OLMSTEAD: Components of a Comprehensive Plan
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What To Look For

þ Commitment of Governor
þ Statement of support of the ADA
"most integrated setting"
þ Includes nursing homes and all other institutions
þ Identifies all affected populations - physical/mental
Children, young adults, older folks
þ Identifies lead agency/plan coordination
þ Identifies funding to implement plan
+ Budget request(s) to State Legislature
þ Provides for input from people with disabilities/older folks
+ Plan development
+ Plan implementation
+ Oversight
þ Data Collection
+ Number in nursing homes and other institutions
+ Number in waivers, Personal Care Option, Home Health, State funded programs
+ Number on all waiting lists
þ Development of Identification Process
+ Use of Community Based Organizations
+ Identifies all populations - public/private
+ Interest Assessment - Service Coordination
+ Dispute Resolution
þ Community Integration Assessment/Plan
+ Assess what community services are currently available
+ Identifies community services/infrastructure needed
+ Identification of barriers to community integration (Nurse Practices Act, licensing, housing, funding transportation, employment, equipment, etc)
+ Support Services needed to move/stay in community
+ Timelines for moving to the community
þ Review/Monitoring of Community Integration

ADAPT

Olmstead Implementation
Identification Process
Suggestions for Action

A first step in implementing the Olmstead decision is to assure there is a formal ongoing identification process that
1. Identifies individuals in nursing homes and other institutions that want to move into the community;
2. Avoids the unnecessary institutionalization of individuals living in the community uses Community Based Organizations (CBO's).

The following are some suggestions on building an effective working identification process focused on using Community Based Organizations (CBO's):

I. Development/Usage of a Community Living Identification Process (CLIP). Has two components -
1. Interest assessment;
2. Service and support needs;
A. Assesses the interest of individuals who want to move into the community. (Not who CAN but who WANTS TO move into the community)

B. Assesses service and support needs to move out of nursing home and other institution, develops service and support plan and provides service coordination to insure a smooth transition.

1. Personal Attendant Services (PAS)
2. Durable Support Equipment
3. Housing - HUD, State funded $300 per month subsidy until eligible for HUD funding, private
4. Transition costs - $2500 per individual for things such as 1st month rent, deposits, kitchen supplies, furniture and other household items.
5. Medical/Prescription needs
6. Transportation
7. Financial benefits

C. Assesses the service and support needs of those on waiting lists. Avoid unnecessary institutionalization (Those in jeopardy of going into a nursing home or other institution)

* Similar mix of service and support needs as above

CLIP could be used as an expanded PASAR process (Pre-Admission Screening and Review which is currently used only for persons labeled DD or having a mental health disability)

II. Administration of CLIP

A. State agency contracts with Community Based Organization (CBO) who has experience with and knows community resources to administer CLIP. (For example $100,000 per CBO to provide the identification and transition services)

B. CLIP administered to those in nursing homes and other institutions as well as those in jeopardy of going into nursing homes or other institutions.

III. Process for CLIP administration by Community Based Organizations (CBO)

A. Done yearly on all individuals when their financial eligibility is conducted.
Or
Done yearly on all individuals when their Minimum Data Set (MDS) is conducted by the nursing home. CLIP, done by the CBO, can be used to ascertain their discharge potential (Section Q of the MDS).

B. CBO gets referral or is single point of entry on all individuals in jeopardy of going into a nursing home or other institution.

IV. Monitoring/Follow-up and Quality Assurances done by CBO

A. Based on quality of life issues - how does living in the community improve the lives of people with disabilities (socioeconomic, employment, and health outcomes)?

B. Based on consumer satisfaction (evaluate whether the transition was done smoothly, were the consumer's goals identified and met, were consumers adequately informed throughout the process, did they have the necessary support to manage their services in the community)

C. Possible consumer advisory networks involved

Example budget to present to State:

$100,000 per CBO per year for Community Living staff and administrative costs
$2,500 per individual transitioning to the community (one time cost)
$3,600 per year per individual ($300 per month) housing subsidy until person gets on HUD program
Cost of waiver services or other program costs

The CBO should develop a proposal with other CBO's in the State and advocate for the State to fund the proposal as part of their Olmstead implementation requirement. This is a private list and should not be disseminated to others without express permission to do so.

ADAPT

OLMSTEAD IMPLEMENTATION

1. Involve all groups concerned about developing more community services and avoiding unnecessary institutionalization. (IL, DD, Mental Health, Aging, etc.).

2. Get data/information on number of people receiving community services, institutional services and waiting lists for each program. Research all funding (Medicaid, VR, state).

* Nursing homes
* ICF-MR's - large and small - public and private
* State hospitals
* Waivers - number? How large? Who does it serve?
* Personal care option - who does it serve? Hours per week.
* Home health
* State funded programs

3. Outline of a comprehensive effectively working plan

* What exists today. Programs, number of people served, waiting lists.
* Development of identification process - using community organizations.
* Development of support services (infrastructure) needed to get/keep people out of nursing homes and other institutions.
* Intensive Service Coordinator
* Simple Intake System
* Waiver and other program development enhancements
* Number of people per year that will transition out of nursing homes and other institutions
* Number of people per year that will be diverted from nursing homes and other institutions
* Identification of and recommendations for the elimination of barriers to community placements
* Regulations (Nurse Practice Acts, licensing, etc.)
* Affordable accessible housing
* Transportation
* Quality monitoring system based on consumer satisfaction
* Per year funding for implementation of plan

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