

September 21-22, 2012

RESTORING LIVES:

Building Integrated Communities and Strengthening Support

A Report of the 2012 Olmstead Implementation Best Strategies and Practices Policy Academy

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

Behavioral Health is Essential to Health • Prevention Works • Treatment is Effective • People Recover

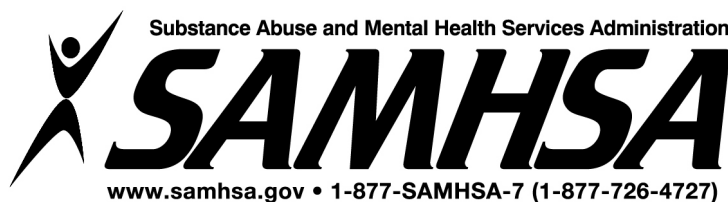


TABLE OF CONTENTS

Introduction	1
From Closing Institutions to Community Integration.....	3
Programs and Practices for Statewide Plans	
Opportunities and Partnerships in Supportive Housing	11
Community Integration for People with Co-occurring Mental Illness and Intellectual/Developmental Disabilities.....	16
Overcoming Obstacles to Community Integration for Children and Adolescents.....	19
Ombudsmen as Advocates in Systems Change.....	24
Medicaid Programs that Support Implementation Strategies	27
Achieving Integration through Person-Centered Planning.....	32
<i>Olmstead</i> Enforcement and Implementation	36
References.....	40
Appendix: Meeting Agenda	45

INTRODUCTION

Since the U.S. Supreme Court's 1999 landmark decision in *Olmstead v. L.C.* (*Olmstead*), many states have expanded their efforts to promote community integration and reduce reliance on institutional care for people with disabilities, including those with mental and substance use disorders. In doing so, states face many challenges, including deep cuts in human services budgets, lack of affordable housing, lack of employment opportunities for people with disabilities, barriers to financing supportive services for people living in community-based settings, and stigma, bias, and discrimination.

In September 2012, the U.S. Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) hosted an *Olmstead* Policy Academy to provide an opportunity for states to learn about effective practices in implementing community integration and develop their own strategies for community integration across multiple agencies and service systems. This Meeting Summary provides:

- A brief overview of the Policy Academy, including the purposes, agenda (Appendix), and background information and resources that were shared with participants before the meeting;
- A summary of central themes and lessons learned presented during plenary and workshop sessions; and
- Examples of successful state initiatives that emerged from discussions at the Policy Academy.

SAMHSA was supported in planning the meeting by several federal agencies, including the Centers for Medicare & Medicaid Services (CMS), the HHS Office for Civil Rights (OCR), the HHS Administration for Community Living (ACL), the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), the U.S. Department of Justice (DOJ), and the U.S. Department of Housing and Urban Development (HUD). In addition, SAMHSA and its federal partners collaborated with the National Association of State Mental Health Program Directors (NASMHPD) to plan and implement the meeting.

Five states—Colorado, Georgia, Illinois, Minnesota, and New Jersey—were selected to send seven-member teams to participate in the Policy Academy. During the meeting, team members participated in plenary and workshop discussions on topics that included:

- Successful transitions from institutional settings;
- Building community partnerships for effective supportive housing;
- Financing community-based services;
- Supporting employment opportunities;
- Effective community-based services for children and people with co-occurring developmental disabilities (DD) and behavioral health conditions; and
- Federal efforts to enforce the community integration mandate articulated in the *Olmstead* decision.

In addition, all states participated in a pre-meeting, half-day Institute on Housing, which was coordinated by OCR with support from CMS and HUD. The Institute on Housing focused on strategies to expand access to affordable housing for people with mental illness and other disabilities, including a discussion of federal resources and programs to support state efforts.

At the Policy Academy, state teams developed customized strategies for community integration and identified technical assistance (TA) needs to support their efforts. SAMHSA and its federal partners are committed to working collaboratively with the states to provide TA and customized expertise to help states meet their community integration goals. At the Policy Academy, federal agencies also emphasized a willingness to consider changes in their own policies and procedures to better facilitate community integration at the state level.

What follows is a summary of each Policy Academy session in the order of presentation. The summary begins with a brief description of the session and a list of presenters. A background and context section provides some historical information and research studies on the topic. This is followed by a description of the discussion at the session with an emphasis on central themes and lessons learned for promoting integration. Each session description concludes with specific state or local practices highlighted by the presenter(s).

FROM CLOSING INSTITUTIONS TO COMMUNITY INTEGRATION

The first plenary session at the Policy Academy explored Pennsylvania's successful efforts to close a state hospital and support its residents in their transitions to the community. Former state officials and a former resident of a state hospital shared their extensive experience developing the infrastructure and providing the necessary peer support for community support planning that implemented individuals' needs and preferences.

Session participants:

- Mary Giliberti, J.D., Section Chief, OCR, HHS
- Estelle Richman, M.A., Senior Advisor to the Secretary, HUD
- Joan Erney, J.D., Director, Office of Policy, Planning, and Innovation, SAMHSA, HHS
- Gina Kaye Calhoun, National Director for Wellness and Recovery Education, Copeland Center for Wellness and Recovery

BACKGROUND AND CONTEXT

Advancing community integration for individuals with serious mental illness has been an evolving process, dating back to the 1950s (Koyanagi, 2007). The process accelerated in the 1960s and 1970s as the federal government began funding community mental health centers, new medications became available, and individuals began to qualify for income support from Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) and health care coverage from Medicare and Medicaid. The high cost of institutional care and legal issues related to hospital conditions and residents' civil rights contributed to community transitions and the closure of some institutions.

In 1993, state spending on community services exceeded spending on institutions for the first time (Koyanagi, 2007; Lutterman, 2010-2011). By 2010, states reported a daily census of 45,000 people being served in 204 state psychiatric hospitals (Table 122 in SAMHSA, 2012), representing 3 percent of people served by state behavioral health authorities and accounting for 26 percent of state agencies' service expenditures (Lutterman, 2010-2011).

In the process of closing institutions and helping individuals transition to community living, states face a variety of barriers, including resistance from some families, workforce concerns, and concerns about adequate housing and supports. Efforts to downsize and close hospitals are continuing. Lutterman (2010-2011) reported that 17 states were considering closing more than 1,700 more beds, as well as six additional state hospitals, and that bed closures include acute-care, long-term care, and forensic beds for both children and adults. Four state behavioral health agencies reported being able to reallocate savings from closing beds for other behavioral health services; 15 states were able to reallocate a portion of the savings, with the remainder used to support other state priorities.

Pennsylvania's public behavioral health system has been very successful in closing state hospitals, transitioning residents to the community, minimizing hospital readmissions, and reinvesting savings in the community behavioral health system. Between 1999 and 2009, the number of individuals served in Pennsylvania's state hospitals declined by 45 percent (Pennsylvania OMHSAS, 2010a). As the state continued to downsize and close hospitals, Pennsylvania kept state hospital readmissions well below the national average for both 30-day and 90-day readmission rates (Pennsylvania OMHSAS, 2010b).

The closure of Mayview State Hospital in western Pennsylvania in 2008 is well documented and provides useful lessons for other states. The process involved various stakeholders who designed a framework committed to promoting recovery, planning collaboratively and transparently, and developing community services and supports. Implementation included using person-centered planning, expanding the counties' capacity for the evidence-based practice (EBP) of Assertive Community Treatment (ACT), developing new housing options, and using peer mentors to help individuals adapt to community life (Allegheny HealthChoices, 2009).

The Mayview Discharge Study (Greeno, Estroff & Kuza, 2011) followed 65 individuals for two years after they left Mayfield. Researchers concluded that individuals transitioning to community living "clearly felt emancipated, not evicted." During the two years after discharge, many individual indicators of health and well-being showed improvement, and no indicators displayed deterioration.

CENTRAL THEMES AND LESSONS LEARNED FOR ADVANCING COMMUNITY INTEGRATION

Officials with experience in successfully closing institutions in Pennsylvania discovered that lack of housing is a consistent barrier to community living for people with behavioral health needs. The availability of housing is essential to successfully closing an institution. Pennsylvania developed primary partnerships with housing agencies in the various cities where it focused its efforts. Key stakeholders reported that securing community housing was the hardest aspect of closing institutions. They

observed that people who are residents of closing institutions are well known to the state and are the focus of extensive needs assessment and planning. They noted that it is more difficult to address the housing needs of those people living in the community who would have entered the closing state hospital because they are not known to the delivery system.

Pennsylvania stakeholders found that strong leadership was key to their success. Commitment from the Governor when closing institutions ensures that needed supports and resources are available. The Pennsylvania Governor was committed to finding jobs for all employees of the closed state hospitals, in part by giving them preferential hiring treatment for other state jobs. This mitigated union opposition to institution closures. Open communication also reduced tension. State officials met with and listened to the concerns of legislators and union officials. In Pennsylvania, a firm but supportive message was necessary to get reluctant stakeholders on board. Stakeholders needed to know that institutions would definitely be closed, but also that their concerns would be heard and addressed.

Based on the Pennsylvania experience, panelists said that closing a state hospital requires careful planning, but the planning period should not extend for more than 12-18 months because longer planning may create negative momentum that derails projects. Pennsylvania had an “all-hands-on deck perspective,” but one official in the Office Mental Health and Substance Abuse Services was the single point of accountability because having a consistent voice was important in the state.

EXAMPLES OF STATE INITIATIVES TO FACILITATE COMMUNITY LIVING

Pennsylvania stakeholders advocate that funds previously supporting state hospitals should follow residents into the community; savings from hospital closures should boost the community system, not the general fund. Pennsylvania has reinvested \$399 million in community supports as a result of closing state hospitals.

Some individuals who transitioned to community living had been residents of hospitals for decades. To assist in the transition, three assessments were conducted before discharge to the community—peer-to-peer, family, and clinical assessments:

- Pennsylvania’s recovery model used a network of certified peer support specialists to help people transitioning to the community explore their possibilities. The peer-to-peer experience helps the individual decide on the kind of environment in which he or she wants to live. Pennsylvania now has more than 2,000 certified peer specialists.
- Family members were asked how much support they could offer and what they thought the person needed in the community.
- Clinical assessments began with identifying personal strengths that would make individuals successful in the community.

A Community Support Plan (CSP) grew out of the assessment process, guided by the principle that a strong individual voice heard during the discharge process increases the likelihood for successful community integration. Instead of relying solely on professional recommendations and asking people to fit into programs independent of their self-identified goals, the CSP supports the person to find programs and services that help them reach their self-identified goals. Pennsylvania implemented the CSP approach in every state hospital closure; it became a very effective practice and a central component of the state's strategy.

RECOMMENDED RESOURCES

- Toward Recovery and Hope: A White Paper Recounting the Mayview Regional Service Area Initiative (http://www.mayview-sap.org/documents/AHCI_FullMRSAPwhitepaperFINAL.pdf)
- Mayview Discharge Study: Two-Year Outcome Report (<http://www.mayview-sap.org/documents/presentations/two%20year%20report%20mayview%20discharge%20study%209.pdf>)
- Perspective: The Closure of Harrisburg State Hospital (<http://www.ccpa.net/DocumentCenter/Home/View/6362>)
- QUIC Facts: Community Integration (http://www.parecovery.org/documents/QUIC_Facts_090110.pdf)
- QUIC Facts: Reducing State Hospital Readmissions (http://www.parecovery.org/documents/QUIC_Facts_052010.pdf)
- SAMHSA's Recovery to Practice and National Association of Peer Specialists, *Certified Peer Specialist Story – Gina Calhoun and Scott Heller* (<https://vimeo.com/49596537>, Password: NAPS2012\$SAMSHA)

EMPLOYMENT INNOVATIONS AND STRATEGIES

This concurrent session provided an overview of the Individual Placement and Support (IPS) model of supported employment and Maryland's experiences implementing IPS statewide. A supported employment program participant from Maryland shared her experiences navigating the mental health system and the impact that Maryland's supported employment program has had on her life.

Session participants:

- Shawn Terrell, Health Insurance Specialist, HHS Administration for Community Living (*moderator*)

- Gary R. Bond, Ph.D., Professor of Psychiatry, Dartmouth Medical School and the Dartmouth Psychiatric Research Center
- Steven Reeder, Chief, EBP Services and Program Evaluation, Office of Adult Services, Maryland Department of Health and Mental Hygiene
- Laurie Scott, supported employment service program participant

BACKGROUND AND CONTEXT

Individuals with serious mental illness typically want to work, but they face many barriers. Strategies to help individuals gain employment often emphasize long periods of preparation, including pre-employment programs, sheltered employment, and work crews. In contrast, supported employment is a vocational service which helps individuals obtain and retain jobs through a place-then-train approach. State vocational rehabilitation agencies pay for supported employment for individuals with intellectual and developmental disabilities (IDD), brain injuries, and severe physical disabilities, as well as serious mental illness.

The IPS model is a refinement of supported employment services, designed to meet the needs of individuals with mental illness. Its goal is to help individuals find competitive, integrated employment—in other words, real jobs in their communities, rather than segregated employment. To do this, IPS eliminates many of the pre-employment requirements common in other approaches to employment for people with disabilities. Key principles of the IPS model include:

- Individuals determine their own readiness to participate;
- Job searches commence quickly;
- Individuals' job preferences are emphasized;
- Employment services are integrated with behavioral health services; and
- Individuals receive long-term support to help them keep their job or find a more suitable one.

Self-determination is integral to IPS, which emphasizes honoring an individual's employment choices and preferences. Employment specialists grounded in the IPS model look for jobs that match individuals' preferences rather than steering them to any available job. The model also emphasizes work incentives counseling to enable individuals make informed choices about the relationship between employment and their disability benefits.

The IPS model has been extensively researched and found to be much more effective than traditional approaches such as day treatment, sheltered employment, and conventional vocational rehabilitation services. Early research explored conversion of day treatment centers to supported employment resources. Four studies examined conversions at six different sites, and three comparison sites. Sites that converted to supported employment experienced nearly a threefold increase in

the rate of competitive employment (Bond, 2004).

Bond, Drake, and Becker (2008) summarized results from 11 randomized, controlled trials comparing high-fidelity IPS supported employment with control groups. Those receiving IPS services had an employment rate of 61 percent, compared to 23 percent for control groups, with 66 percent of those who were employed working 20 or more hours per week.

Using a combined data set from four randomized, controlled trials, Bond, Campbell and Drake (2012) compared employment outcomes in four domains for IPS participants and control group participants. They found that IPS participants had greater job tenure, hours worked per week, and total wages, as well as higher employment rates. Bond and Kukla (2011) studied job tenure of individuals enrolled in IPS services and found that during a 24-month period, they worked an average of nearly 13 months, including an average of 10 months in their initial jobs.

Campbell, Bond, and Drake (2011) conducted a meta-analysis using data from four randomized controlled trials to compare the benefits of the IPS model to other vocational services for different groups of individuals with serious mental illness. Individuals using IPS services had better employment outcomes than did those enrolled in other vocational services, regardless of employment history, demographics, diagnosis, symptoms, or substance use.

Researchers have also found that individuals who are competitively employed have more improvement in nonvocational outcomes than do those engaging in little or no work (Bond, Resnick, Drake, Haiyi, McHugo & Bebout, 2001). Bush, Drake Xie, McHugo, and Haslett (2009) also found that steady employment during a 10-year period was associated with significant reductions in outpatient service use.

Although state vocational rehabilitation agencies are the primary funding source for vocational services for individuals with disabilities, states have relied on Medicaid to help finance IPS-model supported employment, often braiding Medicaid with other funding sources to pay for different components of the EBP (Karakus, Frey, Goldman, Fields & Drake, 2011). Many states use Medicaid rehabilitative services (“the rehab option”) to finance some components, although job placement and coaching are excluded from payment under the rehab option. The Medicaid 1915(c) and 1915(i) home- and community-based services (HCBS) programs can cover long-term employment support, and can also cover job placement and coaching if vocational rehabilitation funds are unavailable. States have also used the flexibility of managed care programs to incorporate supported employment into their menu of covered Medicaid services.

Medicaid can provide other employment supports. In addition to SSI work incentives that apply to Medicaid eligibility, most states offer Medicaid buy-in programs that

allow individuals with disabilities who have significant earnings to qualify for Medicaid. Most states also allow workers with disabilities to use Medicaid personal assistance services in the workplace, as well as at home and in the community. Although not as commonplace, some are beginning to pay for work-incentives counseling to help people understand their options for maintaining Medicaid eligibility while working. (Tremblay, Smith, Xie & Drake, 2006). In short, there are good work incentives within the SSDI, Medicare, and Medicaid programs, but they are complex and not well understood.

CENTRAL THEMES AND LESSONS LEARNED FOR ADVANCING COMMUNITY INTEGRATION

Alignment of policy, goals, and terminology across state behavioral health and employment agencies is important to achieving the community integration goals of supported employment. Congruent with the *Olmstead* philosophy, the IPS model can provide assistance to help individuals with disabilities find competitive employment in the community while supporting and reflecting their individual preferences.

The IPS model is effective, and applicable across different economies or conditions, in both rural or urban environments. Although successful implementation of IPS requires training and fidelity to the model, implementation with high fidelity is relatively easy to achieve. A study of 16 randomized controlled trials of IPS found that in every case, the IPS program had a higher competitive employment rate than did the comparison supported employment program. (Drake, Bond, & Becker, 2012) Evidence shows that about half of participants who were enrolled in IPS were steady workers 10 years later (Salyers, et al., 2004; Becker, et al., 2007). Additionally, of the 165 programs that joined the IPS Learning Collaborative in 2002, 138 were still active in providing services as of May 2012.

Financing is the most frequently reported barrier to sustainability of supported employment programs. Support from state leadership is critical to develop creative funding solutions for supported employment. Medicaid can finance aspects of supported employment through 1915 (c) HCBS waivers, 1915(i) state plan HCBS, rehabilitative services, and Medicaid managed care programs. Funding support for training and evaluation may be available as part of the state's Medicaid administrative match or through block grants, foundation grants, and other funding sources.

EXAMPLES OF STATE INITIATIVES TO FACILITATE COMMUNITY LIVING

Maryland's IPS model of supported employment is the result of a rich history of collaboration between the Mental Health Authority (MHA) and the Division of Rehabilitation Services (DORS), operating under a Memorandum of Understanding (MOU) for the last 20 years. DORS and MHA developed shared definitions to be used by their agencies throughout Maryland. A joint policy aligned policies, regulations, and program protocols across the state.

Maryland overcame financing barriers to sustainability with a long-term solution: They implemented a braided funding mechanism that leverages funding from Medicaid, state general funds, and DORS Vocational Rehabilitation (VR) funds. A short-term solution for other states may be to get a program started with funding through Medicaid only, and then work to develop a long-term plan. Connecting policy goals of VR programs and Medicaid may be difficult given VR programs' short-term goal of a certain period of employment and the more long-term goals of community integration through supported employment for persons with behavioral health needs.

Maryland also implemented a financing strategy that provides incentives to supported employment providers' adherence to program fidelity measures, pays for clinical coordination in supported employment programs, and provides training to entities seeking to become an approved supported employment program. The program has served 3,500 people to date.

Overall, the system transformation resulted in a single point of entry to the mental health and VR system. When a consumer is referred to the mental health agency for supported employment services, a VR application is pre-populated with the consumer's information. DORS counselors, co-located in every supported employment provider agency, can access treatment plans, patient history, and provider information after receiving consumer consent.

A Maryland program participant shared her experiences with the supported employment program. Since the late 1970s when she first became unable to work because of mental illness, she had had difficulty finding steady employment. After many years out of the work force, the speaker returned to Maryland several years ago and was referred to DORS by the MHA. Counselors helped her submit applications and relearn office skills that she had forgotten while unemployed. The speaker was able to find a part-time position working in her community shortly after she began receiving supported employment services, and has since been employed in a full-time administrative position for a state agency.

RECOMMENDED RESOURCES

- Federal Financing of Supported Employment and Customized Employment for People with Mental Illnesses: Final Report (<http://aspe.hhs.gov/daltcp/reports/2011/supempFR.htm>)
- Supported Employment for People with Severe Mental Illness (<http://www.bhrm.org/guidelines/Supported%20Employment%20for%20People%20with%20Severe%20Mental%20Illness.pdf>)
- Promising Practices in HCBS: Maryland—Encouraging Evidence-Based Practices in Supported Employment (<http://www.hcbs.org/files/134/6663/MDSupportedEmployment.pdf>)

- Social Security and Mental Illness: Reducing Disability With Supported Employment (<http://content.healthaffairs.org/content/28/3/761.full.pdf>)

OPPORTUNITIES AND PARTNERSHIPS IN SUPPORTIVE HOUSING

Housing is intrinsic to community living. Even though the *Olmstead* decision was handed down more than a decade ago, several factors are converging to give states new opportunities to meet the decision's promise of transitioning more people from institutional to community settings. Permanent supportive housing has received a boon in recent years from closer federal collaboration, state leadership, and consumer priorities. New opportunities have emerged from:

- **New potential for collaboration.** Federal partners are focusing not just on *Olmstead* enforcement but also on building relationships across departments such as HUD and HHS.
- **New options in the Affordable Care Act.** The Act offers not just the Medicaid eligibility expansion but also a new chance for states to finance supportive housing services.
- **Platforms for connection.** States are starting to build operational platforms to help connect housing agencies and human services.

This session provided an overview of the importance of supportive housing, presented examples from states that are developing effective models of supportive housing, and described the experience of a military veteran providing peer outreach services.

Session participants:

- Gavin Kennedy, M.S., Director, Division of Long-Term Care Policy, Office of Disability, Aging, and Long Term Care Policy, ASPE, HHS
- Martha Knisley, M.A., Director of the Community Support Initiative, Technical Assistant Collaborative, Boston, Massachusetts
- Christy Respress, M.S.W., Executive Director, Pathways to Housing, Washington, DC
- Gerard Thomas, Peer Veterans' Outreach Worker, Pathways to Housing, Washington, DC
- Lynn A. Kovich, M.Ed., Assistant Commissioner, Division of Mental Health and Addiction Services, New Jersey Department of Human Services
- Peggy Bailey, M.P.A., Senior Policy Advisor, Corporation for Supportive Housing, Washington, DC

BACKGROUND AND CONTEXT

For many individuals with serious mental illness, having access to supportive housing can make the difference between achieving community integration and living in segregated settings. Barriers include an inadequate supply of decent, affordable housing in some communities and low income of individuals with serious mental illness due to low-wage and part-time employment, unemployment, or dependence on disability benefits. Permanent supportive housing is an EBP that combines affordable housing with support services to help individuals with serious mental illness or substance abuse live in the community. Empowering people with mental illness to choose their own living arrangements has been shown to increase their retention of permanent housing and their remaining in treatment (Tsemberis, Gulcur & Nakae, 2004).

A number of studies have examined the impact of permanent supportive housing on recovery, stabilization, and service utilization. Culhane, Metraux, and Hadley (2002) studied a large group of homeless individuals in New York City, comparing those who receive supportive housing to a matched control group who did not. They found that those receiving housing combined with supportive services experienced reductions in the use of homeless shelters, hospital admissions and lengths of stay, and time incarcerated. Substantial reductions in utilization of other publicly financed services offset almost all costs of the supportive housing program, with a net cost of \$995 per unit per year (1999 dollars).

Martinez and Burt (2006) analyzed a group of homeless adults in San Francisco with serious mental illness, substance use disorders, and other disabilities. They found that providing permanent supportive housing reduced the use of emergency department and inpatient services sufficiently to offset 10 percent of the cost of housing. Their research did not analyze differences in utilization of a broader set of services as Culhane, et al., did.

A randomized, controlled trial conducted in Chicago compared participants in a program that combined case management and housing with a “usual care” group that received standard hospital discharge planning (Sadowski, Kee, VanderWeele & Buchanan, 2009). The treatment group was offered transitional housing, followed by placement in permanent housing, with case management offered in the hospital and at housing sites. The treatment group had 29 percent fewer hospital days, and 24 percent fewer emergency department visits. Sixty-six percent of those in the treatment group were in stable housing at 18 months, compared to 10.5 percent of those in the control group, who received standard hospital discharge planning.

In addition to improving housing outcomes and reducing use of emergency department, inpatient, and jail services, there is also evidence of improvement in quality of life and satisfaction. A 2010 study conducted in San Diego (Gilmer,

Stefancic, Ettner, Manning & Tsemberis) found that the group receiving housing with services had more favorable responses in all quality-of-life domains measured compared to the control group. A 2009 study conducted in rural Maine (Mondello, Bradley, McLaughlin & Shore) found improvement in all quality-of-life indicators for individuals surveyed before and after placement in housing. A meta-analysis of 30 studies comparing different models of housing found that permanent supportive housing had the highest effect on satisfaction compared to residential care and treatment, residential continuum, and non-model housing (Leff, Chow, Pepin, Conley, Allen & Seaman).

Medicaid offers several options for covering behavioral health services and other health care and social supports for residents of permanent supportive housing. However, Burt and Wilkins (2012) reported that only approximately one-quarter of homeless individuals living on the streets are enrolled in Medicaid, which, under current law, usually requires that working-age adults be determined to have a disability, as well as have very low income. Working-age adults typically get Medicaid coverage by qualifying for SSI disability benefits, a long and uncertain process.

In 2014, most homeless individuals will be able to enroll in Medicaid in states that implement the Medicaid eligibility expansion authorized by the Affordable Care Act (Wilkins, Burt & Mauch, 2012). The Act will provide individuals earning income less than 138 percent of the federal poverty level with Medicaid benchmark coverage, including behavioral health treatment and services; states that implement the expansion will no longer require determination of disability under the SSI program.

CENTRAL THEMES AND LESSONS LEARNED FOR ADVANCING COMMUNITY INTEGRATION

States now have an opportunity to establish permanent supportive housing at scale. To do so, states must mobilize state leadership to develop a plan that lays out state commitments, a cross-agency policymaking process that identifies how new service models will be underwritten, and strategies for directing or reallocating program resources. States must also develop a policymaking apparatus to implement the state plan. A clearly identified interagency group needs to develop program design, operational strategies, and measurable outcomes. States would benefit from creating a cross-system dashboard to track progress across agencies.

Presenters stressed that in achieving community living, some individuals transitioning to the community will take risks and make mistakes, all of which should be considered a natural part of taking responsibility for one's own life. Organizations providing permanent supportive housing need to offer 24-hour access to assistance that will be responsive to the transitioning person and to communities.

EXAMPLES OF STATE INITIATIVES TO FACILITATE COMMUNITY LIVING

New Jersey's supportive housing initiatives began in 1999 with \$3.8 million in funding to provide a safe, affordable home for people with disabilities who wanted to live in the community. The New Jersey budget for supportive housing in fiscal year (FY) 2013 is \$71 million. More than 50 organizations provide supportive housing, most of which have roots in the delivery of social services and began supportive housing programs to address a major need of the populations they serve. The state recently closed a state hospital, Hagedorn, as part of its *Olmstead* efforts to serve people in the community, making supportive housing even more important. The New Jersey experience demonstrates that partnerships and collaboration across state agencies are critical to making supportive housing work; for example, the state's Department of Community Affairs and the New Jersey Housing and Mortgage Finance Agency have developed joint strategies. Trade organizations are also important partners; the New Jersey Supportive Housing Association (a group for housing providers) has been heavily involved in the state's work. Finally, New Jersey places emphasis on identifying consumer priorities and uses focus groups to gather information and input before every major supportive housing initiative.

Louisiana established an Executive Management Team for Supportive Housing, which includes senior leadership of relevant state departments and community representatives. The state vested the Executive Management Team with responsibility for designing programs, identifying financing, setting operational policy, reaching interagency agreements, and tracking performance. The Louisiana experience suggests the importance of developing a unified plan for permanent supportive services that serve different populations in targeted programs, such as people in Medicaid HCBS programs, people in Ryan White HIV/AIDS programs, or adults with chronic health conditions. The state established a single certification process for supports paid through separate funding sources. It also designated a single management organization to manage referrals and pay claims across all programs providing supportive services.

The **District of Columbia** contracts with Pathways to Housing DC, a nonprofit organization in the District of Columbia that works to provide housing and services to chronically homeless individuals with serious mental illness using a scattered-site model. Pathways began with a focus on mental health treatment but shifted toward supportive housing when access to adequate housing was identified as a major barrier to community living for people with mental illness. Pathways DC started with 75 Housing Choice vouchers that were not being used by the District of Columbia Housing Authority and has leveraged other resources such as HUD grants. Two years ago, Pathways received a SAMHSA grant to integrate behavioral health services, including ACT and case management

Pathways DC partnered with the District of Columbia's Downtown Business

Improvement District to build relationships with landlords to increase access to quality housing. To address clients' health care needs, Pathways DC partnered with the largest Federally Qualified Health Center in the district, which set aside appointments for Pathways DC patients in their clinics.

Pathways DC learned that sometimes housing and support services alone are not enough to ensure successful community living. Often, additional money is needed for practical things like furniture and security deposits. A small amount of state seed funding can be a powerful impetus to bring other dollars to the table to address these needs. Pathways DC's experience also reinforced the importance of workforce issues, especially recruitment and training. Important topics for training include not only service delivery but also important administrative responsibilities, such as accurately billing Medicaid.

RECOMMENDED RESOURCES

- SAMHSA's Permanent Supportive Housing Evidence-Based Practice KIT (<http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510>)
- Health, Housing, and Service Supports for Three Groups of People Experiencing Chronic Homelessness (<http://aspe.hhs.gov/daltcp/reports/2012/ChrHomls1.shtml>)
- Medicaid Financing for Services in Supportive Housing for Chronically Homeless People: Current Practices and Opportunities (<http://aspe.hhs.gov/daltcp/reports/2012/ChrHomls2.shtml>)
- Medicaid-Financed Services in Supportive Housing for High-Need Homeless Beneficiaries: The Business Case (http://www.chcs.org/usr_doc/SH_Medicaid_Bz_Case_081712_final.pdf)
- New Housing Resources to Support *Olmstead* Implementation (<http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-06-18-12.pdf>)
- Permanent Supportive Housing: The Most Effective and Integrated Housing for People with Mental Disabilities (<http://www.bazelon.org/LinkClick.aspx?fileticket=q6FsuL6oJw%3D&tabid=241>)

COMMUNITY INTEGRATION FOR PEOPLE WITH CO-OCCURRING MENTAL ILLNESS AND INTELLECTUAL/DEVELOPMENTAL DISABILITIES

Data reported in the Annual National Core Indicators Consumer Outcomes Reports for each of the six years between 2006 and 2011 reveal that approximately 32 percent of people with intellectual/developmental disabilities (IDD) have co-occurring mental illness. Meeting the needs of this population is an important aspect of state efforts to rebalance long-term services and supports in favor of the community in the wake of the *Olmstead* decision. This session presented information on the characteristics of this population, challenges in meeting their needs, and examples of state initiatives to facilitate community living.

Session participants:

- John O'Brien, Senior Policy Advisor, Disabled and Elderly Health Programs Group, CMS
- Charles R. Moseley, Associate Executive Director, National Association of State Directors of Developmental Disabilities Services

BACKGROUND AND CONTEXT

A dual diagnosis of mental illness in individuals with intellectual disability (ID) or developmental disability (DD) is not uncommon: roughly one-third of persons with IDD are estimated to have a co-occurring psychiatric disorder (National Association for the Dually Diagnosed, 2012). Both of the lead plaintiffs in *Olmstead* had a diagnosis of DD and co-occurring mental illness.

In 2004 the National Association of State Directors of Developmental Disability Services (NASDDDS) conducted a three-part research initiative to advance states' efforts to support individuals with co-occurring IDD and mental health conditions. The first initiative was a set of key informant interviews with five consultants who were actively working with state agencies, local providers, people with disabilities and their families, and direct care staff, focusing on developing strategies to address the needs of people with IDD and mental illness. (Moseley, 2004a). They noted that multiple state agencies and state systems are required to support individuals with co-occurring mental illness and IDD. However, the inherent differences between the IDD and mental health delivery systems present coordination challenges, with the IDD system focused on addressing individuals' long-term needs for support coupled with assistance in overcoming communications and cognitive difficulties. In contrast, mental health systems are designed to provide short-term treatment focused on crisis intervention, counseling, stabilization, and recovery.

Second, NASDDDS conducted a survey of state DD agencies to identify approaches to interagency collaboration; DD and mental health agency responsibilities for payment and services provision for individuals with a co-occurring diagnosis; barriers to effective service delivery; and factors that contribute to successful outcomes. (Mosley 2004b). Three program elements were identified as being most associated with positive outcomes: individualized supports offered to individuals with co-occurring conditions; effective and immediate crisis assistance; and effective methods of program planning and support coordination.

Third, NASDDDS convened an invitational symposium to discuss barriers to meeting the needs of individuals with DD and mental health conditions and identify effective ways of overcoming them. (Mosley, 2004c) Major barriers identified included limited provider capacity, expertise, and willingness; the differing characteristics of the DD and mental health delivery systems; and lack of funding designated for individuals with co-occurring conditions. Characteristics of effective strategies identified for meeting the needs of individuals with co-occurring conditions include identified program leadership with clear lines of authority; a primary focus on the individual, particularly through consistent person-centered planning; attention to staff, including recruitment and training; systems that provide for individualization, collaboration, diagnosis, and treatment planning; and a focus on interpersonal relationships that can develop into feelings of trust, dependability, and predictability.

The findings of NASDDDS' work are consistent with two other consensus-development meetings on the needs of individuals with co-occurring diagnoses. Recommendations focused on steps the federal government could take to improve supports for children with co-occurring IDD and mental health conditions, including making services more accessible and child and family centered; increasing provider capacity; facilitating interagency collaboration and partnership at the local, state, and federal levels; providing more flexibility for financing services based on needs; and supporting technology and research (Office of Disability, 2005; Stroul, 2007).

CENTRAL THEMES AND LESSONS LEARNED FOR ADVANCING COMMUNITY INTEGRATION

Results of a survey of state DD program officials reported that although the challenges in meeting the needs of this population are significant, proven successful strategies include individualized services and supports; systems for immediate response, support, and treatment; person-centered program planning and support coordination; and training. States also shared common barriers to treatment, particularly availability of funding, especially targeted flexible resources; providers with sufficient expertise and interest and lack of trained mental health and DD staff; access to appropriate psychiatric treatment and related services; and effective and timely crisis supports.

EXAMPLES OF STATE INITIATIVES TO FACILITATE COMMUNITY LIVING

The presenter highlighted five states with initiatives to improve community supports for people with co-occurring mental illness and IDD, focusing primarily on community-based crisis supports.

Alabama transferred resources from state institutions to develop three community support teams focusing on crisis supports using two models—a comprehensive crisis support provider and a coalition of providers and resources to develop person-centered alternatives. Individuals with IDD are eligible for evaluation, short-term respite, or crisis stabilization *only* if the community-based crisis stabilization team is unable to effectively address his or her immediate needs.

Georgia set up crisis response teams as an alternative to temporary facility placements, which are intended to prevent unnecessary use of emergency rooms, law enforcement involvement, and institutional placement. Program components include on-site stabilization, intensive in-home supports, intensive out-of-home supports in a crisis home, and professional consultation.

Oregon closed its last state institution for people with DD in 2009, and provides supports to people with co-occurring mental illness and IDD through the state's waiver program. Services include enhanced foster care settings with 24-hour supervision, private group homes with enhanced staff and support, state-operated community programs with 24-hour intensive supervision and support, and two group homes funded by state DD and mental health agencies.

New Mexico closed its institutions for people with DD in 1997. It has established a program to support community providers in addressing the needs of individuals with co-occurring mental illness and DD. It has three components: training and TA to providers; on-site support and mentoring to assist providers to gain skills serving this population; and direct crisis support in home or temporary placements.

RECOMMENDED RESOURCES

- A Report of the Summit: State-Community Response to Barriers for Children with Co-occurring Developmental Disabilities and Emotion/Substance Abuse Disorders (<http://www.hhs.gov/od/whitepaper.pdf>)
- Services for Children with Co-Occurring Mental Health Disorders and Developmental Disabilities and their Families (http://www.mockingbirdsociety.org/files/reference/Mental_Health_and_Foster_Care/Developmental_Disabilities_mental_health.pdf)
- State strategy from New Jersey: Executive Summary of “Collaborating to Provide Services for Children and Adults with Co-Occurring Developmental Disabilities and Mental Health/Behavior Disorders” (<http://www.state.nj.us/humanservices/ddd/documents/Documents%20for%20Web/DDTFreport.pdf>)

- NCI Data Brief: What Does NCI Tell Us About People with Dual Diagnosis (http://nasuad.org/documentation/newsroom/friday_updates/Data%20Brief%20--%20dual%20dx%20--%20%20Issue%202%20--%20April%204%202011.pdf)
- NASDDDS Technical Report: Survey on State Strategies for Supporting Individuals with Co-Existing Conditions (<http://www.nasddds.org/pdf/PickingUpThePiecies.pdf>)

OVERCOMING OBSTACLES TO COMMUNITY INTEGRATION FOR CHILDREN AND ADOLESCENTS

This session discussed strategies to reduce the use of institutional placements for children including hospitals, residential child care facilities and juvenile correctional facilities. Presenters described their efforts to develop community-based services and supports to allow children to achieve positive outcomes in community-based settings.

Session participants:

- Larke Nehme Haung, Senior Advisor on Children Youth and Families, Administrator's Office of Policy Planning and Innovation, and Director, Office of Behavioral Health Equity, SAMHSA
- Bruce Kamradt, Director, Wraparound Milwaukee
- Emily Sherwood, Director of Children's Behavioral Health Interagency Initiatives, Executive Office of Health and Human Services, Massachusetts
- Joan Milula, Assistant Commissioner for Child/Adolescent Services, Massachusetts Department of Mental Health

BACKGROUND AND CONTEXT

Children with long-term or behavioral health needs and their families frequently require a complex set of interventions, ranging from primary care to educational supports to mental health treatment to enable community integration. In recent years, SAMHSA has provided substantial support to state and community efforts to bolster the delivery systems serving high-need children in community settings.

The cornerstone of SAMHSA's efforts to support children with serious mental health conditions is its Systems of Care Initiative. According to SAMHSA (2012), "A system of care is an organizational philosophy and framework that involves collaboration across government and private agencies, providers, families, and youth for the purpose of improving access and expanding the array of coordinated, community-based culturally and linguistically competent services and supports for children and youth with a serious emotional disturbance and their families." Eight principles characterize its design: family driven; individualized, strength-based and evidence-informed service plans; youth guided; culturally and linguistically competent; provided

in the least restrictive environment possible; community based; and accessible.

SAMHSA's 2009 Report to Congress on the evaluation findings of its Comprehensive Community Mental Health Services for Children and their Families presents the results of a national evaluation conducted of 59 grant communities funded in FYs 2002-2006 (SAMHSA, 2009). After 24 months of enrollment, the evaluation documented that the percentage of children and youth whose behavioral and emotional conditions in the clinical ranges dropped from 83.1 percent at intake to 62.5 percent. Also improved were attendance at school and afterschool programs; arrest rates declined. The evaluation indicated that the grant communities are reaching children typically underserved by mental health systems, improving children's outcomes, enhancing family outcomes, and expanding the availability of effective support and services.

Within systems of care, a wraparound approach has gained recognition as an effective intervention. Wraparound services stem from a team-driven but family-focused planning process that balancing formal and informal community supports, and identifies individually determined outcomes to be measured for the child, program, or system (Winters & Metz, 2009). Wraparound services are comprehensive, individualized services built around engaging the child, and are provided primarily in the family home and community settings (Bazelon Center for Mental Health Law, 2012).

Wraparound services are developed through collaboration among a team of individuals who have responsibility for and interest in the child's well-being, including family members, service providers, and teachers. Flexible funding is an essential component of this model. SAMHSA has supported the wraparound approach through its Comprehensive Community Mental Health Services Program for Children and Their Families. Fidelity scales have been developed to support quality improvement and evaluation.

Medicaid offers states a key tool for supporting similar initiatives. Medicaid-eligible children have access to behavioral health services as part of the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. This benefit gives beneficiaries younger than 21 access to a range of screening, diagnostic, and treatment services required to "correct and ameliorate" health conditions (Centers for Medicare & Medicaid Services, 2012). Litigation has helped to define the mental health services to which children are entitled under the EPSDT benefit. Specifically, in *Rosie D. v. Romney*, a federal district court ruled that by failing to provide home-based mental health services to children with serious emotional disturbance, the Commonwealth of Massachusetts violated federal Medicaid law (Center for Public Representation, 2008).

Additional community-based services for children and families, particularly for children

with serious emotional disturbance, can be accessed through 1915(c) HCBS Medicaid waivers, which are designed to help states develop community long-term services and supports that help Medicaid beneficiaries avoid institutional placement. HCBS for children with serious emotional disturbance often include wraparound services in recognition of their unique and complex needs.

For example, Kansas offers HCBS to children ages four to 17 with serious emotional disturbance who are at risk of admission to a state mental health hospital. Services provided under the waiver are “designed to provide the least restrictive means for maintaining the overall physical and mental condition of those individuals with the desire to live outside” of a state mental health hospital (Kansas Medical Assistance Program, 2003). Kansas’s waiver provides independent living and skill building, parent support and training, respite care, and wraparound facilitation. Michigan also has a Medicaid serious emotional disturbance waiver that provides services to children and families using a wraparound model (Michigan Department of Community Health, 2007).

States may consider targeted strategies to reach culturally and racially diverse families who need to access behavioral or long-term services and supports. Research conducted by the University of South Florida suggests that providing culturally appropriate services, sustaining engagement with families, and maintaining contact with families after services were completed were effective ways to create a sense of community among families (Burrus, Mowery, Callejas, Nesman & Hernandez, 2010). Creating linkages to informal community supports (e.g., by engaging community and spiritual leaders) can improve families’ trust of community providers and engage them in ongoing treatment and service delivery.

CENTRAL THEMES AND LESSONS LEARNED FOR ADVANCING COMMUNITY INTEGRATION

Through spirited discussion, participants identified core values and structures of change systems, and ideas for financing change in states. They also discussed successes and ongoing challenges faced in the two states represented (i.e., Massachusetts and Wisconsin). Foremost among changes needed to serve children in the community were a focus on outcomes, development of cultural competence, and a foundation in strength-based and person-centered planning, services, and support for families and children. Participants identified a need for an array of services and options, for coordination of services and communication across agencies and providers, and for managed care entities. They highlighted managed care and capitation as potentially appropriate financing structures, and recommended pooling or braiding funding to ensure flexibility. They also proposed Medicaid and other funding sources to cover the cost of new services.

Both Massachusetts and Wisconsin experienced a number of successes, particularly

in the areas of care coordination and service coordination across multiple systems including juvenile justice, schools, child welfare, social services, mental health, and substance use. They also increased consistency of access and services across state or service area (region or county) and emphasized services for diverse populations. Family and child access to advocates grew as well. At the same time, both states closed hospitals and reduced the number of beds in child-caring institutions, while logging fewer hospitalizations and admissions to child-caring institutions and juvenile correction facilities. From an infrastructure standpoint, the introduction of a single information system improved financial management, clinical care, and outcomes measurement across multiple systems. This approach to information technology (IT) enabled the states to track outcomes and costs, demonstrating good clinical and recovery outcomes and lower per-person/per-month rates for individuals compared to the cost for institutional care.

Amid the successes, though, were significant challenges faced in both states. These included difficulties providing services for adolescents and transition-age youth (ages 17 to 25), who are “aging out” of the child system and shifting to the adult system. Participants cited challenges involved in creating 24/7 mobile crisis services, including crisis stabilization housing. There is a need to improve communication and coordination across state and local agencies and providers, and to help providers adjust to new service delivery models—particularly the managed care model. Similarly, it can be challenging to work with multiple federal agencies at once, and participants recommended the use of a central point of contact to simplify the process. They also identified a need for workforce training in new system values and EBPs. Finally, developing and sustaining a provider system, and developing shared data and information systems—or solutions to bridge existing systems—was identified as a barrier.

EXAMPLES OF STATE INITIATIVES TO FACILITATE COMMUNITY LIVING

Wisconsin’s Wraparound Milwaukee, authorized under a 1915(a) Medicaid waiver, braids Medicaid with funding from other service systems including child welfare and juvenile justice. Operated by the Milwaukee County Behavioral Health Division, Wraparound Milwaukee serves families living in Milwaukee County that have a child who has serious emotional or mental health needs, is referred through the Child Welfare or Juvenile Justice System, and is at immediate risk of placement in a residential treatment center, juvenile correctional facility, or psychiatric hospital. Services may include psychotherapy delivered in nonclinical settings; behavioral specialist consultation to develop a behavioral modification plan specific to the child; and one-on-one therapeutic staff support to children and families while implementing the child’s individual treatment plan. Outcomes include significantly reducing the number of children receiving high-end residential services or psychiatric inpatient services, as well as improved clinical outcomes.

Massachusetts offers statewide services for children and adolescents with serious emotional disturbance based on EPSDT under Medicaid. The Rosie D. Remedy Services System was created as the result of a court judgment in the case *Rosie D. v. Patrick*. This new approach to mental health services, which began to be implemented in 2009, provides an integrated and coordinated approach to treatment planning and service delivery, informed by nationally recognized principles of wraparound care. Children receive services that are highly individualized, child and family centered, and strengths based. Services can be provided in any appropriate setting where the child is located, including homes and schools. Families and providers work together to set goals for each service, consider appropriate locations and strategies for implementation, coordinate the delivery of care, and monitor progress toward identified outcomes.

RECOMMENDED RESOURCES

- Medicaid Well-Child Visits: Comprehensive Exam Guidelines Call for Mental Health Screening (<http://www.teenscreen.org/images/stories/PDF/9Medicaid%20Well-Child%20Visits.pdf>)
- Early Periodic Screening, Diagnosis and Treatment (<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html>)
- Rosie D—Litigation Overview (<http://rosied.org/Default.aspx?pagelid=89308>)
- Increasing Utilization: Strategies for Engaging Culturally/Racially Diverse Children and Their Families in Mental Health Services (http://cfs.cbcs.usf.edu/docs/publications/Study5_IncreasingUtilization.pdf)
- Summary of the Wraparound Evidence Base: April 2010 Update ([http://www.nwi.pdx.edu/NWI-book/Chapters/Bruns-3.5-\(evidence-base\).pdf](http://www.nwi.pdx.edu/NWI-book/Chapters/Bruns-3.5-(evidence-base).pdf))
- Expanding Systems of Care: Improving the Lives of Children, Youth, and Families (<http://gucchdtcenter.georgetown.edu/publications/SOC%20Results%205-7-12.pdf>)
- Updating the System of Care Concept and Philosophy (http://gucchdgeorgetown.net/data/documents/SOC_Brief2010.pdf)
- The Intersect of Health Reform and Systems of Care for Children and Youth with Mental Health and Substance Use Disorders and Their Families (http://gucchdtcenter.georgetown.edu/publications/SOC_Brief_Series1_BL.pdf)
- Wraparound Milwaukee Program Description (www.nashpcloud.org/edocs/wraparound_milwaukee.program.description.doc)

OMBUDSMEN AS ADVOCATES IN SYSTEMS CHANGE

This session explored ways that states can partner with their state ombudsman to facilitate implementation of *Olmstead*. The presenter described the relevant roles and experience of an ombudsman program and offered suggestions for partnering to achieve successful transitions to community-based settings.

Session participant:

- Louise Ryan, Ombudsman Program Specialist, ACL/Administration on Aging (AoA)

BACKGROUND AND CONTEXT

It is estimated that more than 500,000 people with mental illnesses (excluding dementia) reside in U.S. nursing homes on any given day. This number, which represents approximately one-fourth of all nursing home residents, greatly exceeds the number of people with mental illnesses in all other health care institutions combined.

The Older Americans Act establishes an effective interrelationship between the federal government, state aging units and local service coordinators called Area Agencies on Aging. Federal, state, and local centers of service are known, collectively, as the Aging Network. The Aging Network is committed to promoting “freedom, independence, and the free exercise of individual initiative in planning and managing their own lives, full participation in the planning and operation of community based services and programs provided for their benefit, and protection against abuse, neglect, and exploitation.”

The Administration on Aging’s Long-Term Care Ombudsman Program serves the following important purposes in promoting implementation of *Olmstead*:

- Promotes and advocates for the rights of individuals to leave nursing homes and move to less restrictive settings;
- Investigates individual complaints and serves as a resource and creative problem solver for residents, their families, and facilities; and
- Works across disciplines and collaborates to improve services and supports.

CENTRAL THEMES AND LESSONS LEARNED FOR ADVANCING COMMUNITY INTEGRATION

The Aging Network has vast experience in supporting transition of individuals from nursing facilities to the community that may be transferable to implementation of other *Olmstead* transitions. These experiences include providing consumers with

information about long-term services and supports through the Aging & Disability Resource Centers (ADRCs). ADRCs, a collaborative effort of AoA and CMS, are designed to streamline access to long-term care. ADRCs provide states with an opportunity to effectively integrate the full range of long-term supports and services into a single, coordinated system.

The Long-Term Care Ombudsman Program is a person-centered consumer protection service that resolves problems and advocates for the rights of individuals who live in nursing homes, assisted living, board and care, and similar adult care facilities. Trained ombudsmen, including certified volunteer ombudsmen, work to resolve complaints of individual residents by representing the desires of the individual and seeking the resolution that they individual wants.

Ombudsmen are experienced in assisting with transitions where the family and institutional representatives (including clinicians) may have different perspectives from that of the consumer and may even oppose a move to the community. Ombudsmen are involved in specific nursing home initiatives that support transitions to community. Their services include providing education to nursing home residents about their options to leave the community. Within certain states that offer Money Follows the Person (MFP) demonstration programs, ombudsmen provide the following:

- Addressing and resolving complaints specific to transitions;
- Consulting with and educating residents, families, and facilities about the MFP transition opportunity;
- Following up with residents after transition;
- Providing systems advocacy focused on state design of systems so that systems are responsive to consumer interests; and
- Delivering enhanced educational materials and presentations to resident and family councils, facility staff, and aging network for Section Q of the Minimum Data Set (MDS), an evaluation to determine whether the consumer would like to receive information about transitioning to the community.

Ombudsmen have identified several systems-level challenges to successful transitions from nursing homes, including the following:

- Insufficient community resources to accommodate transition;
- Lack of timeliness of the process;
- Challenges in discussing community options with residents with dementia or diminished capacity;

- Family/guardian disagreements with resident preferences; and
- Emotional stress and anxiety residents may experience if they believe they can transfer to the community but they have not yet been given community options.

EXAMPLE OF STATE INITIATIVES TO FACILITATE COMMUNITY LIVING

The **Wisconsin** Area Agency on Aging uses quality-of-life measures to track and improve services to consumers.

In **Ohio**, eight of 12 regional ombudsman programs provide transition coordination services for the state's MFP initiative. Ombudsmen serve as transition coordinators, helping residents complete a workbook to identify their specific needs and establish a process for their successful transition to the community. Typically, the transition coordinator will facilitate a discharge planning meeting including the resident, nursing facility staff, case manager, and sometimes family members. The transition coordinator works with the resident to explore housing options, shop for household goods, and serve as a facilitator and problem solver throughout the transition process.

Under **Michigan's** MFP initiative, ombudsmen administer quality-of-life surveys with people who have transitioned out of nursing facilities. A pilot program called Community-Based Ombudsman (CBO) uses trained ombudsmen to offer advocacy and other assistance to people who have transitioned to their own homes or to licensed residential settings and who receive HCBS under a Medicaid waiver. CBOs help arrange for home health equipment, home modification, in-home care, and other services.

In **Maine**, the Long-Term Care Ombudsman Program was designated as the local contact agency for nursing home residents who respond to the MDS Section Q survey that they would like to live in the community. These residents are referred by the nursing home to the Long-Term Care Ombudsman Program for follow up.

Ombudsmen in **Louisiana** help nursing home residents with MFP applications and provide follow-up support.

After a nursing home resident in **Georgia** transitions to the community under an MFP placement, an ombudsman follows up with them three times during their first year. Ombudsmen receive complaints and assist in problem solving.

The **New Jersey** Office of the Ombudsman for the Institutionalized Elderly receives MFP funds to provide education and outreach in long term care facilities and in the greater community, with specific activities designed to help identify potential candidates for transition.

For one year after discharge, ombudsmen in **Rhode Island** provide 24/7 emergency backup for clients transitioned from nursing facilities to the community.

Texas hired a half-time staff person to oversee Long-Term Care Ombudsmen activities related to MDS Section Q implementation, training for local ombudsmen, and reimbursement to ombudsman programs for MFP activities, which include counseling and information to individuals, counseling and information to facilities, and education to facility staff in-service or resident or family councils.

RECOMMENDED RESOURCES

- Administration on Aging (http://www.aoa.gov/AoARoot/AoA_Programs/index.aspx)
- The National Long Term Care Ombudsman Resource Center (www.ltombudsman.org)
- Minimum Data Set 3.0 (<http://www.ltombudsman.org/issues/MDS-3.0>)
- Administration on Aging: Long Term Care Ombudsman Program (http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Ombudsman/index.aspx)

MEDICAID PROGRAMS THAT SUPPORT IMPLEMENTATION STRATEGIES

This session discussed the Medicaid program and options for financing HCBS, as well as state initiatives to close nursing facilities and facilitate residents' transitions to community living.

Session participants:

- John O'Brien, Senior Policy Advisor, Disabled and Elderly Health Programs Group, CMS
- Jean K. Close, Technical Director, Division of Benefits and Coverage, Disabled and Elderly Programs, CMS
- Dawn Lambert, Project Director, Money Follows the Person Rebalancing Demonstration, Medical Care Administration, Connecticut Department of Social Services
- Kathryn Poisal, Technical Director, Division of Long Term Services and Supports, Disabled and Elderly Health Programs Group, CMS

BACKGROUND AND CONTEXT

Medicaid plays a vital role in financing services for individuals with serious mental illness, providing a health care safety net for many low-income Americans. This

synopsis outlines some of the Medicaid options that can help states better meet the needs of individuals with serious mental illness, including helping individuals return to community living, or remain in the community.

States use Medicaid to finance supports for people with long-term disabilities, including those who would otherwise need to be in institutional settings to qualify for Medicaid benefits. Section 1915(c) of the Social Security Act, HCBS waivers, permits states to expand financial eligibility, fund a variety of flexible services and supports in the community, and tailor these benefits to the needs of specific groups, such as medically fragile children, adults with DD, children and youth with serious emotional disturbance, individuals with serious mental illness, individuals with autism spectrum disorders, or older people with major physical impairments.

Individuals with serious mental illness may require long-term services and supports beyond medical or behavioral health treatment to successfully support their recovery in a community setting. Some—especially those transitioning from a hospital or residential facility—may require assistance in managing daily activities such as housekeeping, shopping or meal preparation, personal care, or using transportation. HCBS and supports can be instrumental in maintaining housing and achieving employment and other recovery milestones.

Medicaid offers states a broad range of options for financing supports for individuals with serious mental illness to live in community integrated settings. Medicaid HCBS waivers and several state plan options are an important component of many states' overall efforts to foster community integration for persons with serious mental illness and children and youth with serious emotional disturbance.

Under 1905(a)(13) rehabilitative services—the rehab option—state Medicaid plans can pay for “any medical or remedial service recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level” (HCFA, 1992). The rehab option is one of the primary vehicles states use to provide community services and supports for people with serious mental illness. Kaiser (2007) reports that 73 percent of all rehab option services in state Medicaid programs were delivered to people with a behavioral health diagnosis.

State Medicaid programs use targeted case management to provide critical linkage and care coordination for both adults and children and their families as they navigate fragmented community mental health services and HCBS. In many states it serves as an important locus of treatment planning and service coordination for children with serious emotional disturbance and adults with mental illness.

EPSDT has been an important option in providing flexible supports for children.

EPSDT is unique because states are required under this mandatory benefit to supply all medically necessary services and supports that can be covered under federal Medicaid law to Medicaid-eligible children younger than age 21, even if the Medicaid agency has chosen not to cover the service for others who are eligible. The statutory language has been used in several states to increase behavioral health services for children. Massachusetts, for instance, provides in-home supports to children with behavioral health needs.

1915(c) HCBS waivers are used by states to assist people who might otherwise be in institutional settings to live and receive services in the community. States may obtain waivers of federal requirements to provide a different or richer benefit package for some Medicaid beneficiaries or to offer services in some areas of the state and not others. States may also use 1915(c) waivers to expand financial eligibility to cover people who would otherwise be eligible for Medicaid only in an institutional setting. Settings that may be considered when developing the waiver are limited to hospitals, nursing facilities, and intermediate-care facilities for ID. States can use waivers to cover a comprehensive set of supportive services, including rehabilitation, habilitation, and other supports targeted to a specific population.

States must ensure that the average per-capita costs under the waiver will not be greater than the average per-capita expenditures that would have been made for services provided to waiver enrollees in a hospital, nursing facility, or intermediate-care facility for individuals with intellectual disabilities (ICF/IID). State Medicaid agencies are permitted to manage costs by capping enrollment and limiting services in ways that are unavailable to them in the typical state plan options.

Although states have employed the 1915(c) waiver authority for a broad spectrum of specialty populations, states face federal policy constraints in using 1915(c) to provide supports to individuals with serious mental illness. Waiver services cannot be provided to people who would otherwise receive services in one of two types of institutions: institutions for persons with mental diseases (for individuals between the ages of 22 and 64) and psychiatric residential treatment facilities. However, states may use the 1915(c) waiver for defined populations with serious behavioral health needs who also meet the level-of-care criteria for qualifying institutions, such as hospitals or nursing homes.

The Medicaid State Plan HCBS option [1915(i)] gives states the option of offering HCBS as part of their State Plan, using a less stringent eligibility standard than the 1915(c) institutional care standard. States can offer services and supports designed to support community integration, such as personal assistance services/attendant care, supported employment, and case management, as well as community-based behavioral health services. Self-direction of HCBS is encouraged for people receiving services under a 1915(i) option. The Affordable Care Act amended 1915(i), including expanding the range of services that can be provided under 1915(i), making it

comparable to what is available under 1915(c) waivers and allowing targeting of specific populations such as individuals with mental illness. It also eliminated states' ability to cap enrollment and limit services to specific areas in the state (CMS, 2010).

The Affordable Care Act also established the state Balancing Incentive Program (BIP), which increases the Federal Matching Assistance Percentage (FMAP) to States that make structural reforms to increase nursing home diversions and access to non-institutional long-term services and supports. These structural changes must include implementing a no-wrong-door/single-entry-point system, conflict-free case management services, and core standardized assessment instruments. States must agree to use the enhanced FMAP only to provide new or expanded long-term HCBS and supports. Most states participating in BIP include mental health services in their plans.

CMS' MFP demonstration program is designed to help states rebalance their long-term care systems to transition people with Medicaid from institutions to the community. Forty-two States and the District of Columbia have implemented MFP programs, which focus on eliminating barriers in state laws, state Medicaid plans, and state budgets to support people in getting long-term care in the settings of their choice.

CENTRAL THEMES AND LESSONS LEARNED FOR ADVANCING COMMUNITY INTEGRATION

Medicaid has several options for providing services to beneficiaries under the State Plan, the comprehensive written agreement describing the nature and scope of the state's program. These include health homes, which provide coordinated and integrated primary and ancillary care for individuals with multiple chronic conditions; the 1915(i) HCBS option (as described above); and the 1915(k) Community First Choice Program, which provides enhanced federal funding to states that elect to provide attendant person-centered HCBS and supports to help increase the ability of individuals with disabilities to live the community. These options allow states to add long-term services and supports directly to their State Plans with no requirements that the services be cost neutral.

Several points emerged during discussions by the state participants on strategies for closing or downsizing nursing facilities. States may experience opposition to closing nursing homes and transitioning people into community living. It is important to work with associations representing nursing homes to foster collaboration and keep communication channels open. Stakeholders, residents, and family members must have strong representation on work groups planning for transitions.

Culture change among provider and state staff is critical. If staff are not on board with transitioning individuals into the community, the transitions will be more difficult and

potentially less effective. Ensuring informed, meaningful choice requires providing residents with information about the benefits of living in the community; opportunities to visit community placements and meet with community providers, peer-to-peer and family-to-family supports; and opportunities to have concerns about moving to the community addressed. Rather than focusing on nursing homes as undesirable service settings, states can help to engage nursing home administrators and staff in the process of transitioning residents to homes in the community.

EXAMPLES OF STATE INITIATIVES TO FACILITATE COMMUNITY LIVING

Connecticut's MFP demonstration is guided by the vision that each town or group of towns in Connecticut will have a long-term care compendium of supports and services. Policy decisions are designed to support key principles of person-centered planning: empowering people with information so that they may make their own decisions; ensuring choice; and ensuring the dignity of risk.

Connecticut's MFP program has four program goals:

- Eliminate barriers in State law, State Medicaid plans, and State budgets that restrict the use of Medicaid funds to let people get long-term care in the settings of their choice;
- Put procedures in place to provide quality assurance and improvement of HCBS;
- Strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions; and
- Adjust the supply of HCBS and institutionally-based services to appropriately meet the demand.

In working toward these program goals, Connecticut transitioned nearly 1,200 individuals, including 133 people with a primary mental health diagnosis, from nursing homes into community-based settings. Community services essential to successful transitions—such as peer support, personal care, in-home respite services, supported employment, crisis stabilization, case management, overnight supervision, non-medical transportation, and a flexible, team-based approach to community rehabilitation—were supported by Medicaid for some individuals under a 1915(c) waiver.

More than 70 percent of Connecticut's MFP participants chose to live in their own apartments, with another 20 percent living in their own home or the home of a family member. In follow-up surveys at six, 12, and 24 months, MFP participants reported greater happiness, lower incidence of depressive symptoms, and increased community integration as measured by "doing fun things in the community."

During the last year, eight nursing homes (nearly 600 beds) closed in Connecticut, principally because system-wide vacancy rates higher than 9 percent made them

financially unsustainable.

RECOMMENDED RESOURCES

- Medicaid Policy Options for Meeting the Needs of Adults with Mental Illness under the Affordable Care Act (<http://www.kff.org/healthreform/upload/8181.pdf>)
- Take Advantage of New Opportunities to Expand Medicaid Under the Affordable Care Act (<http://www.bazelon.org/LinkClick.aspx?fileticket=cwAuDZLEmQI%3d&tabid=627>)
- CMS Center for Medicaid and CHIP Services Informational Bulletin (Dec. 3, 2012): Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders (<http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-12-03-12.pdf>)
- Community-Based Long-Term Services & Supports (<http://www.medicaid.gov/Affordable-CareAct/Provisions/Community-Based-Long-Term-Services-and-Supports.html>)

ACHIEVING INTEGRATION THROUGH PERSON-CENTERED PLANNING

This session examined the importance of person-centered planning to achieving the goals of *Olmstead*. Receiving HCBS is not synonymous with having control over one's life. Individuals can be living in the community but still not living the life they want to live. The federal government has worked across agencies to come up with an affirmative statement of the elements of person-centered planning to facilitate services that meet an individual's goals and are provided in accordance with his or her preferences.

Session participants:

- Shawn Terrell, M.S., M.S.W., Health Insurance Specialist, Office on Disability, HHS
- Wilma Townsend, M.S.W., Acting Associate Director for Consumer Affairs, CMHS, SAMHSA
- Michael Head, M.S.W., Former Director, Mental Health and Substance Abuse Services, Michigan Department of Community Health

BACKGROUND AND CONTEXT

Person-centered planning is a comprehensive strategy for putting necessary services and supports in place to help individuals achieve their goals. It is conducted by

individuals who, together with their freely chosen supporters, identify their own strengths, capacities, preferences, needs, and desired outcomes (Alakeson, 2007). It is a well-established method of planning for treatment and recovery. Federal leadership has contributed to its growing use by promoting its use in public programs such as Medicaid- funded long-term services and supports.

In its guidance to states in preparing their FY 2012-2013 Block Grant Applications, SAMHSA emphasized the importance of developing participant-directed services. It further stated that “person-centered planning is the foundation of self-direction and must be made available to everyone” (SAMHSA, 2011).

The value of person-centered planning in advancing the community integration mandate of the *Olmstead* decision is supported by a variety of research findings. Holburn, et al. (2004), conducted a longitudinal study comparing two groups of individuals with ID and “problem behavior” residing in institutions. One group received person-centered planning and the other group received interdisciplinary service planning. Both groups showed significant improvement over time, reflected by specific process and outcome measures, but the person-centered planning group had a significantly higher rate of improvement. Nearly all participants in the person-centered planning group (18 of 19) moved to the community, whereas only five of 18 control group members completed transitions.

The contribution of person-centered planning to individual achievement of recovery goals was also documented by the Western New York Care Coordination Program (2012), which serves people with serious mental illness who have experienced at least one hospitalization. At an early stage, the program incorporated person-centered planning as its core design feature. Program staff recognized that adoption of this new concept needed to permeate all aspects of an individual’s support system, and thus extended provision of training on person-centered planning beyond care coordinators to reach all components of a county’s mental health delivery system. Care coordinators help individuals define their recovery goals, develop a plan to meet those goals, and access needed community services. The program’s documented outcomes for individuals include increased employment, fewer arrests, better coping skills, and fewer emergency department visits and inpatient days. In addition, participating counties had markedly lower costs for inpatient care than did comparable nonparticipating counties.

Incorporating person-centered planning into the delivery of behavioral health, physical health, and disability services is viewed as an essential strategy for improving individual outcomes and enhancing quality of life. Yet implementing it system-wide in a manner consistent with EBPs requires overcoming entrenched provider attitudes that equate traditional case management with person-centered planning, or assume that individuals with significant disabilities are not capable of achieving recovery goals (Tondora).

Smull, Bourne, and Sanderson (2009) present a process for facilitating systems change that results in a more flexible and person-centered system responsive to achieving to individuals' goals. In particular they emphasize the importance of establishing feedback loops that capture participants' experiences for the explicit purpose of driving changes in practice and policy.

CENTRAL THEMES AND LESSONS LEARNED FOR ADVANCING COMMUNITY INTEGRATION

Planning around an individual's needs for discharge and transition to the community requires the active participation of multiple stakeholders. Person-centered planning is an important vehicle for achieving a vision of recovery. Providers must train their staff to work with participants to develop person-centered plans so front-line workers believe in the process. Program participants also need to learn how to be part of this process and understand their responsibilities in a person-centered recovery process.

State experiences demonstrated that person-centered planning must be completely integrated with recovery. If states are to have recovery-oriented systems in which consumers are able to live, learn, and participate in the community, person-centered planning must be central. Instead of concentrating on the person's illness, person-centered planning focuses on activities and strategies needed to improve wellness. In the philosophy underpinning person-centered planning, expectations for recovery are invariably high. Discussion revealed that evaluation is important and supervisors are critical for keeping support workers motivated. Clinicians need to understand that person-centered planning is not about the participant being in the room to endorse the clinician's recommendations, but actual participant involvement.

States have multiple options for implementing person-centered planning. Some jurisdictions may rely on consumer-run organizations to supply facilitators needed to make person-centered planning successful; others may involve providers. State-wide consumer organizations may have the right skill level for this work. A video of person-centered planning supported by peer specialists was presented and provided information on implementing the process.

Person-centered planning enables individuals to be given information and to be engaged so that they can make informed choices about where they want to live. States should assess how they can use their funding streams to accommodate the person's choices. In all types of housing, states need to ensure that the individual is living a full life. Simply living in housing with a small number of beds does not guarantee that a person is fully living and participating in a community.

Participants emphasized that the focus must be on individuals' life goals and preferences, not just clinical outcomes. The process needs to be inculcated into the culture of the entire delivery system so that person-centered thinking structures all

encounters. Accordingly, clinicians need to understand the importance of person-centered planning to effective treatment and recovery. Individuals, family members, and friends all need information and education about the practice so they know what to expect.

EXAMPLES OF STATE INITIATIVES TO FACILITATE COMMUNITY LIVING

Michigan incorporated person-centered planning into its Medicaid program in response to pressure from advocates. The state used its existing HCBS waiver as a mechanism for helping people live a full life in the community; person-centered planning is a required function of the waiver. By statute, person-centered planning became a right for Michigan consumers. It became a centerpiece of Michigan's Medicaid mental health system in 1998, when the state moved to a prepaid health plan model. In Michigan's experience, systems built around person-centered planning have a philosophy that people are competent, have strengths, and can express a preference and make choices.

A pre-planning meeting, in which people can learn about person-centered planning, is necessary to ensure that people are ready to engage in the process. Independent facilitators often help the process unfold and result in better outcomes; using peers as independent facilitators was successful in Michigan. Ultimately, Michigan found that incorporating person-centered planning into its system promoted greater independence and empowerment among those people it was designed to help.

RECOMMENDED RESOURCES

- Achieving Integration through Person-Centered Planning (www.nashpcloud.org/edocs/integration.through.person.centered.planning.docx)
- Centers Medicare and Medicaid Services, Self-Directed Options (<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Self-Directed-Services.html>)
- Western New York Care Coordination Program Evaluation Results (http://www.carecoordination.org/results_periodic_reporting.shtm)
- The Top Ten Concerns about Person-Centered Care Planning in Mental Health Systems (http://www.viahope.org/?ACT=25&fid=17&aid=191_1hdvxOxnu6mN0n487Vq8&board_id=1)
- Becoming a Person-Centered System (<http://www.learningcommunity.us/documents/BecomingaPersonCenteredSystem-ABriefOverview.pdf>)

OLMSTEAD ENFORCEMENT AND IMPLEMENTATION

The *Olmstead* decision provides states with three key opportunities:

- Allowing them to satisfy their legal obligations under the Americans with Disabilities Act (ADA);
- Helping them satisfy their fiduciary responsibilities to taxpayers by moving people to less expensive community settings; and
- Enabling states to better serve consumers by providing services and supports that allow them achieve their goals.

This session described the opportunities that federal partners in DOJ and HUD offer states to meet their responsibilities and provide guidance regarding state obligations under the *Olmstead* decision.

Session participants:

- Alison N. Barkoff, J.D., Special Counsel for *Olmstead* Enforcement, Civil Rights Division, DOJ
- Thomas P. Perez, J.D., Assistant Attorney General, Civil Rights, DOJ
- Estelle Richman, M.A., Senior Advisor to the Secretary, HUD
- Kevin Ann Huckshorn, RN, MSN, CAP, ICADC, Director, Delaware Division of Substance Abuse & Mental Health

BACKGROUND AND CONTEXT

After the 1999 ruling in *Olmstead v. L.C.* that held that unjustified institutionalization of people with disabilities is discrimination and violates the Americans with Disabilities Act (ADA), the federal government moved to enforce the ruling and implement remedies. Subsequent court decisions have found that the ADA's integration mandate applies to persons living in the community who are not institutionalized, but are at risk of institutionalization (Carlson & Coffey, 2010). The *Olmstead* ruling requires states to make "reasonable modifications" to policies and procedures for compliance, but stops short of requiring them to make "fundamental alterations" to state programs.

Following the *Olmstead* decision, the Health Care Financing Administration (the predecessor to CMS) issued a series of letters to Medicaid agencies to help states understand the range of options available for implementing changes to existing long-term services and supports systems (U.S. Department of Health and Human Services, 2001). These initial letters outlined principles for the development of state *Olmstead* plans (co-authored with OCR) and answered state questions. They also clarified rules for offering Medicaid home health services, and provided guidance on targeted case management services, and Medicaid HCBS waivers.

In recent years, the federal government has engaged in a variety of implementation and enforcement activities. To mark the tenth anniversary of the *Olmstead* decision in 2009, new partnerships among HHS, DOJ, and HUD were formed as part of the “Year of Community Living.” HHS and HUD worked to ease transitions of individuals into community living by increasing the availability of accessible and affordable housing for people with disabilities (*Olmstead* Enforcement Update, 2012a). The DOJ and HHS are also collaborating in aiding states to enhance their long-term services and supports community infrastructure.

The DOJ Civil Rights Division is also prioritizing *Olmstead* enforcement and is coordinating these efforts with OCR (U.S. Department of Justice, 2012a). The Assistant Attorney General for the DOJ Civil Rights Division has identified three goals guiding the Division’s *Olmstead* enforcement activities:

- People with disabilities should have opportunities to live life like people without disabilities;
- People with disabilities should have opportunities for true integration, independence, recovery, choice, and self-determination in all aspects of life including where they live, spend their days, work, or participate in their community; and
- People with disabilities should receive quality services that meet their individual needs (*Olmstead* Enforcement Update, 2012b).

Olmstead activities in the DOJ have been wide-ranging. They have included reaching system-wide settlement agreements in states, filing statements of interest in private litigation, bringing suit against noncompliant states, and developing publicly available guidance documents on *Olmstead* enforcement (*Olmstead* Enforcement Update, 2012b). The DOJ currently has multiple ongoing investigations related to *Olmstead*. It is also broadening its focus to ensure that individuals with disabilities have the right to integrated lives in addition to integrated residential settings. For example, in the context of employment opportunities, the DOJ recently stated that “the unnecessary segregation of individuals with disabilities in segregated non-residential employment and vocational programs violated Title II of the ADA and *Olmstead*” (U.S. Department of Justice, 2012b).

CENTRAL THEMES AND LESSONS LEARNED FOR ADVANCING COMMUNITY INTEGRATION

Federal participants emphasized that partnership is the key to success, and collaboration across federal agencies, within and across state and local agencies, and between federal and state partners is essential to achieving the promise of *Olmstead*. The federal government is currently experiencing a level of collaboration among agencies—including DOJ, HHS, and HUD—that is unprecedented. HUD is using a number of levers to support people who want to transition to the community.

This includes Section 811 Housing for Persons with Disabilities, Housing Opportunities for Persons with AIDS, and collaboration with the HHS on the MFP Rebalancing Demonstration.

Olmstead is not about simply where you live; it is also about how you live. High-quality, accessible, affordable housing is a platform for addressing the well-being of both people who are transitioning to community living and those who seek to remain in the community. Similarly, housing is about more than just bricks and mortar; it is about people. Despite the tendency to define institutions in terms of size or number of beds, institutions also reflect a particular mentality. Small size does not guarantee that housing is integrated into the community or is person-centered.

Participants noted that successful states such as Delaware have shown the importance of having strong state-level leaders and change agents. Strong public support of the governor is essential to getting all parties committed. Delaware is now serving many more individuals in the community through the re-investment of funds from the closing of hospital beds. Communication with providers, staff, and other agencies during the transition process is important, as is clarifying the state's mission and values. Participants recommended that states begin reforming their systems immediately after the first DOJ findings letter is issued.

In terms of challenges, criminal background policies among landlords can pose barriers in finding community housing for people transitioning out of institutions. HUD has asked local housing authorities to re-examine their policies on criminal backgrounds, suggesting their exclusions may be too rigid. Transition coordinators in some states report that landlords who are willing to rent to a person with no credit who is transitioning from an institution fear enforcement action if an aggrieved applicant with a great credit score is denied.

EXAMPLES OF STATE INITIATIVES TO FACILITATE COMMUNITY LIVING

In 2007-2008, DOJ visited **Delaware** after several negative press articles about its state hospital. There was no urgency to discharge people, no real advocacy or community involvement, and minimal individualized or active treatment. The state's immediate response focused on improvements in the state hospital's operation. State staff revised organizational missions and visions and trained clinical staff to focus on recovery principle. As a result, use of involuntary medications declined by 90 percent and seclusions and restraints declined by 93 percent.

In 2010, DOJ sent a final findings letter to the Governor focusing on ADA and *Olmstead* violations, particularly the lack of state community infrastructure, services, and supports that would provide an overall preventive approach to institutionalization. The letter noted the state's lack of evidence-based services, integrated housing options, choice, and an integrated data system. In addition to these challenges, Delaware also struggled to identify individuals who were at risk of institutionalization,

and the state was not effective in recruiting landlords to increase the state's low-income housing stock. In beginning to address these issues, Delaware originally failed to predict the capacity of the state government infrastructure needed to implement this extensive policy change, leading to overworked staff.

During the negotiation process, it became clear that the governor and DOJ shared the same philosophy. After six months of work, the governor signed a settlement agreement with DOJ, providing an additional \$5 million to *Olmstead* implementation. The following year an additional \$14 million was added. Delaware is now:

- Expanding a range of community-based services, including Assertive Community Treatment (ACT) teams, Intensive Case Management Services, crisis services, supportive housing, and psychiatric rehabilitation and supported employment services;
- Implementing principles based on the SAMHSA recovery consensus statement;
- Providing people with real choices for community living;
- Expanding performance-based contracting; and
- Increasing awareness of *Olmstead* among communities, providers, and program staff.

As part of its settlement agreement, Delaware agreed to establish 650 new integrated, scattered-site supportive housing units within the next 4 years. More than 100 were created during the last year. In addition, Delaware is in the process of establishing a range of crisis services, including mobile crisis teams, crisis walk-in centers, and crisis respite apartments, staffed by peers and regular staff, 24/7, as an alternative to hospital emergency departments.

RECOMMENDED RESOURCES

- Questions and Answers on the ADA's Integration Mandate and *Olmstead* Enforcement (http://www.ada.gov/Olmstead/q&a_Olmstead.htm)
- *Olmstead*: Upholding the Community Integration Mandate (available on page 56: http://www.thenationalcouncil.org/galleries/NCMagazine-gallery/12_NCCBH%20magazine%231_web.pdf)
- *Olmstead* Enforcement by the U.S. Department of Justice 2009 to August 2012 (www.nashpcloud.org/edocs/doj.Olmstead.enforcement.efforts.2009.september.2012.docx)
- *Olmstead* Enforcement Update: Henry Claypool (<http://www.hhs.gov/asl/testify/2012/06/t20120621a.html>)
- *Olmstead* Enforcement Update: Thomas Perez (<http://www.justice.gov/crt/opa/pr/speeches/2012/crt-speech-120621.html>)

CONCLUSION

The *Olmstead* Policy Academy provided the five participating states—Colorado, Georgia, Illinois, Minnesota, and New Jersey—with innovative strategies to improve community integration for people with behavioral health conditions, focusing on issues such as housing, employment, effective services for special populations such as children and people with co-occurring DD, financing strategies, use of peer supporters, and person-centered planning. All of these strategies are designed to support people to live meaningful, integrated lives in the community, with specific strategies to facilitate successful transitions from institutional settings.

State teams emerged from the meeting with key priorities for their own state's *Olmstead* activities, including such activities as increasing the use of peer supporters, integrating data systems to better understand the use of various residential options and associated outcomes, downsizing state hospitals, and improving interagency collaboration. Many teams also identified technical assistance needs to support implementation of those activities.

The federal partner agencies involved in planning the meeting (described in the Introduction to this report) are committed to collaborating with each other and with the states to improve policy, programs, and technical assistance to support community integration. SAMHSA will coordinate follow-up TA from the federal agencies to the *Olmstead* Policy Academy states, and the states will continue to meet on a regular basis to ensure ongoing collaboration.

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APPENDIX: MEETING AGENDA



**Department of Health and Human Services
2012 Olmstead Implementation Best Strategies and Practices Policy Academy
Restoring Lives: Building Integrated Communities and Strengthening Support
Sheraton Columbia Town Center Hotel
September 20 -21, 2012**

AGENDA

Thursday, September 20, 2012

7:00 a.m. – 8:30 a.m. Registration

8:30 a.m. – 9:30 a.m. **Welcome and Opening Remarks**

Lakeview A&B

Mirtha R. Beadle, M.P.A., Deputy Administrator for Operations,
Substance Abuse and Mental Health Services Administration
(SAMHSA)

Lois Curtis, plaintiff, *Olmstead v. L.C.*

Leon Rodriguez, J.D., Director, Office for Civil Rights,
U.S. Department of Health and Human Services (HHS)

Cindy Mann, J.D., Deputy Administrator and Director, Center for
Medicaid and CHIP Services, Centers for Medicare and Medicaid
Services (CMS)

9:30 a.m. – 10:00 a.m. **Meeting Goals, Overview of the Agenda, and Introductions**

Lakeview A&B

Chris Marshall, Special Assistant to the Director, Center for Mental
Health Services, SAMHSA

Robert Glover, Ph.D., Executive Director, National Association
of State Mental Health Program Directors (NASMHPD)

Carol Bianco, Director of Technical Assistance,
Advocates for Human Potential, Inc. (*facilitator*)

Jenifer Urff, J.D., Senior Policy Associate,
Advocates for Human Potential Inc. (*facilitator*)

10:00 a.m. – 10:15 a.m. **BREAK**

10:15 a.m. – 11:30 a.m.

From Closing Institutions to Community Integration

Lakeview A&B

Mary Giliberti, J.D., Section Chief, Office for Civil Rights, HHS
(*moderator*)

Estelle Richman, M.A., Senior Advisor to the Secretary, U.S.
Department of Housing and Urban Development (HUD)

Joan Erney, J.D., Director, Office of Policy, Planning, and Innovation,
SAMHSA

Gina Kaye Calhoun, National Director for Wellness and Recovery
Education, Copeland Center for Wellness and Recovery

11:30 a.m. – 12:30 p.m.

LUNCH (*on your own*)

Informal Dialogue with Lois Curtis

12:30 p.m. – 2:00 p.m.

**Concurrent Workshops: Programs and Practices for Statewide Plans
Employment Innovations and Strategies**

Lakeview A

Shawn Terrell, M.S., M.S.W., Health Insurance Specialist,
Office on Disability, HHS (*moderator*)

Gary R. Bond, Ph.D., Professor of Psychiatry, Dartmouth Medical
School and the Dartmouth Psychiatric Research Center

Steven Reeder, M.Ed., CPRP, CRC, Chief, EBP Services and Program
Evaluation, Office of Adult Services, Maryland Department of Health
and Mental Hygiene

Laurie Scott, Supported Employment Service Recipient, Maryland

Lakeview B

Opportunities and Partnerships in Supportive Housing

Gavin Kennedy, M.S., Director, Division of Long-Term Care Policy,
Office of Disability, Aging, and Long Term Care Policy, Office of the
Assistant Secretary for Planning and Evaluation, HHS (*moderator*)

Martha Knisley, M.A., Director of the Community Support Initiative,
Technical Assistance Collaborative, Boston, Massachusetts

Christy Respress, M.S.W., Executive Director, Pathways to Housing,
Washington, DC

Gerard Thomas, Peer Veterans' Outreach Worker, Pathways to Housing,
Washington, DC

Lynn A. Kovich, M.Ed., Assistant Commissioner, Division of Mental
Health and Addiction Services, New Jersey Department of Human
Services

Peggy Bailey, M.P.A., Senior Policy Advisor, Corporation for
Supportive Housing, Washington, DC

2

12:30 p.m. – 2:00 p.m.	Concurrent Workshops: Programs and Practices for Statewide Plans Continued
Caucus 2	Community Integration for People with Co-occurring Mental Illness and Intellectual/Developmental Disabilities John O'Brien, Senior Policy Advisor, Disabled and Elderly Health Programs Group (DEHPG), CMS (<i>moderator</i>) Charles R. Moseley, Ed.D., Associate Executive Director, National Association of State Directors of Developmental Disabilities Services
Terrace D	Overcoming Obstacles to Community Integration for Children and Adolescents Larke Nahme Huang, Ph.D., Senior Advisor on Children, Youth and Families, Administrator's Office of Policy Planning and Innovation and Director, Office of Behavioral Health Equity, SAMHSA (<i>moderator</i>) Bruce Kamradt, Director, Wraparound Milwaukee Emily Sherwood, Director of Children's Behavioral Health Interagency Initiatives, Executive Office of Health and Human Services, Massachusetts Joan Mikula, Assistant Commissioner for Child/Adolescent Services, Massachusetts Department of Mental Health
Caucus 1	Ombudsmen as Advocates in Systems Change Louise Ryan, M.P.A., Ombudsman Program Specialist, Administration for Community Living/Administration on Aging, HHS (<i>moderator and presenter</i>)
2:00 p.m. – 2:15 p.m.	BREAK
2:15 p.m. – 3:30 p.m.	Medicaid Programs that Support Implementation Strategies
Lakeview A&B	John O'Brien, Senior Policy Advisor, Disabled and Elderly Health Programs Group, CMS (<i>moderator</i>) Jean K. Close, Technical Director, Division of Benefits and Coverage, Disabled and Elderly Health Programs Group, CMS Dawn Lambert, Project Director, Money Follows the Person Rebalancing Demonstration, Medical Care Administration, Connecticut Department of Social Services Kathryn Poisal, Technical Director, Division of Long Term Services and Supports, Disabled and Elderly Health Programs Group, CMS

3:30 p.m. – 5:00 p.m. **State/Territory Team Work Sessions 1: Mapping Out a State Plan**

Terrace D Colorado
137 Georgia
138 Illinois
Caucus 1 Minnesota
Caucus 2 New Jersey

Experts available for consultation

5:00 p.m. – 5:30 p.m. **Wrap up and Closing**

Friday, September 21, 2012

8:00 a.m. – 8:30 a.m. **Re-cap of Day 1 and Expectations for Day 2**

8:30 a.m. – 9:45 a.m. **Achieving Integration through Person-Centered Planning**

Lakeview A&B Shawn Terrell, M.S., M.S.W., Health Insurance Specialist, Office on
Disability, HHS (*moderator*)

Wilma Townsend, M.S.W., Acting Associate Director for Consumer
Affairs, CMHS, SAMHSA

Michael Head, M.S.W., Director, Mental Health and Substance Abuse
Administration, Michigan Department of Community Health (retired)

9:45 a.m. – 10:00 a.m. **BREAK**

10:00 a.m. – 11:00 a.m. **Olmstead Enforcement and Implementation**

Lakeview A&B Alison N. Barkoff, J.D., Special Counsel for Olmstead Enforcement,
Civil Rights Division, U.S. Department of Justice (DOJ) (*moderator*)

Thomas P. Perez, J.D., Assistant Attorney General, Civil Rights
Division, DOJ

Estelle Richman, M.A., Senior Advisor to the Secretary, HUD

Kevin Ann Huckshorn, RN, MSN, CAP, ICADC, Director,
Delaware Division of Substance Abuse & Mental Health

11:00 a.m. – 12:45 p.m. **State/Territory Team Work Session 2: Completing Strategy Development and Action Steps** (State Team Rooms)

Terrace D Colorado
Terrace A Georgia
Terrace B Illinois
Caucus 1 Minnesota
Caucus 2 New Jersey

Experts available for consultation

12:45 p.m. – 2:00 p.m. **LUNCH** (*on your own*)

2:00 p.m. – 2:45 p.m. **Where We Go (Together) From Here: An Overview of Technical Assistance and Federal-State Dialogue**

Lakeview A&B
Chris Marshall, Special Assistant to the Director, CMHS, SAMHSA

Deborah Baldwin, M.P.A., Branch Chief, State Grants – Eastern Branch,
Division of State and Community Systems Development, SAMHSA

2:45 – 3:00 **Wrap-Up and Adjourn**

Leon Rodriguez, J.D., Director, Office for Civil Rights, HHS