Background Materials

Olmstead Advisory

Committee Meeting

August 26, 2005

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Agenda Item #3
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The Olmstead Decision: A Primer

The Case: On June 22, 1999, the United States Supreme Court issued a decision in the case of *Olmstead v L.C.,* finding that the unjustified institutional isolation of people with disabilities is a violation of the Americans with Disabilities Act (ADA). The case involved two developmentally disabled women, Lois Curtis and Elaine Wilson. Ms Curtis also had schizophrenia, and Ms. Wilson had a personality disorder. Both women were Medicaid beneficiaries who had been treated in institutions.

In 1992, Ms. Curtis was voluntarily admitted to the Georgia Regional Hospital in Atlanta, confined for treatment in a psychiatric unit. By 1993, her psychiatric condition had stabilized and her treatment team determined that her needs could be met in one of the state's community-based programs. However, Ms. Curtis remained institutionalized. In May 1995, she filed suit in federal court challenging her continued confinement in an institution. Ms. Curtis alleged that the state's failure to place her in a community-based program, after her treating professional determined that such placement was appropriate, violated Title II of the Americans with Disabilities Act. In February of 1996, the state placed her in a community-based treatment program.

Ms. Wilson's claim in the case was similar to Ms. Curtis'. Ms. Wilson was admitted to Georgia Regional Hospital in February of 1995, and was also confined for treatment in a psychiatric unit. In March of 1995, the hospital sought to discharge her to a homeless shelter, but abandoned that plan after her attorney filed a complaint. By 1996, Ms. Wilson's treating psychiatrist concluded that she could be treated appropriately in a community setting. However, she remained institutionalized until a few months after the District Court issued its judgment in this case in 1997.

(Source: The previous section is an excerpt from the Kaiser Commission on Medicaid and the Uninsured, Policy Brief: Olmstead v. L.C., the Interaction of the Americans with Disabilities Act and Medicaid).

Understanding Title II of the Americans with Disabilities Act: Federal regulations implementing Title II of the ADA require that public entities administer programs in "the most integrated setting appropriate to the needs of a qualified individual with a disability. To this end, the rules also require that a covered entity make "reasonable modifications" in programs and activities in order to avoid discrimination, unless it can show that the modification would fundamentally alter the nature of the program or activity. The rule requires the public entity to prove that a proposed modification exceeds reasonable levels and rides to the level of a "fundamental alteration." At the same time, however, individuals who file claims under Title II carry the initial burden of demonstrating that a proposed modification is reasonable.
(Source: This section is an excerpt from the Center for Health Care Strategies, *The Americans with Disabilities Act and Integration: Understanding the Concept of "Fundamental Alteration"* May 2002).

The Decision: The case focused on whether regulations implementing Title II of the Americans with Disabilities Act (Title II requires states to operate public programs in a non-discriminatory fashion and to furnish services in the most integrated setting appropriate to an individual's needs) require placement of persons with disabilities in community settings rather than institutions. The Supreme Court's ruling is summarized as follows:

1. The Court noted that unjustified institutional isolation of people with disabilities is a form of discrimination, noting the history of institutionalization as a means of segregating and demeaning persons with disabilities.

2. The Court ruled that states are required to provide community-based services for persons with disabilities otherwise entitled to institutional services when:
    - The state's treatment professionals reasonably determine that community placement is appropriate;

- The person does not oppose such placement; and,
- The placement can be reasonably accommodated, taking into account resources available to the state and the needs of others receiving state-supported services for persons with disabilities.

3. The Court indicated that the "state's responsibility is not boundless", noting that the needs of persons who require institutional services have to be weighed against those who reside in the community. The Court also noted that nothing in the Americans with Disabilities Act condones termination of institutional setting for persons unable to handle or benefit from community settings.

4. The Court found that the Americans with Disabilities Act's reasonable-modifications standard does not require states to make "fundamental alterations" in its services or programs. The Supreme Court indicated that the test as to whether a modification entails "fundamental alteration" of a program takes into account three factors: the cost of providing services to the individual in the most appropriate integrated setting; the resources available to the state; and how the provision of services affects the ability of the state to meet the needs of others with disabilities.

5. The Court found that the reasonable-modifications standard would be met if the state has a comprehensive, effectively working plan for placing qualified individuals in less-restrictive settings, and a waiting list that moves at a reasonable pace not controlled by the state's efforts to keep its institutions fully populated.

Direction from the Center for Medicare and Medicaid Services (CMS): CMS has issued letters to State Medicaid Directors related to the Olmstead decision. These letters provide directions to states in understanding the Olmstead decision, populations impacted, and guidance for implementation. In its first letter, CMS points out that the Court suggests that a State could establish compliance with Olmstead and Title II of the Americans with Disabilities Act if it demonstrates that it has a comprehensive, effectively working plan for placing qualified persons with

disabilities in less-restrictive settings, and a waiting list that moves at a reasonable place not controlled by a State's objectives of keeping institutions fully populated. In its letter to State Medicaid Directors (January 14, 2000), CMS indicates that "Olmstead challenges states to prevent and correct inappropriate institutionalization and to review intake and admissions processes to assure that persons with disabilities are served in the most integrated setting appropriate." CMS has encouraged states to develop plans with the active involvement of persons with disabilities and their representatives in design, development and implementation. CMS has also provided some recommendations about key principles and practices for states to consider as they develop plans. In addition, CMS has responded to a series of questions from states regarding implementation, as follows:

- **Who is covered by Olmstead?** The decision involved two women with developmental disabilities and mental illness. Is the decision limited to people with similar disabilities? ANSWER: No. The principles set forth in the Supreme Court's decision in Olmstead apply to **all** individuals with disabilities protected from discrimination by Title II of the ADA. The ADA prohibits discrimination against "qualified individual(s) with a disability." The ADA defines disability as:
    - (A) A physical or mental impairment that substantially limits one or more of an individual's major life activities;
    - (B) A record of such an impairment; and
    - (C) Being regarded as having an impairment.

To be a "qualified" individual with a disability, the person must meet the essential eligibility requirements for receipt of services or participation in a public entity's programs, activities or services. For example, if the program at issue is open only to children, and that eligibility criterion is central to the program's purpose, the individual must satisfy this eligibility requirement.

- **What about the elderly and children- are they covered by Olmstead?** ANSWER: Yes, but the issue is always based on a person's disability. CMS indicates "no matter what specific impairment or group of people is at issue—including elderly and children – each must meet the same threshold definition of disability in order to be covered by the ADA. The question is "Does the person have an impairment, have a record of impairment, or is s/he being regarded as

having an impairment, that substantially limits a major life activity?" Regarding the elderly, age alone is not equated with disability. However, if an elderly individual has a physical or mental impairment that substantially limits one or more of his or her major life activities, has a record of such impairment, or is regarded as having such impairment, he or she would be protected under the ADA.

Other Federal Efforts

Real Choice Systems Change Grants: Established by Congress in 2000, grants of more than $158 million have been awarded to states from 2001-2004 to create infrastructure and service options necessary for long-term community integration. California currently has six Real Choice grants in operation, including the Money Follows the Person/California Pathways project, the Bay Area Quality Enhancement Initiative, the IHSS Enhancement Initiative, the Transitions Independent Living Partnership Grant, the California Study on a New Respite Benefit for Caregivers of Adults With Cognitive Impairment, and the Aging and Disability Resource Center Initiative (See Attached "California Real Choice Grants" for more information).

New Freedom Initiative: In 2001, as part of the New Freedom Initiative, President Bush issued Executive Order 13217 requiring all Executive Branch agencies to take steps to comply fully with the requirements of the Olmstead decision. The Executive Order required federal agencies to promote community living for persons with disabilities by providing coordinated technical assistance to states; identifying specific barriers in federal law, regulation, policy and practice that impede community participation; and enforcing the rights of persons with disabilities.

Community Responses

People with disabilities have filed Olmstead-related complaints in situations where they believe they have not received services in the most integrated setting. As of May 2004, an estimated 627 Olmstead-related nationwide complaints have been filed with the Federal Health and Human Services Office for Civil Rights, which has responsibility for enforcing Title II of the Americans with Disabilities Act and ensuring compliance with the Olmstead Decision. Of these cases, 459 had been resolved or closed and 168 were still open as of May 2004.

One notable Olmstead-related case in California was the Laguna Honda Hospital and Rehabilitation Settlement, filed in 2000 against Laguna Honda Hospital and Rehabilitation Center (Davis v. California Health and Human Services Agency) on behalf of plaintiffs with mental illness, developmental disabilities, and physical disabilities. The plaintiffs alleged that the City of San Francisco and State of California violated the integration mandate under Olmstead by unnecessarily institutionalizing the plaintiffs in Laguna Honda Hospital and Rehabilitation Center, a nursing home that houses more than 1000 individuals. The case was settled in March of 2003 when the state defendants agreed to modify the Department of Mental Health's Pre-Admission Screening and Resident Review (PASRR) program for individuals with psychiatric disabilities to ensure that the revised assessment process identify community resources for which the persons would qualify, and to consider whether the person's goals and needs could be met with the full range of community-based alternatives to nursing home care. The defendants for the City of San Francisco agreed to set up a Targeted Case Management unit to screen and assess the needs of Laguna Honda residents, individuals on waiting lists for admission to Laguna Honda, and individuals in San Francisco hospitals eligible for discharge to Laguna Honda. The city would use Targeted Case Management to assist these individuals with service and discharge planning and creating linkages with community-based resources. (Source: National Council on Disability and Clearinghouse Review Journal of Poverty Law and Policy, “Where are We Five Years After Olmstead?” January-February 2005)

Olmstead and the Medicaid Program

Medicaid is affected by the Olmstead decision because it is the major source of public financing for long-term services and supports for people with disabilities.

Historically, Medicaid covered only institutional long-term care services, but over the past two decades, the proportion of long-term care financing directed to community-based services and the number of persons receiving services in the community has grown considerably. Sixty-eight percent of federal Medicaid long-term service spending remains institutionally based, while 32% of Medicaid long-term spending is directed to the community. The Medicaid law requires states to provide institutional services to all eligible persons as a mandatory benefit, and permits (but does not require)

states to make services available in the community. This federal government policy is referred to as the “institutional bias.”

The three ways state Medicaid programs can provide home and community-based services are 1) through the home health benefit (a mandatory Medicaid benefit that historically has emphasized skilled, medically-oriented services in the home, but states have the discretion to cover a number of therapeutic services); 2) through one of several optional state plan services (including personal care, rehabilitation services, private duty nursing, physical therapy, occupational therapy, and transportation services); and 3) through home and community-based services waivers. (Source: Kaiser Commission). Some of California’s Medi-Cal home and community-based services include the In Home Supportive Services program (a state plan benefit), the Adult Day Health Care Program (a state plan benefit), the six 1915(C) waivers including the AIDS waiver, the developmentally disabled waiver, the In-Home Medical Care waiver, the Nursing Facility A/B waiver, the Nursing Facility Subacute waiver, and the Multipurpose Senior Services Program waiver.

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Real Choice Systems Transformation Grant – California Proposal
June 2005

Sonoma State University, California Institute on Human Services (CIHS) and the California Department of Rehabilitation (DOR) applied for a 5-year, $3.5 million Real Choice Systems Transformation grant from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS). CMS indicated that proposals must address at least three of six transformation goals identified by CMS as critical to successful systems transformation that will enable youth and adults who have a disability or long-term illness to 1) live in the most integrated community setting appropriate; 2) exercise meaningful choices about their living environment, the providers of services, the types of supports, and the manner by which services are provided; and 3) obtain quality services. Proposals were due and submitted to CMS by California on July 7, 2005.

The Systems Transformation grant focuses on infrastructure reform but allows for limited direct services in implementing pilot projects. The planning team proposed to use funds to support the State's three chosen transformation goals:

- Improved Access to Long-Term Support Services
- Creation of a System that More Effectively Manages the Funding for Long-Term Supports that Promote Community Living Options; and
- Long-Term Supports Coordinated with Affordable and Accessible Housing

Grant Activities:

Planning. CMS requires completion of a strategic plan for the grant implementation prior to allocating the full grant award. Ten percent of the award can be used to develop this plan, which must be completed in the first nine months of the project. Project staff would work closely with Olmstead Advisory Committee members and community partners to create this plan.

Implementation. Implementation components will include, minimally, cross-program infrastructure development at State and local levels, community-level

piloting, statewide outreach and education, research, and evaluation, with additional elements being added as indicated by the plan.

Grant activities, including the pilot project, will be targeted to address populations with unmet needs, diversion and transition from nursing home placements for persons with disabilities and seniors.

The State's three chosen goals will be addressed and replicated statewide as appropriate by:

- *Pilot testing the concept of "Nursing Home Diversion Community Response Teams" in two areas of the State.* Community Response Teams, staffed by "Community Support Coordinators ", will provide a single point of contact for individuals at risk of nursing home placement and would provide connections to and assistance with eligibility and enrollment for various home and community-based services programs. The Community Response Team will be comprised of community-based service programs that can provide services and supports to individuals to assist them in remaining in their home or in the most appropriate integrated setting available to meet their identified needs. The Community Support Coordinators will also provide assistance and information for individuals and their families on local transportation and housing options, including mobility training to familiarize and instruct individuals on using various public and private transportation options. The Community Support Coordinators will work primarily with hospital discharge planners to target individuals who are at risk of nursing home placement, but could also act as an educational resource for the local communities to provide information and referrals on home and community-based services *before* a crisis situation occurs. The Community Support Coordinators will serve as the primarily liaison between the beneficiary and his/her support circle and the Community Response Teams.

- *Developing mechanisms for the Community Support Coordinators to better coordinate and streamline eligibility processes for various community services.* Currently, individuals in California often must apply for programs such as In-Home Supportive Services, home health services, Adult Day Health Care and Multipurpose Senior Services Programs in several different agencies, using duplicative application forms and multiple screening and assessment tools. The Community Support Coordinators will work with the Community Response Team to develop ways to streamline current

application processes in order to assist consumers with obtaining necessary programs and services.

- *Examining the financing and service delivery structures of Medi-Cal, other long-term care programs and accessible transportation in order to make policy recommendations to the Legislature and the Administration as to how to better meet consumer demand for community-based care.* This project will contract with an outside entity to perform an in-depth analysis of the laws, regulations and policies that impact the current financing of California's long-term care system. In addition, the contractor will gather data and perform an analysis on the number of individuals currently residing in publicly funded institutions within the pilot project sites who wish to move into the community, the resources needed to move these individuals out of institutions and keep them in the community, and the resources needed to divert other individuals from entering institutions. The contractor will also analyze the costs and savings of providing services in an institution versus community based care.

- *Evaluating the Community Response Teams to assess what resources are effective at creating opportunities for individuals to live at home and in the community and applying this information to develop ways to better manage resources at the state level*. The evaluation will seek to demonstrate the cost savings to the State of utilizing existing community-based services instead of costly institutional care.

- *Developing and maintaining a statewide web-based resource guide for finding and obtaining affordable accessible housing and necessary support services*, *including transportation*. The project will develop a statewide web-based tool that connects individuals with housing, transportation, long-term supports, and other services to support community living. In addition, the project will develop a tool for consumers to use to determine whether potential housing would meet individual accessibility needs. This component of the project will be leveraged by existing resources set aside in the State Plan for Independent Living to develop a database and advocacy system to promote independent living. The database would include comprehensive accessible and/or affordable public and private housing listings, roommate referrals, In-Home Supportive Services information, transportation alternatives, recreational activities and other home and community-based services.

- *Creating web-based housing registries within the two Community Response Team projects.* Because affordable, accessible housing is often a critical

component for individuals who wish to continue living in the community, the Community Support Coordinators will work directly with individuals to find and obtain local, appropriate, affordable and accessible housing. To facilitate these referrals, registries of housing and roommate services will be created in the two pilot sites.

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Assessments: What is an assessment and why is it important to Olmstead?

Programs use assessments to perform a variety of functions, including functional eligibility determinations, financial determinations, individual preferences, and care plan development. Assessments vary with respect to the functions performed, the populations assessed, the level of automation, the extent of integration with other systems, the administration of the assessments, and the questions included within the assessments.

California's long-term care programs use different assessment tools with different protocol. The following are examples of the various assessments used in different settings.

In Home Supportive Services: The IHSS standardized assessment tool is program-specific to IHSS, and used by county staff to assess the need for IHSS services. County staff determines the amount of assistance required to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), using functional index ranking scales which in most cases range from "1" indicating no assistance required to "5" indicating total assistance needed. County staff also assigns rankings to memory, orientation and judgment. After determining the functional index rankings, county staff determines the total need for the services that are included in the scope of benefits. The total need is adjusted for domestic, meal preparation and cleanup, laundry and shopping if there are others in the household and the need is met in common. County staff also determines the availability of formal or informal alternative resources.

Multipurpose Senior Services Program (MSSP): The MSSP program provides social and health case management to assist persons aged 65 and over, eligible for Medi-Cal and certifiable for skilled nursing care, to remain safely at home. The MSSP assessment tool is designed to determine eligibility and need within the context of the

program. The MSSP tool is program specific rather than geared to a larger system of services.

Adult Day Health Care (ADHC): ADHC programs are not required to use a standardized tool; programs conduct assessments through a team of professionals on staff to assess the consumer's functional ability and informal/formal support systems in order to develop a plan of care.

Adult Day Programs: Adult Day Programs do not have a standardized tool applied to all programs statewide. Program regulations require that certain data elements be captured in the assessment process, but do not require use of a standardized tool.

Home Health Agencies: Medicare-certified Home Health Agencies are required by federal law to use OASIS, an 84-item assessment used for measuring client outcomes and developing reimbursements through the prospective payment system. OASIS can be augmented by individual home health agencies to facilitate care planning.

Skilled Nursing Facilities: Skilled nursing facilities (SNFs) are required by federal law to use the Minimum Data Set (MDS). The MDS is a federally mandated, standardized tool used to assess all residents of all nursing homes that accept Medicare or Medicaid payments. The MDS is solely an assessment instrument that can be used to develop care plans, but within the context of a system, can be used for reimbursement. Under state law, SNFs are also required to include in a resident's care assessment, the projected length of stay, and the resident's discharge potential, including preference to return to the community.

Examining the uniform assessment: The Olmstead Advisory Committee identified the development of a uniform assessment tool as one of its top priorities. A uniform assessment represents a multidimensional, standardized questionnaire, assessing a client's social, physical, mental health, and functional abilities. A uniform assessment instrument is used to determine a consumer's needs and service eligibility across programs and can also be used to track consumers' use of services throughout the system. A uniform assessment can also serve as a planning tool to measure the

personal care needs of anyone receiving services at home, or in an institution, incorporating preference, need, eligibility and a service plan that crosses settings.

Uniform Assessment Initiatives and Work-In-Progress:

- The Money Follows the Person "California Pathways" project (Real Choice Systems Change Grant for Community Living) is developing and field testing a model for a uniform assessment and transition protocol that would enable nursing facility residents to exercise informed choice of home and community-based services and to provide case encounter and cost data that provide the basis for future policy recommendations for Money Follows the Person initiatives in California. The final project report will identify the successes of the pilot project including care-planning models, service costs associated with chronic conditions and those transitioning from nursing facilities to community living.
- The Home Care Assessment Pilot Project (Daucher, AB 786, Chapter 436, Statutes of 2003) tests the use of a uniform, automated screening and eligibility assessment instrument, the Minimum Data Set-Home Care (MDS-HC), by home and community-based programs serving persons with disabilities and seniors until December 31, 2008.
- Statewide Assessment Tool: The Governor proposed development of a statewide Uniform Assessment Tool and Protocol as part of the Acute and Long Term Care Integration (ALTCI) project proposal contained in the 2005-2006 budget. The assessment tool is defined as "a protocol adopted by the state that would augment medical assessment information in order to determine an individual's home and community-based service needs and service preferences across the continuum of long term care services, based on his/her unique abilities, functions and preferences and considering available community and family support systems." The project has not been slated for implementation at this time as the final budget for 2005-2006 passed by the Legislature did not include the proposal.

Agenda Item #6
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DRAFT Policy Statement of the Olmstead Advisory Committee

It is the purpose of the Olmstead Advisory Committee to provide input to the California Health and Human Services Agency on its efforts to evaluate, revise, and monitor the state's implementation of the United States Supreme Court's decision in *Olmstead v. L.C.* It is further the responsibility of the Committee to recommend actions to improve California's long-term care system, and to advise on opportunities to fund activities to support persons with disabilities in the community.

The Olmstead Advisory Committee commits to the following policy statement in its efforts to advise the state in its implementation of the Olmstead decision.

1. The opportunity to direct one's own affairs, live independently, and attain economic self-sufficiency is an essential component of developing self-worth and personal responsibility.
2. The state has a responsibility to protect against the unnecessary institutionalization of all persons with disabilities of all ages, including persons with mental, physical, or developmental disabilities.
3. Unnecessary institutional placement of persons with disabilities of all ages constitutes a form of discrimination based on disability and adversely affects everyday life activities, family relations, social contacts, work options, economic independence, and cultural enrichment of those institutionalized persons.
4. Community-based care and services can be more cost effective than institutional care, and result in a higher quality of life that promotes the values of community participation, inclusiveness, and respect for diversity.
5. The active involvement of persons with disabilities of all ages and the representatives they choose in developing and implementing of activities or services designed to move people into, or allow them to remain in, community-based settings is critical to achieving these objectives.

6. California has a demonstrated record of success in providing services that support the full integration of persons with disabilities in community life through such programs as In-Home Supportive Services, Adult Day Health Care, Adult Day Programs, Medi-Cal, community mental health services, Alzheimers Day Care Resource Programs, the Older Californian's Act Home and Community-Based Services Program, and the comprehensive array of services defined under the Lanterman Act. It is possible to build upon California's previous success to improve procedures and implement new tools that will enable more people to fully access services in the community.

To achieve these objectives, the Olmstead Advisory Committee agrees to follow these principles in its efforts to advise the state in its implementation of the Olmstead decision:

- **Self-determination** by persons with disabilities of all ages about their own lives, including their place of residence.

- **Consumer choice** and access to information on community activities, programs, and services, in a culturally competent and understandable form, to assist in decision-making.

- **Integration** of persons with disabilities into age-appropriate aspects of community life; persons with disabilities who live in community based non-institutional settings must be given the opportunity to fully participate in the community's services and activities through their own choices; the most integrated setting for consumers is at home with their families, and in the community, whenever possible.

- **Culturally competent and accessible community-based services**, that to the maximum extent possible, enable persons with disabilities of all ages and with all types of disabilities, to direct their own lives and live in the community in non-institutional settings.

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DRAFT Olmstead Policy Filter

1. Consistent with the Olmstead decision, achieves measurable progress towards diverting and transitioning individuals from institutions

2. Fosters and promotes an individual's informed choice in his/her living arrangement.

3. Increases an individual's ability to participate and live in the community.

4. Sustains and/or builds upon home and community-based services and supports to enable an individual to live and participate in the community.

5. Forwards the principles and implementation of the California Olmstead Plan.

Agenda Item #7
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Legislation- categorized by status

Bills that are currently moving:
AB 258 (Matthews): Medi-Cal: Durable Medical Equipment
AB 298 (Berg): Personal Income Tax: Caregivers Tax Credit
AB 899 (Ridley-Thomas): In-Home Supportive Services
AB 1378 (Lieber): Developmental Services Facilities
AB 1643 (Jones): PERS Long Term Care Insurance
SB 418 (Escutia)- Rehabilitation Loans
SB 643 (Chesbro): Nursing Facilities and Transition
SB 666 (Aanestad): Congregate Living Health Facilities
SB 962 (Chesbro): Adult Residential Facility for Persons with Special Health Care Needs

- **AB 258 (Matthews): Medi-Cal: Durable Medical Equipment**

Under existing law, durable medical equipment is a covered benefit under the Medi-Cal program, subject to utilization controls. This bill, commencing July 1, 2006, would require any provider of custom rehabilitation equipment and custom rehabilitation technology services, as defined, to a Medi-Cal beneficiary to have on staff, either as an employee or independent contractor, or have a contractual relationship with, a qualified rehabilitation professional, as defined, who was directly involved in determining the specific custom rehabilitation equipment needs of the patient and was directly involved with, or closely supervised, the final fitting and delivery of the custom rehabilitation equipment.

Status: Senate Appropriations Committee

- **AB 298 (Berg): Personal Income Tax: Caregivers Tax Credit**

The Personal Income Tax Law allows a credit for taxable years beginning on or after January 1, 2000, and before January 1, 2005, in an amount

equal to $500 in caregiver tax credits. This bill extends the existing $500 tax credit to 2011.

Status: Senate Revenue and Taxation Committee

- **AB 899 (Ridley-Thomas): In-Home Supportive Services**

Existing law permits services to be provided under the IHSS program either through the employment of individual providers, a contract between the county and an entity for the provision of services, a contract between the county and a nonprofit consortium, or the creation by the county of a public authority. This bill would authorize a service provider to receive wages for up to 6 hours of prescribed instruction per calendar year, approved by the department and pursuant to a collective bargaining agreement if it qualifies for the maximum federal participation. This bill would require the Secretary of the California Health and Human Services Agency to actively pursue available federal funding for training authorized by the bill. The bill would prohibit the training authorized under the bill from counting against assessed hours for a recipient of in-home supportive services.

Status: Senate Appropriations Committee

- **AB 1378 (Lieber, Administration Sponsored): Developmental Services Facilities**

This bill authorizes the Department of Developmental Services to utilize existing Agnews State Developmental Center employees as part of the Administration's plan for its closure. This bill would provide that its provisions shall remain in effect until July 1, 2009, and as of that date would be repealed, unless a later enacted statute, that is enacted before July 1, 2009, deletes or extends that date.

Status: Senate Third Reading

- **<u>AB 1643 (Jones):</u> PERS Long Term Care Insurance**

The Public Employees' Long-Term Care Act provides long term care insurance coverage for members of CalPERS. The coverage of the Act has been expanded over time to include persons covered by various retirement systems and to extend eligibility to parents, siblings, and parents of siblings of covered individuals. However, persons with disabilities who do not meet the underwriting criteria cannot get coverage in PERS LTC Insurance. This bill requires the PERS board to conduct a study regarding the following:

- Expected costs of providing LTC Insurance coverage without underwriting criteria;
- The feasibility and desirability of various options including, charging increased premiums for enrollees not subject to underwriting and imposing increased waiting periods for those not subject to underwriting;
- A proposal for a LTC Insurance program that would maintain the financial stability of the plan while balancing the need to cover the maximum number of individuals with the fewest restrictions on coverage; and
- Other options for ensuring that persons now excluded from the long-term care insurance plan are able to obtain long-term services when needed and are not discouraged from seeking employment in order to continue receiving public benefits.

Status: Senate Appropriations Committee

- **SB 418 (Escutia)- Rehabilitation Loans**

Existing law creates the Rehabilitation Revolving Loan Guarantee Fund, to guarantee loans to persons for the purchase of vans, automobiles, and other special equipment to facilitate transportation of the physically handicapped and to assist with the purchase adaptive aids and assistive devices. This bill would delete the vocational rehabilitation and employment requirements for eligibility under the fund.

Existing law establishes a supported employment loan guarantee program to assist employers and employees with disabilities to purchase durable equipment, adaptive aids, and assistive devices in order to engage in

supported employment. This bill would make loans available directly from the fund to parents of a child with, or persons with, a disability who require an assistive technology device, as defined, that is necessary for independent living. This bill would also require that loans made to any eligible person be based on the person's ability to repay the loan.

Existing law requires the department to adopt regulations which, among other things, establish criteria for determining eligibility for loans in the guarantee program that ensure that applicants have the ability to repay loans. This bill would require the department to adopt regulations that give preference to those applicants not receiving other supports and services from the department.

Status: Assembly Third Reading

- **SB 643 (Chesbro): Nursing Facilities**

This bill would require that a resident's plan of care, if applicable, include services that will assist the resident in maintaining, regaining, and acquiring the skills and level of functioning that would assist in a return to the community, require skilled nursing facilities to comply with new requirements regarding transition services, reduce the provider approval window for independent nurse providers from 180 to 30 days, requires professional assessments for Lanterman-Petris-Short (LPS) conservatees to assess preference to return to the community, requires targeted case management services to be a covered benefit under the Medi-Cal program for skilled nursing facility residents when medically necessary to transition into the community, and expand slots, upon federal approval, for specified home- and community-based waivers.

Status: Assembly Appropriations Committee

- **SB 666 (Aanestad): Congregate Living Health Facilities**: This bill increases the capacity of a congregate living health facility from no more than six beds to no more than 12 beds, with certain exceptions as provided by existing law.

Status: Senate Unfinished Business (concurrence)

- **<u>SB 962 (Chesbro, Administration Sponsored):</u> Adult Residential Facility for Persons with Special Health Care Needs**

This bill authorizes the Department of Social Services (DSS) and the Department of Developmental Services (DDS) to create a new community-care licensing category for persons currently residing in developmental centers, by establishing a pilot project for licensing and regulating Adult Residential Facilities for Persons with Special Health Care Needs.

Status: Assembly Appropriations Committee

Two-Year Bills:
AB 10 (Daucher): Inappropriate Placement of Persons with Disabilities
AB 20 (Leslie): Persons with Disabilities: Access
AB 1258 (Daucher): Adult Day Health Care
AB 1326 (Vargas): IHSS: Health Benefits
AB 1379 (Lieber): Agnews Developmental Center: Closure
AB 1653 (Haynes): IHSS: Provider Wage and Benefit Increases
SB 481 (Chesbro): Self-Directed Services Program
SB 526 (Alquist): Long Term Health Care
SB 642 (Chesbro): Adult Day Health Care Program
SB 855 (Poochigian): Special Access: Liability

- **AB 10 (Daucher): Inappropriate Placement of Persons with Disabilities**

This bill would require the Department of Health Services to adopt, by July 1, 2007, a statewide uniform documentation tool, as defined, for discharge placement or facility placement evaluation of persons with disabilities and the elderly in compliance with Olmstead.

This bill would require the State Department of Health Services to select 3 voluntary pilot programs to be allowed to charge a fee for long-term care navigation services. The fee would be voluntary and would be charged to non-Medi-Cal seniors and persons with disabilities 18 years of age or older who are at risk for nursing home placement and who would like long-term care navigation services. The bill would declare that, upon appropriation by the Legislature, the fee revenue would serve as matching federal targeted case management dollars to provide funding for Medi-Cal eligible seniors and persons with disabilities at risk of nursing home placement to receive the same long-term care navigation services as persons who utilize the private pay method.

Status: Senate Appropriations Committee

- **AB 20 (Leslie): - Persons with Disabilities: Access**

Under existing law, individuals with certain disabilities are entitled to equal access rights to various facilities. Any person who denies or interferes with admittance to, or enjoyment of, public facilities, or otherwise interferes with the rights of an individual with a disability, is liable for each offense, as

specified. This bill would preclude commencement of an action for damages against a public facility for a de minimus deviation from a code or regulation that has no significant impact on a person with disability's right to the goods and services provided by the facility, as specified. The bill would instead provide that the remedy for a technical violation, as defined, is injunctive relief and the recovery of attorney's fees.

Status: Assembly Judiciary Committee

- **AB 1258 (Daucher, Administration Sponsored): Adult Day Health Care**

This bill authorizes DHS to revise its State Plan or develop a waiver to bring ADHC services under the Medi-Cal program into compliance with federal laws and regulations. In addition, this bill specifies some of the terms of the State Plan Amendment (SPA) or waiver, including the restructuring of the interagency agreement with CDA, clarification and expansion of certification requirements, and a cleanup of the ADHC licensing statutes. The bill includes a restructure of the ADHC program under a SPA or waiver, including per service billing and reimbursement in place of the current bundled billing, the establishment of new medical necessity criteria that must be met for prior authorization of ADHC services, and the expansion of audit procedures to ensure compliance with licensing and certification requirements.

Status: Assembly Health Committee

- **AB 1326 (Vargas): In Home Supportive Services- Health Benefits**

This bill would authorize a recipient who receives In-Home Supportive Services through a Long-Term Care Integration Pilot Project/Acute and Long Term Care Integration Project to select his or her own service provider, subject to program requirements.

Status: Senate Third Reading *author intends to make this a two-year bill

- **AB 1379 (Lieber): Agnews Developmental Center: Closure**

This bill requires that Agnews Developmental Center property be subject to certain conditions. Specifically, this bill prohibits classification of property at Agnews as surplus property absent express legislative authorization. The bill establishes the Agnews Developmental Center Campus Advisory Group to provide the Legislature with recommendations regarding the disposition of land at Agnews and requires the group to report recommendations to the Legislature by June 30, 2006. The bill requires the recommendations preserve the land, or its value for people with developmental disabilities under the Lanterman Act.

Status: Assembly Appropriations Committee

- **AB 1653 (Haynes, Administration Sponsored): In-Home Supportive Services Program: Provider Wage and Benefit Increases**

This bill would eliminate the formula for state participation in provider wage and benefit increases, and would instead provide generally that the state shall pay 65% of the nonfederal share of wages and benefits negotiated by a public authority or nonprofit consortium, and associated employment taxes, only up to the state minimum wage. These changes would become effective on October 1, 2005.

Status: Assembly Human Services Committee

- **SB 481 (Chesbro): Self-Directed Services Program**

This bill expands the Self-Directed Services Program to a statewide program. Self-Directed Services is a service delivery model that allows participants to control a budget to purchase services and supports identified in their Individual Placement Plan (IPP).

Status: Assembly Human Services Committee

- **SB 526 (Alquist): Long Term Health Care**

This bill would require the State Department of Health Services to establish dedicated complaint response units in each district office of the Licensing and Certification Division of the Department of Health Services (DHS) by January 1, 2007 following a study of unanticipated costs, require DHS to issue a Class "A" citation when a nursing home resident is sexually assaulted by an employee of the facility, add to the list of resident rights for long-term health care facilities, including changes to requirements regarding transfer and discharge of patients, create requirements for skilled nursing facilities for the admission of patients covered by the Medi-Cal program, and require nursing home operators to document labor costs by submitting payroll records to DHS on a quarterly basis.

Status: Senate Health Committee

- **SB 642 (Chesbro): Adult Day Health Care Program**

This bill makes various changes to the Adult Day Health Care (ADHC) Program and requires the Department of Health Services (DHS) to take all appropriate action to obtain approval for a State Plan Amendment that would conform the ADHC program to requirements of federal law and include specific requirements. The bill would provide that no provision of the ADHC state plan amendment shall be implemented unless and until DHS has obtained full approval for that amendment from the federal Centers for Medicare and Medicaid Services, and the plan can be implemented by DHS.

Status: Senate Third Reading

- **SB 855 (Poochigian): Special Access: Liability**

This bill would impose pre-litigation procedural requirements upon the filing of any claim under the state's civil rights and equal access to public or housing accommodation laws, including claims of violations of the Americans with Disabilities Act in state-owned facilities.

Status: Senate Judiciary Committee

Agenda Item #8
Olmstead Advisory Committee Meeting
August 26, 2005

The California Health Incentives Improvement Project (CHIIP) is a multi-agency collaborative effort working to remove barriers to the gainful employment of people with disabilities, particularly health care and personal assistance barriers. The CHIIP was created in 2002, and is funded by a Medicaid Infrastructure Grant from the federal Centers for Medicare and Medicaid Services. In 2003, California Department of Health Services selected the California Institute on Human Services at Sonoma State University to administer the grant on their behalf.

To help accomplish its mission, the CHIIP is overseen by a steering committee comprised of consumers, community-based organizations, and representatives from state and county government that help to guide the work of the project. This group has been meeting quarterly since 2002. In the fall of 2003, the CHIIP Steering Committee formed two subcommittees: Outreach and Training and Research and Policy.

The CHIIP Steering Committee also meets quarterly with the California Governor's Committee on Employment of People with Disabilities, as the two organizations share a common vision and similar goals. Additionally, California Assembly Bill (AB) 925, Chapter 1088, Statutes of 2002, more closely aligned the two organizations and established parameters for joint collaborative efforts.

In order to facilitate gainful and competitive employment and economic self-sufficiency for people with disabilities, the CHIIP work plan for 2005 consists of four main objectives: 1) *build state and local intergovernmental infrastructure to remove healthcare and other*

barriers to employment for people with disabilities 2) *increase the number of participants utilizing the Medi-Cal Working Disabled and IHSS in the Workplace programs through outreach to people with disabilities, service providers, eligibility workers and employers* 3) *strengthen labor force connections for people with disabilities by expanding and supporting the disability benefits counseling and training infrastructure of state and local program administrators, front line staff and community-based organizations who assist people with disabilities in achieving successful employment outcomes and economic self-sufficiency*, and 4) *improve employment and earnings levels of Medi-Cal Working Disabled participants by evaluating the adequacy and effectiveness of, and developing improvements in, health incentives and other supports for people with disabilities related to employment, including for the Medi-Cal Working Disabled and In Home Supportive Services programs.*

Committee Reference Document
Feedback from Stakeholders in 2003 Olmstead Forums
Assessments

In developing the May 2003 Olmstead Plan, the state held a series of public forums designed to listen to consumer and stakeholder input regarding California's long term care system. The following comments were offered by stakeholders at the November 22, 2002 meeting of the Olmstead Work Group in San Diego. The comments are listed under each of the Key Questions that were discussed.

1. What is the purpose of assessments?

- *Determine all factors, services and housing, physical and emotionally supports, that might be necessary for success in community placement
- *Determine all factors, services and housing, physical and emotionally supports, that might be necessary to deflect placement in institutional setting
- *Assess true desire of individual being assessed
- Use assessment to develop plan
- Assess for what a person can do, not what they can't do
- Use data on unmet needs for system
- Provide guidance to transition workers
- Give consumers and family the tools they need to make choices.
- Enable families to access services provided by school systems
- Identify community resources that address individual functional barriers for individuals who do not oppose community placement.
- Duality in planning – assess in environment & needs in the community
- Individualized process looking at most integrated setting
- "Holographic screen" – know all options available – have template to provide guidance.
- Cultural considerations
- Family situation & involvement

* = priority recommendations

2. Who should be assessed?

- Everyone in a restrictive setting should be assessed [do not assume that severe disability should automatically negate need for continuous or routine assessment]
- Anyone in licensed state facility
- Anyone referred by family or friend or ombudsman
- Anyone who asks
- People at risk of placement in a more restrictive setting
- Individuals going into & leaving high school
- Expand beyond "Medicare-Medi-Cal" identify need & expand
- People experiencing an unplanned medical crisis
- Anyone covered by the ADA
- Persons served by senior services systems
- People not opposed to community placement
- People at risk of placement in a: Children's shelter,Nursing facility, Sub-acute facility,Institution for Mental Disease (IMD),Developmental Center, State Hospital,Large Community Care Facility,Inpatient Facility, Intermediate Care Facility, Juvenile Facility,Trauma Center
- (Did not reach a consensus re incarcerated imprisoned population)
- (Further study is needed to determine what factors to use when identifying "at risk")

3. What information do consumers need so they can participate fully in their own assessment?

- Information should be provided via a facilitator if necessary
- Information about the opportunity to be assessed for placement
- Information about all available choices
- Information on the obstacles/barriers involved in choosing to move to less restrictive setting in the community
- Information on the timeline for implementation of potential plans and outcomes
- Information should be readily available, linguistically and cognitively appropriate
- Information on how to access the system for assessment

- Information should be provided on a voluntary basis and kept confidential
- Information should be provided on all choices in an understandable format, be simple and concise, and use variable formats including graphics
- Information from participant to be included in process
- Information about any entitlement of services, regardless of availability in community
- Information explaining that an individual will not be locked in a living situation, and can test different options and change his or her mind
- Information providing an example of a person with a similar disability & how they live in community – peer counselor, mentor – individual & family members
- Information on what the consumer's rights are
- Information on the objective or purpose of assessment
- Information on how to access what is available; i.e. who to call; what papers must be completed, etc.
- Information should be available on videotape – for informed choice
- Information on financial benefits available in community situations (SSI, IHHS, etc.)
- Information county staff regarding what they can do
- Information on how to obtain a peer/community advocate or how to be a self advocate

4. What training and background do assessors need?

- The team assessment approach
- Objectivity; impartiality; open-minded, flexible
- Olmstead assessment principles and guidelines
- The philosophy of recovery and a person pursuing their own path
- Familiarity with what is available in the community
- Life quality assessment practices
- Training from various entities – seniors, parents, family members – sensitivity to the issues and points of view of consumers and others involved

- A commitment to community options
- Background in community services
- Background in PT/OT (physical therapy/occupational therapy)
- Sensitivity training
- Training on the tools of assessment
- Resource database
- Cultural competence
- No personal or professional conflict of interest or appearance of conflict
- Ability to recognize depression and other mental health conditions
- Awareness of biases of all sorts, including against persons with disabilities
- Involvement in an independent living center
- perspective that focuses on functional limitations and strengths, not disability
- Broad based knowledge – person & system
- Experience in field for which they are doing assessments
- Familiarity with the individual being assessed (observe him/her over time)
- State & Federal guidelines regarding core competencies and credentials
- In depth knowledge of items in question 3) above
- Superb listener, non-judgmental
- Creative, flexible, common sense
- Belief in value of community
- A “can do”, proactive attitude
- Somebody who knows what its like to live in the community
- Disability/Aging awareness
- Personal experience; assessor could be a person with disabilities
- Knowledge of recovery concepts

5. What information should be collected in an assessment?

- The individual’s preferences
- Individual’s risk factors with moving out of institutional care

- What risks are they willing to bear?
- A person's independent living skills
- Basic personal information, health, transportation, safety, insurance, medical diagnosis, etc.
- Cultural, religious and social background
- Geographic area of choice, neighbors, connections in community, likes and dislikes
- Services needed
- Housing and financial needs
- A lifestyle assessment – because of possible need to move in with housemates or roommates
- The person's hopes and dreams in six months to a year
- Recreational needs, likes, and preferences
- Ask "how did you get here & what do you think would get you out /keep you out."
- We can be looking at 2 questionnaires – one who knows what the need is and one who doesn't
- Familiar services & supports (friends, family, community &advocacy support groups)
- Medical information

6. When and how often should assessments be performed?

- Annually
- Ongoing to monthly – so people don't fall through the cracks
- Upon request or when a change in status occurs
- Formally once; then on a scheduled recurring basis (quarterly, annually, etc.); [big and mini assessments]
- Check in on a routine basis after person moves out of the institution
- When a crisis threatens
- At every hospital admission and discharge
- As people age
- At a transitional age – age 14
- Continuously monitor individuals who are in an institutional setting

7. What happens to assessment data? How is it used? What happens to the evidence of unmet needs, both for the individual and in the aggregate?

- Assessment data should be kept confidential, but consumer should get a copy
- Families & conservators should have access to assessment info as allowed by law
- Aggregate information on all consumers should be available for public use
- Use assessment information to create a transition plan
- Use it to identify unmet needs by comparing assessed needs to available resources.
- Use it for state and community planning
- Consumer should have copies of all information
- Info in aggregate's personal info should be available
- W/unmet need, benefit programmer should go out & assess for local services
- Person should know who has access & sign release to share
- Develop plan to get person into community
- Assessment data should be evaluated & amended if indicated/needed (or disputed)
- Change or enact law to allow family access to data.
- Collect info – identify gaps – report results/document improvement
- Link resources with need
- Report Aggregate data on good programs so they can be replicated

8. What rights do consumers have in the assessment process, and how are they protected and… how are they enforced?

- Right to say no, voluntary
- Right to assessment
- Right to add/remove someone to/from his/her assessment team
- Right to information about process
- Right to information about results

- Grievance and appeals processes
- Right to be reassessed
- Right to tell assessor who not to talk to
- Right to full participation
- Right to fail in a placement and be assessed again
- Right to informed choices
- Access to information in the consumer's file
- Control over what information is shared with others
- Be on waiting lists that move at a reasonable pace
- Individual information not liked by consumer – have it deleted
- Confidentiality
- Able to change mind w/o negative outcome
- Training & bring independent capacities up to par
- Right to have recreational & social needs met
- Discussion w/ person & their dreams for what they may be able to do.
- Right to participate (families and conservators)
- Right to object to assessment if they are competent
- Right to peer and family advocacy & representation
- Right to review assessment in own language or communication device.
- Persons who are underserved need to be routinely re-assessed to obtain their actual choice.

Other Issues

In addition to their responses to the key questions, the Work Group participants made a number of comments on related issues. These were as follows:

- The community needs to be ready for the disability community.
- Emphasize positives. Have a positive frame of reference which characterizes the whole service system

- Assess both before & after movement to a facility
- Require a waiver for institutionalization, but not to stay in the community
- Assessment should be a fluid process because changes come with an individual's growth.
- Assessments should be available quickly, on an interim & crisis basis, if necessary to avoid institutionalization.
- Shouldn't have only institutional staff doing assessments, they may not know what's available in the community.
- Assessment should be strength-based, consumer-oriented.
- Reorganize so the state's responsibilities are in one "Department of Assessment." The purpose of this department would be to: 1) to centralize so all assessments will be in one spot, 2) to be the consumer advocate
- The Assumption should be Community Placement - Develop new services so that normal process is staying in the community – full integration
- IF WE DEVELOP AN EFFECTIVE FRAMEWORK WHAT'S A REASONABLE TIMEFRAME FOR IMPLEMENTING IT?
- There needs to be a schedule for implementation. Work group strongly agrees on this final point.

Committee Reference Document
Feedback from Stakeholders in 2003 Olmstead Forums
Diversion

The following comments (found in Appendix F of the May 2003 Olmstead Plan) were offered by stakeholders at the December 10, 2002 Olmstead Work Group Forum in Fresno, California. Each subgroup addressed three issue areas: 1) How to divert consumers from entering institutions; 2) How to transition individuals from institutions to community homes; and 3) What needs to be done to prevent consumers from being re-institutionalized.

For each of these issue areas, the subgroups were asked to identify what processes need to be in place, who should be involved, and what resources are necessary.

Below are the consolidated recommendations from all of the sub-groups, including those who participated via conference call. The recommendations for each of the three issue areas are presented separately.

Questions 1, 2, & 3 – How to divert consumers from entering institutions.

- Assessment needs to be performed before placement into institution; institutions should not be eligible for reimbursement for costs incurred prior to completion of assessment (see Utah and Wisconsin)
- Services should be provided on an ongoing voluntary basis
- Caregivers should be provided with a list of triggers, issues that give a “heads up” that the community placement is in trouble
- People need information on available services and resources regarding community placements, one-stop shopping, presented as a map. Each service provider entity should have a staff person who is well educated in these resources
- Government agency staff adequately staffed regarding Olmstead services and knowledgeable about all other related services

- Doctors, nurses, discharge staff all need to be educated about community placements
- Need to look at shared cost issues
- There need to be half-way houses for people coming out of acute institutions so they don't have to be moved to long-term institutions
- IHSS needs to be set-up prior to discharge from an acute care facility for someone that can be placed in the community
- There should be more prevention services at the community level to keep individuals in community settings. Need to implement SB 953 [set standards for care navigation]
- Need more education about prevention services
- Need 24-hour response care" vs. 24 hr medical care so people can stay at home instead of being placed in an institution
- Look at current structures to include all disabilities. Look at funding streams that are currently divided by type of disability and age; instead, look at by functional ability
- Need to review regulations in light on economic reality, e.g., revisit penalties for being married or living together as domestic partners
- Maximize resources, by helping people in living together who can assist one another
- Multi-disciplinary (continuum of care – involve individuals from different agencies) team approach prior to placement – pre/post assessment and evaluation
- Crisis support services
- Multicultural approach for culturally appropriate svc delivery
- Education of general public on how to live in community as the norm vs. inst care – public service announcements (PSA)
- Universal design for home to be adaptive to needs of the person
- Information should be available to consumers… all interested parties… re: Options /success stories
- Use newsletters & other means of information sharing
- Evaluations need to consider competency/ability of family caregivers
- Assumption should be that non-institutional living options should be considered
- No funding should be provided for institutions until other options have been explored

- An assessment has been done that assumes community placement
- Doctors/med community need to be informed & buy in to non-institutional options
- Chemical dependency intervention
- Temporary institutionalization should include assumption of community placement
- Discharge planning should be more effective and community based. Consumers and family if client agrees
- Individuals knowledgeable about options/resources
- Multi-Disciplinary team including housing, gerontology, medical, advocate, therapies
- Ombudsman
- Reorganize state government so that all social services are in one dept (client chooses social worker)
- All points of entry into LTC should lead to assess & diversion in accord with Olmstead

Questions 4, 5 & 6 – How to transition individuals from institutions to community homes.

- Assessment should include client, family, doctor, community placement staff, institution staff; should address individualized services
- Early planning; list of real needs of individual to stay in home; education and clarification of process to actually move into community setting
- Use the knowledge of the hospital staff
- Implement AB 499 [Assisted Living Demonstration]
- Address services needed other than medical, e.g., transportation, equipment to be needed at home
- Need to be aware of use of language, e.g., process should be consumer “controlled”, not just consumer directed”. Consumer should drive the process and make decisions.
- In all recommendations, need data on who needs services at state and county level
- Cultural competency principles include age, ethnicity, gender, sexual preference

- Modify State Medicaid plan. Instead of expanding services by expanding waiver slots, make it part of the Medicaid plan itself.
- Redefine definition of medical necessity to allow for coverage of Assistive technology, e.g., for people who are transitioning or at imminent risk of going into an institution, e.g., stair glides. (Stair glides were allowed in one decision; should be included in the plan.
- Review durable medical equipment list with consumer participation
- Need durable equipment in place before discharge. Evaluate the home for needed equipment with the person present.
- Review state special circumstances grant: dollars for rent, pots and pans, and move in type expenses
- Modify NF waiver
- Develop "mega team" – people knowledgeable of all services and how to be apply for services (transportation, HUD, independent living, IHSS) and be advocates
- Resources & needs into statewide database (info avail at time it is needed)
- For consumers provide information; provide aggregate data for planning
- Sufficient waiver services, slots & funding for all who are eligible
- Chemical dependency intervention
- Make available temp placements in institutions to find community options
- Independent assessment to avoid conflict of interest
- As easy to "get out" as to "get in"
- OT & AT assessment
- Assistance with transition (to individual for such things as move-in costs, home mod), funding, waivers, collaborations. Loans, etc.
- Avail CMS funds for transition – state should seek security deposits (pre-funding)
- Money should follow person (all disabilities)
- Cash and counseling (consumers decide what services to purchase)
- Guaranteed access for advocates & others to educate clients/consumers in institutions of community options
- Funding should recognize the length of time required for transition

- Caseworkers/staff should understand & have empathy for clients/consumers.
- No county financial incentive for alt to nursing home placements
- Public guardian should be prevented from selling homes of individuals they oversee
- Eliminate disincentives for shared living & shared support services in all programs
- People involved in the transition process should be consumers & peers; the family, if the individual wishes, and the assessment team
- Guardians & conservators actions should be consistent with Olmstead principals
- State & local officials should be involved to access CMS funds, and facilitate regional task forces on unmet needs
- Prohibit “cold calling” – provide orientation period for person
- Provide a strong support system – encouragement from hosp MDT (multi-disciplinary team) family, friends, to help with connections once in community
- Provide access to inform to be released once – not multiple times
- Housing – taking advantage of subsidized programs by using state funds for this – can get more services in home setting
- Have trained individuals who go into home assessing individual
- Focus on hopes/dreams of person & not limitations – while someone who has been thru process/realities – peer counseling
- Provides services needed to ensure successful transition
- Provide safeguards in community – oversight re: quality of care in community – should be similar to monitoring requirements established in institutional Settings
- Safeguards should be focused on community setting – appropriate for the setting of person – make standards applicable to community setting – “common sense applicability”– can be difficult to establish
- General registry of available services for all – for example – Public Authority Consumer Registry for Services
- Payor services

- Formal organization of non-traditional providers/churches, families, caregivers
- Need: intensive 24/7 supports on move to community. Person initiates.

Questions 7, 8 & 9 – How to prevent consumers from being re-institutionalized.

- Need state support for integration and coordination of long-term services; use AB 1040
- Conduct home visits shortly after placement in community; routinely thereafter until person is comfortable with home setting
- Make available physical therapy in home
- All transition plans need elements regarding on-going support.
- People that are at risk need services on demand
- Mandate annual training on current knowledge and resources for all staff involved in transition and deflection
- Provide continuum of care as long as person is in community
- Staff visit consumer, may include other folks placed and living in community
- Fitness and therapy services made available
- Level of Services must meet level of need
- More advocacy to override institution interest
- Timely follow-up & problem resolution
- Inform consumer choice and caregiver knowledge of options & training for both.
- Real time information focused on availability of local services
- - Statewide 211 # -
- Caregiver registry on-line
- On-call caregiver services for short term fill-in
- Best practices (emergency services)
- Organize on-call workers for back-up rapid response
- Rapid response, e.g., emergency back-up, if caregiver doesn't arrive
- Interventions (jobs, housing, Sect 8, SSI, IHSS, etc.) for holding supports during hospitalization

- Coordinate programs & stabilize funding (accountability)
- Drug intervention (staff/clients)
- Increase trained personnel, e.g., social workers and other staff, peer providers, students
- Develop career paths for workers from entry level to professional staff
- Rededicate resources for institutional care to community living
- Training of consumers in skills, transition services
- Need to address Financial aspects (as in planning, managing own finances)
- Need to educate the community at large (especially Police and Fire), need public service announcements
- Transportation, alternative formats of language/communication
- Case management, PT, exercise
- Non-traditional supports – peer groups, volunteer services, friends – may get more information from person on how they are doing – person may be afraid to tell pd svc entities for fear of rehospitalization
- Individual / family counseling
- Need “neighborhood watch” models in communities – limit those taking advantage of person
- request re-evaluators as needed – not just @ prescribed timelines
- refresher courses for info on available services – people forgetful: attend presentation to ask questions – education / training courses for consumers ongoing basis
- Establish simple list of rights – readable format – to be used by evaluator of person also.
- Need a crisis team plus other resources such as a hotline
- Train cross-disciplinary advocates
- Persons who should be involved include: Multidisciplinary team; the individual consumer; family; faith community; doctors; law enforcement; nurses; social workers; resources from the institution who may also have knowledge of person/needs; friends; caregivers; treatment team members
- Train care providers based on need of person
- Respite for caregivers – VERY MUCH NEEDED

Committee Reference Document

CALIFORNIA Real Choice Grants

Grant Information

Name of Grantee	State of California
Title of Grant	Bay Area Quality Enhancement Initiative
Type of Grant	Quality Assurance and Quality Improvement in Home and Community Based Services
Amount of Grant	$499,844
Year Original Funding Received	2003

Target Population(s)

Individuals with developmental disabilities.

Goals

- Design a model and corresponding plans to implement a Quality Services Network to provide person-centered and person-directed quality services and supports to people served within the Bay Area.
- Adopt a systematic approach to measure consumers' satisfaction with services and supports in meaningful ways at important intervals to guide system improvement efforts.
- Apply the "lessons learned" from the project activities to make statewide system reforms.

Grant Information

Name of Grantee	California Department of Social Services
Title of Grant	IHSS Enhancement Initiative
Type of Grant	Real Choice Systems Change
Amount of Grant	$1,385,000
Year Original Funding Received	2002

Target Population(s)

Approximately 300,000 Medicaid-eligible aged, blind, and disabled individuals in the In-Home Supportive Services Program (IHSS), as well as roughly 250,000 care providers.

Goals

- Develop training, educational materials, and other methods of support to aid IHSS consumers to better understand IHSS and to develop skills required to self-direct their care.
- Identify training and other support needs of IHSS care providers and create materials, tools, and work aids that will enable those providers to improve the quality of care they render to the consumer.

Grant Information

Name of Grantee	Community Resources for Independence
Title of Grant	Transitions Independent Living Partnership Grant
Type of Grant	Nursing Facility Transitions, Independent Living Partnerships
Amount of Grant	$337,500
Year Original Funding Received	2002

Target Population(s)

Native Americans and Hispanic individuals with cognitive, mental/emotional, physical, hearing, vision and multiple disabilities, families, and health clinics statewide.

Goals

- Improve access to services by developing a new transition model and conducting outreach and education.

- Assure consumer direction, involvement, and participation at all levels of the project.

Grant Information

Name of Grantee	California Department of Health Services (DHS) and the Department of Rehabilitation
Title of Grant	California Pathways
Type of Grant	Money Follows the Person Rebalancing Initiative
Amount of Grant	$750,000
Year Original Funding Received	2003

Target Population(s)

Adult Medicaid-eligible nursing facility residents.

Goals

- Develop standardized protocols and processes for transitioning nursing facility (NF) residents to home and community settings throughout the State.
- Develop financing models and systems that enable money to follow the person from a NF to home and community settings.

Grant Information

Name of Grantee	California Department of Mental Health
Title of Grant	California Study on New Medi-Cal Respite Benefit for Caregivers of Adults With Cognitive Impairment
Type of Grant	Respite for Adults
Amount of Grant	$100,000
Year Original Funding Received	2003

Target Population(s)

Caregivers of individuals with adult-onset cognitive impairment.

Goals

The goal of this feasibility study is to develop recommendations for ways that California can implement and evaluate a new respite benefit under Medi-Cal for family and informal caregivers of individuals with adult-onset cognitive impairment.

Activities

- Establish an Advisory Committee comprising representatives of key government agencies, consumers, provider and academic entities, to provide advice on issues such as consumer direction and access, information infrastructure and fiscal employer agent options, implementation issues, and an outcome evaluation.
- Review existing Medicaid respite programs including eligibility standards, assessment measures, quality assurance protocols, expenditure caps, extent of consumer direction, and alternative fiscal agent strategies.
- Analyze the need for changes in waiver requirements and investigate how to incorporate a benefit tracking system into the existing data system.
- Review existing national Medicaid data on respite programs and identify the potential benefits to the target population, scope of respite services, cost projections, estimates of caregivers who would use respite, and the impact of service limits on the target population.
- Identify client-assessment tools, protocols and procedures, and outcome evaluation methods currently used in other state programs.
- Develop an implementation and evaluation proposal for expanding respite services.

Aging and Disability Resource Center Initiative

Lead Department: Department of Aging

California will establish a Resource Center in Del Norte County and San Diego County, in partnership with the Area Agencies on Aging, to simplify access to long-term care services. The Resource Centers will identify systems improvements related to access, conduct public awareness activities, target outreach to underserved or hard-to reach populations, identify modifications to the Network of Care website, and partner with physicians who will link with social services. California will evaluate the effectiveness of the two Resource Centers based on geographic, cultural and sociodemographic differences.

California plans to coordinate Level of Care staff and financial eligibility staff at local county sites. In addition, Del Norte County plans to expand existing website to include on-line applications, and additional resources to link consumers and their families to LTC service and assistance. Currently in Del Norte, there is no uniform screening process for aging and disabled services. In San Diego County, individuals are screened through the AIS call center and a case manager does the functional assessment. For Medicaid eligibility, the consumer is then transferred to a regional center where consumer goes and brings info with them, or they can mail-in the application. California is aware that they need a more user-friendly eligibility process. The State has an initiative to go to one application for all programs, and establish MOUs across multiple agencies to share information and develop a single screening tool.