Vaya Housing Initiatives and Justice Re-Entry Program

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VAYAHEALTH

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Vaya Health Transition & Housing Department

Overarching work to deinstitutionalize across disability types:



Olmstead "Money Follows the Person" Team

I/DD and Aging or Physical Disability



Transitions to Community Living (TCL) Team

Mental health



Housing

Programs for people experiencing homelessness and housing insecurity across disability populations



Justice Re-Entry

Support for people coming out of prison

Olmstead Money Follows the Person (MFP) Transition Coordination Programs

(1) Statewide Transition Coordination Program: Older Adults and People with Physical Disabilities

- **Summary:** Helps older adults and people with physical disabilities who reside in Skilled Nursing Facilities (SNFs) or a hospital setting receiving skilled-level care to move back into the community.
- **Counties**: Operates in all of North Carolina's 100 counties on behalf of the North Carolina Department of Health and Human Services.
- **Qualifications:**
  - Receive Medicaid or are eligible for Medicaid in North Carolina (participants are not required to be a Vaya member)
  - Live in a Skilled Nursing Facility or qualified hospital setting for at least 60 consecutive days (this period can include time spent in an acute hospital setting)
  - Have a diagnosed physical disability (age 18 and older) or are above age 55 and Want to live in the community
- **Length of program:** Once referred, MFP starts pre-transition and concludes after a year post transition into the community.
- **Participants served:** since launch 9/18/24, Vaya served over 600 participants; transitioned 85 participants since launch; 3 of 30 participants in Buncombe County transitioned; the remaining are waiting for housing opportunities
- **Housing Type:** back into their own home/apartment, a new home/apartment, into a family member or caregivers home, must be able to afford their own rent unless they receive a targeted unit or housing choice voucher
- **Services Post Transition:** CAP/DA or PACE
- **Referral:** to apply, complete the Application Form (English | Español) and submit to and submit to mfpinfo@dhhs.nc.gov
- **Questions: website:** Money Follows the Person or email MFP@vayahealth.com

Money Follows the Person, cont.

(2) I/DD In-Reach and Transition Coordination Program

Summary: Helps Vaya members with Intellectual and/or Developmental Disabilities (I/DD) people with physical disabilities who reside in a qualified setting to move back into the community.
Counties: Operates in Vaya's 32 Westen NC Counties
Qualifications:

- Receive Medicaid or are eligible for Medicaid (participants are required to be a Vaya member)
- Live in a State Developmental Center (SDC), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IDD), Psychiatric hospital (age 18-65) or Psychiatric Residential Treatment Facility (PRTF)
- Have a diagnosed Intellectual or developmental disability and Disability Determination
- Want to and/or guardian wants them to move back into the community

Length of program: Once referred, MFP starts pre-transition and concludes after a year post transition into the community.
Participants served: since 2009, transitioned 151 participants, 6 transitioned and 2 preparing for transition
Housing Type: back into a family member or caregivers' home, or through an Innovations Waiver service with a provider
Services Post Transition: Innovations Waiver (13 slots allocated this year) or Long-Term Community Supports (LTCS)
Referral: to apply complete the Application Form (English | Español) and submit to mfpinfo@dhhs.nc.gov
Questions: email MFP@vayahealth.com

Transitions to Community Living (TCL)

Transitions to Community Living (TCL) gives eligible adults living with serious mental illness or severe and persistent mental illness the opportunity to choose where they live and work. The program connects participants to wraparound mental health care and other services and supports that help participants maintain a home in the community, instead of living in a facility. Participants develop person-centered plans and are linked to mental and physical healthcare providers in the community to support whole-person care. TCL also helps individuals identify their interests and refers them to supported employment services.

- Vaya currently has 775 participants housed in the community with TCL support. Of the 775, 290 reside in Buncombe County.

Individuals must meet all of the following criteria to be eligible for TCL. Participants must be:

- Diagnosed with a severe and persistent mental illness or a serious mental illness
- Being considered for admission to an adult care home or family care home OR being discharged from a state psychiatric facility into homelessness or unstable housing
- An NC Medicaid beneficiary, eligible for Medicaid OR earning a monthly income of $2,000 or less
- At least age 18 AND willing to accept a minimum of one tenancy support service per month

TCL Referrals

Referrals can be made through the Referral Screening Verification Process (RSVP) in three ways:

- Complete referral using link **RSVP online**.
- Call Vaya's Member and Recipient Service Line at **1-800-962-9003** to make an RSVP referral.
- Request a paper referral form by calling the Member and Recipient Service Line at **1-800-962-9003**.

Back at Home Helene

- Designed to reduce unsheltered and rural homelessness and improve services, health outcomes, and housing stability for highly vulnerable unsheltered individuals and families. The program offers supportive services, permanent housing (rapid re-housing), unit access, financial assistance, move-in financial assistance, and rent or utility assistance.
- Back at Home Helene in Buncombe County accepts referrals through Disaster Case Management which is managed by NC Dept of Public Safety. *Vaya leadership meets monthly with DCM and the City of Asheville's Homeless Strategy Division
- Shortly after Helene (Oct 24), Vaya Health expanded existing Back at Home program to include Back at Home Helene.
- Vaya was awarded (50) slots - $466,511.00 (included start-up in the amount of $75,000.00).
- Vaya is the Housing Stabilization Services agency and Housing Collaborative is the subsidy administrator.
- Vaya is currently serving 48 head of households, 27 additional household members.
- 30 households have been successfully housed to date.

Vaya Independence Project (VIP)

- Supports up 10 participants – state-funded program (currently 9 participants reside in Buncombe)
  - Program provides short-term rental assistance and supportive services (up to 24 months).
  - Support linkage to services, mainstream benefits, and resources.
  - Internal referrals only – primarily Vaya Care Management, Care Coordination, and Justice Re-Entry team(s)
  - Criteria:
    - Individual must be at least 18 years or older
    - Individual must be homeless per HUD definition (staying in a shelter; or on the streets; or a place not meant for human habilitation)
    - Individual referred must have a MH diagnosis. Individual can have a dual diagnosis of MH/SU but current symptoms must be related to their mental health
    - Individual must have at least (4) mental health hospitalizations in the past calendar year
    - Individual must have limited to no income

Integrated Supportive Housing Program (ISHP)

- The program provides interest-free loans for independent apartments where no more than 20% of the units are integrated and set aside for people with disabilities.
- Expanding access to Permanent Supportive Housing options for adults with disabilities.
- Team met with developers across the state (priority counties identified by DHHS) to expand Targeted Unit capacity from 10% to 20%.
- These properties are required to dedicate 10% of their housing units to people with disabilities who are referred by their participating service agency (Referral Agency) through the Targeting Program.
- Human Service agencies become Targeting Program participating service agencies by making a formal commitment to participate in the program and work with their clients to determine eligibility for permanent supportive housing.
- Collaboration with DHHS, NCHFA, and LME/MCO - finances managed by NCHFA/DHHS
  - Criteria:
    - 18 and up and depends upon the age restrictions

Housing Support Grants

- Funds are used as available to help establish less restrictive housing for eligible adult members and recipients whose gross income is equal to or less than 100 percent of the federal poverty guidelines for a single individual.
- Program eligibility determined by Vaya's Housing Team based on recipient/member plan enrollment and linkage to internal or external Vaya contracted agencies.
- Must be a Vaya member who is engaged in and receiving a billable service.
- $500 per recipient/member per fiscal year. Payment can assist with first months' rent, rental security deposit or utility deposit.
- Last fiscal year, HSG supported 16 Buncombe County residents

Housing Team Resources

- Vaya's Housing Support Line at 1-800-893-6246, ext. 4560, connects members and recipients experiencing homelessness or housing insecurity to appropriate resources. Call or email HousingTeam@vayahealth.com to request support.
- Team fields between 150 to 200 housing request(s) per month – some months at least 50% of the requests are for individuals residing in Buncombe County.
- Resources: Flyers

Justice Re-Entry Program

Program intended support individuals transitioning out of State Prisons

Program Eligibility

- Referred by DAC Social Workers
- Severe Mental Illness **and**
- Violent Conviction **or**
- on the Sexual Offender Registry **or**
- Prescribed Clozapine (an antipsychotic medication)

Program Includes

Care Management and Connection to Key Services and Supports such as:

- behavioral and physical healthcare
- medication management
- housing support
- food
- benefits coordination

Program Goals

- Obtain housing
- Address Social Determinants of Health
- Increase Employment
- Increase Community Inclusion
- Access to Medicaid and other benefits
- Connect to community-based mental and physical medical care
- Connect to Tailored Care Management for ongoing support
- Reduce recidivism

Member and Recipient Services

- Transitional Services Post Incarceration aims to support ensuring individuals transitioning out of incarceration have an appointment for BH services.
- **Baseline (Aug 2019):** Only **18–25%** of releasees attended their behavioral health aftercare appointments.
- **Goal:** Partnered with **Department of Adult Corrections (DAC)** to increase attendance to **50%**.
- **Recent Achievement:** Last quarter, **52%** of releasees attended their aftercare appointments — surpassing the goal.
- **Key Strategies:**
  - Monthly **MRS–DAC meetings** to problem-solve and refine strategies.
  - **Direct communication with probation officers** to support appointment compliance.
- **Ongoing Focus:** Continuous improvement and collaboration to sustain and grow attendance rates.

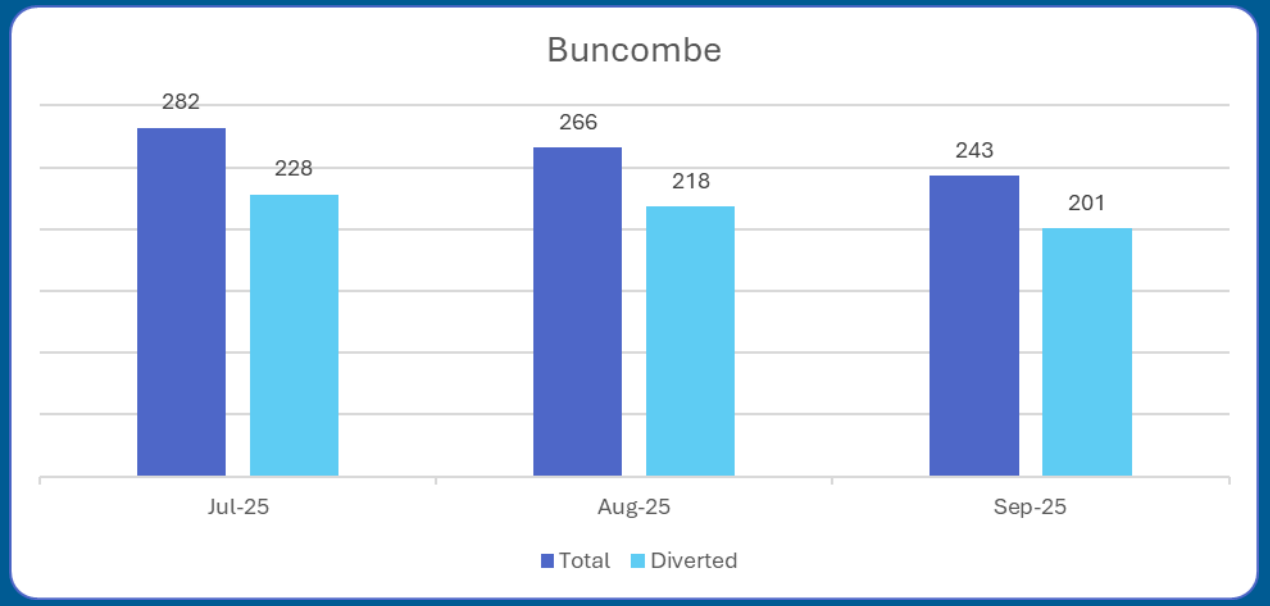
Co-Responder Program

- Mobile Crisis Clinicians with RHA ride along with Sheriff's Deputies
- Available Monday through Friday 8 to 6 currently, with plans to expand with two additional positions
- Most recent data for Quarter 1 for Fiscal Year 2026:

	Buncombe – Sheriff's Office
Referrals	189
Linkage to BH	38%
Arrest	0.6%
Diversion from ED	78%

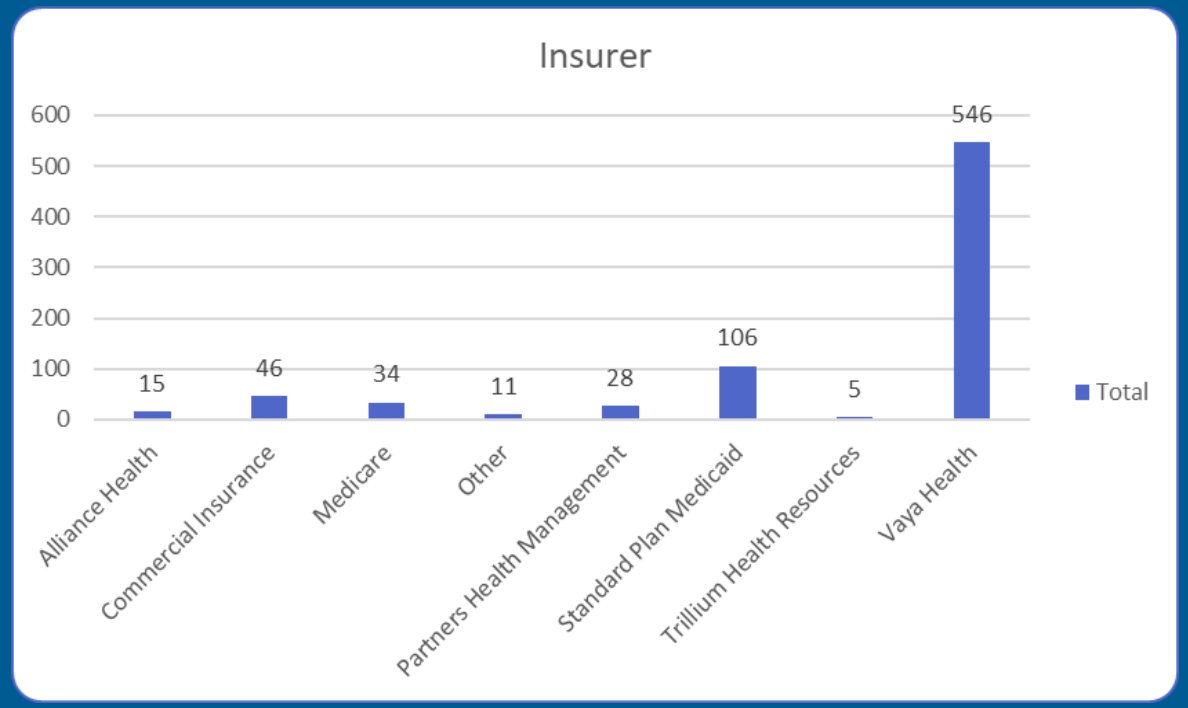
Behavioral Health Urgent Care (BHUC)

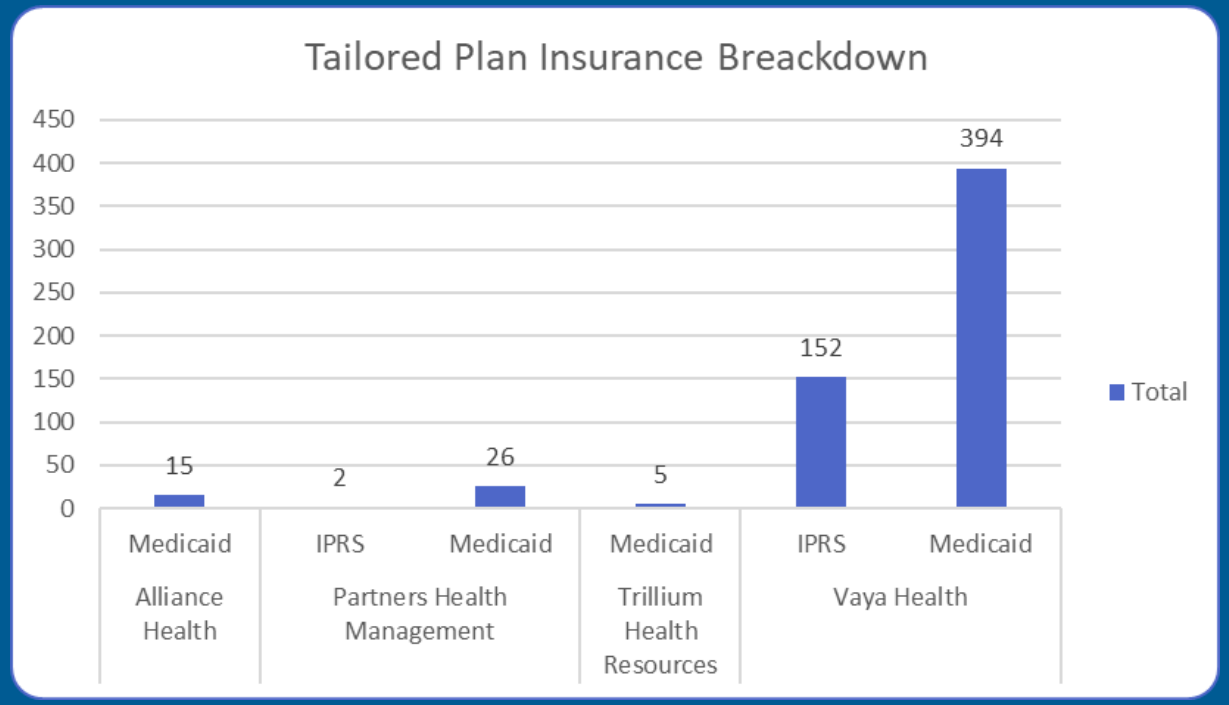
- Hours of operation: 24 hours/day; 7 days/week; 365 days/year
- Crisis assessment and referral to needed level of care
- Individuals may be referred to inpatient treatment (mental health stabilization or detox programs) or outpatient therapy services
- Data from Quarter 1 of Fiscal Year 2026



Behavioral Health Urgent Care (BHUC)

- Insurer and Tailored Plan Medicaid versus State Funding







Thank You

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