Toward an Olmstead Plan:

"Comprehensive and Effectively Working"

Submitted to
Minnesota Governor's Council on Developmental Disabilities

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INTRODUCTION

This report seeks to identify elements which might be considered for incorporation into Minnesota's *Olmstead* Plan.[1]" It includes a detailed outline of suggested contents for a plan, and discussion of key components of a plan, with sample language.

The author recognizes that the development of a Minnesota *Olmstead* Plan requires, first and foremost, the leadership of the Governor and responsible state officials. An effective plan will also embody the participation of various constituent groups and organizations, including consumers, families and service providers.

Long term commitment to the plan's implementation is, of course, as important as its development. An *Olmstead* plan takes years to implement, and sustaining implementation is a never-ending process. For success, the commitments made now must be taken up by successive administrations and the entire community.

This report is not a plan nor is it a substitute for the interchange which will take place among the developers of the state plan. Hopefully, this report will inform the discussions of the planning group, perhaps save some time and also be an encouragement to this vital endeavor.

[1] This report is submitted in satisfaction of the contract with the Minnesota Governor's Council on Developmental Disabilities which requested the author to "review selected Olmstead Plans developed and implemented in other states, prepare a comprehensive summary, and identify positive characteristics what could be incorporated into Minnesota's Olmstead Plan. " APA, Annual Plan Number 29613, PO# G0201-3000000616.

I. THE *OLMSTEAD* MANDATE

A. The Supreme Court's Decision

In *Olmstead v. L.C.*, the United States Supreme Court held that Title II of the Americans with Disabilities Act of 1990 (ADA)[2] requires the placement of persons with mental disabilities in community settings, rather than in institutions, when:

> (1) the state's treatment professionals determine that such a placement is appropriate,
>
> (2) the transfer is not opposed by the individual, and
>
> (3) the placement can be reasonably accommodated given the resources available to the state and its obligation to provide for the needs of others with mental disabilities.

A five justice majority held that a failure to provide care for individuals with mental disabilities in the most integrated setting appropriate to their needs is discrimination, in violation of the ADA, unless the state or other public entity can demonstrate an inability to provide less restrictive care without "fundamentally altering" the nature of its programs. The Supreme Court's decision disfavors institutional placement, and looks positively at community services.

> [I]nstitutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life.[3]

B. The Necessity for a Plan

Olmstead does not require a state plan, but compliance with the court's mandate would be quite difficult to demonstrate without a formal *Olmstead* Plan.[4] The Supreme Court made it clear that the establishment

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[2] 42 U.S.C. § 12132.

[3] *Olmstead v. J.C.*, 527 U.S. 581, 600 (1999).

[4] In addition, federal authorities anticipate development of *Olmstead* plans. *See* Letter from Timothy Westmoreland, Director, HCFA Center for Medicaid and State Operations and Thomas Perez, Director, Office of Civil Rights of the United States Department of

and implementation of a "comprehensive, effectively working plan" is a vital criterion for evaluating a state's compliance with the court's decree.

> If, for example, the State were to demonstrate that it had a *comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings*, and a *waiting list that moved at a reasonable pace* not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met.[5] (emphasis added).

As indicated in the quotations above, the *Olmstead* Plan is to be a placement plan and to address movement from waiting lists. States have recognized that such a plan affects the entire service system and have adopted plans of broad scope.

II. METHODOLOGY

We first sought to identify every state's *Olmstead* Plan. This was accomplished, to the extent possible, in three ways: a) telephoning the relevant state developmental disabilities and/or Medicaid office in every state, requesting documents or citations/webpages for the state plan, b) consulting a published listing compiled by university *Olmstead* researchers of each state's plan,[6] and c) examining the states' public postings on the internet. As a result of these efforts, we obtained an *Olmstead* Plan or related explanatory document for a large majority of the states.

We next studied the material, drawing from it possible elements for comprehensive planning, and options for sample language addressing typical plan sections such as "principles" and "goals."

State plans vary in quality, depth and utility. Some are of high quality, and some simply describe past or already-in-place activities, without clear connection to the *Olmstead* mandate. Some have activities but no timeline; some have timelines but few measurable activities. Some plans

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Health and Human Services, to State Medicaid Directors, dated January 14, 2000 http://www.hhs.gov/ocr/olms0114.htm.

[5] 527 U.S. at 605-606 (1999).

[6] Terence Ng, Alice Wong and Charlene Harrington, "Olmstead Plans and Related State Activity." *PAS Center for Personal Assistance Services.* UCSF National Center for Personal Assistance Services, Aug. 2011. Web. 11 Apr. 2012. Available at http://www.pascenter.org/olmstead/downloads/Olmstead_ Plan_2011.pdf.

have scant detail; some seem overloaded with detail.

There is no "model" template for a plan which fits all. Aside from each plan drawing its mandate from the Supreme Court's decision, and each extracting values and principles from that decision and contemporary professional standards, each plans makeup is state-specific.

We considered two perspectives which we believed might point to plans of states worthy of particular attention: a) states which rank high nationally in the *extent of participation* (in expenditures and percent of client participation) in Home and Community Based Services under Medicaid,[7] and b) states which rank high nationally in reported quality of community Medicaid services.[8] The lists have little overlap.[9]

Neither perspective is particularly useful for evaluation of their *Olmstead* plans. States in both these "top" lists and in other states have plans which, to one degree or another, have instructive elements.

HCBS data are relevant, but do not embody judgments regarding the quality of services. Quality judgments are also relevant, but do not tell the story of expenditures and the balance between HCBS and institutional care. Thus, caution should be exercised in state-to-state comparisons based simply on these or similar factors.

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[7] It is fair to say that *Olmstead* provided a significant incentive for states to expand community services under Medicaid. A major means for states to fund Olmstead compliance are Home and Community-Based Services (HCBS) funded under the Medicaid program.

> Because Medicaid is a major source of health insurance coverage for people with disabilities, HCBS provided by state Medicaid programs are an important means for states to achieve compliance with their Olmstead obligations. Most recently, federal and state Olmstead compliance efforts have focused on rebalancing the overall Medicaid LTC system by shifting services and spending away from institutional care and toward HCBS.

Kaiser Commission on Medicaid and the Uninsured, State Options That Expand Access to Medicaid Home and Community-Based Services (Oct. 2011) at 1.

[8] See the sixth annual examination of the *quality* of Medicaid services. United Cerebral Palsy, *The Case for Inclusion* 2011, http://medicaid.ucp.org/

[9] The highest ranked HCBS participation (appearing in the top ten of both per capita dollar expenditure and percent of client participation) are Alaska, California, Colorado, New Mexico, Oregon and Washington. The top ten states for quality are Vermont, Arizona, Michigan, New Hampshire, California, Washington, Delaware, Nevada, Massachusetts and Connecticut.

There are three related matters which we did not consider in developing this report:

- We did not consider litigation. Since the *Olmstead* decision, there has been a proliferation of litigation seeking to enforce rights directly under *Olmstead* or related to *Olmstead*.[10] Because these suits include both class and individual actions, and are at all stages of maturity (from just-filed to post-judgment or on appeal), it was deemed impossible to utilize litigation as a criterion for assessment of good *Olmstead* planning. In any event, whether or not a judgment or court-approved settlement is in place, the Olmstead mandate must be heeded.

- It was beyond the scope of this effort to assess the resources available to Minnesota, the extent of needed resource expansion, or how those factors may affect development or implementation of an *Olmstead* Plan.

- The quality of implementation of plans was not considered. Many variables affect implementation success, and, for each state, a variety of views (e.g., state officials, local officials, providers, consumers, advocates) would need to be considered.[11]

III. FUNDAMENTAL CHARACTERISTICS OF AN *OLMSTEAD* PLAN

State plans vary in quality, depth and utility. Some are of high quality, and some simply describe past or already-in-place activities, without clear connection to the *Olmstead* mandate. Some have activities but no timeline; some have timelines but few measurable activities.

Based on this review, it is suggested that a high quality plan integrates its purposes with an implementable action plan, and provides for accountability over a sustained period. The core of the highest quality plans consist of a clear vision and statement of principles and goals, together with a detailed workplan. The workplan preferably includes

[10] Terence Ng, Alice Wong & Charlene Harrington. *Home and Community Based Services: Community Integration – Olmstead and Olmstead-Related Lawsuits* (9th Revision, Feb. 2012), available at http://www.pascenter.org/olmstead/downloads/Olmstead_Cases_Table.pdf.

[11] We note, in passing, that there is a vital need nationally for a comprehensive study (and for studies of a smaller dimension) of the quality of implementation of Olmstead plans.

specific tasks, persons or agencies accountable, identification of resources available and needed, deadlines or targets, and a mechanism for tracking progress and for addressing obstacles to implementation.

Fundamental characteristics of a plan include:

- ✓A comprehensive system for identification and assessment of individuals for community living, and periodic review of assessments.[12]
- ✓Creation of services and supports for consumers to live, work and play in the most integrated setting.
- ✓Measurable goals with target dates.
- ✓Recommendations for funding.
- ✓Coordination of the state's *Olmstead*-related efforts, with top-level authority to resolve inter-agency conflicts.
- ✓A tracking system for the plan, and data collection systems for information relevant to the plan.
- ✓Quality assurance / quality enhancement activities, including but not limited to face-to-face interviews with consumers, families, providers, support coordinators, agency personnel, and advocates.
- ✓A mechanism for revisions and updates to the plan, with a feedback loop from the quality assurance / quality enhancement function.
- ✓A commitment to a multi-year implementation period, followed by an indefinite "maintenance" effort, which extends over political and legislative administrations.

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[12] *See* Letter from Timothy Westmoreland, Director, HCFA Center for Medicaid and State Operations and Thomas Perez, Director, Office of Civil Rights of the United States Department of Health and Human Services, to State Medicaid Directors, dated January 14, 2000 http://www.hhs.gov/ocr/olms0114.htm.

> Individuals with disabilities benefit from assessments to determine how community living might be possible (without limiting consideration to what is currently available in the community). . . The plan evaluates the adequacy with which the State is conducting thorough, objective and periodic reviews of all individuals with disabilities in institutional settings. . . to determine the extent to which they can and should receive services in a more integrated setting.

IV. *Olmstead* Plan Outline

Presented below is a detailed outline suggested for consideration for the state's *Olmstead* plan. Each major section is discussed later in this report. For convenience, this outline is reproduced at Appendix A.

BACKGROUND

- *Describe requirements of Olmstead decision.*
- *Impetus within the state for development of the plan*

PLAN DEVELOPMENT

- *Process for assembling those responsible for drafting the plan*
- *The drafting and approval process for the plan.*
- *Specify involvement of agencies, stakeholders, function of public meetings*
- *Presentation of plan*

MISSION

- *Brief statement of the mission of the plan*

PRINCIPLES

- *Statement of the principles which underlie the plan*
- *Recognition of the long-term nature of the plan, a need for continued maintenance of effort.*

GOALS

"WHAT WE HAVE"

- *Identification of state agencies involved in supports to consumers*
- *Identification of current laws and regulations pertinent to the plan*
- *Analysis of populations and programs: status and trends*
    - *History of institutional services*
    - *HCBS*
    - *State-operated long term care facilities*
    - *State-operated psychiatric hospitals*
    - *Nursing facilities*
    - *ICF-DD facilities*
    - *Assisted living residences*
    - *Facilities for children*
- *Description of residential services (institutional, HCBS and other community)*

- *Description of transportation, employment, and other non-residential elements*
- *Description of current assessment, referral and coordination of services methods*
- *Advocacy, self-advocacy, family support and involvement*
- *Baseline data on programs, services, consumers, providers*
- *Baseline budgetary information*

"WHAT WE WANT"

- *Systems*
    - *Individual assessment*
    - *Coordination of services*
    - *Information and referral systems*
    - *Diversion*
    - *Transition from institutions*
    - *Waiting list: "reasonable pace"*
    - *Support service development*
    - *Direct care and other workforce development*
    - *Training*
    - *Funding structures and flexibility*
    - *Rights protection*
    - *Quality assurance / quality enhancement*
    - *Public awareness*
    - *Integrated data systems*

- *Support Services*
    - *Community-based housing*
    - *Transportation and mobility*
    - *Employment*
    - *Assistive technology*
    - *Communication services*
    - *Healthcare*
    - *Aging issues*
    - *Decision-making and guardianship*
    - *Advocacy, self-advocacy, family support and involvement*
    - *"Money follows the person" or other funding flexibility*

SEQUENCE AND PRIORITIES

- *Issues/activities of highest priority*
- *Identification of necessary sequencing of activities*
- *Identify major activities and tasks which can be implemented. . .:*
    - *with rebudgeting, reallocation and internal agency changes within existing funding and regulatory structures*
    - *without fiscal impact or regulatory change*

- *with moderate fiscal impact or regulatory change*
- *only with legislative activity for additional funding or changes in laws*

WORKPLAN

- *Categorization (by plan's goals) and statement of specific tasks*
- *For each task:*
  - *Desired outcome*
  - *Persons or agencies responsible and accountable*
  - *Identification of needed resources*
  - *Deadlines or targets*
  - *Mechanism to track progress*
  - *Mechanism to address obstacles to implementation.*
- *Assignment of responsibility for tracking overall plan status and progress*
- *Reporting methods and documentation*
- *Overall administration of the plan, including authority, and revision/update mechanisms*

CONCLUSION

V. COMPONENTS OF AN *OLMSTEAD* PLAN

This portion discusses each major section of a plan.

For the *key formative elements of the plan* (that is, Background, Mission, Goals and Principles), examples of coherent language are provided. The details of these key elements will be particular to Minnesota; however, the general concepts and principles will be tied to the *Olmstead* decision and to fundamentals of good planning. The plan developers will necessarily address these key elements before turning to the details of a workplan.

It is emphasized that the examples are not intended as a substitute for the wisdom of those in Minnesota who develop a plan best suited for Minnesota. Where indicated, the chosen examples are considered relatively superior means, or routes, for considering the matters each of the examples address.

For the *Minnesota-specific elements of the plan* (that is, "what we have," "what we want," sequence and priorities, and workplan), a general comment is provided.

The suggested components of the plan are:

A. BACKGROUND

B. PLAN DEVELOPMENT

C. MISSION

D. PRINCIPLES

E.GOALS

F."WHAT WE HAVE"

G. "WHAT WE WANT"

H. SEQUENCE AND PRIORITIES

I. WORKPLAN

A. BACKGROUND

An *Olmstead* plan typically opens with a summary of the Supreme Court's decision in the case. Rather than recite the details of the legal analysis, this background will lay out the basic holdings of the case. The Background will also summarize the impetus within the state for the development of the plan at this time.

This is an example of a statement of the *Olmstead* decision:

> *In June 1999, the United States Supreme Court rendered a decision, Olmstead v L.C. which provides an important legal framework for the efforts of the federal and state governments to integrate individuals with disabilities into the communities in which they live.*[13]

[13] Since *Olmstead*, the Executive Branch has directed action to secure compliance with the Supreme Court's decision. E.g., on June 18, 2001, President George W. Bush issued an Executive Order on Community Based Alternatives for Individuals with Disabilities. This Executive Order reconfirmed the Federal Government's support of the Olmstead Decision. It directed the United States Office of the Attorney General; the Secretaries of Health and Human Services, Education, Labor, and Housing and Urban Development; and the Commissioner of the Social Security Administration to "work cooperatively to ensure that the Olmstead Decision is implemented in a timely manner". These departments are directed to work with the States to "help them assess their compliance

The Olmstead case holds:

> *"[s]tates are required to provide community-based treatment for persons with disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with disabilities."*

The Court found that "Unjustified isolation . . . is properly regarded as discrimination based on disability." It observed that:

> *(a) institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life, and (b) confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.*

Olmstead is applicable not only to disabled persons living in developmental disabilities institutions, ICF-MRs, psychiatric hospitals, nursing homes and other institutions, but also to disabled persons living in the community who are at risk of institutionalization.

The Court suggested that a state could establish compliance with the Americans with Disabilities Act if it has

> *1) a comprehensive, effectively working plan for placing qualified people in less restrictive settings, and*
>
> *2) a waiting list for community-based services that ensures people can receive services and be moved off the list at a reasonable pace.*

Another example of a summary of *Olmstead* is in the introduction to this report.

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with the Olmstead Decision and the ADA in providing services to qualified individuals with disabilities." See CMS Letter to State Medicaid Directors; January 14, 2000.

B. PLAN DEVELOPMENT

An *Olmstead* Plan is typically developed by a committee or working group composed of representatives of state and local officials, consumers, providers, families, advocates, and other stakeholders. The work may be coordinated through sub-committees on specific sections.

The assembly and presentation of the data for the report is time-consuming and it is recommended that the development group immediately begin collection of the material for the section, "what we have." Otherwise, collection of that material will delay preparation of the remainder of the plan.

An approval process should be defined, as well as a public awareness and communications strategy. Some states (such as West Virginia) have utilized a Governor's executive order to mark the adoption of the plan.

C. MISSION

It is valuable to state the "mission" or "vision" of an *Olmstead* plan in terms which are inspirational and which also provide a guidepost in drafting and implementing the plan's details. Agreement among the drafters on such a statement is an important (and sometimes difficult) first step.

An example of a "vision statement" is Connecticut's:[14]

> *To assure that Connecticut residents with long-term support needs have access to community options that maximize autonomy, freedom of choice, and dignity.*

Massachusetts's "vision for the future" is more detailed and more oriented toward describing the community service development anticipated by the *Olmstead* decision:[15]

> *Empower and support people with disabilities and elders to live with dignity and independence in the community by expanding,*

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[14] Connecticut Department of Social Services, Connecticut Community Options Task Force, Connecticut Long-Term Care Planning Committee. *Choices are for Everyone: Continuing the Movement Toward Community-Based Supports in Connecticut.* Connecticut Department of Social Services, Mar. 2002: 2.

[15] *The Community First Olmstead Plan.* Executive Office of Health and Human Services, Commonwealth of Massachusetts, 12 Sep. 2008: 2.

strengthening, and integrating systems of community-based long-term supports that are person-centered, high in quality and provide optimal choice.

D. PRINCIPLES

The principles in an *Olmstead* plan are intended to express the plan's underlying values and to support the priorities that are embodied in the workplan. The statement of principles is most useful if it has some detail and is not prosaic.

It is suggested that it is valuable to consider the principles as common themes for all state agencies, and for the systems development contemplated under the plan.

Essential to an Olmstead Plan is recognition that, after the "systems change" phase of implementation, there will need to be continued maintenance of effort. Practically speaking, the plan needs to be sustained from administration to administration. A plan's statement of principles typically implies acceptance of this "sustained effort" but it would be useful for this notion to be explicit.

Massachusetts' principles emphasize the community services highlighted in *Olmstead*, together with action needed to provide services:[16]

> *People with disabilities and elders should have access to community living opportunities and supports;*
>
> *The principle of "community first" should shape state elder and disability policy development and funding decisions;*
>
> *A full range of long-term supports, including home and community-based care, housing, employment opportunities, as well as nursing facility services are needed;*
>
> *Choice, accessibility, quality, and person-centered planning should be the goals in developing long-term supports;*
>
> *Systems of community-based care and support must be strengthened, expanded and integrated to ensure access and efficiency;*

[16] *The Community First Olmstead Plan.* Executive Office of Health and Human Services, Commonwealth of Massachusetts, 12 Sep. 2008: 6.

Public and private mechanisms of financing long-term care and support must be expanded;

Long-term supports developed under this plan must address the diversity of individuals with disabilities and elders in terms of race, ethnicity, language, ability to communicate, sexual orientation, and geography.

Other states focus on the outcomes intended for the consumer. For example, Connecticut's "principles" are:[17]

1. Hope: Connecticut residents with long-term care needs must be assured that a home and a life in the community can and will be available to them within a reasonable time.

2. A Home: Fundamental to community living is a home. The home must be accessible, safe, and affordable.

3. A Life: Individuals living in the community must have a life as well as a home. Priorities for a life include employment and recreation opportunities, individual supports, transportation, quality assurance, and a welcoming community.

4. Transition: Individuals now living in institutions as well as in family homes must be identified and provided with information about independent living. For those who desire it, individuals must be assisted to make transition to the least restrictive environment.

5. Adequate Funds: Individuals must have adequate funds under their control so that they can transition to and remain in a home and have a full life in their community.

Some states express "principles" as general concepts they derive from the *Olmstead* decision and emphasize the planning process itself, with some elements addressing the outcomes. For example, Arizona's "*Olmstead* Principles" are:[18]

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[17] Connecticut Department of Social Services, Connecticut Community Options Task Force, Connecticut Long-Term Care Planning Committee. *Choices are for Everyone: Continuing the Movement Toward Community-Based Supports in Connecticut.* Connecticut Department of Social Services, Mar. 2002: 2.

[18] Arizona Health Care Cost Containment System, Arizona Department of Economic Security, Arizona Department of Health Services. *Arizona's Olmstead Plan*. State of Arizona, 27 Aug. 2001: 6.

The principles of the Olmstead Decision, which this Plan addresses, are:

1. Plan: Develop and implement a comprehensive, effectively working plan (or plans) for providing services to eligible individuals with disabilities in more integrated, community based settings.

2. Involvement: Provide an opportunity for interested persons, including individuals with disabilities and their representatives, to be integral participants in plan development and follow-up.

3. Assessment: Take steps to prevent or correct current and future unjustified institutionalization of individuals with disabilities.

4. Availability: Ensure the availability of community-integrated services.

5. Informed Choice: Afford individuals with disabilities and their families the opportunity to make informed choices regarding how their needs can best be met in community or institutional settings.

6. State and Community Infrastructure: Take steps to ensure that quality assurance, quality improvement and sound management support implementation of the plan.

E. GOALS

Goals are a general statement of the intended outcomes of the plan. One might look at the goals as a statement of: "If we have done what we intended, this is what we would see." One might also look at the goals as a means to measure one's progress along the way toward full implementation, asking "How far are we along in our tasks with regard to each of our goals?"

Some states' goals are unacceptably vague, lacking any detail, and including such unmeasurable "goals" as "address the recommendations of the Centers for Medicare and Medicaid Services" or "demonstrate progress."

Oregon, which is among the states scoring highest in utilization of community services, elected just one goal, with twin briefly-stated strategies to achieve:

To achieve the intent of the Olmstead decision [citation omitted],

Oregon intends to move healthy people to independent housing that promotes recovery, resiliency, independence and wellness in a system that is consumer driven and assists people in obtaining "a key to their own door." Oregon will achieve this goal by reducing the length of stay (LOS) at the Oregon State Hospital (OSH), establishing independent living environments statewide and preventing hospitalization at OSH.

Utah chose to state its "goals" briefly, but with a timeline, a sense of urgency, and an emphasis on continued assessment of consumers' needs:[19]

The State will continue to make good faith efforts to enable qualified recipients in institutional settings to receive applicable services in a less restrictive environment within five years.

Once a qualified individual elects to move to a less restrictive environment and State professional staff agree that such a move is appropriate, the move should occur as fast as reasonably possible given the individual's needs and available supports and funding.

Continue the assessment of disabled individuals and their critical needs to determine whether publicly funded home and community-based services are appropriate.

Taking into consideration the barriers, problem statements and goals identified earlier in this document, the state will continue its efforts to meet the increased needs of the diverse disabled population in the most integrated, least restrictive environment.

A useful and recommended approach is Colorado's which combines three elements: a) a phrase embodying a goal which includes, b) a succinct description of the need or gap in services, and is immediately followed by c) a summary of the initial strategy to reach that goal.[20]

POLICY INTEGRATION - The process of developing policy recommendations related to CBLTC generates an opportunity to examine current state regulations and policies to determine if they

[19] Governor's Office of Planning and Budget, Department of Health, Department of Human Services. *Comprehensive Plan For Public Services in the Most Appropriate Integrated Setting*. State of Utah, 26 Mar. 2002: 36.

[20] Department of Health Care Policy & Financing. *Olmstead: Recommendations and Policy Options for Colorado*. State of Colorado, Jul. 2010: 5.

complicate access to home and community based services. Additionally, there is an opportunity to develop policy or regulations that may enhance access to services.

> *Strategy - Identify areas where current policies related to long term care need to be adapted to support the Olmstead decision and the actions in this document. Additionally, create a policy that prompts systematic, on-going review of progress in implementing these recommendations as well as identification of any needed changes.*

INCREASE HOUSING OPTIONS AVAILABLE FOR PEOPLE WITH ALL TYPES OF DISABILITIES - There is a shortage of options for integrated, supportive housing for people with disabilities and others with long term care needs. Ideal supportive housing for people with long term care needs is located in rural, suburban and urban areas; adaptable to the clients' needs throughout the lifespan; allows for client interaction in the community and is affordable. While there are some housing options in Colorado that meet these expectations, demand far outweighs capacity at this time.

> *Strategy - Improve access to affordable housing that is adaptable for people with physical and intellectual disabilities as well as people with severe persistent mental illness by eliminating barriers to accessing affordable housing, informing the community of existing housing options and increasing the number of affordable and accessible housing units through a number of funding strategies.*

EXPAND THE CURRENT ARRAY OF SERVICES - Failure to provide an adequate array of services and adaptive technologies can contribute to the unnecessary institutionalization of people with disabilities and the elderly. There is a gap between the services available to people in institutions and those available to people in the community that can contribute to unnecessary institutionalization. Currently, cost shifting occurs between systems, such as between the developmental disability system and the mental health system, as a result of services available in one waiver, but not in others.

> *Strategy – After appropriate financial analysis, work toward making many of the current HCBS waiver services available to all individuals using HCBS waiver services and expand the array of services as funding permits.*

STABILIZE AND GROW THE DIRECT SERVICE WORKFORCE - Direct service workers (DSWs) are people who help individuals with disabilities perform activities of daily living, such as personal hygiene, dressing, etc. Historically, there is frequent turnover in the direct service workforce and workers often need additional training. An unstable direct service workforce contributes to reduced access to services and more individuals who could otherwise live in the community may be forced to live in more restrictive settings.

> *Strategy - Identify barriers and opportunities to improve retention and improve recruitment of direct service workers. Identify and implement a method for training and credentialing of direct service workers.*

BETTER INFORM THE COMMUNITY ABOUT THE SERVICES AVAILABLE FOR PEOPLE WITH DISABILITIES - While there are many existing options for long term care services outside of institutional settings, most people do not fully know about these options for themselves or family members which can result in reduced access to these services.

> *Strategy - Identify best practices to encourage informed choice for individuals in need of long term care services. Develop informational tools to disseminate to the public about available home and community based services and resources.*

F. "WHAT WE HAVE"

Olmstead plans include a lengthy and detailed description of the current system of services and supports, including some history, trends, and data locating populations and their characteristics.

This exposition, which would best also describe unmet needs and other gaps in the system, sets the stage for the planned systemic changes identified in the next section.

G. "WHAT WE WANT"

This is the heart of the *Olmstead* Plan. This section will require the most effort from the plan developers. Here, the all the details of the plan's vision for the future are laid out.

It may be that this section will be developed in several stages.

First, the plan developers might write a general outline including preliminary decisions on various points.

That outline might then be shared with the public, perhaps in public forums, and with system stakeholders.

The plan developers might then make revisions, develop final decisions, make budget estimates, and finalize the plan.

H. SEQUENCE AND PRIORITIES

The plan might identify issues and activities which are of the highest priority. Here, the plan would also address the sequencing of activities, so that it can be implemented in a planful manner.

It is suggested that the major activities and tasks be categorized, or labeled, as those which can be implemented:

- with rebudgeting, reallocation and internal agency changes within existing funding and regulatory structures
- without fiscal impact or regulatory change
- with moderate fiscal impact or regulatory change
- only with legislative activity for additional funding or changes in laws

Such categorization will be of assistance in development of the workplan.

I. WORKPLAN

A workplan will list the tasks required by the plan and will categorize each, typically in sections tied to each identified "goal" of the plan.

For each task, there might be stated:

- Desired outcome
- Persons or agencies responsible and accountable
- Identification of needed resources
- Deadlines or targets
- Mechanism to track progress
- Mechanism to address obstacles to implementation.

The initial workplan will be a "work in progress" as it is revisited and probably revised during the implementation of the plan. The work plan should assign responsibility for tracking overall plan status and progress, and reporting back to the authority designated to execute the plan. The

workplan will also include reporting methods and expected documentation.

VI. Conclusion

This report is submitted with the utmost respect for those who will develop the Minnesota *Olmstead* Plan, and who will create a plan which is by, of, and for, the state's citizens. Whatever in this report is useful, may it be used. Whatever is not useful, may it be discarded.

Thank you for the opportunity to participate in this essential process.

APPENDIX A

OLMSTEAD PLAN OUTLINE

Olmstead Plan Outline

BACKGROUND

- *Describe requirements of Olmstead decision.*
- *Impetus within the state for development of the plan*

PLAN DEVELOPMENT

- *Process for assembling those responsible for drafting the plan*
- *The drafting and approval process for the plan.*
- *Specify involvement of agencies, stakeholders, function of public meetings*
- *Presentation of plan*

MISSION

- *Brief statement of the mission of the plan*

PRINCIPLES

- *Statement of the principles which underlie the plan*

GOALS

"WHAT WE HAVE"

- *Identification of state agencies involved in supports to consumers*
- *Identification of current laws and regulations pertinent to the plan*
- *Analysis of populations and programs: status and trends*
    - *History of institutional services*
    - *HCBS*
    - *State-operated long term care facilities*
    - *State-operated psychiatric hospitals*
    - *Nursing facilities*
    - *ICF-MR facilities*
    - *Assisted living residences*
    - *Facilities for children*
    -
- *Description of residential services (institutional, HCBS and other community)*
- *Description of transportation, employment, and other non-residential elements*
- *Description of current assessment, referral and coordination of services methods*
- *Advocacy, self-advocacy, family support and involvement*
- *Baseline data on programs, services, consumers, providers*
- *Baseline budgetary information*

"WHAT WE WANT"

- *Systems*
  - *Individual assessment*
  - *Coordination of services*
  - *Information and referral systems*
  - *Diversion*
  - *Transition from institutions*
  - *Waiting list: "reasonable pace"*
  - *Support service development*
  - *Direct care and other workforce development*
  - *Training*
  - *Funding structures and flexibility*
  - *Rights protection*
  - *Quality assurance / quality enhancement*
  - *Public awareness*
  - *Integrated data systems*

- *Support Services*
  - *Community-based housing*
  - *Transportation and mobility*
  - *Employment*
  - *Assistive technology*
  - *Communication services*
  - *Healthcare*
  - *Aging issues*
  - *Decision-making and guardianship*
  - *Advocacy, self-advocacy, family support and involvement*
  - *"Money follows the person" or other funding flexibility*

SEQUENCE AND PRIORITIES

- *Issues/activities of highest priority*
- *Identification of necessary sequencing of activities*
- *Identify major activities and tasks which can be implemented. . .:*
  - *with rebudgeting, reallocation and internal agency changes within existing funding and regulatory structures*
  - *without fiscal impact or regulatory change*
  - *with moderate fiscal impact or regulatory change*
  - *only with legislative activity for additional funding or changes in laws*

WORKPLAN

- *Categorization (by plan's goals) and statement of specific tasks*
- *For each task:*
  - *Desired outcome*

    - *Persons or agencies responsible and accountable*
    - *Identification of needed resources*
    - *Deadlines or targets*
    - *Mechanism to track progress*
    - *Mechanism to address obstacles to implementation.*
- *Assignment of responsibility for tracking overall plan status and progress*
- *Reporting methods and documentation*
- *Overall administration of the plan, including authority, and revision/update mechanisms*

CONCLUSION