California Olmstead Plan

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
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I. INTRODUCTION

Two of the Congressional findings in the Americans with Disabilities Act (ADA) provide a clear background for the context of the development of an Olmstead Plan. These findings state in part, "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." The Act goes on to say "the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals and the continuing existence of unfair and unnecessary discrimination and prejudice denies people with disabilities the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous, and costs the United States billions of dollars in unnecessary expenses resulting from dependency and non-productivity." (Public Law 101-336, Sections 2(a)(2) and 2(a)(8))

The U.S. Supreme Court's *Olmstead* decision reflects these findings. Persons with disabilities have the right to live in the most integrated setting possible.

The Davis Administration is fully committed to the principles of the *Olmstead* decision and its desire to continue to ensure that persons with disabilities have appropriate access and choice regarding community based services and placement options. The state commits to providing services to people with disabilities in the most integrated setting. The state commits to adopting and adhering to policies and practices that will provide a full array of services and programs that make it possible for persons with disabilities to remain in their communities and avoid unnecessary institutionalization. This commitment involves making changes in current state policies and will require changes in federal policies that are biased towards institutionalization.

Well before the *Olmstead* decision, California was a leader in providing services to support the full integration of persons with disabilities in community life. These services, which were born out of the independent living/disability rights movement, included the availability of personal assistance services to avoid institutionalization for those individuals who required assistance with activities of daily living. In fact, as a result of two decades of state legislative and budgetary actions, California has the largest consumer directed personal care program in the U.S., the In-Home Supportive Services (IHSS) Program, which supports over 250,000 Californians on a statewide basis. In the past three years, expenditures for this program have almost doubled to nearly $2 billion, as increased worker wages and benefits have been phased in.

In addition, through the programs funded by the Lanterman Act, California has been providing comprehensive services to support the integration of persons with developmental disabilities into community life. Since 1993, California has accomplished more than a 40% reduction in the number of clients residing in state developmental centers. Currently, 98% of the persons with developmental disabilities are living in the community. In view of this, in August 2002, the U.S. District Court issued an order in *Sanchez v. Johnson* that found the Department of Developmental Disabilities has complied with the ADA and *Olmstead* decision by establishing a comprehensive, effectively working plan for placing qualified persons with developmental disabilities in less restrictive settings through its Community Placement Plan.

California has also directed a substantial portion of its Med-Cal resources to support community care. By 1998, 91% of Medi-Cal beneficiaries with long term care (LTC) needs were living in the community. Nine percent were receiving care in an institutional setting. In 2000-01, over half of all public long term care spending ($4.9 billion of $8.8 billion) in the state supported home and community based care options.

Finally, since 1992, California has had more than a 67% reduction in the number of state hospital beds maintained for civil commitments. In 1998, only 800 beds were utilized, while more than 540,000 Californians received public mental health services.

Despite these gains, there is still much work to be done and progress to be made. This Plan includes a blueprint for an improved system in California and the steps needed to move towards achieving a system that will provide services in the most integrated setting appropriate for persons with disabilities. This Plan should not be considered a beginning or an end, but rather an important step in the goal to further the *Olmstead* principles in California. The Plan should serve as a foundation for policymakers in implementing changes that will result in system improvements.

This Plan is a recommendation for system change and improvement and is one step in the continuing evolution of a longer-term vision that must continue to be articulated and updated. It must be recognized, however, that future leaders in California may change the direction of this Plan as the needs of the citizens of this state change. The Plan is not written in stone and it cannot bind the future leaders of the state. It is the sincere hope of the current drafters that the future leaders will continue to share the vision of improving the long term care system in this state.

One significant challenge to implementation of certain elements of the Plan is the need for additional resources. While this Plan represents a blueprint for an improved system, certain activities will need to be delayed until the fiscal condition of the state improves. Those steps that require additional resources are identified specifically in the Plan. In addition, there is no guarantee the state's leaders will appropriate the necessary funds for these activities even with

an improved fiscal climate. However, there are important activities in the Plan that can move forward without new resources. These activities may call for a re-direction or alternate use of resources or for better coordination and collaboration among existing programs. Nevertheless, even the completion of these activities may be delayed if existing resources become unavailable or are permanently reduced due to budget constraints.

During the development of this Plan, many stakeholders and consumers throughout the state dedicated their time, commitment and ideas to this effort. The hundreds of statements made by consumers and other stakeholders (included in the Appendix) are a testament to the knowledge, experience, passion, and expertise of these individuals. The Administration is grateful to them for their tireless commitment to working with the state in the development of the Plan, as well as all of their past efforts on these issues.

In order to have a comprehensive, effectively working Plan, it is important to realize that the Plan must be continuously updated, improved, and monitored for implementation. In that respect, this document should be treated as a "living document." Additionally, it is important that the Plan be grounded in a set of guiding principles that reflect consumer-centered values. To this end, and with substantial input from consumers and other stakeholders, we propose to follow these principles:

- Self-determination by persons with disabilities about their own lives, including where they will live, must be the core value of all activities flowing from the Olmstead Plan.
- Promote and honor consumer choice and ensure that consumers have the information on community programs and services, in a culturally competent and understandable form, to assist them in making their choices.
- To support the integration of persons with disabilities into all aspects of community life, persons with disabilities who may 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.
- Consistent with informed choice of consumers, community based services that are culturally competent and accessible should be directed, to the maximum extent possible, to allow persons with disabilities of all ages and with all types of disabilities, to live in the community in non-institutional settings.
- For minor children with disabilities, the most integrated setting is at home with their families, whenever possible.
- In order to be effective, Olmstead Plan development, implementation, and follow-up must be an inclusive effort involving individuals with disabilities and their representatives, family members, providers, vendors, and other stakeholders.

The Olmstead Plan challenges the state to develop more opportunities for individuals with disabilities who desire to live in the community.

With the partnership and collaboration of consumers and other key stakeholders, we can work towards better realizing the goals that are consistent with the *Olmstead* decision. We hope that the future leaders of this State accord the Olmstead Plan the same high priority.

II. BACKGROUND

Olmstead Decision. The Americans with Disabilities Act (ADA) provides that no qualified individual with a disability shall, by reason of such disability, be excluded from participation in, or denied the benefits of the services, programs or activities, or be subjected to discrimination by any such entity. The *Olmstead* case involved two women in Georgia whose disabilities included mental retardation and mental illness who sued the state of Georgia. At the time the lawsuit was filed, both lived in state-run institutions although their treating professionals had determined that they could be appropriately served in a community setting. The women alleged that their continued institutionalization was a violation of their right under the federal Americans with Disabilities Act (ADA) to live in the most integrated setting appropriate.

In 1999, the United State Supreme Court issued its decision in *Olmstead v. Zimring* (119 S.Ct. 2176), in which the court concluded that states are obliged by the ADA to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when:

1) The state's treatment professionals have determined that community placement is appropriate;

2) The individual does not object to community placement; and

3) The placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with disabilities.

The Court also cautioned that the ADA does not require elimination of institutional settings for persons who choose not or are unable to be treated in community settings and that the state's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not unlimited.

Under the ADA states must "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program or activity." (28 CFR 35.130(b)(7)). The Supreme Court indicated that whether a modification results in "fundamental alteration" of a program is based on (1) the cost of providing services to the individual in the most integrated setting appropriate, (2) the resources available to the state, and (3) how the provision of services affects the ability of the state to meet the needs of others with disabilities.

The Supreme Court also gave the states general guidance on how to demonstrate compliance with the ADA. For example, compliance may be shown if a state can demonstrate that it has:

1) a comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings, and

2) a waiting list that moves at a reasonable pace not controlled by the state's endeavors to keep its institutions fully populated.

Federal Department of Health and Human Services (DHHS). Following the *Olmstead* ruling, DHHS recommended that states do the following:

1) Develop a comprehensive, effectively working plan to strengthen community service systems and serve people with disabilities in the most integrated setting appropriate to their needs;

2) Actively involve people with disabilities, and where appropriate, their family members or representatives, in design, development, and implementation.

In offering guidance in the development of an "effectively working" Olmstead plan, the DHHS recognizes that "there is no single plan that is best suited for all States, and accordingly that there are many ways to meet the requirements of the ADA." (DHHS, January 14, 2000 Office for Civil Rights' Olmstead letter to State Medicaid Directors).

Olmstead Planning in California. In April 2002, the California Health and Human Services Agency (CHHSA) Long Term Care (LTC) Council directed its staff to prepare the development of an Olmstead Plan for California. In addition, the Trailer Bill to the Budget Act of 2002 (AB 442) required CHHSA to develop an Olmstead Plan following guidelines specified by the federal Center for Medicaid and Medicare Services. Specifically, AB 442 states:

> *The California Health and Human Services Agency shall develop a comprehensive plan describing the actions which California can take to improve its long term care system so that its residents have available an array of community care options that allow them to avoid unnecessary institutionalization. The plan shall respond to the decision of the United State Supreme Court in Olmstead v. L.C., 526 U.S. 581 (1999) and shall embody the six principles for an "Olmstead Plan" as articulated by the Center for Medicaid and Medicare Services (the Health Care Financing Administration at the time the principles were first articulated). These principles call for: 1) a comprehensive, effectively working plan; 2) a plan development and implementation process that provides for the involvement of consumers and other stakeholders; 3) the development of assessment procedures and practices that prevent or correct current and future unjustified institutionalization of persons with disabilities; 4) an assessment of the current availability of community-integrated services, the identification of gaps in service availability, and the evaluation of changes that could be made to enable consumers to be served in the most integrated setting possible; 5) inclusion in the plan of practices by*

which consumers are afforded the opportunity to make informed choices among the services available to them; and 6) elements in the plan that provide for oversight of the assessment and placement process, in order to help ensure that services are provided in the most integrated setting appropriate, and to help ensure that the quality of the services meets the needs of the consumers. The plan shall be due to the Legislature no later than April 1, 2003.

III. Olmstead Plan Development Process

In 2000 and 2001, the Long Term Care Council conducted four public forums in order to better understand the long term care concerns of consumers and family caregivers. In order to gain input from stakeholders, particularly consumers, families, and other concerned parties unable to travel to Sacramento, these forums were held in Nevada City, San Diego, Oakland, and Los Angeles. Over 290 individuals attended these forums. (See Appendix A) These forums provided the Council with its initial guidance in developing a California Olmstead Plan.

In 2002, the Long Term Care Council directed its staff to develop a process for preparing a formal California Olmstead Plan. At the same time, the Legislature, in the Health Trailer Bill to the 2002 Budget (AB 442), also required the Health and Human Services Agency prepare a plan for submission by April 1, 2003.

As a result of these directives, the Long Term Care Council staff developed a three-part Olmstead planning process that was approved by the Long Term Care Council in July of 2002.

Phase 1 – Hold a series of local Olmstead Forums, hosted by stakeholders, around the state to allow individuals to identify their needs and preferences for living in the community and any best practices.

Phase 2 – Organize a Work Group comprised of consumers and stakeholders to identify options and recommendations, while considering needs and preferences identified in the Forums.

Phase 3 – Prepare an Olmstead Plan Document based on information, ideas, and analyses performed in Phases 1 and 2.

Subsequently, issues were raised by stakeholders that led the CHHSA to modify the planning process in several ways, including: the Work Group was opened up to include all stakeholders who chose to participate; the planning time period was extended by approximately two months; and Work Group meetings were held in various locations around the state, rather than solely in Sacramento, in order to afford more stakeholders an opportunity to participate.

To facilitate information sharing, the state established an Olmstead web page on the CHHSA website (http://www.chhs.ca.gov/olmstead.html). Announcements and documents related to the Olmstead planning effort are posted on this web page. Additionally, the state established an Olmstead e-mail address (Olmstead@chhs.ca.gov) to facilitate communication between the public and the state staff.

Phase 1: Hold Local Olmstead Forums

In order to maximize public and community input into the Olmstead Plan, organizations throughout the state were asked to host community Olmstead Forums. The purpose of the forums was to obtain information on individual needs and preferences for community living and to identify any best practices.

Between September 2002 and January 2003, more than 73 stakeholder groups sponsored or were partners in holding 38 forums with approximately 649 participants. Forums were held in all areas of the state with the exception of the far north. (Appendix B shows the forums and dates held, their sponsors/partners.)

The state developed a "Tool Kit" to assist community organizations in hosting an Olmstead Forum. The Tool Kit included suggested agendas, suggested key issues, a sample checklist for facilities, sample press advisory, and forms to report back to CHHSA information on service needs and priorities, and suggested best practices. In response to requests from stakeholders, Tool Kit documents that would be used by forum attendees were recorded on audio tape and translated into five foreign languages: Spanish, Russian, Vietnamese, Chinese, and Thai.

In total, 1,314 individuals completed and returned surveys, including 685 surveys designed by the Coalition of Californians for Olmstead. (See the results of the surveys in Appendix C along with a summary of the service needs identified by forum participants). Thirty "Best Practices" Forms were received that described programs and services that participants believed to be good service delivery models. These are listed in Appendix D.

Phase 2: Establish the Olmstead Work Group

On September 12, 2002, an invitation from CHHSA Secretary Johnson to participate in the Olmstead Work Group was released. The invitation specified that all those interested were welcome to join the Work Group. The purpose of the Work Group was to develop options and recommendations for the Olmstead Plan, building on the input that had been provided by individuals in the local Forums. The state's Real Choice "Starter Grant" from the federal Department of Health and Human Services (DHHS) covered the travel costs of consumers.

On October 11, 2002, approximately 110 stakeholders gathered with state staff. The agenda for the meeting (see all Work Group agendas, Appendix E) called for spending the first hour discussing the principles for an Olmstead Plan and input on the planning process. The balance of the agenda was allotted to sub-group discussions of the key topic issues that should be addressed in an Olmstead Plan.

Instead, the entire time allotted for the meeting was used to outline the *Olmstead* principles and discuss planning process issues. Stakeholders made two important points: (1) the proposed schedule of meetings should be extended, and (2) the state should arrange to hold Work Group meetings throughout the state.

Staff summarized the October 11 meeting input and posted it on the Olmstead web page along with a solicitation for additional input on the Work Group process and future agenda issues. As a result of these stakeholder comments, the state established meeting locations statewide, adjusted the entire proposed schedule, and established global topics for each of the four planned Work Group meetings.

Date	Topic	Location
• November 22, 2002	Assessment	San Diego
• December 10, 2002	Transition/Planning/Diversion	Fresno
• January 10, 2003	Community Services Capacity	Los Angeles
• January 21, 2003	Quality Assurance	Oakland

November Through January Meetings

Facilities: To keep cost at a minimum, all meetings were held at state locations, two at universities and two at state office buildings. Consumers provided input to state staff to help prevent potential logistical problems in order to ensure access for participants. State staff evaluated each site to ensure disabled access to public transportation, parking, path of travel and curb ramp requirements, building, meeting room, and restroom requirements. State staff further investigated signage, furnishings, and telecommunications capability.

Audioconferencing: In order to ensure access for individuals not able to travel, audioconferencing equipment was installed to facilitate remote participation in all aspects of the meeting from opening to close. During all sessions, a staff attendant monitored calls and equipment in order to ensure immediate resolution in the event of technical difficulties. Again, consumer input was critical to help ensure better facilitation of the audioconferencing activities.

Background Materials: State staff prepared participant information packets for each meeting for all participants to help facilitate discussions. These documents included the agenda, key questions to address, a background document describing current programs, summary of the surveys and the Forum input received to date on the meeting topic, and separate documents submitted by stakeholders and consumers. Electronic copies were e-mailed to all Work Group members in advance of the meeting, and were also posted on the Olmstead web page. Throughout this process state staff sought the input and advice of stakeholders in order to help facilitate the Work Group meetings and improve the quality of the meeting materials for the participants.

Meeting Process: CHHSA Secretary Grantland Johnson presented opening remarks at all Work Group meetings. Next came a presentation regarding the meeting topic by a stakeholder or panel of stakeholders and consumers. This provided the opportunity for individuals to give their perspective on the topics and suggest guidance to participants.

Breakout groups were organized and were provided with an identical list of key questions for which they were asked to develop recommendations. (Due to the broad scope of the Community Services Capacity topic in Los Angeles, breakout groups continued to ask identical questions, but each subgroup applied these questions to different categories of services. Participants were free to attend the subgroup of their choice.) At the beginning of each breakout session, there was a 5-minute background presentation from a state staff person in that field. The phone group was asked to select the categories they wanted to address.

Each subgroup was led by a facilitator and supported by a recorder who put the groups' responses on flip chart sheets. One subgroup was made up entirely of individuals who participated via audioconference. Phone participants received all of the key documents, agenda, key questions, and background information via e-mail. Like the on-site breakout sessions, the phone group had a facilitator and recorder, and also a technical attendant.

After meeting, the subgroups reconvened and each reported on the recommendations proposed by its members. Individual subgroups tended to have a similar core group of recommendations, while also contributing a number of unique suggestions. Recommendations ranged from specific actions to requests for attention to be focused on major concerns.

Attendance: Approximately 80 consumers and other stakeholders attended the San Diego Work Group meeting, and 12 attended by phone. Most attendees were from Southern California, and more than half had not attended the Sacramento meeting.

Approximately 47 consumers and other stakeholders attended the Fresno meeting, 29 of whom were new. Ten individuals participated by audioconference.

Approximately 90 consumers and other stakeholders attended the Los Angeles meeting. Most attendees were from Southern California and 40 percent had never previously attended a Work Group meeting. Twenty-five attended by telephone.

Of the 87 participants who attended the Oakland meeting, 55 percent had never previously attended a Work Group meeting. A total of 15 attended by phone.

(See Appendix I for a list of all individuals who have attended or signed up to attend all Olmstead Workgroup meetings, October 2002 through February 2003.)

Recommendations: Approximately 243 recommendations and comments were made by the subgroups at the San Diego meeting, 152 at the Fresno meeting, 318 at the Los Angeles meeting, and 150 at the Oakland meeting. These numbers include some duplication, in that it was common for more than one individual to offer similar recommendations. Eventually, each of the meetings' subgroup recommendations were made available on the website and in future meeting packets. (For a listing of the recommendations from the subgroups, see Appendix F.) In addition, consumers and stakeholders were asked to submit any additional comments/input throughout these months via the internet or other written form. (See Appendix G for other comments/input submitted.)

Phase 3: Preparation of the Olmstead Plan Document

Based on stakeholder input provided during the five meetings discussed above, the state staff developed a first draft of the "Next Steps" section of the Plan which was distributed to stakeholders on January 29, 2003, and posted to the Olmstead web page on the following day. After receiving substantial comments on this draft, a subsequent draft was released on February 11, 2003.

On February 13, 67 Work Group members met in Sacramento to review and discuss the draft Plan. The attendees were divided into three sub-groups, each of which discussed the entire plan. Additionally, eight individuals participated in a separate sub-group by audioconference. The meeting lasted approximately five hours, and generated more than 200 recommendations for change.

A second draft of the same section of the Plan was prepared and e-mailed to stakeholders, and posted to the Olmstead web page on Tuesday, February 25.

On February 28, 2003, 66 members of the Work Group met again in Sacramento to discuss the draft section of the plan. Eight individuals participated by teleconference. Three sub-groups were established, with the teleconference participants joining one of the three groups (as opposed to being a separate group, as in prior meetings).

Comments from the February 28, 2003 meeting were evaluated and reflected, as appropriate, in the final draft Olmstead Plan. The final draft was made public in Mid-March 2003.

IV. CURRENT PROGRAMS AND EFFORTS

Long Term Care Council

The California Health and Human Services Agency (CHHSA) Long Term Care (LTC) Council was established by AB 452 (Chapter 895, Statutes of 1999). The LTC Council is chaired by the CHHSA Secretary, and includes the Directors of the Departments of Developmental Services, Health Services, Housing and Community Development, Rehabilitation, Alcohol and Drug Programs, Mental Health, Transportation, Social Services, Aging, Veteran Affairs, and Office of Statewide Health Planning and Development. The LTC Council's scope of activities includes promoting coordinated LTC and policy development. The vision statement of the LTC Council is:

"A long-term care system that supports consumer dignity and independence, fosters appropriate home and community-based services, and is cost effective."

The Council has adopted the following values in carrying out its mission: focus on prevention; respect for diversity; honoring choice, dignity, independence, and quality of life; seeking input from consumers, family caregivers, and the community; improving access to timely, complete, and user-friendly information and services; developing a full array of services; using assistive and other forms of technology; expanding the availability of palliative care; developing service coordination strategies to assure that consumers receive the right services at the right time; supporting caregivers; long term care workforce availability; encouraging flexibility and innovation; need for improved program information to facilitate strategic planning; providing education on the risk of needing long term care and viable options available to plan ahead for the potential need; and, assuring responsible stewardship. Some of the activities of the LTC Council have included:

- Conducted four Public Forums in 2000-01 regarding LTC recommendations (see results in Appendix A)
- Made recommendations to improve interagency coordination between the key home and community-based long-term care programs
- Designed and completed an on-line inventory of data currently being collected by public programs at the state level
- Analyzed barriers to consumer access to LTC information and recommended improvements to the state's *www.calcarenetwork.ca.gov* web portal

- Established a workgroup to create an assessment tool to assist in identifying nursing facility residents clinically appropriate for, and interested in, transitioning to a community setting
- Established a workgroup to examine existing licensure requirements for residential services
- Developed budget proposals for inclusion in the Governor's budget for 2001-02 (Nursing Home Assessment and Transition Pilot Project; IMD Transition Pilot; Assisted Living Medi-Cal Waiver Development)
- Worked with departments to apply for several federal grants
- Worked with departments to apply for Medi-Cal waiver enhancements
- Convened a task force to identify barriers to mental health treatment for persons with Alzheimer's disease and related dementias and make recommendations to improve their access to treatment
- Reported to the Legislature on private alternatives to LTC insurance.

Activities for 2003:

- The LTC Council will continue as the lead in developing and implementing the Olmstead Plan
- The LTC Council will develop a strategic plan on aging, pursuant to Chapter 948, Statutes of 1999 (SB 910, Vasconcellos)
- The LTC Council will support and work collaboratively with the Labor and Workforce Development Agency (LWDA) to implement the next phase of the Caregiver Training Initiative, which will utilize $10.5 million in federal Workforce Investment Act monies to train 2,000 new Certified Nurse Assistants (CNA)
- The LTC will support and work collaboratively with the LWDA to implement the Nurse Workforce Initiative (NWI), a $60 million, three year initiative to recruit, train, and retain approximately 5,000 qualified licensed nurses to reduce critical workforce shortages. The LWDA has awarded $34 million in grants to local entities to implement various components of the NWI.

Department of Developmental Services

Enacted in the late 1960's the Lanterman Developmental Disabilities Services Act (Lanterman Act) established a comprehensive statutory scheme which requires that the State identify persons with developmental disabilities, assess their needs, and, on an individual basis, select and provide services to meet such needs. The Department of Developmental Services (DDS), responsible to implement the Lanterman Act, has established 21 Regional Centers (RC) located throughout the state. RCs are operated by private, non-profit community

agencies and either provide or coordinate services that are needed for persons with developmental disabilities. RCs will serve nearly 183,000 persons with disabilities during State Fiscal Year 2002-2003. The primary goal of the RCs is to maintain individuals with disabilities in community settings and avoid institutional placement by providing services such as:

- Providing information about available programs/services, referrals to such services, and advice regarding the utilization of such services
- Assessment of consumer's functioning levels, needs, and progress
- Reviews of assessments done by other professionals regarding consumers
- Development, revision, and implementation of a consumer's Individual Program Plan (IPP)
- Periodic/annual reviews of consumer progress and needs
- Services coordination
- Purchase of necessary services
- Outreach advocacy for the protection and legal, civil, and service rights
- Family support and planning, placement
- Monitoring for 24-hour out-of-home care.

There is no charge to the developmentally disabled for diagnosis and assessment for eligibility. Once eligibility is determined, most services are free regardless of age or income (except a requirement for parents to share in the cost of diapers for children under age 3, daycare, and 24-hour out-of-home placements for children under age 18). A case manager or service coordinator is assigned to help develop a plan for services. An IPP is developed, which includes an assessment of the individual, treatment and placement objectives, and a schedule of services and monitoring to be provided in order to meet the objectives.

RCs use a Person-Centered Planning approach, which focuses on the consumer's strengths, choices, and the supports needed to achieve his/her life goals in the least restrictive environment. There is a strong emphasis on interdisciplinary assessments, interagency collaborations, and the development of specific interventions and supports to meet the individual needs of consumers who are transitioning into community placement. This planning effort is not a single event or meeting, but a series of discussions or interactions among a team of people including the person with a developmental disability, their family (when appropriate), professionals, and members of their circle of support, as identified.

The planning team assists the individual in developing the IPP, which is based on the individual's strengths, capabilities, preferences, lifestyle, and cultural background. The planning team decides what needs to be done, by whom, when and how the individual will begin or continue working toward their preferred future. Once in the community, consumers generally have annual IPP meetings attended by the consumer, family and friends, and the regional center service coordinator.

Among the services included in IPPs are Day Program Services -- community-based programs for persons with developmental disabilities. Day program services may be provided at a fixed location or fully integrated into the community. Types of services available through a day program include: 1) Developing and maintaining self-help and self-care skills; 2) Developing the ability to interact with others, making one's needs known and responding to instructions; 3) Developing self-advocacy and employment skills; 4) Developing community integration skills such as accessing community services; 5) Behavior management to help improve behaviors; and 6) Developing social and recreational skills.

The DDS directly operates five State Developmental Centers (SDC) and two smaller state-operated community facilities. The five SDCs are licensed and certified health facilities, with programs licensed either as Nursing Facilities or Intermediate Care Facilities/Mentally Retarded (ICF/MR). The two small state-operated facilities are licensed as ICF/MR facilities. Admission to any one of the DDS' institutions (including the two smaller state operated facilities) requires a court order, and the individual must also meet stringent admission criteria. Most individuals admitted in recent years have been persons committed by the courts because their behavior in the community led to involvement in the criminal justice system.

All individuals in a SDC are assessed on an annual basis by an interdisciplinary team that includes medical, nutritional, psychiatric and occupational staff, and to the extent appropriate, the consumer. From these assessments, the consumer's IPP is developed identifying the services and supports needed to live as ordinary a life as possible.

Over the past twenty years, California has moved the majority of its developmentally disabled population from institutional placements to community-based care. The population at the SDCs has fallen from 8,500 in 1980-81 to a population of approximately 3,600 by the end of 2002. Today, nearly 114,900 developmentally disabled children and adults, or 68% of the population, live in their own homes or the homes of their parents.

The DDS has a statutory responsibility as contained in the Lanterman Act to ensure that individuals with developmental disabilities live in the least restrictive setting, appropriate to their needs. The Community Placement Plan (CPP) is designed to assist regional centers in providing the necessary services and supports for individuals to, when appropriate, move from developmental centers

(placement). It also provides the resources necessary to stabilize the chosen community living arrangements of individuals who have been referred to the Regional Resource Development Project for alternatives to admission to a developmental center (deflection).

The CPP, among other things, provides for dedicated funding for comprehensive assessments of identified developmental center residents, for identified costs of moving selected individuals from a SDC to the community, and for deflection of identified individuals from SDC admission. CPPs do not limit the responsibility to otherwise conduct assessments and individualized program planning, and to provide needed services and supports in the least restrictive, most integrated setting. In fact, a federal court recently held that the CPP is a comprehensive, effectively working plan for persons with developmental disabilities.

As individuals are identified for possible movement into a community setting, the SDC initiates a meeting of the interdisciplinary planning team to update the individual's IPP. For this purpose, the planning team is required to include developmental center staff knowledgeable about the service and support needs of the consumer. Information is provided in an understandable form to consumers and, where appropriate, their families, conservators, legal guardians, or authorized representatives, that will assist them in making decisions about community living and services and supports.

Consumers may be provided the opportunity to visit a variety of community-living arrangements that could meet their needs, or if necessary a family member or other representative of the consumer may conduct the visits. Once the IPP is completed and to help ensure a smooth transition, a transition conference is held typically comprising the consumer, regional center representative, developmental center representative, and representatives of each provider of primary services and supports identified in the IPP.

To further promote a smooth transition, follow-up services are provided including regularly scheduled contacts and visits with the consumer during the first 12 months after transition. Follow-up services are to ascertain that the IPP is being implemented according to the agreement, and that the consumer and the consumer's parents, legal guardian, or conservator are satisfied with the community placement arrangement.

Once in the community, if the RC determines or is informed by the consumer's parents, legal guardian, conservator, or authorized representative that the community placement or a consumer is at risk of failing and that admittance to a SDC is likely, the RC notifies the appropriate regional resource development program, the consumer, and the parents, legal guardian, or conservator. In addition, RC staff begins an immediate assessment of the situation, including visiting the consumer, determining barriers to successful integration, and recommending the most appropriate means necessary to assist the consumer to remain in the community. If, however, it is determined that admittance to a state developmental center is necessary to prevent substantial risk to the individual's

health and safety, the regional resource development program facilitates admission to a SDC.

For years, the Lanterman Act, departmental policies and procedures, and special initiatives have defined quality assurance (QA) for the developmental services system. A wide variety of measures have been employed for quality assurance and improvement, ranging from licensing requirements, consumer face-to-face monitoring, periodic system monitoring, special incident reporting to individual life quality assessment, satisfaction surveys, and direct service professional training.

The Lanterman Act ensures a community-based system of services for persons with developmental disabilities—in their home communities whenever possible. There are many more service options available to persons with developmental disabilities today than existed in 1968 when the SDCs served 14,000 persons and were the only source of services available for persons with disabilities. Over time, the capacity of the community-based system grew to serve more and more persons with disabilities, thus lessening the need and desire to maintain large, expensive SDCs. The State continually assesses the need to provide services and supports in large institutions and has systematically closed institutions that no longer meet the State's policy goals of providing an integrated, community-based service system as required by the Lanterman Act. The last institutions that closed were the Stockton SDC in 1996 and then the Camarillo SDC in 1997. Over the past several years, the Agnews SDC has been under consideration for closure. A low resident population and being located in the San Francisco Bay Area, it has the highest cost per consumer for all SDCs.

Additionally, DDS has recently taken action to downsize eleven large residential facilities. This action is still underway, and DDS will continue to look for other downsizing opportunities in the future.

Activities for 2003:

The proposed 2003-04 State Budget contains a proposal to close the Agnews Developmental Center by July 2005. It requires the DDS to develop a plan to transition consumers living at Agnews Developmental Center into community-based placements as appropriate, and close the facility by July 2005. In keeping with the Administration's commitment to provide services to individuals with developmental disabilities in the least restrictive setting possible, a planning team will assess consumer needs and identify additional resources necessary to successfully move current Agnews consumers into community placements or other developmental centers.

Department of Rehabilitation

The Department of Rehabilitation (DOR) provides vocational rehabilitation and other services that provide access and independence to eligible Californians with disabilities. Rehabilitation counselors in over 100 field offices located throughout the state work directly with consumers of every type and category of disability.

The Vocational Rehabilitation services program assists people with disabilities to obtain and retain employment and maximize their ability to live independently in their communities. Some of the services provided to consumers may include:

- Counseling and guidance
- Referrals and assistance in obtaining services form other agencies
- Job search and placement assistance
- Vocational and other training services
- Diagnosis and treatment of physical and mental impairments
- Occupational licenses, tools, equipment, initial stocks, and supplies
- Supported employment services
- Rehabilitation assistance technology

Through the Habilitation program, DOR provides work services and supported employment opportunities to approximately 20,000 adults with developmental disabilities. These adults are referred to the DOR by DDS Regional Centers for habilitation and supported employment services. Habilitation program services are designed to increase and maintain consumers at the highest level of vocational functioning. Work services consist of paid work or paid training, and supported employment is competitive employment in the community in an integrated setting with support services such as job coaches.

In 1973, California authorized the creation and support of Independent Living Centers (ILC) and programs. The DOR administers the ILC program and provides technical assistance and financial support for the 29 ILCs across the state. An ILC is a consumer controlled, community based, nonresidential private nonprofit agency that is designed and operated within a local community by individuals with disabilities. Independent living services are to help maximize a person's ability to live independently in the environment of their own choosing. All ILCs provide the following services: peer counseling, independent living skills training, housing assistance, information and referral, individual advocacy, systems advocacy, and assistive technology.

ILCs provide many other services such as children's services, family services, mobility training, physical rehabilitation, preventive services, transportation services, vocational services, and any other services that promote independent living.

The DOR conducts various activities to assure the quality of ILC programs and services including:

- On-site visits and telephone calls to discuss specific issues of concern, solve problems, or review grantees' progress in completing corrective action plans related to compliance reviews.
- Review and approval of grants and quarterly reports based on narratives that include the grantees' stated goals and objectives that will be implemented to improve services.
- Direct technical assistance by the Community Resource Development Specialists and other department staff members and through the provision of Title VIIB (Rehabilitation Act) grants earmarked by the State Plan for Independent Living for technical assistance.

The Client Assistance Program (CAP) is designed to help consumers served by the DOR to understand their rights and responsibilities, and assist them in presenting their concerns regarding DOR's services to the Department. Individuals who are dissatisfied with any action or decision of the Department, and who have been unable to resolve their concerns with their counselor and the counselor's supervisor, may seek help from CAP.

CAP advocates are not employees of the DOR; rather they are independent advocates. If necessary, advocates may help consumers request and prepare for mediation, an Administrative Review, or Fair Hearing. Advocates can also help provide information about services available under the Rehabilitation Act, assistance in negotiating mutually acceptable solutions to disagreements, representation at administrative reviews and fair hearings, and assistance preparing for post appeal/hearing reviews upon request, including assistance in obtaining legal counsel in some cases.

Activities for 2003:

- DOR will issue a Request for Proposal in Spring 2003 for a contractor to develop a consumer-focused transition assessment instrument that considers medical, social, and personal needs. This instrument will be made available to Independent Living Centers and other entities involved in assessing and could become the basis for transition planning for those individuals moving to the community from an institutional setting.
- DOR will issue a Request for Proposals in Spring 2003 for an Independent Living Center in Southern California to replicate the Real

Choice Systems Change Project now being implemented by Community Resources for Independence in Santa Rosa.

- DOR will make available $100,000 per year for two years via contract with Independent Living Centers to be used to pay one-time costs of transition from institutions to community settings not covered by other sources.
- In partnership with the State Independent Living Council, the DOR is sponsoring an update of a 1995 assessment of the needs of individuals with disabilities to live independently in family/community life.

Department of Mental Health

The Department of Mental Health (DMH) is responsible for carrying out the State's missions and goals for mental health services and ensuring that the design and delivery of mental health services is consumer focused, culturally competent, and promotes family involvement. Mental health services are under review by DMH, which carries out quality assurance activities intended to ensure the quality of local programs, including: conduct management audits of state and federal funds for compliance with various laws, regulations, and statutes; conduct annual reviews of systems of care programs for children/youth, adults, and older adults; provide technical assistance to counties in the operation of Medi-Cal managed mental health services; and conduct performance measurement of the public mental health system using key quality indicators and performing special studies.

California has a history of progressive change in its public mental health system, starting in 1957 with the Short-Doyle Act, which created the funding structure for the development of community-based mental health services. In 1991, responsibility for mental health services was realigned giving counties fiscal and administrative authority.

Mental health services for Medi-Cal beneficiaries are provided by county Mental Health Plans (MHP) that operate under a federal 1915(b) Freedom Of Choice Waiver. MHPs must ensure that the type of specialty mental health services provided to each beneficiary are adequate to meet the needs of the beneficiary consistent with medical necessity and eligibility criteria. Services include a wide variety of social rehabilitation services. County staff monitors individual status and, when appropriate, facilitates the movement of individuals from institutions to more integrated community settings. Mental health services for individuals residing in facilities that meet the definition of Institutions for Mental Disease (IMDs) are not covered by Medi-Cal. Since implementation of the Medi-Cal mental health plans in 1995, the use of inpatient services has dropped by more than 50 percent. The number of individuals residing in an IMD is approximately 3,500.

California fully endorses a System of Care approach to service delivery. A mental health system of care is both a conceptual model and a service delivery system for providing mental health services to a targeted population, usually individuals with the most severe mental disabilities. The essential components of a mental health system of care are a single point of responsibility for the client, coordination with other human service agencies, meaningful involvement of clients and their families in treatment planning, client-centered services, cultural competence, and age appropriate services needed to maintain residence in the community.

Children's System of Care (CSOC) is a coordinated service structure that ensures timely and appropriate access to all of the services individuals need, and has partnerships with its consumers and essential agencies and organizations, such as education, child welfare, and probation. CSOCs are structured to produce measurable outcomes and consumer satisfaction, and enhance clinical efficacy and cost-effectiveness to manage risk. An organized, community-based CSOC for children with serious emotional disturbances requires that services be culturally competent and child/family centered; families be an integral part of services planning and delivery; and children should, whenever possible, be served at home or in the most home-like setting possible. Currently, 55 of the 58 counties in the state have implemented CSOC, with a total caseload of between 4000-5000 children and youth.

The State of California expanded the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit to provide mental health services including screening, diagnostic and treatment services to Medi-Cal recipients under the age of 21. As a result of this expansion, state and federally funded outpatient mental health specialty services for children were increased. Services for children and youth with co-occurring mental illness and substance abuse diagnoses are also funded through this benefit.

Adult System of Care (ASOC) is patterned after the much successful CSOC at the local level. One example of this is the AB 2034 Program, Integrated Services to the Homeless. Currently, the state provides approximately $55 million annually for 35 county programs statewide to specifically serve persons with serious mental illness who are homeless or at risk of homelessness, recently incarcerated or at risk of incarceration, probationers, or others who are untreated and unstable. Initially three pilot projects were funded in fiscal year 1999-2000 with the contingency that funding would only be continued if the programs could demonstrate effective outcomes. In each of the past three years, DMH has submitted a report to the Legislature documenting significant reductions in the number of psychiatric hospital days, jail days, and homeless days experienced by the clients enrolled in these programs. Currently, approximately 83% of the 4,881 individuals in this program are being maintained in community based housing. The programs are also beginning to show success with linking individuals to employment.

Additional ASOC services are provided by projects of the Supportive Housing Initiative Act (SHIA). In response to the growing number of homeless people in California, the SHIA was passed into law in 1998, and focuses on the essential blend of permanent, affordable housing with access to supportive services as a way to help people stabilize their lives. The SHIA targets very low-income adults having one or more disabilities, including mental illness. This program provides funding for supportive services and/or rental subsidies. The combination of safe, secure, affordable housing and meaningful services is a fundamental component of all SHIA projects. The SHIA is discussed in more detail in the Housing section, below.

The Department of Mental Health also administers the California Caregiver Resource Center System, the first state-funded family caregiver support program in the nation. The CRC System is comprised of eleven Caregiver Resource Centers (CRCs) and the Statewide Resources Consultant. The CRCs provide assistance to families who are caring for an adult family member at home. Assistance includes consultation and care planning; counseling and support groups; psycho-educational groups; education and training; legal and financial planning; respite care; and other mental health interventions. Governed by the principle that caregivers and their care receivers, to the extent they are able, are *the* experts in their care needs, the CRC System supports a consumer-directed model of in-home respite care, whereby caregivers can choose their own respite workers (direct-pay) or contract for respite services through an agency. The availability of these family supports helps to delay if not eliminate the admission of the family member to a long term care institution.

The DMH is responsible for the direct operation of four state mental health hospitals (SMHH), and the DMH provides mental health services at one facility under the authority of the California Department of Corrections. The patients served by the DMH are often classified on the basis of the legal commitment proceeding that resulted in their placement in a state hospital, either civil commitment or judicial commitment. Judicial commitments result from a person allegedly, or in fact, committing a crime and subsequently being found to be suffering from a mental disorder. Civil commitments result when, upon psychiatric evaluation, a person is found to be a danger to themselves, or others, or to be gravely disabled as a result of their mental disorder. Admission into SMHH during State Fiscal Year 2001-02 numbered 321, and the number of individuals residing in a SMHH due to a civil commitment at any one time is approximately 800.

The DMH begins discharge planning immediately upon admission to a SMHH. The individual patient's interdisciplinary treatment plan (IDP) specifies the patient's treatment goals and discharge criteria. When the criteria are met, discharge preparations can begin. This is a collaborative effort among the interdisciplinary team (IDT), the client, family and significant others, as appropriate, and responsible community agencies (e.g., county liaison/conservator, community mental health representatives, etc). Assessment

of post discharge supports/resources and psychosocial aftercare needs is evaluated and a part of the ongoing planning process.

Typically, the IDT forwards a placement packet to the authorized community placement coordinator. The packet contains documents including the individual's psychiatric evaluation, social history, physical exam and medical records, results of physical and psychological testing, notes current medication orders, court orders and legal documents, and other information and history necessary to ensue continuity of care. The goal is to provide a full range of mental health services in order to reintegrate them into their community.

Activities for 2003:

- The DMH expects shortly to award grants to two local mental health agencies to implement demonstration projects to develop community placement alternatives in the least restrictive setting possible for individuals currently residing in an IMD. Specifically, the grants will determine the feasibility, cost, and impact of transitioning individuals with serious and persistent mental illness from IMD into service-supported community housing situations.

- DMH will sponsor two statewide Olmstead related trainings in April 2003. One of these events is specifically for mental health consumer leadership and will focus on how to advocate for Olmstead plan implementation. The purpose of the second training will be to develop community networks to support employment activities and opportunities for people with mental illness. Both of these activities will be accomplished in collaboration with the California Institute of Mental Health through a grant.

Department of Health Services

The Department of Health Services (DHS) administers a broad range of public health programs and the federal Medicaid (Medi-Cal in California) program. Home and Community-Based Services (HCBS) waivers provide an important tool to help individuals remain in their home rather than being institutionalized hence play an important role in the transition of qualified individuals into community-based settings at a reasonable pace. California has six 1915(c) Home and Community-Based Services waivers serving different subgroups requiring LTC services:

- A Developmentally Disabled (DD) waiver;

- A Multipurpose Senior Services Program waiver (see Department of Aging);

- An In-Home Medical Care waiver;

- A Nursing Facility (NF) A/B waiver (renewed by CMS for an additional 5-years on January 1, 2002);
- A Nursing Facility Sub-acute wavier (approved by CMS on April 1, 2002);
- An AIDS waiver.

In addition, on February 3, 2003, the CMS approved a DHS request to increase the annual caps on enrollment for the DD waiver, approved retroactively to October 1, 2002. This action will permit enrollments to grow at a higher rate annually and by the fifth year grow to 70,000 persons, which is approximately 19,200 individuals more than initially approved.

The waivers can be accessed by individuals who are Medi-Cal eligible, and qualify for an identified level of care such as hospital, intermediate care facilities for the developmentally disabled, or nursing facility care. The cost of their care to Medi-Cal must be no greater than the amount Medi-Cal would spend in the otherwise appropriate institutional setting. Services include case management, nursing care, home health aides, and minor home modifications. The implementation of HCBS waiver programs requires that individuals be afforded freedom of choice in terms of providers and available services, and that the requested waiver services be medically necessary and identified in a plan of treatment. Underlying the provision of waiver services is the requirement that the person be maintained safely in his or her own home or in the community while receiving these services. Each of these waivers utilizes a unique assessment and transition process that is structured to meet the needs of the individuals who are applying for services, and to ensure the provision of all services that are necessary to ensure successful community living.

The DHS directly administers three of the six HCBS waivers and provides monitoring and oversight of the remainder. For these three waivers, DHS staff provides HCBS waiver oversight and management. These activities include providing support and linkages to case management services in the community to assist individuals in facility settings to transition to the community and/or, once in the community, assist individuals in obtaining services and supports needed to remain safely in their home and community. If there is no identified or available community case manager, the DHS staff will directly assist the individual in linking them with needed supports and services in the community. In addition, the DHS staff provides outreach and training on HCBS waiver programs to state and local entities including potential providers of services, regional centers, hospitals, nursing facilities, and intermediate care facilities for individuals with developmental disabilities. The training covers available services, waiver capacity, and applications for services. For waivers administered at the local level where there is DHS oversight and monitoring, the local entity provides the aforementioned case management services.

Each waiver has a specific quality assurance plan with associated activities. These activities are designed around the foundation of the protocol developed by CMS. Inherent to all of the waivers are systems that require:

- Face-to-face contact with the individual and/or providers on a regular basis
- Written confirmation of acceptance or declination of waiver services
- Preservation of rights
- Level of care determination
- Provider training as appropriate
- Information sharing on available services and health and safety determinations.

These activities are conducted on an ongoing basis as long as the person is enrolled in the waiver. As quality assurance activities are conducted, the clients' activities are reviewed and revised accordingly.

All individuals being placed in nursing facilities, with the exception of short-term patients requiring minor medical treatment, receive a Pre-Admission Screening and Resident Review (PASRR). The PASRR process for nursing facilities consist of the Level I and II Preadmission Screening and Resident Review.

> Level I: A screening completed on admission to any Medi-Cal-certified nursing facility. Designed to identify any individual having, or suspected of having, mental illness or developmental disability, the Level I is completed by nursing facility staff, licensed or unlicensed. A PASRR Level I screening is required for Medi-Cal reimbursement for cost of care. When an individual is also identified as having, or suspected of having, mental illness or developmental disability, the Level II field evaluation is also required for Medi-Cal reimbursement.

> Level II: An independent evaluation performed for individuals identified by the Level I screen as possibly having mental illness or mental retardation. If mental illness is suspected, mental health professionals under contract with the DMH perform the Level II screen. If mental retardation is suspected, the Department of Developmental Services (DDS) is responsible for arranging the screen. Level II is an in-depth assessment of the individual, and includes a more detailed evaluation of physical health and treatment history.

If an individual's PASRR Level I assessment reveals developmental disabilities, a PASRR Level II independent clinical field evaluation is completed by professional DDS staff. Individuals identified as having developmental disabilities are eligible for DDS services, which then trigger the development of a person-centered IPP that may result in placement in a development center, an intermediate care facility (ICF) for the developmentally disabled, or in the community.

Three types of ICFs provide services to Californians with developmental disabilities:

- ICF Developmentally Disabled (ICF/DD): 16-bed or larger facilities licensed to provide developmental, training, habilitative, and supportive health services to children and adults with developmental disabilities who have a primary need for developmental services, and a recurring, but intermittent need for skilled nursing services.

- ICF/DD-H (Habilitative): 4 to 15-bed small community facilities licensed to provide in addition to services available from an ICF/DD facility, personal care in the least restrictive setting due to an ongoing, predictable, intermittent need for skilled nursing services.

- ICF/DD-N (Nursing): 4 to 15-bed small community facilities offering the same services as an ICF/DD-H facility, and licensed to provide nursing supervision to medically fragile adults and children in the least restrictive setting due to recurring, intermittent need for skilled nursing services. In addition, under a current pilot project, authorized by AB 359, Statutes of 2000, there are several ICF/DD-N facilities provide 24-hour skilled nursing services for those consumers whose medical conditions require continuous nursing care and observation. These pilot projects are under the authority of a 1915(b) federal waiver.

The Medical Case Management (MCM) Program is responsible for ensuring the health and safety of the severely chronic and/or catastrophically ill fee-for-service Medi-Cal population. The MCM program expedites the authorization of medically necessary services to Medi-Cal beneficiaries who would rather stay at home than be institutionalized in acute care facilities. The nurse case manager facilitates the discharge from acute hospitals by coordinating and authorizing medically necessary services in the home setting. MCM nurse case managers also authorize medically necessary services to promote and support the highest level of health the beneficiary is able to obtain. MCM nurse case managers follow the beneficiary for a period of time after medical services are no longer required in order to determine whether or not the individual is medically stable. Through the MCM program, about 10,800 individuals are assessed annually, and approximately 1,500 individuals receive services each month.

The Programs of All-Inclusive Care for the Elderly (PACE) provide a full continuum of medical, social, and long term care services to nursing home eligible Californians. PACE uses an adult day care center as the primary means of service delivery.

Activities for 2003:

- DHS is implementing several services under the Nursing Facility Waivers in order to assist in the transition process of an individual from a nursing facility back to the community. These services include the provision of case management up to 180 days prior to the person being released from the nursing facility and waiver service coordination, which can be provided once the person is enrolled in the waiver. This allows for the coordination and maximization of services from multiple payer sources, including Medi-Cal and private insurance. DHS will also be closely evaluating the fiscal impact of these new waiver provisions.

- DHS is implementing the Assisted Living Waiver project as authorized by AB 499, Statutes of 2002, which is intended to evaluate the provision of Medi-Cal services in community care facilities and publicly funded housing.

- DHS, in collaboration with other departments, is implementing the California Health Incentive Improvement Project to conduct outreach to individuals with disabilities to encourage participation in Medi-Cal's 250% Working Disabled Program and to increase awareness of other work incentives and disability related employment supports.

- The DHS will provide training on the use of the PASRR Level I for those providers who will use it to ensure they recognize those individuals who want to leave a nursing home and are able to do so with the appropriate supports.

- DHS, with DMH, will modify the PASRR Level II process to assist assessors by providing more specific references to community placement, to include more detailed information about waivers and other community resources, and to provide Level II evaluators with specific training about waivers and community placement.

- The DHS Office of Long Term Care will issue a Request for Applications for up to five development grants and up to five planning grants to local entities intending to implement Long Term Care Integration (LTCI) projects. LTCI projects directly address Olmstead goals by implementing comprehensive and coordinated long-term care systems at the county level.

Department of Social Services

The Department of Social Services (DSS) is the largest social services agency in the nation, serving California residents through a variety of programs that provide aid, services, or protection to needy children and adults. Program responsibilities that are directed at caring for recipients in their homes or communities include:

- Regulate community care facilities such as group homes, foster homes, and residential care for adults and the elderly, and ensure that they meet established standards for health and safety.
- Administer the In-Home Supportive Services (IHSS) program, which helps prevent or reduce inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care.
- Administers the Adult Protective Services program, which investigates abuse, neglect, or exploitation of dependent and elderly adults who are living at home. Services include needs assessment, crisis intervention, emergency shelter, adult respite care, and referral services.

Of these, the (IHSS) program is an essential component of the State's effort to provide services to maintain individuals in their homes and communities. Established in 1973, the program now serves 280,000 aged, blind, and disabled individuals, making it the largest program of its kind in the country.

The IHSS program pays for such services as assistance with housework, meal preparation, laundry, grocery shopping, and personal care services. Additionally, the program pays for accompaniment to medical appointments and protective supervision for the mentally impaired who place themselves at risk of injury, hazard, or accident.

DSS utilizes the IHSS Uniformity System, which was developed in 1988 and facilitates standardization of assessments of recipients' program-related needs. DSS monitors the application of the Uniformity System through reviews conducted at county social services offices and in recipients' homes.

In 1999, the passage of AB 1682 provided for the establishment of IHSS Advisory Committees that give consumers and program stakeholders direct input into the decision making process for their county's IHSS program. It also provided a 'deadline' for each county to establish an employer for IHSS providers for collective bargaining purposes. This deadline provided the impetus for a majority of counties to select a Public Authority (PA) employer model. Through this model, counties can provide enhanced services to IHSS recipients and providers through their PA. These services include assisting recipients in finding IHSS workers by establishing a registry; investigating qualifications and backgrounds of potential workers; establishing a referral system; and by providing access to training for workers and recipients.

Activities for 2003:

- DSS is currently implementing a recent change in law that enhances flexibility in the IHSS program by allowing consumers to use IHSS services in the workplace.
- DSS is currently implementing the Adult Protective Services (APS) Social Worker Training Project to promote statewide uniformity in the administration and delivery of APS services to California's elders and dependent adults who are living in a home-like setting who may be the victim of abuse or neglect.

California Department of Aging

The California Department of Aging (CDA) provides services to seniors and adults with functional impairments and serves as a focal point for federal, state and local agencies, which serve the elderly and adults with functional impairments in California. The CDA administers the Older American Act programs for supportive services, in-home services, congregate and home-delivered meals, and a system of multipurpose senior centers.

Through an interagency agreement with the DHS, the CDA administers the Multipurpose Senior Services Program (MSSP). Established in 1977, the MSSP provides social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community. The goal of the program is to arrange for, and monitor the use of, community services to prevent or delay premature institutional placement of these frail clients. In part, to be eligible for MSSP services, clients must be certified as having disabilities that would qualify them to be in a nursing facility.

The MSSP program is operated under a federal Medical Home and Community-Based, Long Term Care Services waiver and currently is offered in 41 sites throughout the state and has the capacity to serve up to 11,700 clients per month. Costs of MSSP services must be provided at a cost lower than that for nursing facility care. The services that MSSP clients may utilize include: adult day/support centers, housing assistance, chore and personal care assistance, protective supervision, case management, respite, transportation, and meal services.

The Linkages Program serves to prevent institutionalization of frail elderly and functionally impaired adults age 18 and older. Linkages fill a gap by serving individuals who might not be eligible for other services due to exceeding income standards. Clients are assessed and referred to existing community services for transportation, meals, attendant care, and day care. Linkages also arranges for the purchase of assistive devices, medical equipment, and special communication devices in order to maximize individual independence.

Adult Day Health Care (ADHC) centers are licensed by the DHS and certified for Medicaid (Medi-Cal) reimbursement by the CDA. In addition to an annual

unannounced licensing visit conducted by DHS, ADHC centers are surveyed by CDA staff who conduct unannounced visits prior to certification expiration to evaluate the quality of services received by ADHC center participants. The certification survey's primary focus is measuring participant outcomes and evaluating the essential components of the center's service delivery and administrative systems.

In January 2000, the State of California introduced the Aging with Dignity Initiative (ADI) to expand in-home and community-based care options to assist elderly Californians and disabled adults remain at home and live independently in their own community. Nearly $500 million, over one-half of which is State General Fund, in total funding has been approved to assist seniors and younger adults with functional impairments. Some of the initiatives and projects funded under the ADI include:

- In-home supportive services increases: $354.4 million budgeted for increased wages and extends health benefits to in-home care workers.
- Allow low-income seniors and disabled individuals to keep more income for at-home care: $47 million budgeted to reduce out-of-pocket payments made by over 13,000 aged and disabled persons towards their own medical costs before Medi-Cal is available.
- Long-term care innovation grants: One-time challenge grants worth $14.2 million to fund innovative models that provide more options to remain in their own home and communities.
- Long-Term care tax credit: eligible caregivers may now receive $500 tax credit for families caring for seniors and disabled adults at home.
- Senior Housing Information and Support Center: $1 million to provide ongoing information concerning housing options and home modification alternatives.
- Senior Wellness Education Campaign: $1 million to fund an ongoing campaign that offers information to seniors, their families, and health professionals on healthy aging practices.

Activities for 2003:

- CDA will implement the newly authorized MSSP waiver flexibility, which permits program care managers to work with nursing home residents on transition into the community and into the waiver. CDA will also evaluate the fiscal impact of this new provision on the program.

California Housing Programs

California operates two types of housing programs. The most well known examples are homeownership programs that lower interest rates, provide down payment assistance, or reduce the amount that a person must contribute from their own pocket and are directly available to qualified borrowers. The second kind of housing programs are rental housing programs that assist developers and local governments in building housing for those of very low income. These programs are not directly available to individuals.

The principal state source of homeownership financing is the California Housing Finance Agency (CalHFA). CalHFA loan products are available locally through banks and mortgage finance companies. CalHFA strives to serve the diverse needs of the state and has programs designed for specific populations and geographic areas. CalHFA has a new loan product for disabled Californians called HomeChoice℠. It is a single-family mortgage loan designed to meet the mortgage underwriting needs of low- and moderate-income people who have disabilities or have family members with disabilities living with them. HomeChoice mortgages offer flexibility in the areas of loan-to-value ratios (LTVs), down payment sources, qualifying ratios, and the establishment of credit. CalHFA also administers the Special Needs Financing Program, under which it provides loans at less than 3 percent interest to non-profits or public agencies that are developing housing for special needs populations.

The Department of Housing and Community Development (HCD) and the California Tax Credit Allocation Committee manage state rental housing programs. Whether funded by tax credits, General Fund appropriations, or bond proceeds, both departments provide capital to developers to build or rehabilitate housing. The use of government funds to pay for construction and land means the developer does not have to borrow as much money from a lender. Smaller mortgages means smaller mortgage payment, which then allows lower rents to be charged for the units.

Many state rental-housing programs prioritize the use of state funds for housing for those with special needs or for supportive housing with services. Applicants for funds are more likely to receive an allocation if they provide some units designed for these populations. Individuals desiring a unit in such a project must apply directly to the developer or property management firm in charge of renting the project.

Rental subsidies are available primarily through the federal Housing and Urban Development (HUD) Section 8 program. This program is administered in most cases by local housing authorities and routinely has waiting lists of two to five years. Some rural housing programs operated by United States Department of Agriculture (USDA) also provide rent subsidies. The federal McKinney program also provides rent subsidies through the Shelter Plus Care program for homeless or formerly homeless persons. Rental subsidies are generally not available for

most state rental housing programs with the one exception being the Supportive Housing Initiative Act (SHIA).

Most housing programs are operated at the local level and contacting the city or county housing authority is usually the first place to start. Housing authorities manage both the Section 8 program and the local stock of public housing. They can often provide individuals with the names of for-profit and non-profit housing providers who manage rental housing not under the jurisdiction of the housing authority. HCD does manage federal housing programs like Section 8 for 14 rural counties.

The SHIA, administered by the DMH, HCD and the Supportive Housing Program Council, encourages innovative Supporting Housing Projects for persons who have mental illness and are homeless or at imminent risk of becoming homeless. The goals of this initiative are to increase housing for persons with serious mental illness who may also have coexisting disorders including substance abuse; decrease homelessness and its associated fiscal and social costs; increase work force participation as a result of housing stability; and increase philanthropic support as a result of government's increased commitment to matching this support. Currently, 46 projects located throughout California have received funding for supportive services, rental subsidies, or both. SHIA projects have been awarded $48.2 million from the General Fund. These projects are projected to serve 8,400 people during the life of the grants. Although most SHIA projects serve individuals with multiple disabilities, 45 of the 46 projects include individuals with mental illness as a primary focus.

Characteristics of SHIA projects include: 1) projects that are located in both rural and urban communities, employ a variety of housing models and approaches to services deliver; 2) projects that are collaborative and bring together partners to access existing, and develop new, housing options; and 3) projects are linked to supportive services that are flexible and voluntary. The services are offered in a manner that meets the tenant's needs. Supportive services are offered on-site where tenants live as well as in the community.

The DDS administers an affordable housing program designed to increase affordable housing for Regional Center clients. These projects are designed to increase capacity building and housing production of affordable housing for persons with developmental disabilities. Capacity building projects develop resources in the community for persons with developmental disabilities to acquire affordable housing. Housing production projects increase the stock of affordable housing through the purchase, rehabilitation, or construction of real property.

Transportation

Paratransit programs provide door-to-door transportation services to people with disabilities and persons of age. The American with Disabilities Act requires all

public entities that operate fixed route transportation services to also provide complementary paratransit services for individuals unable to use the fixed route system. Paratransit organizations are located throughout the state, and their mission is to organize, maintain, and manage a comprehensive, coordinated, specialized transportation system designed to serve the transportation needs of people who are unable to use public transportation for reasons attributed to age or disability.

The Older Americans Act (OAA) Title III (B) funds are primarily used to support transportation services. General transportation is a means of going from one location to another and does not include any other assistance activity. Assisted transportation provides transportation and other assistance, including escort service, to a person who has difficulties (physical or cognitive) using regular vehicular transportation. CDA allocates OAA funding to the 33 Areas Agencies on Aging, which contract for these transportation services. Eligibility for this funding is limited to individuals aged 60 years or older.

Regional Centers provide transportation services to eligible clients depending on the specific needs of the individual. Some of the more common transportation modes include taxi, paratransit, vouchers, city bus, rail, or that provided by family, friend, or caregiver.

V. RECOMMENDED FUTURE ACTIONS

The following lists some next steps for improving the long-term care system so that California residents will have available an array of community care options that allow them to avoid unnecessary institutionalization The "Policy Goals" describe the policy goals to be pursued in order to improve the long term care system, and the bullets under each of the goals indicate the strategies to be implemented to reach those policy goals. These policy goals reflect a clearly articulated direction, one that has never been previously defined or so clearly stated. Some of the recommended future actions require additional funding. These funding requirements are identified in the text. Additionally, even the completion of actions which do not require additional funding may be delayed if current resources become unavailable or are permanently reduced due to budget constraints. In addition, because this plan is a living document, the policy goals articulated today may change depending upon the leadership of the state.

State Commitment

Policy Goal: The rules, regulations, and laws of the State are consistent with the principles of the *Olmstead* decision.

- The LTC Council will review and monitor the implementation of the Olmstead Plan. The plan shall be updated annually to reflect changes in state or federal law, funding availability, or new or revised activities.
- LTC Council departments will review their strategic plans to see that they are consistent with the principles of the *Olmstead* decision and present their findings and any recommended changes by the Fall 2003 meeting of the Council.
- CHHSA Directors who are members of the Long Term Care Council will report at the quarterly Council Meetings, beginning with the Fall 2003 meeting, on key activities engaged in by their Departments that support the achievement of Olmstead Plan policy goals, including reviewing and revising regulations and policies.
- The CHHSA will establish, by June 30, 2003, an Olmstead Advisory Group, which includes stakeholders and consumers, to provide continuing input in the review, implementation, and updates to the Olmstead plan.

Data

Policy Goal: Improve information and data collection systems to improve the long-term care system so that California residents will have available an array of community care options that allow them to avoid unnecessary institutionalization.

- Beginning June 1, 2003 the Long Term Care Council (the Council) will identify data needs, based on internal review and consumer/stakeholder input to the Olmstead Plan. Consumers and stakeholders will be asked to review and comment on the identified needs. The Council will identify the data needed for purposes of planning for assessments for persons in institutions, service planning for individuals, and services needed for transition, assessments for diversion from institutions, service planning for individuals, and services needed for diversion, systemic planning, and resource development purposes. Data needed may include, but not be limited to:

  Assessment

  a. Identify all individuals living in publicly-funded institutions, including children with disabilities in out-of-home placements.

  b. For each person residing in a publicly funded institution, identify the services and supports, if any, which would enable him or her to live successfully in an integrated community setting.

  c. Determine, of the individuals so identified, those who, after receiving information on community options in an understandable form and having the benefit of an assessment, seek and/or do not object to community placement and whose assessment team has identified this as a feasible option.

  d. The length of time between assessment and community placement.

  Diversion

  e. Reasons persons are at-risk for institutionalization.

  f. Numbers of people diverted from institutionalization.

  g. Numbers of people not diverted due to lack of community-based services, including identification of the specific services that were needed.

  h. What services are needed to divert individuals from unnecessary institutionalization.

Transition

i. Identify the estimated timeframe for actual movement of the resident to a community setting.

j. Length of time between when the person was assessed as appropriate for community services and when the individual received the needed community service, including waitlist information.

k. Number of individuals moved to the community, type of placement, and location of placement, services, and supports.

l. Numbers of individuals returning to institutions after moving to the community, and length of time in community prior to return.

Community Capacity

m. Unmet community service needs, the gap between existing services and consumer needs, and the timeframe and funding which would be needed to undertake the resource development to fill these service gaps.

n. Numbers of trained service providers and location of providers - reviewed for possibility of shortage.

o. Number of community placements available and location of community services.

p. Data on net costs or cost savings resulting from community as opposed to institutional service.

Housing

q. Number of affordable, accessible housing units needed for assisting currently institutionalized individuals to transition to the community, organized by county, including information about any specialized housing needs.

r. Identify and describe all housing subsidy programs that are targeted to persons with disabilities (even if no current vacancies exist), including all specifics regarding target populations and affordability levels and restrictions, along with contact people in each county for further information on each program.

s. Identify, by county, the number and type of subsidized housing units or Section 8 vouchers currently targeted specifically to persons with disabilities.

t. Identify, by county, the number of persons with disabilities currently receiving housing assistance, the number of persons with disabilities on waiting lists for housing assistance, and the length of current waiting lists

for people with disabilities for subsidized housing generally and for housing targeted specifically to persons with disabilities.

u. Estimate, by county, the number of non-subsidized accessible housing units.

v. Calculate the gap (number of units needed) between the housing needs of people with disabilities in institutions and the available housing units.

Quality Assurance

w. Documented incidents of abuse or neglect, name of service provider, location of abuse, type of abuse, resolution taken, and follow-up planned.

x. Data on consumer satisfaction with services and supports, quarterly, yearly, etc.

y. Comments about inadequacy of services by particular providers.

z. Grievances, including the issue grieved, the service provider who is the subject of the grievance, if applicable, and the resolution of the grievance.

The Council will identify what data is currently available, what databases exist, and what data is currently unavailable. To the extent possible, the existing data will be grouped by geographic service area. The Council will also ensure any activities are compliant with confidentiality and HIPAA rules.

Subject to additional resources, the Council will pursue the relevant state processes required to contract for the services of a consultant to collect the data that is currently unavailable and incorporate it into a database, subject to confidentiality rules.

The LTC Council, with participation of consumers and stakeholders, will review the data that is currently available, identify trends and issues, recommend actions for improvement in the programs and identify areas where additional data is needed and cost projections for collection of this data. The results of these activities will be reflected in the next update to the Olmstead Plan, April 1, 2004.

DHS will request approval from the federal government to have access to Minimum Data Set (MDS) evaluations for Medi-Cal eligible individuals being placed in nursing facilities. The MDS contains some resident data that could help identify those individuals in nursing homes who are candidates for more in-depth assessment and transition activities. This activity would be a subset of the recommended activity above to identify what data is currently available or unavailable.

Comprehensive Service Coordination

Policy Goal: Implement a comprehensive service coordination system that will improve the long-term care system so that California residents, regardless of disability, will have available an array of community service options that allow them to avoid unnecessary institutionalization.

- By April 1, 2004, the LTC Council will prepare a conceptual design for a comprehensive assessment and service coordination system for individuals placed in, or at risk of placement in, publicly funded institutions. This conceptual design will be included in the next update of the Olmstead Plan. The Council will solicit consumer and other stakeholder comment and review on the conceptual design. This comprehensive system would include elements such as the following:

    a. State level entities responsible for system administration.

    b. Community services that build upon existing service systems and provide for a variety of living options, taking into consideration regional issues.

    c. A database containing information on individuals residing in institutions, those at risk of placement, and those who have been placed.

    d. A standardized assessment process for individuals in institutions that includes consumer and family participation as well as professional team members. This process should build upon the past work related to the LTC Council's California Uniform Assessment Instrument project.

    e. A standardized diversion process for individuals at risk of placement in institutions. Multi-disciplinary teams will be used that include the appropriate expertise (e.g., dementia expertise for a person with Alzheimer's Disease).

    f. A standardized transition process for persons in institutions moving into the community.

    g. Required linkages and protocols between service providers.

    h. Service coordination for each consumer.

    i. The development of a service plan, including needed services and supports for each consumer.

    j. Training for service coordinators in obtaining needed services; establishing linkages with all needed services (e.g. local housing agencies); and use of an informal support network.

k. A process for assessing unmet community service and support needs, including family caregiver support needs, and seeking resources to respond to those needs.

l. A system to measure and report the outcomes of individuals placed in service plans.

m. The implementation of the service plan, with necessary consumer follow-up by the care coordinator.

n. A process for updates of consumer service plans.

o. A process for appealing items included in, or excluded from, the service plan.

p. A process for monitoring any waiting lists that arise and initiating actions to assess that such lists move at a reasonable pace.

q. The development of information on all available funding options, and creation of a budget methodology to ensure adequate system funding.

r. The structuring of funding sources and "categorical" funding streams into a coherent system for long tem care.

s. Identification of the procedures and regulations to be established by the state oversight entities to assure system effectiveness and quality, and that services reflect and are accessible by California's diverse population.

t. Comprehensive assessment of the housing needs of institutionalized persons and oversight of resource development to assist with identifying affordable, accessible housing for these persons.

u. Reducing disincentives to community-based options over institutions.

v. Monitoring processes by all entities involved.

The conceptual design should build upon existing models, best practices, and services. Beginning April 1, 2004, the LTC Council will identify elements of the conceptual design that could be implemented within existing resources and develop recommendations for implementation. The LTC Council will also identify costs of additional resources needed to implement the conceptual design.

- The DMH, with consumers, stakeholders, and counties, will begin to develop recommendations to ensure that a comprehensive assessment and service-planning system is in place for individuals placed in, or at risk of placement in, institutions due to mental health conditions. The recommendations could include components mentioned in the items "a" through "v" above, and will be integrated into existing county mental health programs. The

recommendations will include an implementation schedule and identify needs for additional resources. The recommendations could build upon counties' Adult System of Care or Children's System of Care. A major focus of the system should be on diverting individuals from entering long term care institutions by developing community based services and supports. This activity would be a subset of the recommended activity above.

- DHS will support implementation of the Long Term Care Integration (LTCI) Pilot Projects. If determined feasible, support efforts to pilot test LTCI projects administered by non-government entities.
- Enact legislation to make permanent the Program for All-Inclusive Care for the Elderly (PACE).
- DHS will plan for expanding the number of PACE sites statewide with a long-term goal of establishing 10 PACE organizations in California. DHS will identify barriers to additional PACE sites.

Assessment

Policy Goal: Provide timely assessments for persons in institutions to determine supports and services needed for individuals to transition and live successfully in the community. Provide assessments for persons living in the community, who are at risk of placement in an institution or more restrictive setting, to remain in the community in the least restrictive setting. Assessments should result in an informed choice for the consumer as to the most appropriate and integrated setting.

- Beginning July 1, 2003, the LTC Council departments, using existing resources, will review all existing assessment procedures used for individuals residing in institutions and for individuals at risk for placement in institutions, for consistency with the *Olmstead* principles and parameters listed below. Each department will seek input as appropriate from consumers and stakeholders. The departments shall, beginning with the Fall 2003 Council meeting, report at the LTC Council meetings recommended changes for improvement and identification of any additional resources that would be needed. Additional resources would be needed to implement activities covered under the parameters if resources are not currently available for that activity. In the state's current fiscal situation, there is no guarantee that funds will be available and appropriated for implementation. The parameters shall include, but not be limited to:

  a. Assessments should be used to determine the specific supports and services that are appropriate for the person and that he or she needs to live in, or remain in, the community, including those needed to promote the individual's community inclusion, independence and growth, health and well being.

  b. Assessment tools and/or planning processes must not act as artificial barriers to individuals moving swiftly to the community.

  c. The individual assessment/planning process should be "person-centered" and focus on the person's goals, desires, cultural and language preferences, abilities and strengths as well as relevant health/wellness/ behavioral issues and skill development/training needs. An individual should not be required to make a decision about moving prior to completion of an assessment.

  d. People should always be involved in their own assessment/planning process and must be provided with information in a form they can understand to help them make choices and consider options. Information on options for living arrangements should be included.

e. The individual being assessed for community placement must be given the opportunity to visit and temporarily test out a choice of community services options prior to being asked to choose where one wants to live.

f. Individuals must be given understandable information about the results of their assessments and plans, in writing, and "sign off" on these documents.

g. Family members, friends, or support people have an important role in the assessment/planning process, to the extent desired by the person with a disability. Assessments should include the individual's "circle of support".

h. People must have the supports which best enable them to communicate, e.g., communication devices or the presence of people who can best interpret for them.

i. Reduce duplicative assessments.

j. Assessments should be conducted on a periodic basis that reflects the need and situation of the individual.

k. Peer support and/or independent advocates should be available to assist individuals in the assessment/planning process.

l. Professionals who prepare assessments and/or participate in planning must be qualified. In order to be qualified, a professional must have knowledge in their field of relevant professional standards and core competencies related to community-based services (including knowledge of the full variety of community living arrangements).

m. Professionals who work in the community must be involved in assessment and planning. Assessments may be done by a "team approach".

n. Assessments and determinations as to the most integrated setting must be based on the individual person's needs and desires for community services and not on the current availability or unavailability of services and supports in the community.

o. Information should be provided to consumers regarding the opportunity to be assessed for placement; on the objective or purpose of assessment; on how to access the system for an assessment; on the timeline for implementation of potential plans and outcomes; on any entitlement to services; on consumer rights; on the option to change living situations, test different options, and change his or her mind; on how to obtain a peer/community advocate; or consumer's individual risk factors faced when moving out of an institution. Ensure that individuals in institutions and the community will both receive, and be able to understand, information on service options.

p. If an individual is unsatisfied with recommendations made or results, she or he must have the right to appeal and be informed of how to do so.

q. Assessments should clearly identify the range of services needed and preferred to support the person in the community, including, where appropriate, housing, residential supports, day services, personal care, transportation, medical care, and advocacy support.

r. Assessment for minor children who have been placed in, or are at risk of, out-of-home placement, shall determine the services and supports that should be made available to the child and his/her family to enable him or her to remain in or transition to the least restrictive environment as required by state and federal laws.

s. Service planning should be person centered and client/consumer-driven and maximize the natural supports and relationships--familial and otherwise--that will enable the individual to remain in the least restrictive, most integrated environment.

Diversion

Policy Goal: Divert individuals from entering institutions and ensure that they are served in the most integrated setting appropriate, based on informed consumer choice.

- Beginning July 1, 2003, the LTC Council departments, using existing resources, will review current service planning procedures for effectiveness in diverting persons from placement in institutions consistent with the *Olmstead* principles and parameters listed below. Each department will seek input as appropriate from consumers and stakeholders. The departments shall, beginning with the Fall 2003 Council meeting, report at the LTC Council meetings, recommended changes for improvement and identification of any additional resources that would be needed. Additional resources would be needed to implement activities covered under the parameters if resources are not currently available for that activity. In the state's current fiscal situation, there is no guarantee that funds will be available and appropriated for implementation. The parameters shall include, but not be limited to:

    a. The service plan will consider a full array of services based on need and regardless of disability category. If a service is not available, the individual will be placed on a waiting list.

    b. Service plans, based on the assessments, should clearly identify the range of services needed and preferred to support the person in the community, in all relevant areas, such as housing, residential supports, day services, personal care, transportation, medical care, education, respite, supported employment, and advocacy support.

    c. Provide service coordination for each consumer to connect the individual with community providers and assist in any diversion activities as necessary. Clarity as to who is responsible to connect the individual with community providers is necessary for accountability.

    d. Service planning should be conducted on a defined, periodic basis and include follow-up with consumers on the care plan and updates as necessary.

    e. Persons involved in the diversion process should be qualified and knowledgeable of community living options, such as experts in transportation and housing.

    f. Consumers and families should be educated about community placements.

    g. All materials should be clear and understandable to the consumer and family.

h. Service planning should be person centered and consumer driven. For minor children and their families, service planning should be child and family centered and driven by child and family strengths.

i. Data regarding unmet needs should be used to identify the need for more services for the individual and in the aggregate.

j. Care planning should be person centered and client/consumer-driven and maximize the natural supports and relationships--familial and otherwise--that will enable the individual to remain in the least restrictive, most integrated environment.

- By April 1, 2004, the LTC Council departments will evaluate existing crisis response programs and report to the LTC council to identify recommended models that could be adopted by counties without existing programs. The models should focus on timely actions that can maintain an individual in community settings with appropriate services and supports and identify any need for additional resources. Stakeholders and counties should participate in this activity.

- Subject to additional resources, the Department of Developmental Services will expand the use of the Regional Resource Development Project approach specified in WIC 4418.7 to all individuals whose community home is failing and for whom any type of institutional placement – not just developmental center placement -- is a likelihood.

Transition

Policy Goal: Transition individuals from institutions to the most integrated setting appropriate, based on consumer choice.

- Beginning July 1, 2003, the LTC Council departments using existing resources will review current discharge planning procedures for consistency with the *Olmstead* principles and parameters listed below. Each department will seek input as appropriate from consumers and stakeholders. The departments shall, beginning with the Fall 2003 Council meeting, report at the LTC Council meetings recommended changes for improvement and identification of any additional resources that would be needed. Additional resources would be needed to implement activities covered under the parameters if resources are not currently available for that activity. In the state's current fiscal situation, there is no guarantee that funds will be available and appropriated for implementation. The parameters shall include, but not be limited to:

    a. The service plan should consider a full array of services based on need and not limited by disability category. If a service is not available, the individual will be placed on a waiting list, if applicable.

    b. Service plans, based on the assessments, should clearly identify the range of services needed and preferred to support the person in the community, in all relevant areas, such as, housing, residential supports, day services, personal care, transportation, medical care, respite, education, supported employment, and advocacy support.

    c. Provide service coordination for each consumer to connect the individual with community providers and assist in any transition activities as necessary. Clarity as to who is responsible to connect the individual with community providers is essential to ensure accountability.

    d. Service planning should be conducted on a defined, periodic basis and include follow-up with consumers on the care plan and updates as necessary.

    e. Persons involved in the transition/planning process should be qualified and knowledgeable of community living options. Consumer and families should be educated about community placement including information about available service providers.

    f. All materials should be clear and understandable to the consumer, with an independent advocate or peer available to assist as needed.

g. Data regarding unmet needs should be used to identify the need for more services for the individual and in the aggregate.

h. Service planning should be person centered and client/consumer-driven and maximize the natural supports and relationships--familial and otherwise--that will enable the individual to remain in the least restrictive, most integrated environment.

i. Experiential opportunities to ensure informed consumer choice must be provided.

j. If a school age individual is transitioning, certain elements, such as an Individualized Education Program, should be in place prior to the move.

- Pending State and federal approvals, the MDS-Home Care assessment tool will be pilot tested by one county to assess its potential to be used as a mechanism to transition nursing facility residents to a community setting.

- Subject to the availability of resources, DSS and DHS will evaluate the cost to increase IHSS hours to the maximum allowed during the first 90 days after an individual transitions from an institution to the community. This 90-day transition period is when consumers, especially those living alone, are most vulnerable to transfer trauma that can result in re-institutionalization.

- Beginning in 2003, DHS will begin to expand the DHS Medical Case Management (MCM) Program. Currently, the MCM Program is expanding in the San Francisco Bay Area where the Department does not have a program. Plans to expand also include the Central Valley (Fresno/Bakersfield), the Los Angeles area, and the establishment of a new satellite office in Redding for expansion in Northern California. This effort will facilitate and coordinate timely access to those appropriate medical and community-based services in a home setting that help stabilize and improve a beneficiary's health status and reduce preventable institutionalization.

- In 2003, DDS will continue downsizing eleven large residential facilities, moving persons with developmental disabilities to smaller community homes and will survey its regional centers to identify additional facilities for downsizing.

- Beginning in 2003, CDA and DHS will explore expanding the existing authority for nursing home residents to make transition visits to adult day health care programs. These visits assist nursing home residents in determining whether the services of adult day health care programs can meet their needs, which in turn will help them gauge the feasibility of community living.

- Beginning in 2003, the LTC Council will identify options to reach residents in institutions in order to inform and educate them regarding the *Olmstead*

decision, and will work in collaboration with stakeholders to identify options that may be pursued.

Community Service Capacity

Policy Goal: Develop a full array of community services so that individuals can live in the community and avoid unnecessary institutionalization, including participating in community activities, developing social relationships, and managing his or her personal life by exercising personal decisions related to, among other things, housing, health care, transportation, financial services, religious and cultural involvement, recreation and leisure activities, education, and employment. Services should be appropriate to individuals living with and without family or other informal caregivers. Increase capacity for local communities to divert consumers from institutionalization and re-institutionalization. Support family caregivers by providing an array of information and services that will allow them to support a family member with disabilities in their home.

- During 2003, the Department of Health Services will request approval from the federal Centers for Medicaid and Medicare Services to expand by 300 the number of Nursing Facility waiver slots, in order to serve everyone currently on the waiting list.

- During 2003, the LTC Council will identify state actions that could be used to improve the availability of paratransit services based on consumers' need for services, coordinate paratransit services across transit districts, and expand rural services.

- Beginning July 1, 2003, the LTC Council departments will analyze their current waitlists and report, beginning with the Fall 2003 LTC Council meetings, at the quarterly LTC Council meetings, on the status and movement of those waitlists and describe efforts to ensure waitlists move at a reasonable pace, including need for additional resources. The departments will seek consumer and stakeholder input. The departments will make their reports available to the public.

- Subject to additional resources, expand programs that assist consumers in living in the community. In the state's current fiscal situation, there is no guarantee that funds will be available and appropriated for implementation of program expansion. These include programs that provide in-home care and services; transportation and housing; supported living; information and assistance; respite; care management; caregiver assistance; day programs; services for children and adolescents, including expanded supports (wraparound) for families; and other services and supports. To the extent possible, expansion of programs should be based on data analysis consistent with recommendations under the "Data" section of this plan.

- In 2003, the DOR will implement a Workforce Inclusion Initiative. This initiative supports the goals of equality of opportunity, full participation,

independent living, and economic self-sufficiency for people with disabilities. Working in cooperation with the State Employment Development Department, this initiative will increase the employment of individuals with disabilities by assuring that they are able to access the full array of state and local employment programs. The DOR will seek input of stakeholders and consumers.

- Beginning in 2003, the DOR will work with one-stop career centers to enhance the centers' abilities to establish policies regarding working with persons with disabilities. The DOR will seek input of stakeholders and consumers.

- Beginning in 2003, DHS will support the use of social health maintenance organizations, which utilize community-based organizations to provide social and health care services and supports, which allow participants to avoid nursing facility placement.

- In 2003, to promote human resource development, and to increase consumer choice and options, DMH will develop and disseminate to county mental health departments a technical assistance manual on working with high school career academies in promoting career paths into mental health professions.

- During 2003, CHHSA will evaluate the projects funded under the Governor's Caregiver Training Initiative and identify additional job training and skills training that would be beneficial for direct-care staff.

- In 2003, DSS will explore the need for, and feasibility of, licensing assisted living type facilities for younger individuals with disabilities.

- In 2003, DSS will review licensing regulations and statutes to identify any barriers to placement or retention in community care facilities, including looking at social rehabilitation facility models and residential treatment alternatives to acute and long-term institutional care.

- Subject to additional resources and analysis of relevant data, the LTC Council departments will develop and implement further strategies to increase and stabilize the recruitment, education, training, and retention of health professionals and other paid caregivers. Subject to additional resources, this might include additional rate increases for community long term care service providers or expanding caregiver support services in order to allow them to serve more family caregivers.

- DDS and DHS will seek a federal Home and Community-Based Services Independence Plus Waiver to fund the continuation and expansion of self-determination for regional center consumers.

Housing

Policy Goal: Expand the availability of housing options for persons with disabilities. Ensure the availability of housing options that can be augmented by supports that facilitate the full inclusion of the person into the community.

- Subject to the availability of additional resources, the Department of Housing and Community Development (HCD) will develop a database of housing resources available to persons with disabilities in each city and county. Information will be collected on the number of Section 8 housing vouchers available; number of subsidized public housing units; number of subsidized units that are accessible; number of subsidized accessible units that are occupied by people without disabilities; the number of bedrooms and bathrooms in each unit; and any other data deemed relevant for planning purposes by the department. This information would be made available to the public in a database where individuals can learn about the availability of accessible and affordable housing in their community. HCD will encourage local public housing agencies to make this information locally available, and to identify units as accessible or convertible. Additional resources will be needed to collect, maintain, and disseminate the data. In the state's current fiscal situation, there is no guarantee that funds will be available and appropriated for development of the database or for collection, maintenance, and dissemination of the data.

- HCD will implement Proposition 46, including the supportive housing program and Grants for Ramps program. To the extent permitted under state law, HCD will ensure that housing for persons with disabilities is a priority use for Proposition 46 funds. HCD will award State dollars only to projects that require ground floor apartments be reserved for individuals with disabilities, and require all apartments to be convertible for use by persons with disabilities.

- HCD will review programs, services, and funds for accessibility and Local Government Housing Elements to insure that they include adequate sites for all housing needs including households with special needs. HCD will provide local housing entities with information on the *Olmstead* decision and emphasize the importance of making housing available in order to meet Olmstead goals. HCD will require that Consolidated Plans and Housing Elements reflect Olmstead goals as a condition of certification. HCD will consider establishing an Olmstead Ombudsman and grievance procedures to process reports of non-compliance.

- Increase local capacity for home modification by providing planning grants from local Community Development Block Grant (CDBG) funds. Utilize funding from the CDBG program, the HOME Investment Partnership Act,

Proposition 46 funds and other sources to increase funding for home modifications.

- Subject to additional resources, add rental housing after Proposition 46 resources are allocated, and resources for housing specifically designed to meet the needs of individuals with disabilities.
- Subject to additional resources, expand DMH's Supportive Housing projects.
- Subject to additional funding, provide funding for county planning grants to co-plan housing and transit.
- HCD, with the participation of stakeholders, will develop a Universal Design/Visitability Ordinance that can be adopted by local governments.
- HCD will notify the operators of HUD housing regarding access requirements for publicly subsidized housing. HCD will also encourage local governments to enforce Fair Housing laws regarding access and home modification.
- HCD will request that the federal Housing and Urban Development commit to a major expansion of federal rental assistance so that each eligible household or person can get aid.

"Money Follows the Individual" and Other Funding

Policy Goal: Develop a "Money Follows the Individual" model to provide resources for individuals to live in the community rather than an institution. Seek opportunities to increase resources and funding options.

- As an ongoing activity, LTC Council departments will identify new federal funding sources and apply for grants that will transition individuals out of, and divert others from entering, institutions.
- As an ongoing activity, the LTC Council departments will evaluate the options of expanding the HCBS waivers, particularly for populations not now served, that will enable individuals to transition out of, or be diverted from entering, institutions. For example, subject to the availability of resources, DMH and DHS will conduct the analysis required by SB 1911 (Chapter 887/01, Ortiz). DHS, DMH, CDA, and DDS will review the opportunity offered by the Independence Plus Waiver.
- In 2003, the Department of Health Services will propose to the Centers for Medicare and Medicaid Services that the existing institutional bias in funding in the Medicaid program be replaced by a new policy. The new policy would specify that long term care services are to be provided in community settings whenever feasible.
- Beginning July 1, 2003, the LTC Council, with input from consumers, stakeholders, and experts in other states and the federal government, will design one or more models for programs in which "the money follows the person" for individuals seeking to move from institutions. The models would be piloted for expansion statewide. Additional resources would be needed to develop and implement the pilots and statewide expansion. In the state's current fiscal situation, there is no guarantee that funds will be available and appropriated for implementation.

Consumer Information

Policy Goal: Provide comprehensive information regarding services to persons with disabilities in order to make informed choice and for service planners for planning purposes. No individual with disabilities should be prevented from living in the community due to a lack of information. Develop information, education, and referral systems, as needed, to meet this goal.

- In 2003, DSS will evaluate the option of opening the Public Authority's IHSS registries for use by all individuals and the impact on consumer information, while ensuring compliance with confidentiality rules.
- In 2003, the CDA will train general Information and Referral providers and Area Agency on Aging Information and Assistance providers according to the Alliance for Information and Referral Systems (AIRS) standards. Utilizing these standards will help ensure that the AAAs are best able to provide information to consumers, families, and other stakeholders that can help them meet their service needs in their home communities.
- The DHS will, to the extent resources permit, provide outreach and training on Medicaid Home and Community-based Services Waiver programs to state and local entities including potential providers of services, regional centers, state ombudsmen, IHSS staff, Area Agency on Aging staff, and hospital nursing facilities on available services, waiver capacity, and applications for service.
- The LTC Council will continue to provide consumer information via the internet at www.calcarenet.ca.gov, and will identify ways to expand internet and hard copy access to comprehensive information about community-based services, including information on crisis services, by improving the existing systems and developing new ones as appropriate. This could include a directory of all relevant Internet sites and telephone-based information numbers. Additionally, the LTC Council will develop hard copy materials for distribution to the public in regular text and alternative formats, including non-English languages. Additional resources may be needed to develop materials, disseminate information, and develop new internet based systems. In the state's current fiscal situation, there is no guarantee that funds will be available and appropriated to develop materials and new internet-based systems, and to disseminate information.

Community Awareness

Policy Goal: Educate communities regarding the *Olmstead* decision. Provide background information on the Americans with Disabilities Act, the Fair Housing Amendments Act, and other related federal and state laws, to community decision makers, to ensure that they take the needs of individuals with disabilities into account when making decisions regarding public services and resources. Provide information to California communities so that community planning can be conducted to address the needs of that community's individuals with disabilities.

- As an ongoing activity, CHHSA departments will inform and advise state and local entities, including the courts, regarding the Americans with Disabilities Act (ADA), the federal and state Fair Housing Amendments Acts (FHA), the *Olmstead* decision, and other related state and federal statutes, and seek the assistance of local and disability organizations in this activity. The Council will also share this information with local and disability organizations and request their assistance in similarly informing and educating these entities. The Department of Rehabilitation will coordinate this activity.

- The LTC Council, subject to additional resources, will hire a consultant to develop, in concert with consumers and stakeholders, a public awareness campaign to ensure that the public is aware of the existence of long term care options other than institutional options. This effort will supplement similar departmental efforts. Additional resources would be required to hire a consultant to produce and implement the public awareness campaign. In the state's current fiscal situation, there is no guarantee that funds will be available and appropriated to hire a consultant.

Quality Assurance

Policy Goal: Continually improve quality of services based on desirable outcomes and measures and increase the level of consumer satisfaction.

- Beginning July 1, 2003, the LTC Council departments will review their current quality assurance efforts for consistency with the criteria below, which are intended to promote the use of outcome based models. The departments will solicit input from consumers and stakeholders. The departments will identify any instances in which their current efforts do not meet the criteria, and specify the improvements that will be made. Additional resources would be needed to implement activities if resources are not currently available for that activity. In the state's current fiscal situation, there is no guarantee that funds will be available and appropriated to implement identified activities. By April 1, 2004, the departments will report their findings and recommendations to the Long Term Care Council. The criteria include:

    a. Service, quality and program standards, as appropriate.

    b. Measurable and measured outcomes. Outcome measures should allow for an acceptable level of risk management by service planners and the consumer.

    c. Data collection and key indicator reporting, with the understanding that monitoring is not only a paper review.

    d. Fraud, abuse, and exploitation prevention, including ombudsman

    e. Grievance and appeals processes.

    f. Monitoring, auditing and evaluation methodology, considering the use of tools such as program accreditation and certification.

    g. Education and training for providers, family caregivers, and program quality monitors. For example, training could include independent living training that is provided by consumers, or long-term care facilities.

    h. Service provider standards, rights, and expectations.

    i. Peer support.

    j. Consumer rights, including confidentiality of personal information.

    k. Examine evidence-based practices: successful community models should be used to assist clients during transition and diversion.

    l. Provide incentives/awards for good practices.

m. People should be allowed to live in their own homes without intrusive oversight.

n. Publication of results, such as Medicaid Waiver quality assurance and performance monitoring activities that are required by CMS.

o. Regular review of individual service plans and the use of monitoring teams which include persons with disabilities, family and community members, service providers, and others as appropriate.

p. Centralized responsibility for overseeing program quality, and authority to impose sanctions for violations

- Subject to the availability of resources, the DMH will work with the counties to evaluate the efficacy of the treatment programs utilized in IMDs, SNFs and MHRCs. The purpose will be to identify treatment programs that are particularly effective in preparing individuals to transition to community living, and which are consistent with the Mental Health Planning Council's platform statements on in-facility focus and IMD transition:

  a. In-facility focus: Guided by client self-determined goals, facilities should provide treatment, recovery, and support services that prepare the client for successful placement into the community.

  b. IMD Transition: The client's community placement goal should be identified at admission and be the organizing focus of treatment, rehabilitation, and support services. Discharge planning should identify treatment and recovery services and enlist the support of family and friends to ensure a successful transition to community placement.

- In 2003, DSS, with input from consumers and stakeholders, will begin to develop training, educational, materials and other methods of support to (1) aid IHSS consumers to better understand IHSS and to develop skills required to self-direct their care, and (2) aid providers in better meeting the needs of consumers. This item is the result of the award of a federal "Real Choice Systems Grant" that is expected to take three years to complete.

- In 2003, DSS will revise regulations to further strengthen the criminal background check process for those who operate, own, live, or work in community care licensed facilities.

- In 2003, the DMH will make available on the DMH web site and in hard copy, mental health performance outcome measures as provided to the State Quality Improvement Council.

- Beginning in 2003, CDA will monitor and improve Area Agency on Aging Information Assistance services to ensure program consistency statewide.

- Beginning in 2003, CDA will encourage general information and referral providers and Area Agency on Aging Information and Assistance workers to become certified Information and Assistance/Referral (I&A/R) specialists through the California Association of Information and Referral Specialists (CAIRS), the California AIRS associate.

- Subject to the availability of resources, the DSS will evaluate the IHSS enhancements made pursuant to AB 1682, including a provider registry, provider referral system and qualifications investigations, to determine the impact on service quality.

- As an ongoing activity, the DMH will audit statewide the extent to which county Mental Health Plans are providing covered Medi-Cal Specialty Mental Health Services consistent with statewide medical necessity criteria, including but not limited to the provision of the following services:

    a. Individual Mental Health Services.

    b. Targeted Case Management/Brokerage Services.

    c. Crisis Residential Treatment Services.

    d. Adult Transitional Residential Treatment Services.

    e. Crisis Intervention Services.

- In 2003, DDS will revise the current DDS quality assurance systems into a "Quality Management Model" utilizing the Centers for Medicaid and Medicare framework. This model incorporates within it the quality measures identified through DDS' Service Delivery Reform effort.