participants to be accountable for their own treatment through the provision of tools that support skill development and self-reliance.

Program Outcomes: Between April 2016 and June 2017, 474 individuals participated in the program. Of these (total n=453), 91% were not re-admitted to any hospital within 30-days of re-entering the community, 94% were not readmitted to a state psychiatric center while participating in the program, 92% had a BH appointment within 30 days of hospital discharge, 84% had a medical appointment within 90 days of discharge, 75% were enrolled in a Health Home, and 8% were bridged to more intensive services



**Cabinet for Health and Family Services
DEPARTMENT FOR BEHAVIORAL HEALTH,
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**Steven L. Beshear
Governor**

**Audrey Tayse Haynes
Secretary
Mary Reinle Begley
Commissioner**

This FINAL REPORT covers the total TTI grant period between January – September 2015.

State of KENTUCKY

Department for Behavioral Health, Developmental and Intellectual Disabilities (KDBHDID)
Division of Behavioral Health
275 East Main Street; 4W-G
Frankfort, KY 40621

SC-1076-KY-01

Contract Number HHSS28320120002011

Task Order Number HHSS28342001T

Reference Number 283-12-2101

“Transformation Transfer Initiative” – “Young Adult Peer to Peer Crisis Services in Kentucky”

Janice Johnston

BH Program Administrator

502-782-6170

Janice.Johnston@ky.gov

FINAL REPORT – SEPTEMBER 2015:

Overview of Project:

In collaboration with National Alliance on Mental Illness Kentucky Chapter (NAMI KY), the Kentucky Division of Behavioral Health (DBH) proposed to utilize Transformation Transfer Initiative funds to jump-start the

implementation of a coordinated infrastructure around peer support services for individuals being discharged from any of the four state operated psychiatric hospitals, with the priority population being young adults 30 years old or younger, particularly those who have been admitted due to a first episode of psychosis. Kentucky implemented a Core TTI Team responsible for initiative management and accountability. This team also held discussion meetings within the four hospital district areas of the state to provide an overview about the project and gain feedback from local area stakeholders regarding strengths and barriers to providing peer bridging services within the community. Specialized training for agency personnel, peer specialists and their supervisors was organized and is scheduled for September – October 2015. Additional specialized trainings will be provided

in the next several months. Marketing materials will be developed in the next several months to assist with the seamless bridge to community care for young people.

Benefits of this Transformation Transfer Initiative:

This report will highlight the efforts that have taken place in Kentucky through the support of the Transformation Transfer Initiative (TTI) funding. This funding has clearly jump-started efforts to the bridging of peer support services for young adults between psychiatric hospital facilities and the community. As indicated in each of the “Lessons Learned”, this funding made it possible to provide a venue for purposeful discussion of Peer Bridging and how this type of care can change the life of a young adult. It also allowed Kentucky to utilize technical assistance and training that may not have been accessible otherwise.

See below for Kentucky’s Goals and Expected and Actual Outcomes that occurred through the TTI funding, as well as Lessons Learned throughout the project.

Goals/Expected and Actual Outcomes/Lessons Learned:

1. Collaborate with NAMI KY to ensure adequate coordination and accountability of initiative activities/tasks below.

Expected Outcome: All of the tasks and activities of the TTI grant will be carried out in a timely and effective manner.

Actual Outcome: NAMI KY provided excellent coordination of all activities and tasks related to the TTI initiative. DBHDID partnered with NAMI KY to facilitate the interagency committee (Core TTI Team) that met several times over the course of the initiative. NAMI KY provided facilitation, follow up and connection with committee members and community partners to ensure efficient coordination of the initiative. The Core TTI Team met to agree on priority needs and determined that additional partner informational meetings should be held in combination with community mental health centers and the 4 state operated psychiatric centers (hospital district meetings). NAMI KY organized these hospital district meetings set up across the state. These meetings provided further support to the implementation of peer bridging services for young people. There was rich discussion on how to move ahead to support a more seamless system of care using peer support as a bridge to the community. These meetings also gave DBHDID the ability to share information about the other transition age youth initiatives going on in the state at this time, including Early Interventions for First Episode Psychosis and the Healthy Transitions Grant.

Lessons Learned: Words are not adequate to express the necessity of incorporating consumer voice in every part of this change process. The incredibly rich discussion held at each of these meetings could not have happened without the voices of young adults with lived experience and peer specialists who were integral to the success of these meetings and were willing to share their voice throughout the process. In addition, holding the hospital district meetings in several areas of the state provided a chance for local discussion of strengths and issues as well as targeted support for these areas. This increased the community’s ownership of the areas that needed to be improved upon. Two of the hospital districts were already beginning to incorporate peer support into their workforce, and a third has since begun the process to hire an additional peer specialist.

2. ***Gain technical assistance from various states regarding Peer Bridging Services (services that bridge the gap between hospital and community) and the process and protocol used within this type of service in order to implement this process within Kentucky.***

Expected Outcome: DBH will receive technical assistance from at least one best practice state. This information sharing will be offered to state psychiatric facilities using face to face sessions, web-based training and conference calls.

Actual Outcome: The Core TTI Team received technical assistance from Ike Powell of the Appalachian Consulting Group; Sean Harris from Michigan's Recovery Institute; Ally Linfoot, the Peer Services Coordinator for Clackamas County, Oregon; and Janet Walker from Portland State University who is coordinating a youth peer support supervision pilot. This information was shared at the hospital district meetings and will continue to be utilized during the implementation of this project.

Lessons Learned: The individuals that delivered technical assistance to our Core TTI Team gave Kentucky a wealth of information about their lessons learned regarding peer support services in general, and specifically the supervision of peer specialists. This information will allow Kentucky to address these barriers during the early part of the implementation process.

3. ***Collaborate with NAMI KY, KYSTARS, PAR and KPFC to develop specialized curriculum and provide a least 4 trainings to hospital and community mental health center staff and supervisors regarding the benefits and essential need to provide peer support services; how to support peers in the work place; how to supervise and coach peers in the work place; how to support families of young adults; the specialized developmental needs of young adults; the components of recovery and the role of peer support in each treatment setting.***

Expected Outcome: At least four trainings will be convened for hospital and Community Mental Health Center (CMHC) staff and supervisors.

Actual Outcome: Through the planning and administration of this TTI project, Kentucky determined that many agencies lack knowledge and understanding of the peer specialist role as well as how to effectively supervise this new workforce. The Core TTI Team chose to gain the assistance of Ike Powell, who is the Director of Training at the Appalachian Consulting Group. He will provide a training for agencies that employ peer specialists, entitled "Guidelines for Peer Specialist Supervision". This training will be provided to agency teams that will be comprised of peer specialists, supervisors, and administrative staff. The training will occur on four different occasions (September 22-23, 2015 and October 15-16, 2015) at four different areas of the state.

Lessons Learned: Through the technical assistance calls, the TTI core team determined that curriculum and training is in existence for peer specialists and their supervisors. Kentucky was able to collaborate with one of these technical assistance sites to provide Kentucky with needed supervisor training without having to create a new curriculum. It was also decided through discussions at the hospital district meetings and the Core TTI Team meetings that additional specialized trainings will occur in the future that will include strategic sharing and self-care for peer specialists and supervisors.

4. ***Collaborate with NAMI KY, KYSTARS, PAR KPFC and marketing agency to create developmentally appropriate tools to outreach, engage and support young adults and their families as they are transitioning from the hospital to the community.***

Expected Outcome: Messaging will be created related to this project and will be disseminated to at

least 500 individuals, family members, the four state psychiatric facilities, CMHCs and other providers via printed and web-based materials.

Actual Outcome: The advocacy organizations involved on the Core TTI Team are in the process of convening several focus groups with young people and their family members regarding outreach, engagement and support of young adults as they are returning to the community from the psychiatric hospital. This information will be used to develop marketing and resource materials for young people and their families.

Lessons Learned: It is necessary to include the voice of young people and their families in the implementation of peer bridging. The use of targeted focus groups is very helpful in this process, but can take time and require outreach efforts. It has been very helpful to utilize the advocacy organizations involved in the Core TTI Team in the implementation of these focus groups.

5. *Provide training and support ion implementation of pertinent substance abuse (SA) screening/assessment within the four state operated psychiatric facilities as data shows that many young adults who enter the hospital also have a substance use issue.*

Expected Outcome: At least 4 trainings will be held within the four state operated psychiatric facilities. **Actual Outcome:** Initial discussions were held with the community partners in attendance at the hospital district meetings regarding the existing use of substance abuse screening and assessment. The Core TTI Team also received technical assistance from the Youth Substance Abuse Treatment Coordinator at DBH regarding suggestions for substance abuse screening tools. These tools include the CRAFFT, the CAGE-AID, and the UNCOPE. The Core TTI Team is in the process of working with DBH and their State Adolescent Treatment Enhancement and Dissemination (SAT-ED) Grant to assist in the coordination of a specialized substance abuse screening training for the four state hospitals.

Lessons Learned: DBH is fortunate to be a recipient of a recent SAT-ED Grant. This grant will provide excellent support in the implementation of a screening training for the four state hospitals.

Next Steps/Potential Outcomes This Coming Year:

Kentucky's TTI proposal stated several long term goals of this project:

1. Increase in the number of peer specialists hired to bridge the gap between hospital and community.
2. Increase in the number of young adults receiving peer support services within the hospital and transition to community.
3. Increase in patient and family satisfaction in services received through the hospital and transition to the community.
4. Decrease in the overall number of young adults in Kentucky that are readmitted to a state psychiatric facility within one year.

It is expected that these long term goals will become actual outcomes over the next year. Community partners and psychiatric hospitals are excited about the opportunities that providing peer bridging will afford. The continued work on this project will provide support to the additional transition age youth initiatives occurring in Kentucky at this time, including the Healthy Transitions Grant and the Early Interventions for First Episode Psychosis Project.

NASMHPD Letter to Administrator Verma on Coverage of Inpatient Mental Health Transitions

cc:

Michele Blevins,
KDBHDID Beth
Jordan, KDBHDID
Cathy Epperson,
NAMI KY



DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

6th FLOOR ANDREW JACKSON BUILDING
500 DEADERICK STREET
NASHVILLE, TENNESSEE 37243

BILL HASLAM
GOVERNOR

MARIE WILLIAMS
COMMISSIONER

December 22, 2017

As a Department, we support all programs that enhance effective transitional care. We have several initiatives in Tennessee which focus on getting individuals out of hospital settings and into the community with an additional emphasis on increasing community tenure. We also continue to work with our providers, Managed Care Organizations and the TennCare Bureau to stabilize the programs we have now and develop new programs to enhance treatment success and support in the community.

Accordingly, if more funding were available either through IMD exclusion changes or other sources of CMS funding, we recommend that the following type programs be funded:

1. Tennessee Move Initiative, a program to transition individuals from long-term units to community based housing with services based on intensive, customized care coordination and founded in community resources;
2. RMHI Peer Engagement Program, providing Certified Peer Recovery Specialists in our Regional Mental Health Institutes (RMHIs) to engage patients in their own recovery;
3. Inpatient Targeted Transitional Support, which provides temporary financial support to eligible individuals transitioning from one of our RMHIs to the community for things like rental and utility assistance, transportation and medication co-pays.

I have attached additional information on these three programs to help you understand them in more detail.

Thank you for the opportunity to comment and please let me know if you have any questions.

A handwritten signature in cursive script, appearing to read "Marie Williams".

Marie Williams, LCSW
Commissioner

Inpatient Targeted Transitional Support -- East Tennessee

5. SCOPE OF SERVICES AND DELIVERABLES:

- The Grantee shall provide the Scope of Services and Deliverables ("Scope") as required, described, and detailed in this Grant Contract.
- Service Definitions:
 - The Inpatient Targeted Transitional Support – East Tennessee (ITTS-ET) program provides temporary financial support to eligible ITTS-ET service recipients as identified in Section A.3. ITTS-ET funds for eligible services, identified and described in Section A.5.h., may be disbursed on behalf of each eligible ITTS-ET service recipient for a maximum of one hundred and eighty (180) days, in two (2) ninety (90) day increments.
 - "Co-occurring disorders," for purposes of this Grant Contract, means combined conditions of mental illness and substance use disorder.
 - "Furlough," for purposes of this Grant Contract, means that a service recipient has not yet been discharged from a State Regional Mental Health Institute (RMHI), but rather is placed at a facility in the community on a trial basis to determine if the facility is appropriate for the service recipient.
 - "Gatekeeper," for purposes of this Grant Contract **if** the service(s) being provided under this Grant Contract are appropriate for inclusion in the state services directory located at www.kidcentraltn.com, is the person designated by the State to do the following tasks:
 - provide instructions for which services should be included in the state services directory located at www.kidcentraltn.com; 2) invite the Grantee to create program profile(s) in the designated state services directory at www.kidcentraltn.com; 3) review, approve, and publish the program profile(s) created by the Grantee; and 4) monitor update activity related to the program profile(s) created by the Grantee.
 - "Mental illness," for purposes of this Grant Contract, means a psychiatric disorder as diagnosed by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) or more current edition.
 - "Substance use disorder," for purposes of this Grant Contract, means a substance-related disorder as diagnosed by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) or more current edition.
- Service Recipients:
 - Any Tennessee adult eighteen (18) years of age or over, or an emancipated youth, who has received inpatient treatment or Crisis Stabilization Unit (CSU) services treatment for a mental illness or co-occurring disorder **and**:
 - is ready for discharge, or has been discharged within the last thirty (30) calendar days, from one of the State's Regional Mental Health Institutes (RMHIs) **but** requires temporary financial assistance until his or her financial benefits/resources can be established or restored; **or**
 - is potentially ready for discharge, but is on furlough, as defined in Section A.2., from a State RMHI **and** the furlough has been approved in writing by the State's Office of Housing and Homeless Services (OHHS) **and** requires financial

NASMHPD Letter to Administrator Verma on Coverage of Inpatient Mental Health Transitions

assistance to cover furlough-associated costs since alternate funding sources are insufficient or cannot be found; **or**

- (3) is ready for discharge, or has been discharged within the last thirty (30) calendar days, from one of the State-contracted providers of inpatient psychiatric services to uninsured adults (hereinafter SCPs) **and** for whom the Tennessee Department of Mental Health, Tennessee's Medicaid program TennCare, or Medicare has paid for the inpatient psychiatric services provided by the SCP **but** requires temporary financial assistance until his or her financial benefits/resources can be established or restored; **or**
- (4) is ready for discharge from an area CSU (Cherokee's, Frontier's, or Helen Ross McNabb's) and had been in the CSU for twenty-four (24) hours or more **but** requires temporary financial assistance until his or her financial benefits/resources can be established or restored; **and**
- (5) is expected to reside in a Tennessee County in Mental Health Planning and Policy Region Two (II) as shown on Attachment 2.

A.4. Service Goals:

- a. To reduce length of hospitalization stay.
- b. To reduce homelessness following inpatient psychiatric hospitalization.
- c. To increase the opportunity for successful community tenure.

A.5. Structure:

- a. The Grantee shall identify eligible ITTS-ET service recipients jointly with staff of the RMHI or the SCP or the CSU regardless of which Community Mental Health Agency (CMHA) provides services to the eligible ITTS-ET service recipient after discharge.
- b. The Grantee shall assure that eligible ITTS-ET service recipients have a furlough plan previously approved, in writing, by the State's OHHS or a discharge service plan that is agreed upon by the service recipient, the RMHI or the SCP or the CSU, the Grantee, and the CMHA that has primary responsibility to provide services to this service recipient during furlough or after discharge.
- c. The Grantee shall provide ITTS-ET funds for eligible services, identified and described in Section A.5.h., for ninety (90) days or until more permanent financial benefits/resources are available for the eligible ITTS-ET service recipient. If benefits/resources have not been established or restored within the first ninety (90) days, prior written approval must be obtained from the State for an additional ninety (90) days of funds for eligible services. There shall be only one (1) extension.
- d. The Grantee shall provide ITTS-ET funds for eligible services, identified and described in Section A.5.h., to vendors of those services on behalf of eligible ITTS-ET service recipients only until more permanent financial benefits/resources have been established or restored or until the timeframe described in Section A.5.c. has been reached, whichever occurs first.
- e. The Grantee shall obtain prior written approval of the State for funding support in excess of One Thousand Dollars (\$1,000.00) per month per household for the first month and subsequent months of funding support to an eligible service recipient after discharge from inpatient psychiatric hospitalization or discharge from an area CSU.

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- f. The Grantee shall receive prior written approval from the State's OHHS for **all** funding support being provided for the purpose of furloughs.
- g. The Grantee shall provide a monthly report to the State's RMHI and/or the SCP and/or the area CSU indicating the amount of specific assistance funding utilized during the previous month and the amount of specific assistance funding available for the remainder of the current state fiscal year.
- h. The Grantee shall provide ITTS-ET funds to pay for the following eligible services:
 - (1) Housing, including rental deposits and assistance; supplemental support payments; utilities deposits and assistance; medication management services, such as psychotropic medications, doctor's appointments and lab work;
 - (2) The Grantee shall provide funds directly to a dental provider for needed dental care for the service recipient. Expenditures in excess of five hundred dollars (\$500.00) must receive prior written approval from the State before the dental work is performed.
 - (3) The Grantee shall provide funds directly to an optical provider for the costs of vision care for the service recipient. Expenditures in excess of two hundred fifty dollars (\$250.00) must receive prior written approval from the State before the vision care is performed; and
 - (4) Transportation, including transport to/from scheduled appointments and support services, and to-and-from day programs; case management and counseling; and other services as needed for each eligible ITTS-ET service recipient and approved by the RMHI or the SCP or CSU and the Grantee to meet Service Goals in Section A.4 for the service recipient.
- i. In determining the appropriate level of funding support from this Grant Contract for these services, the Grantee shall consider the service recipient's current ability to also contribute support for these services.
- j. The Grantee may provide up to three (3) annual, individual Homeless Management Information System (HMIS) user fees for Woodridge Hospital staff members to access and participate in the local HMIS to assist linking homeless eligible ITTS-ET service recipients to appropriate services upon discharge.
- k. Title VI Compliance. In accordance with Section D.10. of this Grant Contract; Rules of the Tennessee Human Rights Commission (1500-01-03); Tennessee Code Annotated (TCA) §§ 4-21-203 and 4-21-901; Title VI of the Civil Rights Act of 1964 (42 USC §§ 2000d et seq. and its accompanying regulations); and the Civil Rights Restoration Act of 1987, the Grantee shall comply with Title VI (also referred to as Nondiscrimination) and show compliance by all of the following:
 - (1) Annually provide the State with the name and contact information of the Grantee's Title VI Coordinator.
 - (2) Ensure that the Grantee's Policies and Procedures Manual contains a section on Title VI that includes information on the following:
 - i. Filing a complaint;
 - ii. Investigations;
 - iii. Report of findings;
 - iv. Hearings and Appeal Process;
 - v. Description of the Title VI Training Program; and
 - vi. A Limited English Proficiency (LEP) procedure.

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- (3) Ensure that all staff (regular, contract, volunteer) are trained on Title VI upon employment and annually thereafter. Documentation on all training must be maintained and made available upon request of the State. Documentation shall include the following: 1) dates and duration of each training event; and 2) list of staff that completed the training on each date.
 - (4) Annually complete and submit to the State a Title VI self-survey. The self-survey shall be supplied to the Grantee by the State along with information on completion, submission, and what to do in the event another department of the State of Tennessee is also requiring the completion and submission of a Title VI self-survey.
- I. kidcentraltn.com. **If** the services being provided under this Grant Contract are appropriate for inclusion in the state services directory located at www.kidcentraltn.com, the Grantee shall meet the following additional requirements:
- (1) Program Profile(s) at, and linking to, www.kidcentraltn.com. The Grantee shall, under the guidance of the Gatekeeper, defined in Section A.2., create and maintain agency program profile(s) in the designated state services directory located at www.kidcentraltn.com. The Grantee may have more than one service which is appropriate for the state services directory located at www.kidcentraltn.com. The Gatekeeper, defined in Section A.2., will provide instructions for which services should be included in the state services directory located at www.kidcentraltn.com. Further, the Grantee shall update the agency program profile(s) in the designated state services directory at www.kidcentraltn.com at least every six (6) months and shall, in the event of any change in information, update the agency program profile(s) within ten (10) business days of any change. The Gatekeeper, defined in Section A.2., shall monitor the agency program profile(s) for update activity. If the Grantee has a website, Grantee's website must link to the www.kidcentraltn.com website from an appropriate section of Grantee's website. If the Grantee would like to link to specific features of the www.kidcentraltn.com website such as the My Profile, Mobile App, Facebook, or State Services Directory features, the State will provide specific copy, links, and images for those features.
 - (2) Use of the kidcentral tn logo and brand. If the Grantee develops print or electronic materials, on behalf of the State or using State funds, intended for general distribution to parents, families, children, or professionals working directly with children or families, the Grantee must place the kidcentral tn logo on those materials. Examples of covered materials include brochures, flyers, posters, and promotional postcards or mailers. The State shall provide the kidcentral tn logo. The State may instruct the Grantee to apply the full kidcentral tn brand to certain materials, using designed templates provided by the State. The kidcentral tn logo requirement does not apply to materials that have already been printed or designed, nor does it apply to materials that originate from the federal government, national organizations, or other groups where the Grantee serves as a pass-through of those materials. Further, the kidcentral tn logo and brand should not be applied to individualized correspondence or individualized materials which are intended for a single family or professional and should not be applied to materials where the subject is purely administrative, such as materials about rules, sanctions, regulations, or enforcement.

m. Annual Report and Audit - Sanctions and Possible Sanctions for Noncompliance. If the Grantee meets the requirements of Sections D.18. and D.19. of this Grant Contract, pursuant to and in accordance with the federal requirements of the Office of Management and Budget's (OMB's) Circular A-133, or subsequent publication, in addition to the State requirements described in Sections D.18. and D.19., the State is required to:

- (1) When the Grant Contract is funded in whole or in part with federal funds: In cases of continued inability or unwillingness to have an audit conducted in accordance with the federal requirements, Federal agencies and pass-through entities shall take appropriate action using sanctions such as:
 - i. Withholding a percentage of Federal awards until the audit is completed satisfactorily;
 - ii. Withholding or disallowing overhead costs;
 - iii. Suspending Federal awards until the audit is conducted; or
 - iv. Terminating the Federal award; and
- (2) When the Grant Contract is funded with only State funds: In cases of continued inability or unwillingness to have an audit conducted in accordance with Sections D.18. and D.19., the State shall consider taking appropriate action using sanctions such as:
 - i. Withholding a percentage of payments until the audit is completed satisfactorily;
 - ii. Withholding or disallowing administrative costs (Indirect Costs, Line 22 of the Grant Budget, Attachment 1);
 - iii. Suspending Grant Contracts until the audit is completed; or
 - iv. Terminating the Grant Contract.

A.6. Process:

- a. For each service recipient expected to be served by the Grantee after discharge from inpatient psychiatric hospitalization (hereinafter inpatient discharge) or discharge from the CSU, the Grantee shall assist each eligible ITTS-ET service recipient as needed in establishing or restoring more permanent financial benefits or resources such as Tennessee's Medicaid Program, TennCare; Supplemental Security Income (SSI); Social Security Disability Income (SSDI); employment or other non-governmental income source. Beginning the first month following inpatient discharge, the Grantee shall document the plan and efforts to implement this plan. All such documentation shall be available upon request of the State.
- b. The Grantee shall create, maintain, and implement guidelines to safeguard the appropriate utilization of funding provided for this program. The guidelines must address the following:
 - (1) Funds shall not be paid directly to an eligible ITTS-ET service recipient;

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- (2) Funds shall be distributed only for those services and items essential to meet each eligible ITTS-ET service recipient's needs upon discharge from the RMHI or the SCP or the CSU;
 - (3) Timely payment of funds to the appropriate service vendor, such as a landlord or utility company, so there is no delay in each eligible ITTS-ET service recipient's discharge from the RMHI or the SCP or the CSU; and
 - (4) Use of funds for eligible ITTS-ET service recipients who choose to either not be served or to be served by another behavioral health provider, and then return to the Grantee requesting support for a second month or subsequent months following inpatient discharge. In either of these cases, the plan described in Section A.6.a. shall be reviewed to determine the existence of such a plan and any steps made toward implementation of the plan before funds are distributed for a second month or subsequent months. Documentation of this review shall be included with payment authorization.
 - c. The Grantee shall maintain records to document Inpatient Targeted Transitional Support (ITTS) funding and submit monthly, intake, and discharge reports according to the accepted State format (Survey Monkey). Monthly reports should be completed prior to the submission of the monthly invoice. Intake reports shall be completed upon service recipient admittance into the ITTS program. Discharge reports shall be completed upon service recipient discharge from the ITTS program. Failure to submit these reports within the specified time frame could result in delay in reimbursement until the Grantee complies with this requirement. It is expressly understood and agreed that the obligations set forth in this section shall survive the termination of this Grant Contract as specifically indicated herein.
 - d. The Grantee shall maintain, for each service recipient, a record of eligibility; expenditures made on their behalf; and if payment was made for a second month or subsequent months support, the status of the implementation plan for more permanent income as described in Section A.6.a. These records shall be made available upon request of the State.
 - e. The Grantee shall request each eligible ITTS-ET service recipient who received ITTS-ET services to complete a State-approved survey, or survey prescribed by the State, at the termination of the assistance. Further, the Grantee shall compile results of the completed and returned surveys to ascertain the impact of the assistance. Results shall be made available upon request of the State.
 - f. If payment on behalf of an eligible ITTS-ET service recipient is provided to a housing provider and said individual stays in the housing for less than fifty percent (50%) of the pre-paid time period, the Grantee shall seek appropriate reimbursement from the housing provider.
 - g. The Grantee shall participate in networking meetings sponsored by the State.
- A.7. Outcome – Access:
- a. The Grantee shall make program funds available to those identified in Section A.3.
 - b. The Grantee shall inform other agencies in the designated region at least once a year of the availability of this assistance. Documentation of the provision of this information shall be kept in files maintained by the Grantee and made available upon request of the State.
 - c. The Grantee shall provide funds to the appropriate service vendor, such as a landlord or utility company, on behalf of each eligible ITTS-ET service recipient in a timely manner

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that does not delay each eligible ITTS-ET service recipient's discharge from the RMHI or the SCP or the CSU.

A.8. Outcome – Capacity:

- a. The Grantee shall utilize one hundred percent (100%) of the available funding.
- b. The Grantee, in consultation with the RMHI or the SCP staff or the CSU staff, will assure these funds are allocated equitably across the months of the fiscal year so that eligible ITTS-ET service recipients being discharged from inpatient psychiatric hospitalization near the end of the fiscal year will have access to these funds.

A.9. Outcome – Effectiveness:

- a. As long as funds remain available in this Grant Contract, one hundred percent (100%) of the potential service recipients in an RMHI or an SCP eligible for discharge from inpatient psychiatric hospitalization or potential service recipients in a CSU eligible for discharge but who would otherwise remain in the RMHI or the SCP or the CSU until their financial resources are established or restored will be discharged using this support. No one will stay in the RMHI or the SCP or the CSU because of the lack of funding for discharge-related needs.
- b. The Grantee shall maintain a record of the eligible ITTS-ET service recipients continuing to be served by the Grantee who have applied to establish or restore TennCare, SSI, SSDI, and other benefits and the number of these service recipients who actually received any benefits for which they applied. Ninety percent (90%) of service recipients served in this program more than one (1) month following inpatient discharge and needing their benefits established or restored will have initiated application for the appropriate benefits within one (1) month of inpatient discharge from the RMHI or the SCP.
- c. For eligible ITTS-ET service recipients continuing to be served by the Grantee more than one (1) month following inpatient discharge, the Grantee shall maintain a record of the plan and implementation efforts targeted at establishing or restoring employment or other non-governmental means of financial support, as described in Section A.6.a. Ninety percent (90%) of these service recipients will have developed this plan and begun implementation efforts within one (1) month of inpatient discharge from the RMHI or the SCP.
- d. At least eighty percent (80%) of the completed and returned ITTS-ET service recipient surveys, described in Section A.6.e., will indicate that the assistance received helped maintain or improve the community living situation.

Tennessee Move Initiative

Providers: Alliance, McNabb, LifeCare

The primary purpose of the Tennessee Move Initiative(TMI) is to successfully transition identified individuals from long-term units (90+days on average) to community based housing by providing ongoing, intensive, and individualized support to individuals, families, and community providers. RMHIs assist to identify those subacute patients that may benefit from the TMI. There are currently four TMI teams across the state: one team in Memphis, two teams in Nashville, and one team in Chattanooga. Each team consists of a Care Coordinator, Peer Support Specialist, and part-time Nurse. Services provided by the TMI are recovery-focused, intensive, and customized for each individual, therefore it has been imperative to keep caseloads at no more than ten active clients per team to ensure the highest level of client support. All teams are currently operating at capacity or near capacity.

Services began in January 2017 and so far the data for the initiative has been promising. Of the 35 individuals served by TMI in the community, zero were re-hospitalized after 30 days compared to an 11% readmission rate for RMHI patients overall. Of those served by TMI, 17% were readmitted to the RMHI after 180 days compared to a 25% readmission rate for RMHI patients overall. The median length of stay for the 35 patients evaluated was about 4 months in the hospital at a median cost of \$67,000 per patient compared to a median cost of \$6,700 for clients in the TMI: an overall healthcare system savings of over \$60,000 for each MOVE client maintained in the community for 4 months. There have been 99 patients referred to the TMI so far in 2017.

The goals of TMI include: decreasing prolonged hospitalizations and repeated readmissions that impose negative implications on an individuals' quality of life, including their path to recovery; delivering recovery-focused, intensive, and customized care coordination services which support identified individuals in the least restrictive and most integrated setting appropriate to individual need; ensuring a continuity of care which leads to sustained hope, personal empowerment, respect, social connectedness, and self- responsibility relative to the individuals served; providing services are centered on the individual, sensitive to the family, culturally and linguistically competent, and founded in community resources.

RMHI Peer Engagement Program

Provider: Tennessee Mental Health Consumers Association, Inc

The RMHI Peer Engagement Program places two Certified Peer Recovery Specialists (CPRS's) in each RMHI to provide peer support, share their personal stories of recovery, and engage patients into their own recovery process. TMHCA hires, trains, and supervises the CPRS's. The CPRS's also carry small caseloads of individuals in a Peer Intensive Care program where they connect with the individual after discharge and follow them in the community in order to increase their connection back to the community and reduce readmission.

The TMHCA CPRS's share their personal stories of recovery from mental illness and their strategies for maintaining wellness with:

2. RMHI staff at orientation, training, and treatment teams
3. RMHI acute patients on units and treatment groups
4. RMHI subacute patients in classes on building Wellness Recovery Action Plans (WRAP®) and Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES)
 - 743 in FY17
5. RMHI discharged patients participating in TMHCA's Peer Intensive Care program for up to 90 days post discharge
 - 232 in Peer Intensive Care program in FY17

Group Participation Highlights for 2017	
Individual Encounters	15,393
Personal Story of Recovery Shared	6,050
Recovery Education	5,665

Certified Peer Recovery Specialists help others on the path to recovery from mental illness or substance abuse. CPRS's are peers. They have firsthand experience with mental illness and/or substance abuse

and can offer support and understanding. CPRSs use their personal recovery to help others. CPRS's promote self-determination, personal responsibility, and empowerment. The Certified Peer Recovery Specialists program began in 2007. The 40-hour training is free to accepted applicants and includes role plays, feedback, group work, self-examination, tests, and six hours devoted to ethics. Topics covered include communication, problem solving, values, motivation, and wellness, among others. More than 525 Certified Peer Recovery Specialists have been certified in Tennessee.

Inpatient Targeted Transitional Support

Providers: Centerstone, Volunteer, Frontier, Helen Ross McNabb, Case Management Inc., Pathways

The Inpatient Targeted Transitional program assists persons awaiting discharge from Regional Mental Health Institutes by providing them temporary financial assistance up to 6 months for items such as rental and utility deposits, transportation, medication co-pay, etc. until their SSI or other income and benefits can be restored, thereby enabling them to move into community settings when they are clinically ready. These are people who otherwise would need to stay in the Regional Mental Health Centers because they do not have the resources necessary to begin their life outside the institute. Payments are not made to the individuals, but rather directly to the vendors, such as the landlord or utility company. TDMHSAS contracts with community agencies in each service area which then work with the Regional Mental Health Institutes to identify individuals eligible for the program. Over 2,600 served by the program in FY17.

State: Texas

Program: Money Follows the Person Behavioral Health Pilot (BHP) and IMD Pilot

Background: Individuals with serious mental illness (SMI) are more likely to develop chronic medical conditions, including substance use disorders, and become physically debilitated earlier in life. Nationally, significant numbers of nursing facility residents have a primary diagnosis of mental illness, with 25 percent being younger than age 65. From 2008 through 2017, Texas operated a Behavioral Health Pilot (BHP) under the federal Money Follows the Person Demonstration grant (MFPD) from the Centers for Medicare and Medicaid Services (CMS). BHP was designed to help adult Medicaid clients with serious mental illness and substance use disorders leave nursing facilities and successfully live in the community. MFPD has enabled Texas to test the efficacy of new services and techniques for this special population. In addition to SMI, pilot participants had multiple health challenges, including chronic health conditions, physical disabilities and substance use disorders. Many had been institutionalized for extended periods of time, in some cases many years. Additionally, psychiatric institutions are a source of nursing facility admissions. IMD residents without community living skills who meet level of care criteria are routinely transferred to nursing facilities. Intervention in the IMD setting could potentially avert NF placement, enabling these individuals to return to the community and remain there, saving Medicaid dollars. Texas employed MFP-like practices in a small state-funded pilot designed to transition individuals from a state psychiatric institution to the community but was unable to include IMDs in the BHP due to federal restrictions on the provision of Medicaid services to IMD residents.

Description: BHP services included Cognitive Adaptation Training (CAT), a rehabilitative service designed to help individuals establish daily routines, organize their environment and build social skills, relocation assistance, employment services, and substance use disorder services. Services were provided up to six months before discharge and up to one year post-discharge. Services were delivered by therapists trained in CAT and substance use treatment counselors. BHP services were provided in partnership with Medicaid MCOs, local mental health authorities, relocation specialists and others in several central Texas counties.

Outcomes: Over 450 individuals transitioned to the community. Outcomes include improved functioning and quality of life on standardized scales including the Quality of Life Scale (QLS), the Multnomah Community Ability Scale (MCAS) and the Social and Occupational Functioning Scale (SOFAS). The gains were sustained after interventions ended. Almost 70 percent completing BHP services remained in the community, per independent evaluation. Examples of increased independence include getting a paid job at competitive wages, driving to work, volunteering, getting a GED, teaching art classes, leading substance use peer support groups and working toward a college degree. There were also significant net cost savings to the state's health care system overall. The IMD pilot also demonstrated promising results, with 60 percent remaining in the community.