

Nebraska Division of Behavioral Health Community Integration in Nebraska's Behavioral Health System

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Introduction

Since the Nebraska Behavioral Health Reform Act (BHRA) of 2004, Nebraska's behavioral health system has been engaged in a process of reform designed to monitor and improve outcomes, reduce reliance on state operated inpatient facilities, and promote person-centered, recovery-oriented services throughout the system. In February 2011, the Division released a five year strategic plan, the *Nebraska Division of Behavioral Health Strategic Plan 2011-2015* that builds off of the BHRA and work of recent Behavioral Health Oversight Commissions, and identifies strategies to move DBH toward "the development of recovery-oriented systems of care that are community-based...."

In November 2012, the Nebraska Division of Behavioral Health sought to further evaluate its current approach toward supporting individuals with mental illness in integrated community settings within the context of its overall system activities and implementation of its strategic plan. As part of this process, DBH retained the Technical Assistance Collaborative (TAC) to conduct a limited evaluation of DBH's activities in the context of community integration, and to provide guidance regarding ways that DBH can strengthen its approach to supporting community integration within the overall implementation of its strategic plan.

Throughout this process, it became evident that DBH, under the leadership of Dr. Scot Adams, is committed to strengthening the behavioral health system's ability to support individuals in the most integrated settings possible. A preliminary review of Nebraska's behavioral health system, which included interviews with relevant stakeholders, suggests that the Nebraska state government could do more to support the community integration of people with behavioral health disorders,¹ and faces some exposure to *Olmstead* litigation absent a collective and coordinated planning and implementation process.

This report elaborates on TAC's observations, identifies themes that emerged during the process, and provides three overarching recommendations that provide direction for DBH to strengthen its ability to support individuals in integrated settings. Each overarching recommendation contains more specific recommendations that serve as actionable steps that DBH can begin to take. The three overarching recommendations are:

1. DBH should initiate and lead an *Olmstead* planning process that leads to the development of a working '*Olmstead* Plan.'
2. DBH should maximize services and funding strategies to support community integration.
3. DBH should maximize housing opportunities and partnerships to support community integration.

¹ The ADA and *Olmstead* apply more broadly to all people with disabilities; however, the focus of this report is primarily on the behavioral health population served by DBH.

Background and Policy Framework

Most people with mental illness² can, and do, live successfully in integrated, community settings. Research, program outcomes from across the country, and firsthand experience show that individuals with more serious mental illness are also living successfully in integrated settings, often through the provision of affordable housing supports and person centered services. However, a significant number of individuals with serious mental illness in states across the country still live in more restrictive settings than needed or they would choose if other options existed, and many are at risk of more restrictive settings due to inadequate service delivery systems.³

Title II of the Americans with Disabilities Act (ADA) of 1990 established a mandate to public entities to ensure that people with disabilities live in the least restrictive, most integrated settings possible. The 1999 U.S. Supreme Court's *Olmstead* decision affirmed this civil right. Furthermore, the U.S. Department of Justice (DOJ) interprets *Olmstead* to also apply to individuals who are at risk of institutionalization. DOJ states that an *Olmstead* violation could occur if "a public entity's failure to provide community services or its cut to such services will likely cause a decline in health, safety, or welfare that would lead to the individual's eventual placement in an institution."⁴ In a recent decision on April 2, 2013, the U.S. Court of Appeals for the Fourth Circuit upheld a North Carolina decision extending *Olmstead* to people who are at risk of institutionalization.⁵ The Court held that reducing funding for personal care services would place individuals at risk of institutionalization, and that the state's budgetary constraints argument was not a sufficient 'fundamental alterations' defense.

A report released by the Senate HELP committee on July 18, 2013, *Separate and Unequal: States Fail to Fulfill the Community Living Promise of the Americans with Disabilities Act*, discusses the systemic changes that have occurred since the ADA and *Olmstead* decisions, and details the continued struggles to provide the most integrated settings.⁶ Of the many findings, the report is critical that "when individuals are transitioned, it remains unclear whether they are transitioned to the most integrated setting possible or merely to a 'less' institutional setting, and each state defines specific settings very differently," and while "most of the responding states also increased the number of individuals served in community settings from 2008 to 2012, they also reported transitioning more individuals with disabilities from institutions into other congregate settings, including group homes, assisted living facilities, and other shared living arrangements." Nebraska was one of the states that responded to the Senate HELP

² As suggested in its name, DBH serves individuals with behavioral health disorders (i.e. mental illnesses and/or substance use disorders). However, this report focuses primarily on those with mental illness since there has been very little *Olmstead* activity directly related to individuals with a primary substance use disorder.

³ Bazelon Center for Mental Health Law. March 2009. *Supportive Housing: The most effective and integrated housing for people with mental disabilities*. <http://www.bazelon.org/Where-We-Stand/Community-Integration/Housing/Housing-Policy-Documents.aspx>

⁴ U.S. Department of Justice; http://www.ada.gov/olmstead/q&a_olmstead.pdf

⁵ *Pashby v. Delia* (U.S. District Court for the Eastern District of NC Case # 11-cv-0273-BO; U.S. Court of Appeals for the Fourth Circuit Case # 11-2363). Information found on Disability Rights North Carolina website: <http://disabilityrightsncc.org/cases-we-are-working>

⁶ Senate HELP Committee. July 18, 2013. *Separate and Unequal: States Fail to Fulfill the Community Living Promise of the Americans with Disabilities Act*. <http://www.help.senate.gov/newsroom/press/release/?id=909ecec1-4c87-4891-8314-7b35e5316a35&groups=Chair>

committee survey that was used to inform the final report. Nebraska's response confirmed the behavioral health system move toward community-based supports, but also confirmed that it does not have an 'Olmstead plan' and it did not address the congregate settings that the report calls into question, such as Assisted Living facilities and Mental Health Centers.

With increasing pressure to ensure that systems support individuals in integrated settings, states, such as Nebraska, are confronted with this integration mandate under the ADA and *Olmstead* as they plan and implement strategies to meet the needs of individuals with disabilities who are in or are at risk of institutional settings. Historically, 'community integration' was 'achieved' by moving people out of large, state run institutions into community settings – deinstitutionalization. But, in the past decade, there has been increasing scrutiny that large, congregate residential settings in the community are restrictive, have characteristics of an institutional nature, and are inconsistent with the intent of the ADA and *Olmstead*. These type of facilities are known by different names in states (e.g., adult care homes, residential care facilities, boarding homes), but have similar characteristics, including a large number of residents primarily with disabilities, insufficient or inadequate services, restrictions on personal affairs, and housing that is contingent upon compliance with services. Some states, including North Carolina, Illinois, and New York, have been sued for overreliance on such facilities, and are now implementing settlement agreements under DOJ supervision to correct for these issues.

On July 29, 2013, a statement developed by key national stakeholder organizations, *Community Integration for People with Disabilities: Key Principles* was released to serve as a guide to policy makers, funders, providers, the housing community, and service recipients.⁷ The principles address employment, housing, choice, and use of public funding. In addition, the DOJ defines integrated settings as:

“Integrated settings are located in mainstream society; offer access to community activities and opportunities at times, frequencies and with persons of an individual's choosing; afford individuals choice in their daily life activities; and, provide individuals with disabilities the opportunity to interact with non-disabled persons to the fullest extent possible. Evidence-based practices that provide scattered-site housing with supportive services are examples of integrated settings. By contrast, segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own

⁷ Bazelon Center for Mental Health Law. July 29, 2013. <http://bazelon.org/portals/0/ADA/7.30.13%20Key%20Principles%20-%20Community%20Integration%20for%20People%20with%20Disabilities.pdf>

activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities.”⁸

In its 1999 decision, the U.S. Supreme Court strongly encouraged the development of ‘*Olmstead* plans’ to thoughtfully establish actionable strategies to support integration, as well as, to serve as a defense for states facing allegations that it was violating the integration mandate under the ADA. According to DOJ, a comprehensive, effectively working plan must:

“...do more than provide vague assurances of future integrated options or describe the entity’s general history of increased funding for community services and decreased institutional populations. Instead, it must reflect an analysis of the extent to which the public entity is providing services in the most integrated setting and must contain concrete and reliable commitments to expand integrated opportunities. The plan must have specific and reasonable timeframes and measurable goals for which the public entity may be held accountable, and there must be funding to support the plan, which may come from reallocating existing service dollars. The plan should include commitments for each group of persons who are unnecessarily segregated, such as individuals residing in facilities for individuals with developmental disabilities, psychiatric hospitals, nursing homes and board and care homes, or individuals spending their days in sheltered workshops or segregated day programs. To be effective, the plan must have demonstrated success in actually moving individuals to integrated settings in accordance with the plan. A public entity cannot rely on its *Olmstead* plan as part of its defense unless it can prove that its plan comprehensively and effectively addresses the needless segregation of the group at issue in the case. Any plan should be evaluated in light of the length of time that has passed since the Supreme Court’s decision in *Olmstead*, including a fact-specific inquiry into what the public entity could have accomplished in the past and what it could accomplish in the future.”

More specifically, putting policy into action requires states to proactively: a) budget for integrated housing and services, usually through new and/or re-purposed funds; and b) consider statutory, regulatory, and administrative changes to accelerate the creation of new integrated housing and services in order to begin to address unmet need. Accordingly, states’ approaches to improve their support of community integration often include a broad range of possible legislative, regulatory, and budgetary measures that are applied depending on state priorities and identified needs. Legislatively driven examples in states have included establishing housing advisory committees and interagency councils on homelessness. Budgetary measures have included the establishment or expansion of state-funded rental assistance/bridge subsidy programs, reallocation of funds from institutional or congregate living programs or underperforming services toward integrated, evidence-based practices, and service package development through Medicaid plans and waivers. Regulatory examples include changes to

⁸ U.S. Department of Justice. Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.* http://www.ada.gov/olmstead/q&a_olmstead.pdf

Qualified Allocation Plans (QAPs), target populations and eligibility criteria, and housing models that will be prioritized for selection and funding from various state agencies.

Concurrently, states must consider the appropriate balance of housing options for individuals with disabilities in order to provide meaningful choice and be considered integrated. This involves consideration of concentration level, or density, of people with disabilities living in a single site, and to what extent the development or preservation of single site or congregate residences is appropriate given the current balance of housing options within the available portfolio of housing. In order to inform the discussion, the U.S. Department of Housing and Urban Development (HUD) issued its own statement on the role of housing in accomplishing the goals of *Olmstead* on June 4, 2013.⁹ The statement contained guidance for public housing authorities, housing providers, and other recipients of federal financial assistance from HUD on supporting individuals in integrated settings. This is particularly important in states currently at risk of *Olmstead* lawsuits alleging that individuals with disabilities are in segregated living arrangements (e.g., state hospitals, nursing homes, or other congregate settings, such as boarding homes, adult care homes, or assisted living facilities). Accordingly, states proactively planning for *Olmstead* or facing litigation are assessing current housing options and planning for new affordable housing for people with disabilities in the context of *Olmstead*. This also involves assessing and planning state approaches in the context of DOJ enforcement actions and associated settlement agreements in states.¹⁰

Regarding the potential exposure to litigation, no state is immune. Important to note is that there is an existing DOJ settlement agreement (2008) in Nebraska that addresses safety, quality of care and community integration concerns for people with developmental disabilities. DOJ currently has investigations or actions in several states on mental health systems alone. While it may seem that DOJ has focused on states with larger populations, it entered into a settlement agreement with Delaware, for example, a small state by geography and population in 2011 following an investigation. Furthermore, litigation filed in several states emanated out of state Protection and Advocacy (P&A) organizations, such as in New Jersey, New York and Connecticut. In each of these states, the Bazelon Center for Mental Health Law, a Washington, D.C. based advocacy group, also took a proactive role assisting the plaintiffs with their investigations and settlement process. As P&A's become more sophisticated and attuned to this issue, they may be more likely to file litigation, particularly in less populous states. Also, 'class' size can vary significantly. Georgia's settlement agreement targets 9,000 individuals with serious mental illness, but the P&A suit in Connecticut, a nursing home case, has a class of roughly 100 people.

⁹ HUD Statement of the Department of Housing and Urban Development on the Role of Housing in Accomplishing the Goals of *Olmstead*. <http://portal.hud.gov/hudportal/documents/huddoc?id=OlmsteadGuidnc060413.pdf>

¹⁰ North Carolina, Illinois, and Georgia are states that were evaluated for this report and have *Olmstead* Settlement Agreements.

Environmental Scan

TAC utilized various sources of information to conduct an environmental scan of potential community integration issues in Nebraska's behavioral health system. The types of information that TAC utilized are briefly described below.

Literature Review

Several documents and information from various website pages were reviewed in order to provide background and context for onsite meetings, interviews, and the development of recommendations contained in this report. The types of documents include those related to strategic plans, services, budgets, housing, statutes, and regulatory standards. A list of documents is attached in Appendix A.

Meeting with DBH in February 2013

On February 5, 2013, TAC spent the day with leadership from the Division of Behavioral Health and facilitated a discussion related to community integration in Nebraska. The morning consisted of a presentation by TAC on trends and activity at the national level regarding community integration, including several examples of how various states are working on ADA and *Olmstead*. During the afternoon, TAC facilitated a discussion with DBH staff to identify strengths and potential weaknesses in the system related to community integration, and provided some insight as to how states have addressed similar issues.

Presentation on Community Integration at the Annual Statewide Behavioral Health Conference

In a follow up to the February 5th meetings, Dr. Adams requested Kevin Martone, Executive Director of TAC, to facilitate a workshop at the Annual Statewide Behavioral Health Conference on May 14, 2013. The purpose was similar to the initial meeting with DBH in that a national perspective that included the experiences of other states was presented. The audience consisted of approximately 75 stakeholders, including consumers, family members, service providers, legal advocates, and state staff, and a question and answer session followed the presentation. The presentation is attached as Appendix B to this report.

Feedback Sessions at MHA Conference

In addition to the conference presentation, four feedback sessions were held at the conference on May 14th and 15th in order for TAC to directly solicit perspectives from stakeholders about community integration issues in Nebraska. Each group received a handout with a definition of community integration as defined by the U.S. Department of Justice as a basis for the facilitated discussion. Each session lasted roughly an hour and a half, and participants were asked to provide comments in relation to the definition and how they perceived the concept of community integration in Nebraska's behavioral health system.

Dr. Adams participated in two sessions, but also excused himself so that participants could feel that they could speak candidly.

Roughly 50 individuals participated in the feedback sessions. Below is a list of the types of individuals and groups that were represented and participated in the process.

Feedback Session Participants	
<ul style="list-style-type: none"> • Consumers and Family members • Providers • Regional Consumer Specialists • Assisted Living Facilities owners and management • Mental Health Centers • Oxford House • Mental Health Association of Nebraska; staff and Board members • Nebraska Recovery Network • Lincoln Regional Center staff • Lincoln Regional Center Patient Advocate • U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) • Magellan Health Services (NE ASO) 	<ul style="list-style-type: none"> • Division of Behavioral Health staff • Division of Public Health staff • Division of Medicaid and Long Term Care staff • Division of Developmental Disabilities staff • Department of Health and Human Services staff • Department of Economic Development staff • Nebraska Investment Finance Authority • Regional Behavioral Health Authority Administrators • Regional Housing Coordinators • Lincoln Housing Authority • Nebraska Healthcare Association

Related Interviews and Calls

Additional interviews and calls were conducted to gather additional information or to clarify questions that arose throughout the process. Among these included calls with Dr. Scot Adams, Director of DBH, Jim Harvey, DBH, Dr. Blaine Shaffer, Chief Clinical Officer, Sherrie Dawson, Deputy Director of DBH, Carol Coussons-de Reyes, Administrator for the Office of Consumer Affairs, and Mary O'Hare, consultant to the System Enhancement Initiative.

Observations and Themes

Building a system that supports community integration is difficult for many reasons, including competing interests for funding, lack of affordable housing and integrated employment options, diverse opinions on the capability of persons with mental illness, and stigma. Complicating matters, Nebraska is a large rural state with a population of approximately 1,855,525 people, making it the ninth least densely populated state in the United States. The state has 93 counties and spans two time zones. For people with serious mental illness, the large, rural nature of the state presents additional challenges to integrated community living.

Over the past decade, the system reforms being planned and implemented in Nebraska suggest a strong desire on behalf of DBH to support individuals in recovery-oriented, integrated, community-based settings. There appears to be genuine intent on the part of DBH to support individuals with serious mental illness in person centered, recovery-oriented, integrated settings.

This was evident in discussions with Dr. Adams and several members of his team, and supported by several stakeholders during the feedback sessions.

However, Nebraska does not have an *Olmstead* plan that addresses the community integration needs of people with mental illness,¹¹ and Nebraska's state government could do more to support the community integration of people with psychiatric disabilities. As a result, the state faces some exposure to *Olmstead* litigation absent a collective and coordinated planning and implementation process. Sometimes, states perceive that developing an 'Olmstead plan' will only expose them and place them at greater risk of litigation, or that a state may believe that because it has a small population that it has less risk of DOJ investigation as compared with a larger, more populated state. As discussed above, however, the DOJ has certainly investigated smaller states (e.g., Delaware), and does have an existing settlement in Nebraska related to individuals with intellectual and developmental disabilities.¹² Protection and Advocacy (P&A) agencies in some states are increasingly sophisticated on this issue and have also filed *Olmstead* litigation in states (e.g., New Jersey, New York, Connecticut). In fact, Disability Rights Nebraska, the state's P&A, has engaged DBH in conversations related to *Olmstead*, including long term stays at Lincoln Regional Center.

Several themes emerged out of TAC's observations made during its environmental scan of Nebraska's community integration efforts. While a wide variety of issues were identified in the feedback sessions, individual interviews and document reviews, the major themes that emerged are summarized below. These themes form the basis for recommendations in the next section.

Coordinated Planning

DBH incorporates sister agencies and key system stakeholders into its various planning processes. Among these include the strategic planning process that led to the five year strategic plan and the State Advisory Committee on Mental Health that is required as part of the federal block grant planning process. These mutual planning processes provide a forum for DBH to develop and advance its ideas on mental health system priorities, such as person-centered planning and recovery supports. They have also led to DBH's active role in facilitating affordable housing opportunities for its target population and addressing housing-related issues when they arise. For example, in 2006-2007, DBH convened Assisted Living operators, behavioral health providers, and service recipients, to address housing concerns that were raised by providers and service recipients. However, specific conversations or documented planning regarding how DBH and its partner agencies and stakeholders can advance community integration throughout the system are not evident, and could result in missed opportunities to leverage, for example, additional housing, create additional employment, or address transportation barriers. The fact that there is not an *Olmstead* plan leaves the State vulnerable.

¹¹ Nebraska does not have an *Olmstead* plan that addresses any disability group.

¹² United States v. State of Nebraska: Settlement Agreement;
http://www.justice.gov/crt/about/spl/documents/us_v_nebraska_beatrice_center_7-2-08.pdf

Choice and Options

Several statements were made in the feedback sessions that there are not enough housing options available within the state and choice is limited for many consumers. Many acknowledged that lack of choice and options is partly related to the rural nature of the state, as well as a lack of federal and state rental assistance. A report completed in 2003, *The Statewide Consumer Housing Need Study Extremely Low income Persons with a Serious Mental Illness, Findings and Conclusions*, confirmed the need for more affordable housing opportunities for people with SMI, but also identified a large number of vacancies across the state that could be utilized if rents were more affordable to the target population.¹³ This report was an impetus for the development of the successful Housing Related Assistance Program.

There was also a feeling that there was the presumption by clinicians and residential program directors that people needed more supervised settings like Assisted Living Facilities and Mental Health Clinics, and that the system did not do enough to create a range of options for consumers to choose from. Without an organized voice to combat this stigma and push for more integrated housing options, there is little sense of urgency to allocate additional state resources to things like the Housing Related Assistance Program.

Assisted Living and Mental Health Centers¹⁴

Several concerns were voiced about the Assisted Living facilities and Mental Health Centers licensed by the State. Among these include: a) that these are the primary residential options for individuals with serious mental illness and that few other options like permanent supportive housing exist; b) that the quality of these facilities is highly variable; and c) the facilities tend to be restrictive. There is an opportunity to restructure these facilities and orient them person-centered and recovery-based practices. These perspectives were verbalized most strongly by consumers. Operators of Assisted Living facilities and Mental Health Centers were in some of the focus groups and presented favorable viewpoints while suggesting that substandard facilities should be dealt with. One operator commented that “none of the residents in the facility could live outside of a hospital setting without my services.” Another commented that the facility “is the most integrated setting and that individuals’ fail when they try more independent settings.”

These statements, contrasted by those made by consumers about their desire for choice and more integrated housing options highlight the complexity of this work and the need to build a system that empowers consumers and incorporates a person-centered planning process as part of its culture. Any successful *Olmstead* planning and implementation will need to make significant efforts to change the culture of thinking about consumers ‘needs.’

¹³ Hanna:Keelan Associates, P.C., (2003) *The Statewide Consumer Housing Need Study Extremely Low income Persons with a Serious Mental Illness, Findings and Conclusions*. Lincoln, NE. Under contract with Nebraska Department of Economic Development - Community and Rural Development Division and Nebraska Department of Health and Human Services - Office of Mental Health, Substance Abuse and Addiction Services.

¹⁴ Assisted Living Facilities means a facility where shelter, food, and care are provided for remuneration for a period of more than 24 consecutive hours to four or more persons residing at such facility who require or request such services due to age, illness, or physical disability. Mental Health Centers provide 24 hour residential programming, including room, board and services exclusively for individuals with mental illness.

As of June 4, 2013, there are 37 licensed Mental Health Centers with 879 beds in the state for adolescents and adults.¹⁵ Most of these programs have fewer than 16 residents. However, eight facilities for adults range from 28 – 93 beds. As of July 15, 2013, there were 286 Assisted Living facilities with 11,628 beds.¹⁶ It is unclear without further analysis the extent to which these beds are occupied with individuals with mental illness or other disabilities who could benefit from or would choose to live in more integrated settings. Similarly, it is unknown how many individuals with mental illness are living in nursing facilities in Nebraska. However, given the attention to this across the country, variability in application of the Pre-Admission Screening and Resident Review (PASRR) process,¹⁷ and its relationship to *Olmstead*, there are likely individuals with serious mental illness in nursing facilities who could benefit from or would choose more integrated settings that can meet their needs. DBH has taken steps to improve its PASRR process. The contract was rebid in 2011, and a memorandum of understanding between DBH and state Medicaid program was developed that outlines roles and responsibilities. Additionally, a thorough review of protocols and processes related to PASRR is underway.

Rental Housing Vacancy and Shortage of Rental Assistance

Unlike in some states or markets where there is little rental vacancy, there appears to be vacancy in much of the rental market in Nebraska. (Participants suggested that there is minimal vacancy in some parts of the state, particularly in western Nebraska.) However, for individuals with serious mental illness, many of whom are in poverty, the housing stock is unaffordable, and there is a lack of available federal or state funded rental assistance for individuals with mental illness to be able to access these units.

Housing Related Assistance Program

There was strong support for this program in meeting the affordable housing needs of eligible individuals with mental illness, and that it is an effective resource for facilitating community integration. A significant amount of useful information about program participants is collected, albeit manually. Several participants suggested that more funding should be put towards this program since available resources do not meet demand.

Regional Housing Coordinators

The role of the Regional Housing Coordinators in each region was seen as a positive addition to the state system. Participants felt that their knowledge of services and housing are a critical link at the local level, and that they serve an important role in securing and helping to maintain housing. However, there was a feeling that the Housing Coordinators could provide more systems level advocacy and assistance (e.g., working with Public Housing Authorities to

¹⁵ Nebraska Department of Health and Human Services. Facility Rosters: http://dhhs.ne.gov/publichealth/Pages/crl_rosters.aspx

¹⁶ Nebraska Department of Health and Human Services. Facility Rosters: http://dhhs.ne.gov/publichealth/Pages/crl_rosters.aspx

¹⁷ Linkins, K.; Robinson, G.; Karp, J.; Cooper, S.; Liu, J.; and Bush, S. *Screening for Mental Illness in Nursing Facility Applicants: Understanding Federal Requirements*. SAMHSA Publication No. (SMA) 01-3543. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, July 2001.

establish preferences; housing trainings), but that they are under-resourced to handle additional work and their role across the State is not well defined.

Public Housing Authorities

There are over 100 Public Housing Authorities (PHAs) in Nebraska that provide some type of federal rental assistance and/or subsidized housing. These PHAs may provide an opportunity to gain additional affordable housing for people with mental illness. For example, local PHAs in Pennsylvania, Washington, Illinois, and California have partnered to develop new or set aside housing subsidies for homeless individuals with behavioral health conditions, and homeless families with a head of household living with a serious behavioral health condition. DBH, in coordination with Regional Housing Coordinators, should provide education and consultation to PHAs about the housing needs of the population, the role of local service providers, and the availability of services for individuals who might reside in public housing. Regional Housing Coordinators in each of the state's six regions work locally to assist individuals with their housing. As discussed above, participants generally spoke favorably of the Coordinator's roles, and felt that they could help broker stronger relationships with the PHAs in their communities to establish local disability preferences and respond to PHA, housing operator, and service provider concerns. However, given their workload, this function would be difficult to accomplish without additional support.

Service Delivery System

Several participants commented that much of the behavioral health system is based on legacy services that do not provide good outcomes, and that DBH should move toward more evidence-based, in home interventions, such as Assertive Community Treatment. Several individuals commented that DBH is moving in the right direction, but that more could be done. Participants suggested that there should be more Medicaid funding and options made available to the behavioral health system for Assertive Community Treatment, peer delivered services, and other community-based and in-home supports to assist people in their housing. It was suggested that as the state moves to risk-based managed care effective September 1, 2013, Magellan Health Services will have to assume a responsibility, and be held accountable, to reimburse for services designed to support community integration. One commenter suggested that it is more cost effective for Magellan to fund services in single sites. However, this statement may not be accurate and may conflict with the integration mandate required under the ADA and *Olmstead* as discussed earlier in this report.

In addition, DBH has the ability to manually collect and analyze meaningful information that is critical to identifying strengths, weaknesses, trends, gaps, and other outcomes in the system. However, it lacks its own information technology infrastructure which would significantly enhance its ability to utilize data to drive decision making. Consequently, the division's ability to utilize data to inform its decision making is compromised. In order to effectively design, finance, and implement a system that is outcome-oriented and supports individuals in integrated settings, DBH must have its own data collection mechanism and review process. Through the Nebraska Information Technology Commission, there is a plan to establish a centralized data

collection system for DBH to achieve these objectives, including a request for proposals that has been issued.

Lincoln Regional Center

A well run, right sized state psychiatric hospital enhances a system's capacity to meet the needs of the smaller percentage of individuals most impaired by mental illness who require longer term inpatient treatment. DBH has taken steps to maximize its use of the Lincoln Regional Center (LRC), and ensures that only those individuals requiring this level of care are admitted. Admission to LRC occurs only after a person has demonstrated the need for longer term inpatient treatment than is available in the community.

Additionally, since the Nebraska Behavioral Health Services transformation (LB 1083) went into effect in 2004, the state's general psychiatric hospital capacity at LRC is reduced to 90 beds and community-based services are serving more individuals who previously may have been institutionalized. However, there remain patients who have unique and significant needs that make rapid discharge from LRC to the community a challenge. As a result, Dr. Adams established the Behavioral Health System Enhancement Initiative (SEI) in 2013 to identify and implement the necessary supports to discharge individuals from LRC. This process involves key stakeholders and also utilized a survey tool that was distributed to LRC and Regional Behavioral Health Authorities administrators and key staff to identify contributing barriers to discharge and preliminary recommendations to resolve these issues.

The SEI is important a) for the consumers at LRC who may benefit from this intensive, individualized planning process; b) because it will help inform the ability of DBH to address barriers to discharge from LRC; and c) it can inform DBH's overall community integration efforts at the system level. Several participants felt that this intensive, individual planning process is important to build into the system.

Workforce Issues

As DBH moves toward more person-centered, recovery-oriented, and integrated community services, many felt the workforce needed additional training and support in order to meet the needs of service recipients, particularly around housing resources; housing and tenancy support issues facing consumers; and effective support service strategies. There was a feeling that the service delivery system must be responsive to housing operators, especially on evenings and weekends, and that this was critical to an individual's success and permanence in housing. It was suggested that this could be accomplished partly through the types of training made available to the workforce. The Behavioral Health Education Center of Nebraska provides various work force training, and may be one logical partner to meet the training and other workforce development needs related to DBH's community integration obligations. Additional partners to involve include higher education, labor, and other Nebraska Workforce Investment Board member entities.

RECOMMENDATIONS

The recommendations that follow are intended to be a starting point for Nebraska to improve its ability to organize a behavioral health system that serves people in the least restrictive, most integrated settings possible. They have been developed based upon the findings and observations identified in this report, and within the context of what is occurring nationally in the area of community integration. Recommendations are formatted with a brief description of the recommendation and include short and longer-term actions.¹⁸ The three overarching recommendations are:

1. DBH should initiate and lead an *Olmstead* planning process that leads to the development of a working ‘*Olmstead Plan*.’
2. DBH should maximize services and funding strategies to support community integration.
3. DBH should maximize housing opportunities and partnerships to support community integration.

1. DBH should initiate and lead an *Olmstead* planning process that leads to the development of a working ‘*Olmstead Plan*.’

DBH should initiate an *Olmstead* planning process that leads to the development of a working ‘*Olmstead Plan*.’ The *Olmstead* Plan should affirmatively incorporate community integration strategies into its overall system planning and implementation activities. While much of DBH’s reform work involves the development of person-centered, recovery-oriented services, a greater, more explicit emphasis needs to be placed on community integration throughout all DBH activities. Compliance with the ADA and *Olmstead* should not just be a reactionary initiative to mitigate the risk of or comply with litigation. Rather, the planning and implementation of systems designed to facilitate community integration should transcend Administrations, with responsibility and accountability collectively assigned to the various state agencies, not just DBH. Because of its focus on behavioral health, DBH is uniquely qualified to lead such a planning effort. However, the success of *Olmstead* initiatives is often contingent upon successful Medicaid financing, the availability of affordable housing, and access to employment, for example. Accordingly, the development of the plan should involve key internal and external stakeholders, including the active involvement of key partners like state Medicaid, housing, labor, and other related agencies.

Some states have created standalone *Olmstead* planning committees, and others have incorporated planning functions into standing committees, such as Nebraska’s State Advisory Committee on Mental Health Services, and advocacy and planning groups. As discussed earlier in the report, this process should strive for meaningful planning that result in measurable progress toward community integration.

A good example of community integration planning at a consumer level is the System Enhancement Initiative (SEI) established by Dr. Adams. As outlined in its charter, the SEI is

¹⁸ Short-term recommendations are those that can be initiated within one year. Longer-term recommendations are those that may take over one year to implement and/or should be examined annually going forward.

charged with developing specific recommendations for thirty-six individuals currently at the Lincoln Regional Center who have been there for longer than one year, as well as developing recommendations for systemic improvements as a result of the findings for the thirty-six individuals. The system recommendations that emerge from this process should be incorporated into DBH's broader community integration planning and implementation efforts.

1.1. Short-term Recommendations:

- a. DBH should initiate and lead an *Olmstead* planning process that will lead to the development of a working '*Olmstead* Plan.'
- b. DBH should seek the commitment of other state agencies to participate in this process. Among these can include the Division of Medicaid and Long Term Care, the Department of Economic Development, the Nebraska Investment Financing Authority, and the Department of Labor. The process should also convene one or more planning committees that include key external partners such as providers, consumers, and family members.
- c. The planning process should lead to the development of an *Olmstead* plan that addresses the behavioral health system and contains measurable goals.¹⁹
- d. DBH should evaluate the findings from the SEI, and implement those recommendations that will facilitate the community integration of those who no longer require the level of care at the Lincoln Regional Center. DBH should also consider these findings in the planning process in the first recommendation.

1.2. Longer-term Recommendations:

- a. The *Olmstead* Plan should be reviewed annually and revised as needed.
- b. The *Olmstead* Plan and subsequent Annual Reports should be shared publicly.
- c. Annual budgets should consider strategies to further the community integration objectives identified in the *Olmstead* Plan.
- d. Policies and regulations, as well as related statutes, should be reviewed and revised accordingly to ensure consistency with the ADA and *Olmstead*.

2. DBH should maximize services and funding strategies to support community integration.

As part of its planning, DBH should evaluate its services and funding in the context of community integration. The goals identified in the 2011-2015 strategic plan and other documents articulate a direction for services that is consistent with community integration, but do not specifically address what DBH will do to implement a system that supports individuals in integrated settings. As part of the planning process identified above, DBH should modify or suspend those programs and services that do not produce data showing positive outcomes.

As the recognized State Mental Health Authority, DBH should also shape and influence the types of services and funding that support individuals with mental illness that may be under the

¹⁹ Nebraska's *Olmstead* planning should address all disability groups. However, states have taken different approaches with some developing a plan that covers all disability groups while others develop plans for specific disability groups (e.g., Intellectual and Developmental Disabilities, physical disabilities).

oversight and direction of other state agencies or their contractors. For example, significant concerns were raised about Assisted Living facilities and Mental Health Centers in terms of quality of care and whether they were the most integrated settings for individuals. While many of these facilities may provide good care for individuals, DBH should work with its partner agencies to examine potential quality of care issues and the role that these facilities play in a system working toward supporting people in the most integrated settings possible. Included could be a review of facility standards, the ability of residents to move to more integrated settings, and funding that is made available to operators to shift toward more integrated service delivery models.

In addition, DBH should strive to expand services that are designed to support individuals in integrated settings, including Assertive Community Treatment (ACT), peer delivered supports, and other permanent supportive housing services. It is critical that DBH work with and influence the types of services that are reimbursable through the Division of Medicaid and Long Term Care to ensure that services are not only consistent with best practices, but also the law under the ADA and *Olmstead*. Further, this means that as the state moves toward risk-based managed care for behavioral health, that Magellan be held accountable to ensuring that it is reimbursing services that support individuals in the most integrated settings and away from those that don't. During the feedback sessions, Magellan seemed to be a willing partner, and it is important for DBH and Medicaid to work with them on this.

Consistent with strengthening the service delivery system and funding to support individuals in integrated settings, the workforce must be trained and aware of issues related to community integration. This includes training on housing, tenancy supports and tenant responsibilities. In addition to staff working on ACT teams, for example, workers in Mental Health Centers and Assisted Living facilities should be included in training designed to prepare residents for greater independence. During the feedback sessions, consumers voiced concerns that staff in these facilities do not believe that they can move toward more integrated settings, and comments made by some operators reinforced this.

Louisiana, Pennsylvania, and New Jersey, for example, are incorporating training on supportive housing and independent living into their Medicaid credentialing process so that providers are being trained on how to deliver services that promote successful community living, and are credentialed or certified to bill Medicaid at the same time.

2.1. Short-term Recommendations:

- a. DBH should evaluate its current appropriation to see if there is existing funding that can be allocated to expand direct services or related infrastructure that support individuals in integrated settings.
- b. DBH and Medicaid should work together to ensure that the existing Medicaid state plan or waiver services are sufficient to meet the service needs of individuals in the most integrated settings possible.

- c. DBH and Medicaid should examine the role that managed care will play in community integration.
- d. DBH must have the capacity to collect and utilize data to inform decision making. The solicitation to develop a centralized data system has been issued, but not awarded at the time of this Final Report. DBH should establish performance measures and indicators and utilize the data that will be available in the centralized data system to evaluate system performance.
- e. DBH should establish training and work force development initiatives that focus on developing the culture and skills needed to support community integration. Training could be required of all providers, and a certification designed to address the community integration/independent living needs of individuals could be developed for direct services staff. DBH should consult with the Behavioral Health Education Center at the University of Nebraska to explore the feasibility of the Center participating in this process.

2.2. Longer-term Recommendations:

- a. DBH should develop and implement a standardized assessment process for individuals living in Lincoln Regional Center, Assisted Living facilities, Mental Health Centers and other residential options to determine how many are interested and able to move to less restrictive settings. DBH should work to ensure that individuals are appropriately matched to their settings using the assessment and a person-centered planning process, and also utilize aggregated data to inform the types of housing and services that should be expanded.
- b. DBH should evaluate its annual spending patterns to inform development of the Governor's biennial budget request so that it is consistent with community integration planning.
- c. If necessary, DBH and Medicaid should work together to amend or modify existing Medicaid strategies to meet the community integration needs of individuals. This may include modifying or amending Medicaid state plan or waiver services, or the contract with the managed care provider.
- d. As part of the planning process recommended above, DBH should work with the Division of Public Health to examine the role of Assisted Living Facilities and Mental Health Centers through an ADA and *Olmstead* lens to ensure that these are the least restrictive, most integrated settings for individuals who are referred to or are currently living in these facilities. If necessary, screening and referral processes or modifications to regulations should be considered.

3. DBH should maximize housing opportunities and partnerships to support community integration.

One of the biggest barriers to community integration is the lack of affordable housing. DBH should work with its partners to maximize access to integrated, affordable housing opportunities. Within Nebraska's behavioral health system there are various, but limited housing options that individuals may reside in. Among these include congregate settings (e.g., Assisted Living Facilities, Mental Health Centers), scatter-site supported housing through state funded rental

assistance, and independent living. While there is no recognized formula, DBH should evaluate the balance of housing options for people with mental illness in Nebraska that currently exists, as well as consumer housing preferences, in order to guide the types of integrated housing options that should be funded, developed, or supported in the future.

3.1. Short-term Recommendations:

- a. DBH should engage in discussions with the Nebraska Investment Finance Authority (NIFA) and the Nebraska Department of Economic Development (NDED) to maximize affordable, integrated housing opportunities for individuals served by DBH, including establishing target goals for number of available units and timeframe to accomplish. Two examples that emerged in this process include taking advantage of a) new rental assistance funding through the U.S. Department of Housing and Urban Development (HUD) Section 811 program, and b) vacancies in Low Income Housing Tax Credit (LIHTC) projects.

The Section 811 program offers a unique opportunity for states to receive additional rental assistance funds for individuals with disabilities. Several states are using these funds to support their *Olmstead* community integration efforts. States are generally using these funds to leverage into LIHTC projects to ‘write down’ rents so that they are affordable to extremely low-income individuals with disabilities. An added feature is that the program requires coordination between the state housing finance agency and the Medicaid and related human services agency to ensure that there is coordination of services for individuals who access housing. Nebraska did not apply last year for the first round of funding, but HUD will issue a second round of funding, likely within the next few months. This would require DBH, NIFA, and NDED to begin planning now.

In addition, DBH should discuss with NDED a plan to establish a set-aside program within existing vacant LIHTC units and leverage available Housing Related Assistance Program funds to ensure their affordability for extremely low-income individuals. Rent in the LIHTC program is generally affordable to low-income individuals, but is unaffordable to individuals with extremely low incomes (i.e., often the population served by DBH) without some form of rental assistance. An opportunity exists for individuals served by DBH with rental assistance from the Housing Related Assistance Program to rent vacant units in LIHTC projects. Rather than have to subsidize up to the full fair market rent in a non-LIHTC unit, DBH can subsidize the difference necessary to make the unit affordable to extremely low-income individuals. The individual benefits from quality housing, it provides DBH an opportunity to maximize its funding in the Housing Related Assistance Program, and the property owner/manager benefits from occupied units.

- b. DBH should conduct a gaps analysis that includes an inventory of Assisted Living Facilities, Mental Health Centers, and other residential options to create a profile of residential services in Nebraska, and the amount of various sources of funding allocated to support each model. As part of this analysis, DBH should identify the additional need

for various types of housing, particularly independent living arrangements, such as apartments. This will help inform the need for additional state funding for the Housing Related Assistance Program.

3.2. Longer-term Recommendations:

- a. Consideration should be given to expanding resources to the Housing Related Assistance Program to accommodate individuals who can benefit from more integrated settings, including individuals in Assisted Living facilities and Mental Health Centers who could live in and choose to move to more independent settings. The Housing Related Assistance Program managed by DBH appears to be a cost-effective bridge rental assistance program for eligible individuals, but it does not meet demand.
- b. Housing Coordinators perform important functions including helping people to a) locate and secure housing; and b) successfully maintain housing through the provision of various housing and tenancy supports, such as skill development and landlord relations. DBH should convene Housing Coordinators from across the state to engage in a planning process to identify common issues, share successes, address system barriers, and work to establish common expectations for this important role. A goal of this process is to improve the ability of Housing Coordinators across Nebraska to assist consumers in accessing and maintaining housing while enabling (clinical) service providers the capacity to focus on non-housing related work.

In addition to locating and securing housing, DBH should standardize or redefine the role of Housing Coordinators to include: a) active relationship building with local Public Housing Authorities resulting in increased access to PHA units; b) responsibility to cultivate and manage relationships among local networks of landlords; and c) Tenant Services Liaison functions to serve as a connector and first responder to mediate tenant/landlord issues. DBH should also consider allocating additional funding to accommodate this broader role, where needed. As more people achieve more independent and integrated housing settings, the volume of work is increasing, and additional Housing Coordinator capacity in the system will enable Housing Coordinators the ability to provide enough attention to individuals that they are working with, as well as an improved capacity to work with existing housing authorities and potential landlords to address broader issues (e.g., working with PHAs to establish disability preferences; addressing landlord concerns).

- c. There are over 100 public housing authorities in Nebraska that provide federally supported rental assistance and/or affordable housing. DBH could play a leadership role in convening various PHAs to discuss affordable housing opportunities for consumers, as well as challenges and barriers to meeting the housing needs of this population. The housing authorities likely serve many individuals served by DBH, and additional housing opportunities potentially exist. Housing authorities can establish preferences for disabilities and homelessness, for example that may create additional opportunities for

individuals served by DBH. DBH should also work with and encourage Regional Housing Coordinators to foster partnerships with the housing authorities.

CONCLUSION

The Nebraska Division of Behavioral Health has been working to build a person-centered, recovery-oriented system of care. As part of this process, DBH, through the leadership of Dr. Scot Adams, also sought to assess its role in supporting the community integration of individuals served through the system. This report provided a set of recommendations for DBH to consider that can strengthen the system's ability to serve people in integrated settings, and to minimize potential litigation risks identified in this process for people with mental illness whose access to the least restrictive, most integrated settings may be limited.

Like other systems, however, Nebraska faces various challenges, including the amount of funding for services and housing it makes available to support integration. Community integration – and, more specifically the civil right of individuals to live in the most integrated settings possible – is the law, and state government collectively, not just singular agencies, should affirmatively plan and ensure that individuals with mental illness and other disabilities are afforded these opportunities. In order for Nebraska to meet its requirements under the ADA and *Olmstead* and minimize litigation risks, it will need to initiate an actionable planning process that results in an effectively working plan aimed at supporting people with mental illness in integrated community settings.

Appendix A – Literature Review

1. Behavioral Health Reform Project Housing Team, Recommendations to the Nebraska Health and Human Services System and the Nebraska Department of Economic Development; August 10, 2004
2. DBH 2012 Behavioral Health Consumer Survey Summary of Results; December 2012
3. DBH Cost Burden and the Nebraska Housing Related Assistance Program; Prepared by Jim Harvey; March 14, 2007
4. DBH Strategic Plan Update; September 2012
5. DBH Policy on Housing Related Assistance; Revision Date July 1, 2010
6. Disability Rights Nebraska Testimony on LB 260; Bradley Meurrens; February 14, 2013
7. Division of Behavioral Health Strategic Plan 2011-2015
8. Division of Public Health Licensure Unit; Mental Health Center Roster; Updated June 4, 2013
9. Division of Public Health Licensure Unit; Assisted Living Facilities Roster; Updated July 15, 2013
10. Housing Related Assistance Program Consolidated Data 2012 and 2013
11. Medicaid Annual Report Draft, September 15, 2011
12. Medicaid Behavioral Health Service Definitions
13. Mental Health Center Regulations; Title 175, Chapter 19
14. Mental Health Services Proposed Regulations; Title 206
15. Nebraska Assisted Living Facility Regulations; Title 175, Chapter 4
16. Nebraska Behavioral Health Oversight Commission Final Report; June 22, 2009
17. Nebraska Behavioral Health System Enhancement Initiative Draft; March 13, 2013
18. Nebraska's Behavioral Health Workforce – 2000 to 2010 Final Report, August 2011. Submitted to the Nebraska Behavioral Health Education Center. Nebraska Center for Rural Health Research, College of Public Health, University of Nebraska Medical Center
19. Nebraska Center for Mental Health Services Block Grant Application 2012-2013
20. Nebraska National Outcome Measures Uniform Reporting System 2011 Report
21. Nebraska Service Definitions Attachment to 206 NAC
22. NIFA 2013 LIHTC Allocation Plan
23. Omaha ACT Team TMACT Fidelity Review Feedback Report; December 1-2, 2009
24. PIER – Lincoln NE ACT Team Fidelity Assessment; October 15-16, 2012
25. Report on Nebraska Revised Statute §81-3134 Access to Services for Individuals with Co-occurring Conditions
26. Response to US Senate HELP Committee Olmstead Inquiry; September 7, 2012
27. US Senate HELP Committee Report, *Separate and Unequal: States Fail to Fulfill the Community Living Promise of the Americans with Disabilities Act*. July 18, 2013

State Approaches to Community Integration

Presented by: Kevin Martone
Technical Assistance Collaborative, Inc.
May 14, 2013



The Mandate for Community Integration

- In the landmark *Olmstead v. L.C.* decision (1999), the U.S. Supreme Court held that states have an affirmative obligation to ensure that individuals with disabilities live in the least restrictive, most integrated settings possible.
- The regulations implementing Title II define an integrated setting as one that “enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible.”
- 28 C.F.R. § 35.103(d)
- 28 C.F.R. § Pt. 35, App. A (2010) (addressing § 35.130)



Community Integration Defined

“Integrated settings are located in mainstream society; offer access to community activities and opportunities at times, frequencies and with persons of an individual’s choosing; afford individuals choice in their daily life activities; and, provide individuals with disabilities the opportunity to interact with non-disabled persons to the fullest extent possible. Evidence-based practices that provide scattered-site housing with supportive services are examples of integrated settings.”

U.S. Department of Justice. *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.*



Community Integration Defined

“By contrast, segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals’ ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities.”



Implementing Olmstead

- In its decision, the Supreme Court stated that if a state had a, “...**comprehensive, effectively working plan** for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the state’s endeavors to keep its institutions fully populated, the reasonable modification standard [of the ADA] would be met.”
- For an *Olmstead* Plan to serve as a reasonable defense against legal action it must include, “...concrete and reliable commitments to expand integrated opportunities...and there must be funding to support the plan.”



Olmstead Points

- Not a passing trend.
- The Policy, Clinical Thinking and the Law - beliefs and opinions regarding whether a person is ready for more independent living or what an integrated setting is may conflict with what the Courts decide;
- Just because it’s in the community doesn’t mean it’s integrated;
- “Choice” may have different meanings;
- A plan to plan is not a plan;
- Budget cuts and bureaucracy do not trump civil rights



Critical Areas for System Planning and Implementation

- Role and Focus of Leadership
- Key Relationships To Establish
- Inter-departmental Collaboration and Partnerships
- Assessing Strengths and Risks
- Financing Considerations
- Need for Statutory and/or Regulatory changes
- Using Data



Leadership

- Important to have good understanding of “Olmstead” and “community integration”;
- Leadership = Division leadership up through the Governor;
- Much of the battle is education, communication and marketing;
- Must deal with internal and external resistance.



Opportunities

- How does the current system already support the mandate for community integration?
- What Key Relationships Already Exist?
- Cross Agency Collaborations?
- How can Consumers help?
- How can resources be maximized or reallocated?



Partnerships

- Medicaid/Managed Care
- SMHA/SSA
- Employment/Labor
- Transportation
- Welfare
- Housing
- Primary care/Health
- Dental
- Providers
- Consumers, families
- Public Health
- Federal, state, county, local,
- Executive, Judicial, Legislative branches
- Academia
- Corrections/Criminal Justice



Assessing Risk - Inpatient

- Role of Inpatient (perceived/actual)
- Use of inpatient
- # of people hospitalized who do not meet civil commitment criteria
- # of people hospitalized due to lack of community options
- Emergency Department boarding
- Quality of discharge planning



Assessing Risk - Residential

- Role of Residential; System beliefs
- Where do people live?
 - congregate group homes
 - nursing homes
 - board and care facilities
 - homeless
- Size of residential environments
- Restrictions in group homes



Assessing Risk – Resource Allocation

- % of funds for inpatient vs community services
- % of funds for congregate living vs independent living (housing + services)
- % of funds for facility based day programming vs ACT, Community Supports
- \$ spent on housing in congregate settings



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Financing Considerations

- Maximizing state and federal resources
- State funds
- Medicaid
- Housing
- Examples from States
- ACA Impact



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State Experiences

- Community Integration/Olmstead takes resources, new and/or re-allocated
- Leadership
- Working with Governor's office, Budget offices and other State agencies, legislature.
- Prepare Staff
- Prepare Stakeholders
- Anticipate and manage resistance
- Talking about it is not a good defense, nor is a plan that sits on a shelf.



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Common Implementation Threads

- Expansion of community services
- New and/or re-allocated resources
- Permanent Supportive Housing, ACT and Crisis services are core components of plans and Settlement Agreements
- Movement away from segregated models and programs with poor outcomes



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Key Olmstead Litigation - Georgia

- Target population: 9,000 individuals with SPMI who are currently being served in the State Hospitals, who are frequently readmitted to the State Hospitals, who are frequently seen in Emergency Rooms, who are chronically homeless, and/or who are being released from jails or prisons.
- Also includes Developmentally Disabled.
- 2010 – 2015
- Significant expansion of community services.
- Specific limitations on # and size of residential options.



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Georgia

- "Supported Housing includes scattered-site housing as well as apartments clustered in a single building. By July 1, 2015, 50% of Supported Housing units shall be provided in scattered-site housing, which requires that no more than 20% of the units in one building, or no more than two units in one building (whichever is greater), may be used to provide Supported Housing under this agreement.
- "It is the intent of the parties that approximately 60% of persons in the target population receiving scatter-site Supported Housing will reside in a two-bedroom apartment, and that approximately 40% of persons in the target population receiving scattered-site Supported Housing will reside in a one-bedroom apartment."

*Excerpted from Georgia DOJ Settlement Agreement



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Key Olmstead Litigation - Illinois

- 3 cases (Colbert, Williams, Ligas)
- Colbert – Nursing Home residents who can move to more integrated settings
- Williams – Individuals with mental illness in large IMDs
- Ligas – Developmentally Disabled in ICF-DD's of nine or more, or who are at risk of going into these settings



Key Olmstead Litigation – New Jersey

- Target Population: Individuals with mental illness in state psychiatric hospitals who no longer meet commitment criteria and are awaiting community placement.
- Filed by Protection & Advocacy group
- Serve 1,065 being discharged from state hospitals or who are at risk of hospitalization
- 2010 -2014



Key Olmstead Litigation – Delaware

- DOJ CRIPA investigation into state psychiatric hospital; led to investigation of community system; Settlement Agreement
- Target population is individuals with serious mental illness who are at the highest risk of unnecessary institutionalization
- Significant expansion of community services, housing and other supports
- 2011-2016



Delaware

- "All new housing created under this agreement will be scattered site supported housing, with no more than 20% of the units in any building to be occupied by individuals with a disability known to the State."
- "All new housing created under this agreement will have no more than two people in a given apartment, with a private bedroom for each person. If two people are living together in an apartment, the individuals must be able to select their own roommates."

*Excerpted from Delaware DOJ Settlement Agreement



Key Olmstead Litigation – North Carolina

- DOJ investigation of Adult Care Homes; Settlement Agreement
- Target population: SPMI/SMI
- 3,000 housing slots between 2012-2020 to move people into more integrated settings
- Expansion of community services
- Loss of Medicaid revenue (IMD issue).



North Carolina

- Housing Slots created pursuant to Settlement:
- are permanent housing with Tenancy Rights;
 - are scattered site housing, where no more than 20% of the units in any development are occupied by individuals with a disability known to the State, except as set forth below:
 - Up to 250 Housing Slots may be in disability-neutral developments, that have up to 16 units, where more than 20% of the units are occupied by individuals with a disability known to the State
 - the priority is for single-occupancy housing

* Excerpted from NC DOJ Settlement Agreement



Key Olmstead Litigation – New York

- Litigation filed by P&A group
- Target Population: Thousands (4,000) of individuals with mental illness living in Adult Homes in NYC.
- Case recently returned on appeal due to lack of standing of plaintiffs. However, DOJ may file suit. Parties are negotiating.



Key Olmstead Litigation – Connecticut

- Litigation filed by P&A.
- Target Population: Individuals with mental illness living in Nursing Homes who can live in more integrated settings.
- Case still pending.



How do Nebraska Division of Behavioral Health activities support Community Integration?

- Administers, oversees, and coordinates the state's public behavioral health system.
- Responsible to coordinate public behavioral healthcare.
- Magellan Behavioral Health Services operates as ASO for Division of Medicaid and Long Term Care Behavioral Health carve-out, and the DBH.



Vision and Mission

- Vision
 - The Nebraska public behavioral health system promotes wellness, recovery, resiliency and self determination in a coordinated, accessible consumer and family-driven system.
- Mission
 - The DBH provides leadership and resources for systems of care that promote and facilitate resiliency and recovery for Nebraskans.



2011-2015 Goals

- The public behavioral health workforce will be able to deliver effective prevention and treatment in a recovery-oriented systems of care for people with co-occurring disorders.
- The DBH will use financing mechanisms which support innovative service content, technology and delivery structures (e.g. tele-health; in-home acute services; Peer Support Services).
- The DBH will reduce reliance on the Lincoln Regional Center for general psychiatric services
- An effective system to safely manage sex offenders in outpatient settings will be ready for implementation.



Types of Community Based Services

- General mental health services
 - Primary acute care mission & short term and time limited
 - Acute and sub-acute inpatient, outpatient, day treatment, crisis stabilization, Emergency community response, mental health respite, day support, assessment, Intensive Case Management, and Medication Management
- Psychiatric Rehabilitation and Support
 - Longer term
 - Community Support, Psychiatric Residential Rehabilitation, Assertive Community Treatment, and Day Rehabilitation
- Substance Use Disorder
 - Use of standardized assessment to determine level of need
 - Outpatient; IOP; PH; Residential, Halfway House/Intermediate Residential; TC; Social detox; and Opioid Maintenance Therapy
- Recovery and Resiliency
 - Supported Housing, Supported Employment, Peer Run Hospital Diversion

