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Implementing *Olmstead* in California: COCO Recommendations

California shall make a commitment to providing services to people with disabilities in the most integrated setting. It shall enact and adhere to policies and practices which make community living California's priority and norm, and make institutional living a last resort. Today, because of federal and state policies, it is easier to get into a nursing home than to find adequate services at home. By implementing *Olmstead*, the state shall tip those scales until they are reversed.

The *Olmstead* Plan must:

- Recognize that *Olmstead* is a civil rights mandate, not limited by current funding streams.
- Incorporate cultural competence throughout
- Include goals, timetables, outcomes. For people who want to get out of institutions and have already been approved: move them out NOW!
- Include or provide for baseline data and ongoing data
- Have action steps, deadlines, funding
- Maximize federal money, identify cost-neutral or money-saving options. As federal money increases, it must be used to enhance deinstitutionalization, not fill budget gaps.
- Include closing institutional beds, which is especially important in hard budget times.
- Include Medicare populations who are at risk of institutionalization.
- Include legislation that will drive funding when the economy is improved
- Be cross-disability and cover people of all ages
- Ensure that all services are voluntary - that no one is forced to accept any service or placement

- Ensure consumers right to decide whether information will be shared.
- Mandate a coordinated long term care system with multiple points of entry.
- Establish one-stop centers and toll-free number for all long-term care information and resources

Concrete steps and recommendations

A. Assessments

1. Assessment should be grounded in *Olmstead* principles: person-centered planning and community options. All NAPAS parameters should be incorporated.
2. Data on needs and gaps in services of people being assessed should be compiled county by county. Should be reviewed by stakeholders group (incl. Consumers, advocates primarily).
3. All current assessment procedures, such as PASRR, should be reviewed and measured against *Olmstead* principles, any deviations should be fixed.
4. Outcomes of assessment must be monitored; goal should be 10% institutional outcomes for assessment – check with Oregon figures for reasonable ratios and goals.
5. By April 1, 2004 everyone in institutions should be assessed for community placement, and thereafter annually or by request. By that date, includes process for people at risk.
6. Consumers should have major role in developing assessment tool and procedures.
7. Anyone with financial interest – vendors, institutional staff – should not be doing assessments.
8. State should develop process for including peer advocates in assessments.
9. State should identify and train assessors within one year.
10. Appeals process must be in place.
11. Consumers must have pre-assessment meeting to be informed about what will happen.
12. All assessments, decisions, explanations must be available in writing for consumers. All must be done in understandable, culturally competent format.
13. Influence community options databases, including self-evaluation and info for community options and
14. Point of entry – single point vs. multi point: not decided.
15. People being assessed must have chance to look at community options.
16. Workers should have access to same long term care information.

17. Information to be kept in database should match SB 533 (Senator Chesbro, 2001)
18. Uniform assessment may be too difficult, considering diversity in California.
19. Self-assessment should be part of process.
20. I & R phone system should be in place.
21. Data on children with disabilities in out of home placements, including but not limited to special education, juvenile justice and foster care placements, should be compiled and assessment tools developed to 1) avoid unnecessary out of home placements in the first instance, and 2) transition children from out of home institutional placements to home and community based placements.

B. Diversion

1. Comprehensive LTC assessment must be done prior to institutionalization – funding is not given unless assessment is completed. Institutional vendors don't get paid if consumer has not had pre-placement assessment and been given the opportunity for community living.
2. State should convene statewide meeting to create a public awareness campaign to highlight options in LTC.
3. Extend DDS diversion language to any regional center client (or any person with a disability) before they are placed in any institutional setting.
4. People who work on diversion must be trained in community services, crisis services, and the voluntariness of accepting services.
5. The state must set measurable goals and outcomes for diversion.
6. The state must collect data on unmet needs from the diversion effort, and aggregate that data for planning and resource development purposes
7. Any diversion system must take into account indicators of risk, and must take into account events and process. Must be continuity of care, as in the On Lok model.
8. Diversion should have streamlined process for intake.
9. Information should be shared when consumer agrees, and refusing to share should not be barrier to receiving services.

C. Transition

1. Require comprehensive discharge plans for all persons residing in institutions that identify the resources and supports they need to live in the community, including what waiver, if any, the individual should apply for. (Many folks call IHO and are put on the wait list for the A/B waiver when they may actually need services under a different waiver that may or may not have a wait list.)

2. State supports trial visits to community living situations.
3. State should develop pool of funds for first and last months rent, other options from waivers and grants, loan pool.
4. Assistive technology, IHSS, all other services must be in place. Home modifications must be done first.
5. Expand waiver slots.
6. Reinstate special circumstances grants.
7. Find a Medicaid state plan way to include technology under medical necessity for people who are in imminent risk of institutionalization or in transition from an institution.
8. State should have a plan, including money for more affordable accessible housing.
9. State and local entities should help people retain housing.
10. State should promote universal design.
11. State legislature should determine a mechanism for levying fee on housing for affordable accessible housing fund.
12. Public guardians should not be able to sell houses of people who are institutionalized who want to return home. Develop a state mandatory policy and guiding principles around the states commitment to avoid institutionalizing people on conservatorship whenever possible. Benefits and case management training for conservators, including property managers who work for the conservatorship offices.
13. Mandate access for teams, such as AAA/IL community living teams, into institutions. Involve community groups and peer advocates in helping people get out or stay out of institutions, including awarding outreach grants for the groups.
14. Eliminate the financial disincentive for individuals to use nursing homes; that is, the disparity between nursing home and IHSS eligibility.
15. Develop training or education materials for people in facilities and people in the community on:
    - How to start the process for getting out of a facility,
    - how to get case management services and what a case manager can do
    - What independent living centers do and how to get help,
    - Develop a state resource guide

D. Community Capacity recommendations:

1. State should support increased community capacity based on data on unmet community needs.
2. Change state regs on IHSS to better serve people with various non-physical disabilities: e.g. authorize readers, help with money management, help for clutterers.

3. Expand crisis services, in home or in another home, for people with psychiatric crises, including hostels for people in crisis.
4. For all of those eligible for waivers, expand 283 hours cap on IHSS.
5. Adopt cash and counseling option, e.g. Independence Plus waiver
6. Fund housing modifications. (see transition)
7. Mandate greater interagency cooperation.
8. Provide more support services for consumers living in board and care homes.
9. State should create a population formula for institution-eligible people (who are living at home) in each county, and use formula to supplement paratransit in that county.
10. Eliminate county disincentive for IHSS v. nursing homes. That is, counties now pay portion of IHSS costs but do no pay part of nursing home costs.
11. Eliminate county match for targeted case management (TCM).
12. Expand TCM for anyone at risk.
13. More care coordination choices should be available, including self-coordination.
14. Increase funding to attract new providers where an insufficient local supply can be documented
15. Adopt the "money follows the person" program so that individuals can choose whether to spend MediCal funds on care at home or care in an institution
16. Increase Medicaid Waivers annually so everyone who meets Medicaid's requirements gets services to stay out of institutions if they want to
17. Increase consumers' knowledge of their rights and options, including their right to choose among available service options
18. Eliminate cap on IHSS (attendant care) hours per consumer
19. Allow long-term care consumers to design their own services plans within a set budget (this may be called "self determination" or "cash and counseling")
20. State should financially support Wraparound and Children's System of Care programs in every county and should explore new Medicaid home and community based waivers and/or options to help children with disabilities avoid unnecessary institutionalization or transition from institutional placements
21. State should develop policies, including legislation, that guarantee that families will not unnecessarily need to relinquish custody of their children with special needs in order to obtain services and supports for them.
22. Mandatory benefits training for state employees (doctors-TAR process training, case managers-waiver trainings-TAR process training, providers, etc.) providing Medi-Cal related services **or** have the state identify “benefits experts” in each office that provides case management services, and field office where TARs are reviewed and approved.

Quality recommendations:

1. State should have task force, within one year, develop outcome-based model for quality of services. (modeled on DDS outcome system). Consumers define quality, and should make up at least half the task force.
2. LTCC should be expanded to include consumers, including people who are living or have lived in institutions, and advocates. Consumers should be compensated for their participation.
3. First monitoring task is to make sure *Olmstead* plan meets *Olmstead* guidelines.
4. State should measure all services against *Olmstead* principles
5. (look at HSRI)
6. Tie funding with quality of service outcomes.
7. Increase wages and benefits for direct care workers, with concurrent research on outcome of increases on the lives of consumers.
8. Tie wages to personnel standards and knowledge and build a career ladder
9. Using model program approach, reward high-quality programs for being a mentor for programs who need to improve.
10. Issue public report cards on quality of providers – based on consumer reviews.
11. Develop quality assessment tool for consumers to use with providers. Safety, reliability. Nature of quality assurance will change as consumer direction becomes the norm.
12. Choice is paramount – consumers must be able to switch providers.
13. All services must include a non-retaliative appeal and complaint process for consumers.
14. Build in carrots and sticks, adding incentives for good performance.

The following come from a new study by Mike Stortz of PAI. They could be generalized to people in other settings.

A Tale of Two Settings: Institutional And Community-Based Mental Health Services In California Since Realignment In 1991

1. **DMH and the California County Mental Health Directors should conduct a statewide evaluation of need for persons placed in institutional settings, and implement a statewide integration plan that includes the following:**

   a. Identification of the number of persons whose needs could be appropriately met in the home- or community-based setting of their choice with the provision of home- and community-based services, including but not limited to: (i) integrated system-of-care services; (ii) self-help and peer counseling; (iii) public and subsidized housing programs, such as public housing units and section 8 subsidies, shelter plus care, or the California Statewide Supportive Housing Initiative Act (which includes rental subsidies and/or security deposits); and (iv) Medi-Cal Specialty Mental Health Services (which include crisis residential services and one-to-one mental health services).

   b. Client-directed evaluations of all persons placed in institutional settings, including: state hospitals (for both LPS conservatees and forensic patients[1]); Skilled Nursing Facilities with Special Treatment Programs (SNF/STPs); SNFs without STPs; Mental Health Rehabilitation Centers; Community Treatment Facilities; short-term acute care facilities (which includes persons held on administrative day status); private, residential care facilities with 16 or more beds; prisons, jails and juvenile detention facilities; and homeless shelters.

   c. Evaluation should also include and identify persons who are at risk of placement in a segregated setting (such as children at home who are at risk of out-of-home placement; adults residing in single room occupancy hotels; older adults residing in board-and-care homes).

   d. Conducting a preliminary cost estimate for the provision of long-term services and programs for persons who are evaluated, consistent with their preferences and rehabilitation or recovery goals. This cost estimate should include information about the current, total cost of service provision (such as supplemental rates to SNF/STP and CTF providers).

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[1] State law provides for mental health treatment and supervision in the community for forensic patients under the Forensic Conditional Release Program (CONREP). (Welf. & Inst. Code § 4360). Recommendations for CONREP program placement should be based on the full scope of home and community based services available, including but not limited to Medi-Cal covered crisis residential and adult transitional residential services.

e. Implementing a plan, including funding requirements, to ensure the system capacity is increased so that persons with psychiatric disabilities have reasonably prompt access to needed home- and community-based services.

2. DMH should conduct a statewide audit of the extent to which county Mental Health Plans (MHPs) are providing covered Medi-Cal Specialty Mental Health Services consistent with statewide medical necessity criteria, including but not limited to the provision of the following services:

a. Individual Mental Health Services.

b. Targeted Case Management/Brokerage Services.

c. Crisis Residential Treatment Services.

d. Adult Transitional Residential Treatment Services.

e. Crisis Intervention Services.

3. The California Mental Health Planning Council should review, assess, and make systemic recommendations regarding the following:

a. The adequacy and equity of rates for private, residential care facilities that serve persons with psychiatric disabilities. In addition, this review should assess and make recommendations regarding the current and future role of private, residential care facilities in the state's mental health system.

b. The statewide frequency of and reasons for inter-county (and interstate) transfers of persons with psychiatric disabilities, including children.

c. The development of performance standards governing access to home- and community-based service options for all persons placed at state hospitals.

d. The development and use of self-help and peer supports by persons with psychiatric disabilities in all areas of the state.

4. The California Legislature should review, assess, and make recommendations to eliminate fiscal and other incentives that perpetuate the unnecessary confinement of persons with psychiatric disabilities in institutional settings, including but not limited to the following:

a. Rates of reimbursement for care in institutional settings.

b. Rates of reimbursement for home- and community-based services.

c. State and county supplements for care in institutional settings.

d. State and county supplements for home- and community-based services, including but not limited to state rates for supplemental security income (SSI).