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Community Integration for Every New Yorker



Olmstead Progress Update

January 29, 2014
Most Integrated Setting
Coordinating Council



The Olmstead Plan – Key Elements

- Community transition
- Common assessment and outcomes measurement
- Reforms to support community integration
- Accountability



Today's Focus - Community Transition

- People with Intellectual and Developmental Disabilities in Developmental Centers, Intermediate Care Facilities, and Sheltered Workshops
- People with Serious Mental Illness in Psychiatric Centers, Nursing Homes, Adult Homes, and Sheltered Workshops
- People in Nursing Homes



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OPWDD Update

Laurie Kelley
Acting Commissioner



OPWDD & OLMSTEAD PROGRESS

Olmstead Report Called for OPWDD Action in 3 Areas

- Accelerate community integration from segregated developmental centers, workshops, and Intermediate Care Facilities
- Continue expanding person-centered services through Front Door initiative and Money Follows the Person
- Launch the START Model to better serve people in the community who experience crisis so they can live in the community with a safety net and return to the community when ready



OPWDD & OLMSTEAD PROGRESS

DC and ICF Community Integration

- Finger Lakes and Wassaic DCs closed on 12/31/13
- DC census declined from 1,015 on 4/1/13 to 780 on 1/1/14
- Plan for ICF Integration remains on schedule



OPWDD & OLMSTEAD PROGRESS

Money Follows the Person

- A federal demonstration to help people live in their communities
- MFP includes providing community supports for individuals with developmental disabilities and utilizing peer-to-peer outreach in which people who have left institutions meet with people living in institutions to discuss community living
- Goal: Assist 875 people in moving from institutional settings into the community within 4 years. Status: 94 individuals transitioned to MFP-qualifying settings to date



OPWDD & OLMSTEAD PROGRESS

START Model

Systemic Therapeutic Assessment, Respite and Treatment

- START provides emergency crisis services and limited therapeutic respite services
- Launching in OPWDD Regions 1 and 3 in January 2014 (Western New York and Hudson Valley)



OPWDD & OLMSTEAD PROGRESS

Executive Budget Proposal

- Reaffirms New York's commitment to transition individuals from segregated settings to more integrated, community-based support systems
- Invests more than \$9M to support the development of expanded community services to appropriately serve individuals transitioning from institutional programs
- Seeks to amend the Nurse Practice Act to improve community care



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OMH Update

John Tauriello
Deputy Commissioner and Counsel

John Allen
Special Assistant to the Commissioner



Fulfilling the Olmstead Mandate

*Creating More Integrated Settings and Opportunities for
Persons With Serious Mental Illness*

- **Regional Centers of Excellence Plan:** The Office of Mental Health's redesign of State-Operated mental health services, through its Regional Centers of Excellence Plan, will relocate the delivery of many of these services from segregated institutional settings to the community
- **Expanded Community Services** include:
 - Crisis/Respite beds
 - Community Integration Teams
 - Housing Support Teams
 - Peer-lead Recovery Services
 - Mobile Crisis Teams
 - Urgent Care capacity at OMH clinics
 - Extended Evening and Weekend hours of clinic operation



Reduce Adult Inpatient Long-stay Population 10% over 2 years

- **Promise:** OMH will reduce the number of long-stay (one year or more) patients by 10% within two years after the release of the Olmstead report (October 2013)
- **Performance:** The number and percent (just over 50%) of long-stay individuals has slightly increased (1,337 in January 2014 vs. 1,328 in July 2014 and 1,321 on October 31, 2013)
- **Future Actions:** OMH believes that the expansion of more effective community-based services under the RCE Plan will substantially reduce the number of long-stay patients. Work with facilities which have not shown a decline in their long-stay census to craft plans to regularly review long-stay cases and take all necessary steps to speed their discharge



Reduce adult inpatient long-stay

2014-15 Budget Actions

- **2014-15 Budget:** OMH will close 399 adult and children's inpatient beds. The savings will be used in part to create 158 new community residential beds and new community services
- **Reinvestment:** \$25 million in 2014-15 (fully annualizing to \$44 m); expands both State-operated and voluntary community services
- **Behavioral Health Investments totaling \$120M:** To support transformation and prepare for implementation of Health and Recovery Plans(HARPS)/Managed Care



Adult Home Initiative

- **Settlement Agreement** with the Department of Justice and private plaintiffs - filed with the Brooklyn Federal District Court on 7/23/13
- The settlement requires the State to dedicate a minimum of 2,000 Supported Housing units to transition AH residents. Queens and Brooklyn 1,050 units (six housing contractors). Additional units to be developed in Staten Island and the Bronx (funding in budget)
- **Health Homes and Managed Long Term Care** plans will conduct comprehensive assessments of each NYC Adult Home Resident with SMI, and provide a **care coordinator** to implement a **person-centered plan of care** (consistent with MRT goals - integrated care management)
- **Assessment of housing and service needs:** Housing in the most integrated setting appropriate for the individual; behavioral and physical health services needed to support the individual, based upon assessed needs and personal preferences



Adult Home Initiative – Actions to Date

- **Housing contractors are developing and training “in-reach” teams** - One professional clinical staff and one peer staff to provide education about housing and services available in the community and to provide encouragement to residents - “motivational interviewing” techniques.
- **Phase 1:** In-reach and assessments will begin in three adult homes to ensure smooth implementation in the remainder of the homes. In-reach is expected to start in February/March of this year.
- **Independent Reviewer** (Clarence Sundram) has been appointed to oversee the implementation of the settlement. Parties have met with Mr. Sundram to work out implementation logistics.
- A **Fairness Hearing** was held on 1/9/14 - Judge heard testimony from AH Residents on support or opposition to the settlement. The Judge indicated likely will approve the agreement. (Expect within days or weeks.)



Nursing Home Settlement

- In September 2011, New York settled a federal class action lawsuit, *Joseph S. v. Hogan*, concerning people with serious mental illness discharged or at risk of discharge to nursing homes from State-operated psychiatric centers and psychiatric wards of general hospitals.
- 1,516 of 1,962 Remedy Members have been assessed (by 1/13/14).
- 252 have been determined to be appropriate for and desirous to move to the community (additional remedy members were discharged to community as part of the normal NH discharge planning processes prior to assessments).
- OMH and DOH worked collaboratively in advance of the settlement to help repatriate remedy members from out of state nursing homes back to the community in NYS.
- In addition, some remedy members were diverted from Nursing Homes altogether and were discharged to the community directly from OMH PCs.



80 Total discharges to the community from Nursing Homes

- Congregate/Community Residence: 23
- Private Residence: 15
- Adult Home: 14
- Assisted Living Program: 10
- Other: 5
- Apartment Treatment: 3
- Supported Housing: 3
- HASA Housing: 1
- CR-SRO: 2
- TBI Waiver: 1
- Family Care: 2
- OPWDD: 1



Sheltered Workshops Initiative

- In January 2011, OMH began a three year plan to shift reliance on sheltered workshops to integrated, competitive employment
- As of January 1, 2014, all OMH funding of community sheltered workshops ended. All OMH-operated sheltered workshops will be closed by March 31, 2014
- Agencies received technical support (through NYSRA and the Medicaid Infrastructure Grant) to develop sound business plans to transition individuals in sheltered workshops to integrated competitive employment
- Local governmental units played integral roles in developing and reviewing plans
- Ongoing partnership with local government and community agencies to assist persons to become employed/self-employed:
 - Assisted competitive employment, transitional employment program, affirmative business, and transitional business programs.



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DOH Update

Dr. Howard Zucker
First Deputy Commissioner



Overview

- The Olmstead report provided the framework for New York to serve people with disabilities in the most integrated setting appropriate to their needs
- The Money Follows the Person (MFP) Demonstration and the Balancing Incentive Program (BIP) within the Department of Health share common goals with the Olmstead report. Both of these programs:
 - Assist in transitioning people with disabilities into the community from developmental centers, ICFs, psychiatric centers, adult homes, and nursing homes
 - Enhance services available to people with disabilities



Money Follows the Person

Federal Goals

- Increase the use of community and reduce the use of institutional long term services and supports (LTSS)
- Eliminate barriers or mechanisms that restrict use of Medicaid funds so individuals receive support for LTSS in the setting of their choice
- Strengthen the ability of states to assure continued provision of LTSS to individuals who choose to transition from institutions into community settings
- Ensure quality procedures are in place



Money Follows the Person Eligibility

- Individual must Have been in a facility for at least 90 consecutive days (less any Medicare short term rehabilitative days) prior to transitioning to the community
- Individual must have received those Medicaid inpatient services for at least one day prior to the transition.

MFP Qualified Setting:

- A home or apartment owned or leased by an individual or family member, or a community based residence with no more than 4 unrelated individuals

Current Approach:

- Uses some existing Long Term Care waivers (NHTD, TBI) for service delivery. Plan is underway to expand to additional service options i.e., MLTC



Money Follows the Person

Current Rebalancing Initiatives

- Increase access to assistive technology and durable medical equipment (TRAID program)
- Provide objective information on home and community-based long term care options to individuals residing in facilities (ID & Outreach project). This project is undergoing a major restructure which will result in a new program design
- Enhance volunteer guardianship (VERA program)



Restructuring the ID & Outreach Project

- The Identification and Outreach project began on 1/1/2010
- OPWDD population approved for MFP in Spring 2013
- MLTC plans being phased in and will be the predominant service delivery mechanism in NYS



Restructuring the ID & Outreach Project

- Reasons why the Identification and Outreach Project is being re-designed:
 - More emphasis on transitioning individuals out of institutions
 - More emphasis on cross-population collaboration
 - Strengthens and supports the current transition process
- Current RFA is in the approval process with an anticipated release date by mid-February



Money Follows the Person Accomplishments

Individuals who have transitioned from facilities:

DOH (as of 1/1/14):

- 768 individuals through the NHTD Waiver
- 356 individuals through the TBI Waiver
- 1,124 individuals

OPWDD (since 1/1/2013):

- 94 individuals
- Total individuals to date: 1,218



Balancing Incentive Program Overview

The Balancing Incentive Program (BIP) is a funding opportunity offered under section 10202 of the Affordable Care Act

- Provides enhanced FMAP (+2%) to participating states to rebalance Medicaid Long Term Services and Supports (LTSS) by increasing access and expanding community services as an alternative to institutional care
- **Requires 3 structural changes:**
 - No Wrong Door/Single Entry Point network (NWD/SEP)
 - Core Standardized Assessment Instruments
 - Conflict Free Case Management



Balancing Incentive Program Overview

BIP involves:

- Rebalancing the delivery of long-term services and supports (LTSS) towards community-based care
- Promoting enhanced consumer choice
- Standardizing information for eligibility determination and enrollment processes
- Improving access to and expanding community LTSS



Balancing Incentive Program Overview

- Participation in BIP will reinforce New York's ongoing efforts to improve access to home and community-based long term care services for those with physical, behavioral health, and/or intellectual and developmental disabilities throughout the state
- Under BIP, the State will enhance the existing NY Connects network to assure a no wrong door/single point of entry network for long term care services and supports, implement a standardized assessment instrument, and assure conflict-free case management services



The Relationship Between MFP and BIP

MFP and BIP:

- Share a rebalancing goal of moving individuals from an instructional setting to home and community based settings
- Provide enhanced funding which complement the program requirements:
 - MFP funding can be used for the implementation of broader infrastructure developments such as “no wrong door” access to care systems
- Are designed to work together and across populations



Community First Choice Option

- CFCO State plan amendment was submitted in December of 2013 to CMS
- Builds on work from the state CFCO advisory group
- No comments or questions to date from CMS



Olmstead Implementation Activity

- To date, DOH has taken the following steps to implement the Olmstead recommendations:
 - Commissioner Shah appointed Dr. Howard Zucker to lead multi office effort
 - OHSM/OHIP internal team has been established
 - DOH specific work plan in development