Community Integration Self-Assessment Tool for State Mental Health Agencies: Pilot Project Final Report

State Mental Health Technical Assistance & Quality Assurance

Submitted by:

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Disclaimer

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Executive Summary

The Supreme Court decision, *Olmstead versus L.C.*, provided a landmark interpretation of Title II of the Americans with Disabilities Act (ADA), in determining that persons with disabilities are entitled to receive services and live in the most integrated settings appropriate for their care. During the decade since the Olmstead decision, state governments, in particular the mental health systems, have worked to modify their service systems to comply with the ADA, by making it possible for individuals to live in their own communities while providing the appropriate mental health services and supports. State mental health authorities (SMHAs) have also used strategies to prevent lengthy and inappropriate use of restrictive settings.

SAMHSA provided funding to develop and pilot a self-assessment tool on community integration designed for use by SMHAs. This self-assessment tool is intended to provide the SMHA an opportunity to proactively identify their strengths and weaknesses. SMHAs may benefit from a set of measures that serve as early warning signs for possible problems that may disrupt efforts of community integration. These measures are specific to community integration and are not intended to replace a comprehensive state mental health outcomes or performance measurement system.

Guided by a Policy Expert Panel (PEP) of senior federal and SMHA leadership, and assisted by a group of technical experts, this pilot project tested the burden and utility of a set of 30 measures that comprised the pilot self-assessment tool. Five SMHAs (Delaware, Illinois, Oklahoma, Vermont, and Washington) tested the tool over 14 weeks during the Spring/Summer of 2012.

This report describes the process for the development of the Community Integration Self-Assessment Tool, as well as the experiences of the pilot states testing this tool. More specifically, it contains a process evaluation, an overview of each state's current community integration efforts, and the pilot states' ratings of the burden and utility of individual measures.

Methodology

A review of recent literature on community integration, including definitions, measurement tools, and performance measures, was conducted to guide the tool development. The review identified available definitions of community integration, potential populations, and appropriate treatment settings to consider in the pilot design. The literature review also identified potential state and national data sources that could be used to complete the pilot.

NRI and AHP worked with two expert panels to develop the pilot design process. The PEP represented a diverse group of stakeholders and experts involved in efforts to advance community integration in public mental health care. They identified a broad scope of populations and service settings for which the tool could be developed, including persons receiving care in institutions, persons receiving services in the community at risk of institutionalization, as well as persons living in the community with mental illnesses not receiving any mental health services and are also at risk of institutionalization. The PEP also recommended that measures for children and adults, persons served by other state agencies beyond the SMHA (e.g., Medicaid, child welfare, juvenile justice, criminal justice, etc.), and persons who have only received services in the private sector be considered as well. The Technical Expert Panel (TEP), comprised of six individuals with expertise in state behavioral health data systems, performance

measurement, planning, Olmstead, and state community integration efforts, provided technical assistance and guidance to states throughout the project.

Due to limitations in both the time available to states to complete the study and access the information to test the community integration measures, the TEP recommended to limit the focus of this pilot only to persons with mental illnesses living in institutional settings and the supports necessary to help move consumers out of these settings and live in their own communities. SAMHSA and the PEP approved this recommendation. The five primary settings the tool addressed include:

- State Psychiatric Hospitals
- Nursing Homes
- Adult Care Homes and Other Congregate Living Settings:
- Residential Treatment Centers
- Jails and Prisons

The final self-assessment tool contained two parts: Part I included a set of questions to gather each state's current community integration efforts, and Part II contained 30 recommended measures across five domains. Each domain contained from two to nine measures. The domains are as follows:

- Financing and Resources
- Movement to the Community and Recidivism
- Community Capacity
- Housing
- Well-Being

Key Findings

Domains

Every state collected data for at least one measure within each domain. Of the five domains, the housing domain posed the biggest challenge with three housing measures not reported by any of the pilot states. One state indicated that they were unable to test these housing measures because the data were located with the state housing authority, and were not readily accessible by the SMHA.

Community Integration Measures

States tested and evaluated the utility and burden of each measure on a three-point Likert Scale (1=least utility/least burden to 3 = most utility/most burden). Ideal performance measures have the most utility and are also the least burdensome to collect; however, not all measures can be both useful and collected without burden. Some measures may be rated as most useful, but are prohibitively difficult or expensive for SMHAs to collect. The following are the highlights of the pilot results:

- States varied in the number of measures they collected, ranging from 14 to 26 of the recommended measures. The collected information for each measure varied across states by type of populations, settings, and data sources.
- There were ten measures for which all five states could collect data.
- Only one measure received a score of "3" (most) on utility from all five pilot states: Number of patients in the institution with a length of stay greater than one year at the end of the year.

- Of the total 26 measures tested, 23 measures received a utility score greater than or equal to 2 with a corresponding burden score of less than or equal to 2.
- There were four measures that none of the pilot states tested: Number of Home and Community Based Service (HCBS) slots available, Number of housing vouchers and slots available by type for persons with mental illness, Number of persons with SMI on a housing waiting list, and Average wait time for housing (in months)

In addition to measures that are highly useful and less burdensome to attain, future generations of this project should consider the wide array of measures that proved difficult to collect yet could provide critical information about a state's level of community integration. Data to populate these measures may be difficult to gather because they exist in agencies outside of the mental health system, or because the infrastructure to collect these measures within the SMHA has not yet been established. Measures contained within this first generation of the tool could also be revalidated to determine their relevance and usefulness in evaluating a state's level of community integration. SMHAs may benefit from SAMHSA providing technical assistance on accessing and compiling information from other agencies, particularly housing, where most pilot states had difficulty obtaining necessary data.

Introduction

In 2011, the Substance Abuse and Mental Health Services Administration (SAMHSA) provided funding to develop and pilot a self-assessment tool on community integration designed for use by state mental health agencies (SMHAs). The Advocates for Human Potential (AHP), in collaboration with the National Association of State Mental Health Program Directors (NASMHPD) Research Institute, Inc. (NRI) were contracted to work with policy and technical experts, as well as five states to pilot this tool. The development and pilot testing of this tool was only one of many activities in SAMHSA's effort to partner with states to facilitate community integration and client recovery.

The Supreme Court decision, *Olmstead versus L.C.*, which provided a landmark interpretation of Title II of the Americans with Disabilities Act (ADA), determined that persons with disabilities are entitled to receive services and live in the most integrated settings appropriate for their care. Since there was no standard, universally-accepted definition of community integration, the Bazelon Center for Mental Health Law's definition was used for guidance. It states that community integration is the "individual's ability to live in his own home, spend time with family and friends, find meaningful work, and enjoy the small pleasures of being part of a community" (Bazelon, 2010). The Department of Justice further explained that "the most integrated setting is one that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible" (DOJ, 2011).

A self-assessment tool for community integration for SMHAs provides an opportunity for them to proactively identify their strengths and weaknesses. SMHAs may benefit from a set of measures that serve as early warning signs for possible problems that may disrupt efforts of community integration. Based on the outcomes of the measures, decision-makers can identify the types of resources that should be mobilized, and where they should be directed. They can also determine which areas need to be strengthened, as well as determine where systemic vulnerabilities lay. Through this improved understanding, states will be better able to speak with confidence on their efforts in addressing risks, meeting standards, and using opportunities to create an environment where adults and children with mental illnesses can receive services in the most integrated and appropriate settings.

Contained within this report are the results of the fourteen-week pilot of the Community Integration Self-Assessment Tool. Since it was agreed upon that all data on performance measures collected during this pilot should remain within the state, the information provided in this report is limited to the pilot states' experiences. More specifically, it contains process evaluation, an overview of each pilot state's current community integration efforts, and the pilot states' ratings of the burden and utility of individual measures.

Methodology

In compliance with a SAMHSA task order, AHP and NRI recommended to SAMHSA a variety of experts to serve on two different panels: the Policy Expert Panel (PEP), and the Technical Expert Panel (TEP).

The PEP represented a diverse group of stakeholders and experts who have been involved in efforts to advance community integration in public mental health care. It was comprised of representatives from a variety of Health and Human Services Agencies, including SAMHSA's Center for Mental Health Services; Centers for Medicaid and Medicare Services; state representatives, including State *Olmstead* Coordinators, SMHA Commissioners, and Clinical Directors; consumer advocacy groups; and research organizations. The PEP met once via conference call to guide the scope of the tool. They were also given the opportunity to provide feedback on the draft version of the tool via a second conference call before it was administered to the pilot states for completion.

The TEP was comprised of six individuals with expertise in state behavioral health data systems, performance measurement, planning, *Olmstead*, and state community integration efforts. The TEP provided operational support to AHP and NRI in defining the scope of the pilot, selecting domains and individual performance measures for inclusion in the self-assessment tool. Members of the TEP also provided technical assistance to states on data collection and potential use and interpretation of the measures. TEP members were available to states on bi-weekly conference calls and for other specific technical assistance issues on an as-needed basis throughout this project.

In addition to the expert advice from the TEP and PEP, NRI also conducted document reviews of state *Olmstead* Plans and *Olmstead* Settlement Agreements with the U.S. Department of Justice. Input was also solicited from the National Disability Rights Network (NDRN). NDRN held a conference call with their attorneys who have experience working on *Olmstead* cases. The results of this call were considered in the development of the self-assessment tool.

To provide theoretical context in the development of the tool, a review of recent literature on community integration, including definitions, measurement tools, and performance measures was conducted. The review provided guidance on identifying available definitions of community integration, potential populations, and appropriate treatment settings to consider in the pilot design. The literature review also identified various national and state publications and data sets as possible sources of secondary data and information. See Appendix A.

One of the initial issues addressed by the PEP and SAMHSA was the intended purpose and structure of this pilot project. SAMHSA indicated that its goal was to support SMHAs in their work to assure their systems support the community Integration of mental health consumers, and that this project was part of a broader technical assistance effort to help states understand their system's strengths, weaknesses, and areas most in need of attention. The stated goal of this pilot was to develop a tool to help states to conduct their own assessments of how well they provide high quality mental health services to consumers in the least restrictive settings possible. With this focus, the PEP recommended to SAMHSA that this pilot should be designed so that each state would retain all data compiled as a result of this effort. The states would then report to SAMHSA information on their pilot experience, measures they

assessed, the burden of compiling each measure, and the utility of the compiled information from the policy and planning perspective of their state leadership and planners. SAMHSA supported this strategy.

The PEP and SAMHSA recognized that this pilot would limit the ability to provide benchmark results across pilot states, and that states would therefore need to assess the results within the context of their own system over time. It was recommended that pilot states collect at least three years of historical data to adequately evaluate the utility of each measure. This recommendation allowed pilot states to consider the value of the measure either on a single year or across years, and on this basis determine whether the information was useful.

Development of the Self-Assessment Tool

Scope

The PEP identified a broad scope of populations and service settings for which the tool could be developed, including persons receiving care in institutions, persons receiving services in the community at risk of institutionalization, as well as persons living in the community with mental illnesses but not receiving any mental health services and who are also at risk of institutionalization. The PEP also recommended that measures for children and adults, persons served by other state agencies beyond the SMHA (e.g., Medicaid, child welfare, juvenile justice, criminal justice, etc.), and persons who have only received services in the private sector be considered. However, due to limited time, the TEP determined it best to narrow the focus for this initial effort to include only persons receiving care from different types of institutional settings. The TEP did recommend that for future efforts, target populations be broadened to include those living in the community who may be at risk of institutionalization. The decision to limit the focus of this pilot was supported by the following rationale:

- Information is more readily available for persons living in institutional settings. This is a population group that is also less complicated to define and count, as states have much more information about persons currently residing in institutional settings than on persons living in the community who may not have had any prior interaction with the public mental health system.
- Identifying consumers currently living in the community who are "at-risk" of institutionalization is much more difficult to operationalize than those living in institutions. It is also not consistently measured across states or even across various systems within states.

The TEP discussed various institutional settings for inclusion in the pilot. They considered the focus of *Olmstead* litigation and settlements, as well as settings recommended by the PEP and findings from the community integration literature review. Based on these discussions, they recommended the following settings and operational definitions for use in the pilot:

- ***State Psychiatric Hospitals*** provide services to consumers with high levels of need, including those who are a threat to themselves or others. These facilities provide acute care services, long-term treatment, and forensic services to mental health consumers. For the purpose of this pilot, long-term forensic patients (including sexually violent predators) were excluded to the extent that they could be identified. Long-term forensic patients include defendants in legal cases who were acquitted not guilty for reason of insanity (NGRI); defendants convicted as guilty, but mentally ill; persons transferred from prison to the state hospital for mental health

treatment and persons who have been determined incompetent to stand trial. Additionally, it was recommended that states that have sexual offender or sexual predator laws that allow for a civil or criminal commitment to psychiatric facilities of convicted sex offenders deemed to need treatment exclude these patients from the census for this pilot. The care and treatment of forensic patients, particularly the NGRI, is usually long-term, and their releases are subject to more stringent conditions (usually approved by criminal justice courts) compared to patients under civil commitment. If a state's forensic population included persons admitted for pretrial competency evaluations that were considered long-term, it was also recommended that these be excluded from the pilot.

- ***Nursing Homes*** provide services to persons with significant medical conditions who have been assessed as needed nursing level of care, but who are not acutely ill enough to require treatment in a hospital. The majority of nursing home residents tend to be older adults, but children and younger adults with disabilities are also served by nursing homes. Studies estimated that nearly 50 percent of those receiving care in a nursing home have a mental illness (Mental Health and Aging, 2012). Nursing homes provide on-site access to staff 24 hours per day.
- ***Adult Care Homes and Other Congregate Living Settings:*** Each state has different nomenclature for adult care homes. For the purposes of this pilot, adult care homes were defined as any congregate residential settings targeted toward people with low income, where more than half of the residents have psychiatric disabilities. This setting included group homes for persons with mental illnesses funded by state or county dollars.
- ***Residential Treatment Centers*** are often used to provide services to children; however, these facilities sometimes provide services to adults and older adults. All residential treatment facilities were included in this pilot.
- ***Jails and Prisons:*** Many persons with mental illnesses end up in jails or prisons due to a lack of alternative (diversionary) community services and other supports.

Selection of Domains and Measures

The TEP recommended the following five domains:

- Financing and Resources
- Movement to the Community and Recidivism
- Community Capacity
- Housing
- Well-Being

Under each domain, a variety of measures were identified for consideration. Overall, 90 potential measures were selected from State *Olmstead* Plans, DOJ Settlement Agreements, NDRN recommendations, and the literature review. Each member of the TEP was asked to independently review each of the measures and evaluate which ones should be considered in the pilot. NRI staff tallied the results of the individual TEP selections and presented a shorter list of measures for a final group review and discussion. Only measures that received support from at least four of the six members were included for final consideration. The final self-assessment tool contained 30 of the original 90 measures

across the five domains. The measures included in this pilot were reviewed by policy (rather than legal) experts and are not intended to define the scope of a state's legal obligations under civil rights laws.

General Framework

The self-assessment tool was comprised of two parts. To provide context to the measures within each pilot state, Part I requested qualitative information on current state efforts to promote community integration. Topics included the following:

- Role of the SMHA in *Olmstead* implementation
- State *Olmstead* investigations
- State practices in identifying and evaluating consumers in institutional settings
- Interagency collaboration to promote community integration
- Use of Medicaid funds to provide services that promote community integration
- Follow-up activities to sustain community transition/integration
- Diversion programs and related activities to keep consumers in integrated settings
- Budget development to finance community integration
- State stock of affordable housing for people with mental illness
- Role of peers in community integration efforts

Part II contained the final set of 30 measures. The final measures were identified by the TEP, reviewed by SAMHSA and the PEP, and further refined at the kick-off meeting held on June 12, 2012. The final self-assessment tool is included in Appendix B.

To evaluate the effectiveness of the tool, two additional documents were developed by NRI, and reviewed and refined by the pilot states and the TEP during a series of bi-weekly conference calls. Pilot states were asked to complete the "Implementation Tracking Guide for the Community Self-Assessment Pilot" (Tracking Guide, Appendix C), as well as the "Utility Evaluation Form for the Community Integration Self-Assessment Pilot" (Utility Evaluation Form, Appendix D).

The Tracking Guide attempted to collect information about the implementation process adopted by each of the pilot state, as well as information about specific measures. The Tracking Guide requested information about the following:

- Which offices within the SMHA had the lead in conducting the pilot, as well as which other divisions within the SMHA contributed to completing the pilot;
- SMHA collaboration with other state government agencies to access data and information for the pilot, including which offices within those other agencies participated in the pilot;
- Evaluation of the 30 different measures of community integration. For each measure, SMHAs were asked to report the following:
    - Whether a measure was already collected by the SMHA, either as part of an *Olmstead* Settlement or other initiative.
    - Which service settings the SMHA was able to provide data for, including state psychiatric hospitals, nursing homes, residential treatment facilities (RTFs), emergency rooms, adult care homes, jails, prisons, and/or other settings (it is important to note that some measures may be relevant to only one or two specific settings).

- Which client age groups the SMHA was able to provide data for (e.g., children and or adults).
- The sources of data the SMHA relied on to complete specific measures.
- If any specific indicator required modifications to complete, and if an indicator was modified, an explanation of how it was modified.
- A rank of the level of burden the SMHA experienced in collecting each indicator. Burden was measured using a three-point Likert Scale (1 = least burdensome to 3 = most burdensome).
- A narrative describing the benefits and challenges the SMHA experienced using the self-assessment tool.

The Utility Evaluation Form gave states the opportunity to evaluate the level of utility of each measure and provide feedback about the usefulness of the tool in identifying strengths and weaknesses in each state's approach to community integration. Similar to the Tracking Guide, the Utility Evaluation Form also relied on a three-point Likert Scale (1 = least utility to 3 = most utility).

Implementation Process

Within a 14-week period, commencing at a face-to-face meeting on June 12, 2012, the five pilot states tested the feasibility of collecting data for the set of performance measures outlined in Part II of the self-assessment tool. Bi-weekly conference calls following the kick-off meeting were held to provide a forum for states to support one another and ask questions about the measures and protocol of the pilot, identify areas of technical assistance, and provide updates on the status of their pilot implementation. Representatives from each of the pilot states, staff from AHP and NRI, and members of the TEP attended each of these calls.

In addition to testing the measures, pilot states also completed Part I of the tool (contextual information). States submitted their responses to NRI, who then shared the results with the TEP. By the 13th week, pilot states were asked to submit the completed Tracking Guide that contains, among others, their rating of the level of burden in collecting each of the measures. By the 14th week, pilot states were asked to complete and submit the Utility Evaluation Form. In order to complete this form, each pilot state was asked to convene a group of stakeholders involved in their community integration efforts (which may include, but is not limited to the SMHA Commissioner, State Planner, and State *Olmstead* Coordinator) to discuss their experiences in the implementation of the pilot, the measures the state was able to collect, and on these bases provide a collective utility rating of the tool. The collective view of the group was used by the state in its utility rating.

Pilot States

At the onset of the pilot, there was intent to provide an open invitation to all states. Due to the limited amount of time allotted for the pilot, an alternative method of state selection was used. Staff from NRI and AHP consulted with the TEP to identify potential states using the factors enumerated below:

- Good mental health data systems capable of providing information beyond people receiving services from the state hospital(s)
- Existing data relationships with Medicaid and other important data systems

- Historical interest and background in *Olmstead* planning, *Olmstead*-related investigations, and/or settlement agreements
- Expressed interest to participate
- Approval/support from higher-ups, such as the SMHA Commissioner
- Regional representation
- Diversity in SMHA population size and organizational structure

Potential states were then independently consulted to gauge their level of interest in the project. A total of ten states' SMHAs were submitted to SAMHSA for consideration.

SAMHSA approved five states to participate in this pilot. These states represent various regions of the country and are at different stages of implementing community integration: Delaware, Illinois, Oklahoma, Vermont, and Washington. See Table 1 for a summary of their organizational characteristics.

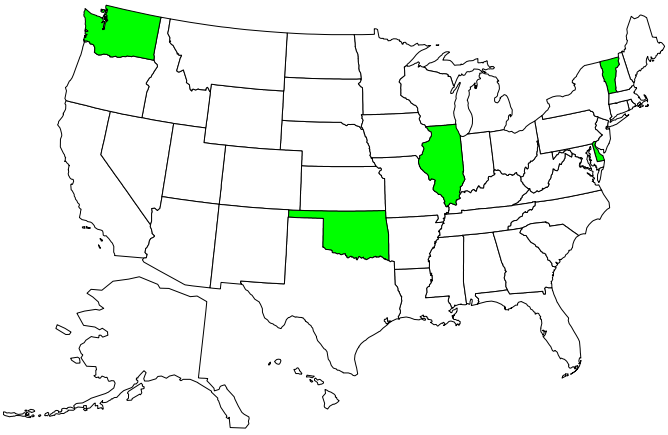
Table 1: SMHA Summary Characteristics

State	Region	2011 Total SMHA Served Population	Per Capita MH Expenditures (by State Population)	State MH System Features	*Olmstead* Involvement	State MIS Capacities
Delaware*	East	9,161 (Small)	$106.04	SMHA Operated & SMHA-Contracted Community MH System Separate Adult & Child MH Agencies	Implementing Settlement Agreement	DSAMH pulls Medicaid client eligibility and claims data into its data warehouse (DAMART)
Illinois*	Midwest	145,546 (Large)	$80.43	SMHA Contracted Community MH	Implementing Settlement Agreement	Medicaid paid claims data are available to SMHA weekly basis
Oklahoma	South	61,570 (Medium)	$53.05	SMHA-Contracted & SMHA Operated Community MH System	*Olmstead* case settled in 2003	Both SMHA & Medicaid data are part of the same data system
Vermont	East	24,166 (Small)	$239.84	SMHA-contracted community MH system	No *Olmstead* or *Olmstead*-related cases	SMHA has direct access to Medicaid paid claims; MH database is integrated with data of a number of state agencies; SMHA has the capacity to use a variety of direct linkage techniques such as PPE
Washington	West	140,685 (Large)	$113.57	County-based community MH system	Implementing Settlement Agreement and two open cases	State Umbrella agency has data warehouse that combines MH data with Medicaid and other health & human services data

**State is represented on the Olmstead Policy Expert Panel (PEP)*

Description

Figure 1: Geographic distribution of the pilot states



In succeeding paragraphs, each pilot state's ongoing efforts in promoting community integration are described. The information used is a summary of state responses to questions contained in part 1 of the self-assessment tool.

Delaware

The state's strategies for *Olmstead* are contained in a report, "A Path Forward: Building a Community-Based Plan for Delaware," issued by the Governor's Commission on Community-Based Alternatives for Individuals with Disabilities. The report contains the goals and strategies to address the needs of individuals with disabilities and their families for 2008-2012.

Delaware is in the second year of implementing a Settlement Agreement in conjunction with the U.S. Department of Justice and its Court Monitor. The target population is the state-funded (DSAMH, Medicaid) adult population with severe and persistent mental illness. The focus is on redesigning the service delivery systems to promote integration of clients with SPMI into the community and enable them to live as "normal Delawareans."

Current efforts to promote community integration in the state entailed a synthesized approach to deinstitutionalization, housing, case management, financing, crisis services, judicial reform, and establishment of a network of community clinical and peer supports along an acuity gradient. This involves the following activities: 1) collaboration with other state agencies, such as the Delaware State Housing Authority and the Division of Vocational Rehabilitation; 2) adoption of Assertive Community Treatment (ACT) Teams, Intensive Case Management (ICM) Teams, TCMs, and innovative pre-paid model of care entitled CRISP; and 3) use of peer services across the continuum of care. Diversion programs and related activities to keep clients in integrated settings and prevent unnecessary institutionalization are also provided in the form of crisis walk-in service, reinforced use of the State's crisis line and 24-hour mobile crisis capabilities, and conduct of educational activities with law enforcement, the judicial system, emergency rooms, providers, clients and client families as to their alternatives in case of crisis. The state expects to ultimately have a corps of mental health screeners trained to perform crisis assessments and diversion to the most appropriate providers for clients in crisis.

The State of Delaware does not have a Medicaid HCBS Waiver or Option.

Illinois

Illinois' Disabilities Service Plan, developed in 2003 and updated in 2006 by the Disability Services Advisory Committee, contains a broad base of services for persons with disabilities and older adults in compliance with the Americans Disabilities Act of 1990 and the Supreme Court's decision in *Olmstead* v L.C. of 1999.

Illinois has a consent decree filed in 2010 for the Williams v Quinn case on behalf of persons with mental illness who were institutionalized in a privately-owned Institution for Mental Diseases. A second class action lawsuit (Colbert v Quinn) was filed in 2007 alleging unnecessary segregation and institutionalization of people with disabilities in nursing facilities.

The SMHA has been collaborating with the Office of the Governor and other state agencies (such as the Department of Healthcare and Family Services, the Illinois Housing Development Authority, and the

Department of Aging towards the promotion of community integration of people with disabilities in general, and people with mental illness, in particular. This includes (1) efforts under the Rebalancing Initiative for state services, and (2) activities undertaken with the Housing Development Authority in response to the Williams v Quinn consent decree. The SMHA has also promoted Wellness Recovery Action Planning (WRAP), including implementation of a WRAP Class Locator, and worked with the Illinois Certification Board and other DHS divisions and state agencies to develop a Certified Recovery Support Specialist Certification. In terms of ensuring timely discharge from IMDs, under the Williams Consent Decree, the SMHA is conducting structured resident review assessments to determine if individuals with diagnoses of serious mental illnesses meet eligibility criteria for nursing facility level of care or other appropriate community-based services. In addition, the SMHA engages in programs and initiatives that keep consumers in integrated settings and prevent unnecessary institutionalization. Among these are the conduct of Pre-Admission Screening (PAS) to assess eligibility for nursing facility level of care for individuals with serious mental illnesses, the Jail Data Link Project and the Rockford Crisis Service Collaboration both of which allow for immediate engagement of detainees with necessary community services, Court Diversion Initiatives, assertive community treatment, closure of state hospitals, and the implementation of regional crisis care systems.

Illinois does not currently have a Medicaid HCBS Waiver specific for mental health services. Similarly, the 'Money Follows the Person' demonstration project is to provide community-based services for persons with disabilities, not just for people with mental illness. However, Illinois receives $55.7 million in federal Medicaid reimbursement specifically to assist individuals with serious mental illness and living in non-IMD nursing facilities for seamless community reintegration. The SMHA, in collaboration with the Illinois Department of Healthcare and Family Services, is also a recipient of a $2 million grant from CMS to implement a federal Medical Emergency Room Diversion.

Oklahoma

The Oklahoma *Olmstead* Strategic Plan was developed in August 2006 by the *Olmstead* Planning Committee created by the Oklahoma Legislature. The Plan outlined the state's strategies in providing services and supports, including mental health, to persons with disabilities ready to move out of an institutional setting. In 2007, a new committee was formed to revise the mental health section of the Oklahoma *Olmstead* Strategic Plan.

Oklahoma had only one *Olmstead*-related case filed in 2002, which was settled in 2003. It was a class action lawsuit challenging the decision to limit the number of prescribed medications that Home and Community Based Services waiver participants (with physical disabilities) could receive, arguing that this would force plaintiffs into institutions.

The SMHA promotes community integration using several strategies: (1) collaboration with other state agencies such as the Housing Finance Agency, Rehabilitation Council, Interagency Council on Homelessness, and the Living Choice Advisory Board; (2) provision of diversion programs/activities such as crisis intervention, emergency detention, Crisis Intervention Team (CIT), Female Jail Diversion programs, Projects for Assistance in Transition from Homelessness (PATH), and Programs of Assertive Community Treatment (PACT); and (3) support in the use of peer services in both community and inpatient settings. Clients' readiness for discharge is determined at the institution level. The SMHA provides a financial incentive to providers that meet contractual requirements on twelve measures

which include aftercare engagement of client within 24 hours (but no later than 72 hours) from discharge and inpatient readmissions, both of which directly affect community integration efforts. Client transition from prisons to the community is supported by the Re-entry Intensive Care Coordination Teams by providing support in engaging individuals to needed community services.

Oklahoma's Medicaid HCBS waiver and 'Money Follows the Person' funding are available for use by persons with disability, but not specifically targeted only for persons with mental illness. Community-based services that promote community integration and recovery are funded by Medicaid through the Rehab Option.

Vermont

Vermont has a comprehensive *Olmstead* Plan that addresses the support and service needs of people with disabilities, including people with mental illness (children and adults) and their families. The Plan was developed by the Vermont *Olmstead* Commission, in consultation with the Agency of Human Services: an umbrella agency for all Human Services activities within Vermont state government.

Vermont does not have any existing or past *Olmstead*/*Olmstead*-related lawsuits.

The SMHA promotes community integration through several strategies, which includes (1) collaboration with different state agencies, i.e., Department of Employment and Training, Department of Children and Families, and Department of Corrections, Housing Finance Agency, State Housing Authority, Housing and Conservation Trust; and (2) use of peer services in the form of peer-operated crisis/respite beds, peer-operated temporary housing program, peer-run community mental health centers, and peers as outreach staff, caseworkers, paraprofessionals, and support service providers. The SMHA's utilization review helps in the timely discharge of clients from institutional settings. It also conducts service assessment or offers intake appointment to clients returning back to the community, develops treatment plans for community placement for persons requiring additional intervention to transition, and offers financial incentives to programs that successfully show reduction in the use of specified high cost services (including incarceration and hospital inpatient services).

A broad range of Vermont's community mental health services are Medicaid reimbursable.

Washington

In 2005, the Department of Social and Health Services led the state effort in developing the State *Olmstead* Plan which contained broad range of services and activities to further the intent of *Olmstead*. It addressed issues and ways to increase community options including housing, transportation, integration, employment, and systems change.

The Center for Personal Assistance Services (PAS) website published an "Introduction to *Olmstead* Lawsuits and *Olmstead* Plans" that show two open *Olmstead* cases filed separately in 2009 (T.R. et al. v Dreyfus) and 2010 (M.R. et al. v Dreyfus). Seven other *Olmstead* and *Olmstead*-related lawsuits filed since the 1990 had either been settled or won by the plaintiffs.

Washington's System Transformation Initiative and other resources it had pursued allowed the SMHA to transform its statewide service delivery system to one that promotes community living and client recovery. These activities include (1) an expansion of community housing options for people with persistent mental illness in collaboration with the Department of Commerce (Washington's state

housing agency), Washington Families Fund, the Gates Foundation, the Impact Capital, and other organizations; (2) provision of housing subsidies through HOME – Tenant Based Rental Assistance, Non-Elderly Disabled Vouchers, Project Based Section 8, and local homeless funding; and (3) use of peer services to provide community transitional services. It utilizes the Peer Bridger model, Community Links program that matches consumer volunteers with individuals transitioning to the community, and peers involvement in PACT, provision of supportive housing services, and crisis services. The SMHA also support programs and services to divert individuals from being institutionalized, which includes PACT, crisis services, and a short-term acute psychiatric inpatient treatment in a community hospital or certified freestanding Evaluation and Treatment facility. The state psychiatric hospitals maintain a 'ready for discharge' list while in one hospital, it has started a 'discharge ward'. Individuals in skilled nursing facilities are continually assessed for timely and appropriate discharge by state social workers.

The State received a Medicaid 1915(b) in 1993 which funded outpatient mental health services and in 1997 financed the integrated community mental health. In 2007, the state also received funds from Roads to Community Living Project through the 'Money Follows the Person Project' funded by CMS to support individuals up to 21 years of age or older than 65 years old to move from psychiatric institutional settings to community-based living.

Results

Project Implementation

When the pilot states were asked which division or office within the SMHA had the primary role in this pilot, three of the states (Oklahoma, Vermont, and Washington) reported their Evaluation and Research Office as the lead. The Director's Office took the lead in Delaware, while in Illinois the Bureau of Information Technology, Evaluation/Research, and Planning took the lead. The pilot states also involved other divisions within their SMHAs, including the *Olmstead* Coordinators (four states: DE, IL, OK, WA), Budget/Finance (four states: DE, IL, OK, WA), Clinical/Program staff (three states: DE, IL, WA), Quality Improvement (three states: DE, VT, WA), Information Technology (two states: DE, WA), Commissioner's/Director's Office (two states: IL, VT), Planning (two states: DE, WA), and Consumer Affairs (one state: DE).

The pilot states also either reached out to other agencies to implement the pilot or used data from other agencies that they can access through an existing data sharing agreements and/or joint initiatives established prior to this project. These agencies are listed in Table 2 below.

Table 2: Other State Agencies Engaged in the Pilot Implementation

Agency	Delaware	Illinois	Oklahoma	Vermont	Washington
Attorney General					
Corrections				X	
Housing	X			X	X
Medicaid	X	X	X	X	X
Intellectual Disability/DD				X	
Substance Abuse	X		X	X	X
Vocational Rehab	X			X	
Early Intervention				X	X
Juvenile Justice				X	
Child Welfare	X			X	

Evaluation of the Tool Structure

Domains

The self-assessment tool consisted of five domains, including Financing and Resources, Movement to the Community and Recidivism, Housing, Community Capacity, and Well Being. Every state was able to collect data for at least one measure within each domain. Of the five domains, the Housing domain posed the biggest challenge with three of its seven measures not tested by any of the pilot states. Of the four measures that were tested, none were common to all five pilot states. One state indicated that they were unable to provide data for the housing measures because data from the Housing Authority were not accessible by the SMHA. Table 3 shows the frequency distribution of the number of states and the number of measures within each domain that were reported.

Table 3: Number of Measures Tested by Domain

Domain	Total Number of *Recommended* Measures within Domain	Number of Measures Tested by at Least One State	Number of Measures Tested by all five Pilot States
Financing & Resources	3	2	2
Movement to the Community & Recidivism	9	9	6
Housing	7	4	0
Community Capacity	9	9	1
Well-Being	2	2	1

Measures

The tool contained 30 measures. States varied in the number of measures they collected data for, ranging from 14 to 26 of the recommended measures. However, all five pilot states collected data for ten measures. Information on which populations and settings the states collected data for, along with the data sources used for each measure are provided below (when available; one state did not submit information on settings, and two states did not provide information on data sources for any measure):

- State mental health expenditures on community-based programs
  - Populations: Children (3 states); Adults (4 states)
  - Settings: State Hospitals (2 states); Residential Treatment Facilities (2 states); Adult Care homes (2 states); Jails (1 state); Prisons (1 state); Other Settings (3 states)
  - Data Sources: State-Funded Expenditure Data (which included Medicaid, 1 state); SMHA Financial Dataset (1 state)
- State expenditures on psychiatric hospital/inpatient care
  - Populations: Children (2 states); Adults (4 states)
  - Settings: State Hospitals (4 states); Nursing Homes (1 state); Residential Treatment Facilities (1 state); Adult Care Homes (1 state)
  - Data Sources: Hospital Databases (2 states); SMHA Administrative Data (1 State)
- Number of patients in the institution with length of stays greater than one year (at end of year)
  - Populations: Children (2 states); Adults (5 states)
  - Settings: State Hospitals (4 states); Nursing Homes (2 states); Adult Care Homes (1 state)
  - Data Sources: Hospital Database (2 states); SMHA Administrative Data (1 state)
- Number or percentage of persons with a length of stay greater than one year discharged during the year
  - Populations: Children (2 states); Adults (5 states)
  - Settings: State Hospitals (4 states); Nursing Homes (1 state); Residential Treatment Facilities (1 state); Adult Care Homes (1 state)
  - Data Sources: Hospital Database (2 states); SMHA Administrative Data (1 state)
- Number of persons with SMI/SED readmitted to any (or same) type of institution within six months
  - Populations: Children (3 states); Adults (5 states)

    - Settings: State Hospitals (4 states); Nursing Homes (1 state); Residential Treatment Facilities (1 state); Adult Care Homes (1 state); Other Settings (1 state)
    - Data Sources: Hospital Database (2 states); SMHA Administrative Data (2 states); Children's Department's Clinical Information System (1 state)
- Average Daily Census
    - Populations: Children (3 states); Adults (5 states)
    - Settings: State Hospitals (4 states); Nursing Homes (1 state); Residential Treatment Facilities (1 state); Adult Care Homes (1 state)
    - Data Sources: Hospital Database (2 states); SMHA Administrative Data (2 states); Children's Department's Clinical Information System (1 state)
- Number of persons with SMI/SED admitted to institutional care
    - Populations: Children (4 states); Adults (5 states)
    - Settings: State Hospitals (4 states); Nursing Homes (1 state); Residential Treatment Facilities (1 state); Adult Care Homes (1 state); Other Settings (1 state)
    - Data Sources: Hospital Database (2 states); SMHA Administrative Data (1 state); Children's Department's Clinical Information System (1 state)
- Number of licensed psychiatric beds available
    - Populations: Children (4 states); Adults (5 states)
    - Settings: State Hospitals (4 states); Nursing Homes (2 states); Residential Treatment Facilities (1 state); Adult Care Homes (1 state); Other Settings (2 states)
    - Data Sources: Public Health Database (2 states); Hospital Database (1 state)
- Number of persons with SMI employed OR Number of persons served by the SMHA who were employed
    - Populations: Children (2 states); Adults (5 states)
    - Settings: Community (2 states); Other (1 state)
    - Data Sources: SMHA Administrative Data (3 states); Department of Labor (1 state)
- Number or percentage of consumers reporting positively about social connectedness (MHSIP Survey Module)
    - Populations: Children (2 states); Adults (5 states)
    - Settings: Community (3 states)
    - Data Sources: Consumer Satisfaction Survey Results (3 states)

There were four measures that none of the pilot states collected. Lack of reporting may be due to resource constraints or the fact that the state does not offer certain services (e.g., some states do not have HCBS waivers or options; therefore, they would be unable to report on the HCBS measure). These four measures are:

- Number of Home and Community Based Service (HCBS) slots available
- Number of housing vouchers and slots available by type for persons with mental illness
- Number of persons with SMI on a housing waiting list
- Average wait time for housing (in months)

The Tracking Guide also requested states to indicate whether the measure is part of a separate initiative, and whether or not the measure needed to be modified to fit the state's needs. Of the 26

measures that were tested, 25 measures were already part of the state's performance measurement system. Table 4 gives the frequency of the number of states that tested each measure, the population for which it was tested, and whether it is part of an existing measurement system.

Four states tested several of the recommended measures using different specifications. The modified measures are as follows:

- "Number of Persons with SMI Admitted to Nursing Homes Identified through PASRR Assessments" (DE, IL, and VT): One of the three states that modified this measure explained that they did not use the PASRR Assessments. Another state indicated that the measure collected the number of individuals who were eligible for admission to nursing homes based on the PASRR Assessment.
- "State Mental Health Expenditures on Community Based Programs" (OK): The state modified this measure by breaking it out into two categories: 1) community-based services provided in the community, and 2) community-based services provided in other institutions.
- "Number of Persons with SMI/SED Awaiting Discharge by Type of Institution for More than Three Months" (DE): The state modified the measure to identify the source and frequency of data collection.
- "Number of Persons with SMI/SED Readmitted to Any (or same) Type of Institution within Six Months" (VT): The state modified this measure to better capture the six-month data.
- "Number of Persons with SMI/SED Admitted to Institutional Care" (VT): The state modified this measure to reflect estimates of the SMI/SED population.

In addition to the recommended pilot measures, Delaware also tested two additional measures:

- New Measure: "Funds Directed toward Housing, Specifically SRAP/S" (Domain: Financing and Resources). Delaware was able to collect this measure for adults.
- New Measure: "Waiting List for SRAP Vouchers within the SMHA" (Domain: Housing). Delaware was able to collect this measure for adults

Table 4: Measures Tested by Pilot States

Measure	States Already Collecting Measure	Number of States Reporting Measure in the Pilot		
		Children	Adults	Total
1. State mental health expenditures on community based programs	5	3	4	5
2. State expenditures on psychiatric hospital/inpatient care	5	2	4	5
3. Number of HCBS slots available	0	0	0	0
4. Number of persons with SMI/SED awaiting discharge by type of institution for more than three months	1	0	2	2
5. Number of patients in the institution with a length of stay greater than one year (at end of year)	5	2	5	5
6. Number or percentage of persons with a length of stay greater than one year discharged during the year	5	2	5	5
7. Number of persons with SMI/SED readmitted to any (or same) type of institution within six months	5	3	5	5
8. Number of persons with SMI/SED admitted to institutional care	4	4	5	5
9. Average daily census (calculated by sum of total patient days during the year/365)	5	3	5	5
10. Number of licensed psychiatric beds available	4	4	5	5
11. Number of persons with SMI/SED declining transfer into the community	0	0	1	1
12. Number of persons with SMI admitted to nursing homes identified through PASRR Assessments	3	0	3	4
13. Number of persons with SMI receiving permanent supported housing	4	1	4	4
14. Number of persons with SMI receiving supervised housing	3	0	3	3
15. Number of persons with SMI receiving other housing services	3	0	2	2
16. Number of housing vouchers and slots available by type for persons with mental illness	0	0	0	0
17. Number of persons with SMI receiving housing subsidies	1	0	2	3
18. Number of persons with SMI on a housing waiting list	0	0	0	0
19. Average wait time for housing (months)	0	0	0	0
20. Number of persons with SMI/SED receiving targeted case management services	3	1	3	3
21. Number of persons with SMI receiving Assertive Community Treatment	4	1	4	4
22. Number of persons with SMI enrolled in supported employment	4	1	4	4
23. Number of persons with SMI employed OR Number of persons served by SMHA who were employed	5	2	5	5
24. Number of children with SED receiving wraparound services	3	3	1	3
25. Number of crisis residential beds available for inpatient diversion	4	2	4	4
26. Number of children receiving in-home services	4	4	0	4
27. Number of SED persons receiving family support services	3	3	1	3
28. SMI emergency room admissions to general hospital	2	1	2	2
29. Number or percentage of consumers reporting positively about social connectedness (MHSIP Survey Module)	5	2	5	5

Measure	States Already Collecting Measure	Number of States Reporting Measure in the Pilot		
		Children	Adults	Total
30. Number of adults with SMI involved in peer support	3	1	2	3

One of the most frequently cited issues with the tool is that the settings did not align with the populations for certain measures. Four of the five pilot states recommended that further work be done to refine the measures to request only the appropriate populations and settings (for example, request only nursing homes as an available setting for the measure "Number of Persons with SMI Admitted to Nursing Homes Identified through PASRR Data").

Data Sources

Pilot States were asked to report on the data sources used to test the 30 community integration measures. Four of the five pilot states supplied information about data sources. Heavy reliance on SMHA data systems, Medicaid data, and the Nursing Home Preadmission Screening, Annual Resident Reviews (PASRR) was reported. Information about the number of licensed psychiatric beds primarily came from a Health or Public Health Department. Few SMHAs were able to access housing data beyond that included in the SMHA system. The various data sources used were as follows:

- Four pilot states used SMHA Administrative and Financial Data Systems
- Four pilot states used PASRR databases
- Three pilot states used state hospital data systems (including clinical information systems)
- Three pilot states used Medicaid paid claims data
- Three pilot states used Public Health/Health Department data on licensing

Utility and Burden Ratings

State Assessments of the Utility of Compiling Community Integration Measures

After each pilot state completed the process of reporting information for as many of the measures as possible, they held a meeting with their respective senior management involved in *Olmstead* and overall mental health planning. The purpose of these meetings was to present the results for each of the measures and discuss with potential state users the utility of the measure to enhance the state's understanding of how effectively their efforts are toward promoting community integration of people with mental illness. States were requested to rate the utility of each measure using a three-point Likert score (1 = least useful to 3 = most useful) and a statement that supports their rating. Utility evaluation forms were received from all five pilot states.

All five reporting pilot states rated the utility of the measures for which they have data. Additional measures were given utility rating by three states despite the absence of collected data but solely on the basis of their collective perspective of the measures' potential use. A total of 33 measures were rated, including the state-specific measures. Table 5 shows the states' utility scores for each of the measures. The only measure to receive a score of "3" (most useful) from all five pilot states was the "Number of patients in the institution with a length of stay greater than one year at the end of the year."

Nine measures received a score of "3" from at least four reporting states:

- State mental health expenditures on community-based programs
- State expenditures on psychiatric hospital/inpatient care
- Number of persons with SMI/SED readmitted to any (or same) type of institution within six months
- Number or percentage of consumers reporting positively about social connectedness – MHSIP Survey Module
- Number of persons with SMI receiving permanent supported housing
- Number of patients in the institution with length of stay greater than one year
- Number of persons with SMI employed OR Number of persons served by the SMHA who were employed
- Number or percentage of persons with a length of stay greater than one year discharged during the year
- Number of children w/SED receiving wraparound services

Rated "3" by three reporting states:

- Number of persons with SMI receiving supervised housing
- Number of children receiving in-home services
- Number of licensed psychiatric beds available
- Number of persons with SMI receiving ACT
- Number of persons with SED receiving family support services
- Number of adults with SMI involved in peer support programs

Table 5 shows none of the 30 recommended measures received a rating of "1" (least utility) from more than two pilot states. Six measures were rated as "1" (least) on utility by two states, but for five of these measures an equal number of states (two) rated their utility as "3" (most). The six measures reported as least useful (score of "1") were:

- Number of persons with SMI/SED receiving targeted case management services
- Number of persons with SMI/SED awaiting discharge by type of institution for more than three months
- Number of persons with SMI/SED declining transfer into the community
- Number of SED persons receiving family support services
- SMI emergency room admissions to general hospital
- Number of crisis residential beds available for inpatient diversion

Table 5: State Assessments of the Usefulness of Potential Community Integration Measures

Domain		Measure	Please rank the Utility of collecting this indicator (1 = Least Useful to 3 = Most Useful)						Number of States scoring measure as Least Utility or Most Utility	
			State 1	State 2	State 3	State 4	State 5	States Reporting	# Least Useful (1)	# Most Useful (3)
Financing & Resources	Increase in Funding for Community-Based Programs	**1.** State MH expenditures on community-based programs	3	3	3	3	2	5	0	4
		2. State expenditures on psychiatric hospital/ inpatient care	3	3	3	3	2	5	0	4
		3. Number of HCBS slots available	1*		2*	3*		3	1	1
Movement to Community & Recidivism	Decrease in length of time waiting to be discharged	**4.** Number of persons with SMI/SED awaiting discharge by type of institution for more than three months	1	1	3*	3*	2*	5	2	2
	Decrease in length of stay	**5.** Number of patients in the institution with length of stay greater than one year (at end of year)	3	3	3	3	3	5	0	5
		6. Number or percentage of persons with a length of stay greater than one year discharged during the year	3	3	2	3	3	5	0	4
	Decrease in readmission rate	**7.** Number of persons with SMI/SED readmitted to any (or same) type of institution within six months	3	3	3	3	2	5	0	4
	Decrease in utilization rate of institutional settings	**8.** Number of persons with SMI/SED admitted to institutional care	3	3	2	1	2	5	1	2
		9. Average daily census (calculated by sum of total patient days during the year/365)	3	3	2	1	2	5	1	2
		10. Number of licensed psychiatric beds available	2	3	3	1	3	5	1	3
		11. Number of persons with SMI/SED declining transfer into the community	1	3*	3*	1*		4	2	2
		12. # of persons w/SMI admitted to nursing homes identified through PASRR Assessments	1	3	2	3	2*	5	1	2
Housing	Increase in percentage of persons with SMI receiving housing supports	**13.** Number of persons with SMI receiving permanent supported housing	3	3	3		3	4	0	4
		14. Number of persons with SMI receiving supervised housing	3	3	3			3	0	3

Domain		Measure	Please rank the Utility of collecting this indicator (1 = Least Useful to 3 = Most Useful)						Number of States scoring measure as Least Utility or Most Utility	
			State 1	State 2	State 3	State 4	State 5	States Reporting	# Least Useful (1)	# Most Useful (3)
		15. Number of persons with SMI receiving other housing services	3	1*	3		2*	4	1	2
		16. Number of housing vouchers and slots available by type for persons with mental illness	1*	3*	3*		2*	4	1	2
	Increase in housing subsidy per capita	**17.** Number of persons with SMI receiving housing subsidies	2	3				2	0	1
	Decrease in length of time on housing waiting lists	**18.** Number of persons with SMI on a housing waiting list	1*	3*	3*			3	1	2
		19. Average wait time for housing (months)	1	3	3			3	1	2
Community Capacity	Increase in utilization of community-based services	**20.** Number of persons with SMI/SED receiving targeted case management services	3	1	2	1*		4	2	1
		21. Number of persons w/SMI receiving Assertive Community Treatment (ACT)	3	2	3	1*	3	5	1	3
		22. Number of persons w/SMI enrolled in supported employment	2*	1	2	3	3	5	1	2
		23. a) Number of persons with SMI employed OR b) Number of persons served by SMHA who were employed	3	1	3	3	3	5	1	4
		24. Number of children w/SED receiving wraparound services	3	3*	3		3	4	0	4
		25. Number of crisis residential beds available for inpatient diversion	3	2.5	3	1*	1	5	1	2
		26. Number of children receiving in-home services	3	3*	2	2	3	5	0	3
		27. Number of SED persons receiving family support services	1*	1*	3	3	3	5	2	3
		28. SMI emergency room admissions to general hospital	3	1	1*	3*		4	2	2
Well-Being	Increase in percentage of persons expressing social inclusion or	**29.** Number or percentage of consumers reporting positively about social connectedness (MHSIP Survey Module)	3	3	3	3	1	5	0	4

Domain		Measure	Please rank the Utility of collecting this indicator (1 = Least Useful to 3 = Most Useful)						Number of States scoring measure as Least Utility or Most Utility	
			State 1	State 2	State 3	State 4	State 5	States Reporting	# Least Useful (1)	# Most Useful (3)
	connectedness	**30.** Number of adults with SMI involved in peer support programs (including clubhouse programs)	2	3*	3	3*	2	5	0	3
		Number of Measures Scored	**30**	**29**	**29**	**22**	**22**		**18**	**31**

**Indicates that the state rated the utility of the measure, but did not test the indicator.*

State Assessments of the Burden of Compiling Community Integration Measures

All five pilot states submitted an assessment of the burden associated with collecting each measure. The pilot states provided burden ratings on 26 measures. Table 6 shows the state ratings of burden scores. Four measures were rated as "1" (low burden) by at least four of the pilot states. These measures were as follows:

- State mental health expenditures on community-based programs
- State expenditures on psychiatric hospital/inpatient care
- Number of persons with SMI receiving Assertive Community Treatment (ACT)
- Number of persons with SMI employed OR Number of persons served by the SMHA who were employed

No measures were rated as "3" (high burden) by more than one pilot state. Examples of the measures that received a score of "3"were:

- Number of persons with SMI/SED declining transfer into the community (rated 3, but only one pilot state reported this measure)
- SMI emergency room admissions to general hospital (rated 3 by one state with two states reporting)
- Number of persons with SMI receiving other housing services (rated 3 by one state, with two states reporting)
- Number of persons with SMI receiving housing subsidies (rated 3 by one state, with two states reporting)

Table 6: State Assessments of the Burden of Community Integration Measures

Domain		Measure	Please rank the BURDEN of collecting this indicator (1 = Least Burden to 3 = Most Burden)						Number of States scoring measure as Least Burden or Most Burden	
			State 1	State 2	State 3	State 4	State 5	States Reporting	# Least Burden	# Most Burden
Financing & Resources	Increase in Funding for Community-Based Programs	**1.** State MH expenditures on community-based programs	1	1	2	1	1	5	4	0
		2. State expenditures on psychiatric hospital/ inpatient care	1	1	1	1	1	5	5	0
		3. Number of HCBS slots available						0		
Movement to Community & Recidivism	Decrease in length of time waiting to be discharged	**4.** Number of persons with SMI/SED awaiting discharge by type of institution for more than three months	3	1				2	1	1
	Decrease in length of stay	**5.** Number of patients in the institution with length of stay greater than one year (at end of year)	1	2	1	1	2	5	3	0
		6. Number or percentage of persons with a length of stay greater than one year discharged during the year	1	2	1	3	2	5	2	1
	Decrease in readmission rate	**7.** Number of persons with SMI/SED readmitted to any (or same) type of institution within six months	2	1	1	2	2	5	2	0
	Decrease in utilization rate of institutional settings	**8.** Number of persons with SMI/SED admitted to institutional care	1	2	1	2	2	5	2	0
		9. Average daily census (calculated by sum of total patient days during the year/365)	1	2	2	1	2	5	2	0
		10. Number of licensed psychiatric beds available	2	2	3	1	2	5	1	1
		11. Number of persons with SMI/SED declining transfer into the community	3					1	0	1
		12. # of persons w/SMI admitted to nursing homes identified through PASRR Assessments	3	1	1	2		4	2	1
Housing	Increase in percentage of persons with SMI receiving	**13.** Number of persons with SMI receiving permanent supported housing	2	1	2		2	4	1	0

Domain		Measure	Please rank the BURDEN of collecting this indicator (1 = Least Burden to 3 = Most Burden)						Number of States scoring measure as Least Burden or Most Burden	
			State 1	State 2	State 3	State 4	State 5	States Reporting	# Least Burden	# Most Burden
	housing supports	**14.** Number of persons with SMI receiving supervised housing	2	2	2			3	0	0
		15. Number of persons with SMI receiving other housing services	2		2			2	0	0
		16. Number of housing vouchers and slots available by type for persons with mental illness						0		
	Increase in housing subsidy per capita	**17.** Number of persons with SMI receiving housing subsidies	3	1				2	1	1
	Decrease in length of time on housing waiting lists	**18.** Number of persons with SMI on a housing waiting list						0		
		19. Average wait time for housing (months)						0		
Community Capacity	Increase in utilization of community-based services	**20.** Number of persons with SMI/SED receiving targeted case management services	1	3	1			3	2	1
		21. Number of persons w/SMI receiving Assertive Community Treatment (ACT)	1	1	1		1	4	4	0
		22. Number of persons w/SMI enrolled in supported employment		1	3	1	1	4	3	1
		23. a) Number of persons with SMI employed OR b) Number of persons served by SMHA who were employed	2	1	1	1	1	5	4	0
		24. Number of children w/SED receiving wraparound services	1		1		1	3	3	0
		25. Number of crisis residential beds available for inpatient diversion	1	2	1		1	4	3	0
		26. Number of children receiving in-home services	1		2	1	1	4	3	0
		27. Number of SED persons receiving family support services			1	1	1	3	3	0
		28. SMI emergency room admissions to general hospital	2	3				2	0	1
Well-Being	Increase in percentage of persons expressing	**29.** Number or percentage of consumers reporting positively about social connectedness (MHSIP Survey Module)	1	2	1	1	1	5	4	0

Domain		Measure	Please rank the BURDEN of collecting this indicator (1 = Least Burden to 3 = Most Burden)						Number of States scoring measure as Least Burden or Most Burden	
			State 1	State 2	State 3	State 4	State 5	States Reporting	# Least Burden	# Most Burden
	social inclusion or connectedness	**30.** Number of adults with SMI involved in peer support programs (including clubhouse programs)	3		1		1	3	2	1
		Number of Measures Scored	**24**	**20**	**22**	**14**	**18**		**22**	**10**

Utility and Burden of Measures by Domain

Ideal performance measures would be rated of highest utility to state planners and decision-makers, and would also be of lowest burden to collect (that is, those that are the most useful and also the easiest or less burdensome to report). However, not all measures can be both useful and collected without burden. Some measures may be rated as very useful, but be prohibitively difficult or expensive for SMHAs to collect. SAMHSA and states will need to analyze the tradeoffs of compiling measures that are of medium or high utility, but that are also very difficult and/or expensive to collect.

The Community Capacity Domain, with ten measures, had two measures that were scored both "3 – highest utility" by all five states, and were also scored "1 – lowest burden" by all five states.

The Financing and Resources Domain, with three measures, had two measures that were scored both as having very high utility. Four of all five states reporting the two measures as having the highest utility, and all five states reported them as being the least burdensome (score of "1"). However, one of the three recommended measures was not reportable by any state (measure number 3, Number of HCBS Slots Available). The reason for this lack may be attributed to the fact that several of the pilot states did not have a Medicaid HCBS waiver or option, and therefore no data about HCBS slots could be collected in these states.

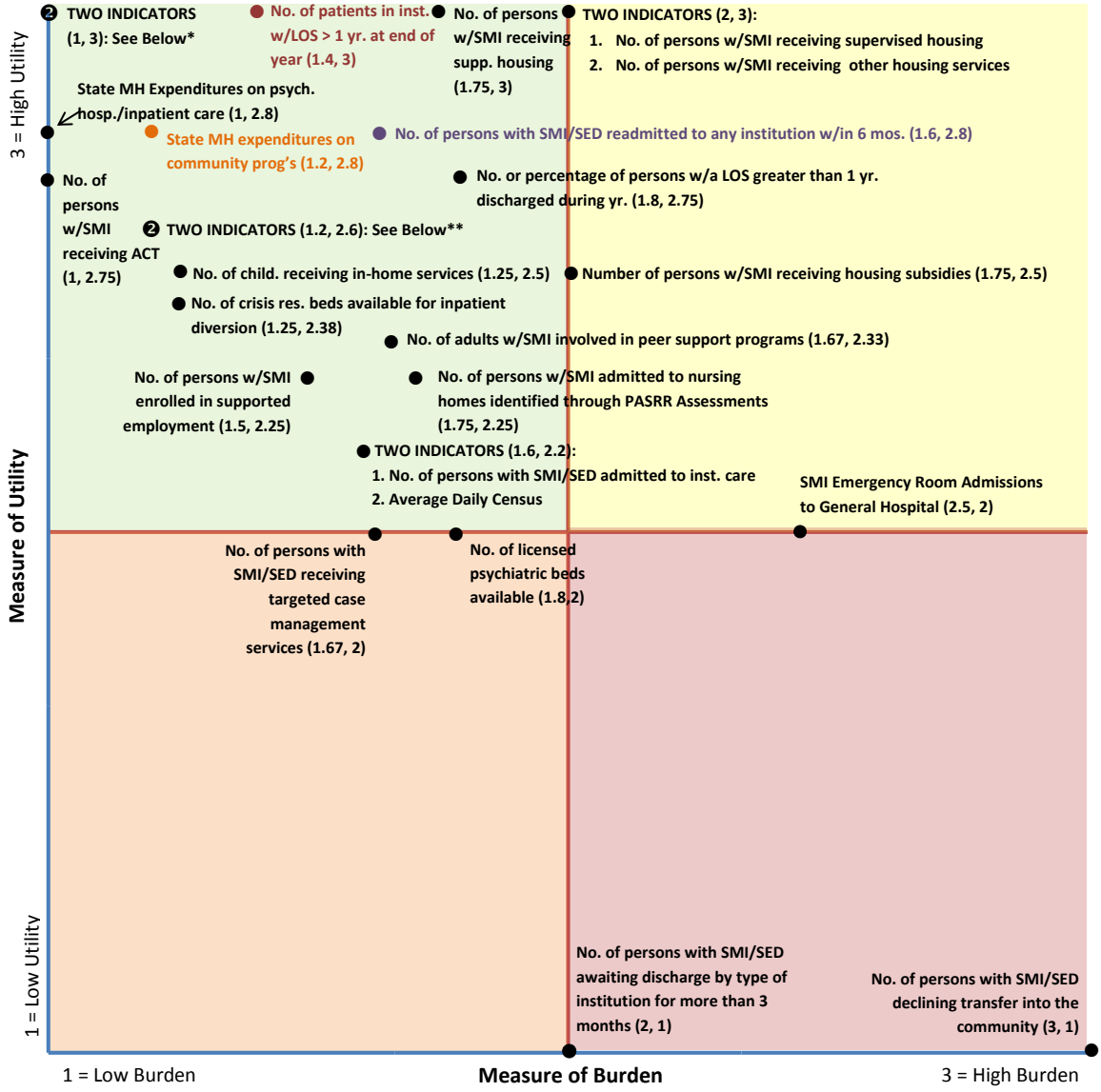
The Housing Domain had seven measures, of which only four were able to be collected by any state. However, six of the Housing measures were scored as "Most Useful" by over half of the states. Thus, despite the difficulty of getting housing information, SMHAs rated the Housing Measures very high.

The Movement to the Community and Recidivism Domain had nine measures, of which four were rated as highest utility by at least three states. Only one of the measures in this domain was rated as lowest burden by at least 3 states, and 5 measures were rated as "3" (most burdensome) by at least one state.

Utility and Burden of Measures

Figure 2 shows the correspondence between measures of utility and burden. Measures in the upper left quadrant were rated by states as must useful and least burdensome to collect. Measures in the bottom right quadrant were less useful to states and were most burdensome to collect. Only two measures scored below the mid-range in terms of usefulness (Likert scale = 2), but had varying levels of burden to the states reporting.

Figure 2: Relationship of Utility and Burden Assessments of Community Integration Measures



KEY:

*❷ INDICATORS (1, 3):

1. Number of children w/SED receiving wraparound services
2. Number of SED persons receiving family support services

**❷ INDICATORS (1.2, 2.6):

1. Number or percentage of persons reporting positively about social connectedness
2. Number of persons with SMI employed OR No. of persons served by the SMHA who were employed

High Utility, Low Burden
High Utility, High Burden
Low Utility, Low Burden
Low Utility, High Burden

Based on this scoring, Table 7 below shows the highest rated measures that also had low burden scores. The table also provides examples of state descriptions of the utility of the measures. The state comments provide examples of how state *Olmstead* planners and others presented the results of the

community integration pilot results rated the utility of the measure for their work in assessing the status of their state regarding community integration. For some measures, states added additional recommendations for potential enhancements for future work on assessing community integration by mental health consumers.

Table 7: Measures Rated for the Highest Utility

Measure Number/Name	# States Rating Highest Utility	Number of States rating Utility	# States Rating Lowest Burden	Number of States Rating Burden	State Utility Comments
2. State expenditures on psychiatric hospital/ inpatient care	4	5	4	5	Opinion was that this measure was useful, and documents an allocation of resources. If five years of data were examined, the results might be more useful. There was some conversation about definition of community, and how community programs can sometimes be more restrictive than inpatient care. Community-based programs do not necessarily represent community integration.
1. State MH expenditures on community-based programs	4	5	4	5	Increase in expenditures on community-based programs is a good indicator of movement or commitment to community integration however due to the current fiscal environment, for some states it may be difficult to see an increase in funding. So, there may be a downward trend over the years but does not mean less commitment, just less money for community based mental health services.
29. Number or percentage of consumers reporting positively about social connectedness (MHSIP Survey Module)	4	5	3	5	State: Good indicator with regard to community integration. Individuals residing in the community should have positive social relationships. It is important for consumers to provide their evaluation of care. State: Leadership liked this measure, mostly because our results were positive, but they did feel it was useful.
5. Number of patients in the institution with length of stay greater than one year (at end of year)	4	5	3	5	State: Length of stay is a critical component to identifying problem areas and ensuring individuals are being discharged in a timely manner. We broke the measure into smaller time frames rather than one year. State: Decrease shows evidence of individuals transitioning to less restrictive settings.
7. Number of persons with SMI/SED readmitted to any (or same) type of institution within six months	4	5	2	5	State: Useful to track so that states have an idea as to numbers of individuals with longer terms stays who transition to other settings. State: Recidivism in general admissions could be evaluated. Currently we look at involuntary hospitalization, but we could look at voluntary also. A limitation is that for general admissions we only have data for involuntary admissions. Collection of this data may be a desired goal on the part of the hospital, but we are unsure of the implementation of this. This is important information – we need to know this. It would be important to distinguish between voluntary and involuntary admissions.
23. a) Number of persons with SMI employed OR b) Number of persons served by the SMHA who were employed	4	5	4	5	State: Employment is an important component in an individual's ability to stay in the community. State: We reported this indicator using the denominator of state CRT clients rather than the estimated state SMI population, and our management felt this was appropriate. Our definition of SMI is CRT clients. This includes supported employment. Seeing a longer time frame would be helpful. A rolling ten years would be valuable. Conversation arose about fidelity of comparisons and staffing numbers to provide support to clients.
30. Number of adults with SMI involved in peer support programs (including clubhouse programs)	3	5	2	3	This would be helpful as we have many new initiatives in this area and it would be good to collect and report on this data. Good indicator, but because of the nature of peer run services, this data is not collected.
6. Number or percentage of persons with a length of stay greater than one year discharged during	3	5	2	5	State: Useful to track so that states have an idea as to numbers of individuals with longer terms stays who transition to other settings. State: We looked at everyone discharged during the year, not just those with a length of stay greater than one year.

Measure Number/Name	# States Rating Highest Utility	Number of States rating Utility	# States Rating Lowest Burden	Number of States Rating Burden	State Utility Comments
the year					
24. Number of children w/SED receiving wraparound services	3	4	3	3	State: Wraparound services focus on utilizing community supports to keep the child with the family and out of an institution. State: Potentially a good indicator. The panel was unsure of the operational definition for wraparound services. Are we referring to the basic community services that are "wrapped around youth", or are we talking Wraparound Services as an evidence based practice?
13. Number of persons with SMI receiving permanent supported housing	3	4	1	4	State: Housing is a key component of living in the community. State: States should track individuals who have transitioned to permanent supportive housing, so this is a key indicator. It was also noted however that some local providers have worked with individuals that they serve to move to permanent supportive housing, but this information is not tracked at the state level, and probably not consistently at the provider level. Both pieces of data would be important to know and understand.
14. Number of persons with SMI receiving supervised housing	3	3	0	3	This indicator is also of high utility however it is important to define supervised housing. The Illinois panel think that tracking the number of individuals who access this level of housing is useful IF it is a stop along the way to permanent supported housing.
26. Number of children receiving in-home services	2	5	3	4	Good indicator evidencing a focus on a less restrictive environment in which service is delivered. In reporting this we used a denominator of children receiving services, not the estimated state population. Leadership felt this was appropriate. Discussion took place about SMHA's definition of SED (GAF score of LE 60). National definition is LE 50.
17. Number of persons with SMI receiving housing subsidies	1	2	1	2	State: This would be important in knowing the availability of housing support with persons with mental illness. State: This is a key indicator and useful to track.

State Overall Assessment

States were asked to provide an overall assessment of their experience in the pilot, citing the following:

- Benefits of participation
- Problems and challenges encountered
- Usefulness of the technical assistance provided by the TEP
- How the results of the pilot would help them advance their community integration efforts
- Next steps, if any, the state is considering based on the results of the pilot.

In succeeding paragraphs, the state assessment is presented in verbatim. The feedback represents a collective view of the participants in the respective state policy meetings where the state self-assessment pilot results were presented and discussed.

Delaware

Benefits: Among the many benefits experienced were 1) identifying other "standards" for addressing compliance with *Olmstead* (outside of those for which our state is currently under a Consent Decree); 2)

working with other stakeholders within our agency to bring content to this study; 3) having the templates and guides were a major advantage for coordinating and tying all elements together.

Challenges: The challenges included 1) developing a method for collecting and reporting on the few measures that our state didn't already track; 2) there were some limitations to what external data/information our agency has access to (i.e., Corrections, Labor, Housing, etc.); 3) lastly, and most importantly, the biggest challenge was with the time constraints coupled with our own *Olmstead* Settlement internal reporting needs.

Technical Assistance: The Technical Assistance team was extremely helpful and patient. Kudos to the UPenn staff for keeping us on track; their guidance, as always, is greatly appreciated!

Utility: The process aided in identifying key performance and outcome measures. Our USDOJ *Olmstead* Committee will review those essential components and analyze on a continuing basis.

Next Steps: Moving forward, it is recommended that our state connect with outside agencies and organizations to address any barriers in developing data sharing agreements for ease of access to pertinent information.

Illinois

Benefits: The individuals participating in the indicator review thought it was useful to have measures/data that provide a self-assessment for states. However, there are some other data that might potentially be useful, but data collection would be difficult because it would be spread across several or many agencies at both the state and local agency level. At the state level, there would need to be data sharing agreements developed and work undertaken to develop good operational definitions that each agency would then apply. Collecting additional data at the agency level might be difficult given data system changes that would probably be required to capture this information. It was useful to convene a meeting with a targeted focus on measures and data.

Challenges: The biggest challenge to gathering indicator data occurs, as would be expected, is when data are sought from other agencies. The data needed may or may not be a priority in the realm of other agencies' prioritized work. We were able to obtain data for a number of measures that may reside in other agency databases in other states because we have developed some specialized databases to capture data for initiatives on which we work with other agencies. The agency that we worked with on this pilot self-assessment was the State Medicaid Agency, who agreed to work with us and who agreed to run reports and provide data for the measures. However, because the requests that we made were not for routine reports, it has taken more time than expected to generate the reports. Participants also discussed the fact that there needs to be work undertaken to develop operational definitions to help states better refine data collection.

Technical Assistance: It was good to meet with the TEP at the start of the project. The panel asked thought-provoking questions, and helped clarify the goals and expectations of the project. When it comes to gathering data, which is generally a responsibility of the state, however, it would be useful to meet with the panel once the project is complete to discuss the outcome of the pilot.

Utility: Illinois is currently implementing its plan to meet the conditions of one Consent Decree, and we are on the verge of another. The participants in the indicator review were surprised by some of the trends in the data, and so that will probably lead to some further discussion. There was a consensus that many of the measures were useful, although some were identified as primary measures with others being secondary or second-level measures. The participants thought that many of the measures were good measures of community integration. However, others could probably be eliminated.

Next Steps: No new data sharing agreements have been implemented as a result of the pilot; however, the participants did briefly discuss the fact that we would need to establish agreements to collect data across a wide range of agencies to capture information on a few of the measures that might be particularly useful.

Oklahoma

Benefit: The most beneficial aspect of this pilot was having an outline for a process to look at community integration measures and the opportunity to do somewhat of a self-study.

Challenges: The challenge was with the time constraints. However, we completed what we could, given the time frame.

Technical Assistance: The technical experts were most helpful in the beginning when trying to understand the purpose and scope of the project and determining relevant measures. Having the discussions with the consultants and the other states was very helpful in thinking through how to make the measures meaningful.

Utility: The measures have helped to identify some of the gaps of information we could be looking at to inform our planning and implementation efforts. With further utilization and analysis, we should be able to more clearly see the impact of efforts.

Next Steps: The results of the pilot will be used to help inform *Olmstead* strategic planning. Future policy changes may occur as a result of the findings. Additionally, the SMHA may seek data from other agencies for further analysis.

Vermont

Benefits: Meeting with senior staff was very beneficial regarding the data. These meetings and review of the measures identified some data that have not been routinely reported on and distributed here in Vermont, but should be. We intend to make reports on these measures readily available in the future.

Challenges: Measures were not readily available in our databases and differences in project and local nomenclature were barriers to the project. In some cases we were able to develop a crosswalk to translate to local nomenclature which was more specific. We were unsure of the exact fit of this translation. In other cases we could find no match. A number of senior management staff expressed concern that the assumptions underlying a number of these measures are not relevant to our system of care.

Technical Assistance: Vermont made minimal use of the technical experts.

Utility: Some of the measures have been selected to become part of our normal reporting routine. For example, our Medical Director identified the measure, "Number of persons with SMI/SED awaiting discharge by type of institution for more than three months" as a measure of value and interest and we will work to collect and report on this measure. Some of the measures were determined not to be useful, such as the "Number of licensed psychiatric beds available," because this measure, once established, does not change much over time.

Next Steps: Some of the measures have been selected to become part of our normal reporting routine.

Washington

Benefits: This pilot study will help us measure how well a state system helps individuals with SMI integrate into the community. To us, housing and employment are two of the most concrete measures indicative of integration into community settings.

Challenges: One of the barriers encountered in completing the self-assessment was the access to data from other systems. Developing partnerships with other systems is strongly encouraged and embedded into the philosophy of our state's system; however, the nature of confidentiality, funding streams and information systems still pose barriers to sharing data. An example of this barrier includes access to public housing authorities. Funds to housing authorities flow directly to them. Access to data within that system requires significant outreach in a large state such as Washington where there are 40 separate local housing authorities.

Technical Assistance: We had one conference call with technical team to discuss the criteria and definitions of some measures. It was helpful to communicate with experts to understand the purpose and data issues related to this pilot study.

Utility: In a parallel project with the SAMHSA *Olmstead* funds contracted through AHP we are developing a comprehensive plan that will incorporate the vision of recovery to assist individual's transition from institutional settings. Information from the self-assessment will be used to inform and craft the plan. DBHR's Supported Housing/Supported Employment Program Administrator is also participating in a cross-departmental housing workgroup to promote and identify affordable for individuals who are homeless or at risk of homelessness. Information from the self-assessment will be disseminated at the workgroup.

Next Steps: Information from the self-assessment will be used to inform and craft the (comprehensive) plan. Information from the self-assessment will be disseminated to the (housing) workgroup. See discussion above.

Conclusions

The overall pilot experience produced significant information towards the initial effort in developing a self-assessment tool for the SMHAs. All five pilot states, given the limited time to test 30 measures, were able to rate the burden and utility for most measures through a participatory process involving other offices/divisions of different subject expertise within and outside the SMHAs. The highlights of this effort are summarized as follows:

- State ratings of the utility of the proposed community integration measures confirmed that the tested measures are of high quality to SMHAs in conducting self-assessments of their state's efforts at achieving community integration.
- The approach allowing pilot states to retain control of the pilot data resulted in the full participation of states. However, it constrained the ability of this process to produce benchmarks or standards that states can use to compare their performance against other states or some kind of an index that sets a level of acceptable performance.
- The development of the tool will benefit from an iterative process (continued pilot testing of additional domains/measures using additional states).
- Discussion should continue on how best the tool can serve its purpose and the ideal structure of the tool (whether it should be modular for specific population, when and how often can it be administered, how comprehensive should it be, etc.) to maximize its utility.

Considerations for Future Tool Refinement

Based on this pilot experience, the following suggestions are offered for consideration in future refinement efforts of the tool:

- Allow for a longer pilot implementation time. For pilot states to collect data from other state agencies, the process would take a longer time as this would require entering into a data sharing agreement.
- Consider the modifications made by some of the pilot states and their suggestions (e.g., dividing length of stay into smaller increments, as well as looking at changes in services over longer periods of time).
- Continue to test the four measures that no one pilot state was able to complete (Table 8). Three of these are housing measures, and one is related to Medicaid. While these states were not able to compile information for these four measures during the pilot, three states supplied utility scores for their potential, and each of the measures was rated as highest utility by at least one pilot state.

Table 8: State Assessment of the Potential Utility of Measures they were Unable to Complete

Utility Scores of Measures States were Unable to Complete	Number states Rating Most Useful	States Scoring
3. Number of HCBS slots available	1	3
16. Number of housing vouchers and slots available by type for persons with mental illness	2	3
18. Number of persons with SMI on a housing waiting list	2	2
19. Average wait time for housing (months)	2	3

- The tool should be refined so that categories of response options fit the actual measure and list outpatient services as a type of care. Community settings should also be included.
- In addition to measures that are highly useful and less burdensome to attain, future generations of this project should consider the wide array of measures that proved difficult to collect, yet could provide critical information about a state's level of community integration. Data to populate these measures may be difficult to gather because they exist in agencies outside of the mental health system, or because the infrastructure to collect these measures within the SMHA has not yet been established. The following questions might be considered:
    - Who has been recommended for community placements?
    - How long have they been waiting for placement in the community?
    - What needs and preferences do consumers have regarding community placement?
    - Once placed in the community, are their needs being met? Are they receiving adequate services?
    - Is their functioning improving? Are they on the path to recovery?
- Future efforts could expand the focus away from individual measures to a more holistic approach to understanding how the measures work together to determine effectiveness of community integration efforts within the state.
- Following the recommendations of the PEP and the TEP, this pilot was limited to focus on people served in institutional settings. Future work could be expanded to include those living in the community but at risk of institutionalization.

Possible Areas for SAMHSA-State Partnership

Several areas were identified where states could benefit from future SAMHSA initiatives around community integration. Those areas include:

- Assist states in accessing housing information about vouchers, subsidies and waiting lists that SMHAs were unable to identify or access during this pilot.

- Assist states in using results from a state community integration self-assessment to understand their systems' strengths and limitations in community integration (e.g., once an SMHA conducts the self-assessment, how do they use the results to identify and execute the efforts should be taken to improve community integration).
- Link the development of this tool with other SAMHSA initiatives on community integration, particularly in planning and policy development.

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Appendix A:

Community Integration Data Indicators Literature Review

NASMHPD RESEARCH INSTITUTE, INC.

Community Integration Self-Assessment Tool for State Mental Health Agencies: Pilot Project Final Report

February 1, 2012

Executive Summary

In 1999, in response to *Olmstead v. L.C.*, the Supreme Court of the United States interpreted Title II of the Americans with Disabilities Act (ADA) to mean that persons with disabilities are entitled to receive services and live in the most integrated settings appropriate for their care. For the purposes of informing a pilot test to measure community integration, this review attempts to 1) assist in developing an agreed-upon definition of community integration, and 2) identify potential populations and settings for consideration in the pilot.

At present, there is no standard, universally accepted definition of community integration. A review of the literature provides five definitions for consideration in the pilot. Abbreviated versions of each definition are as follows:

1. Department of Justice: Integrated settings enable people with disabilities to fully interact and engage with non-disabled people. Integration means having the right to live, work, and receive services in the community.
2. UPENN Collaborative on Community Integration: Community integration allows people with disabilities "the opportunity to live in the community and be valued for one's uniqueness and abilities, just like everyone else" (Salzer, 2006).
3. The Bazelon Center for Mental Health Law: Community integration provides the ability "to live in their own homes, spend time with family and friends, find meaningful work, and enjoy the many small pleasures of being part of a community" (Bazelon – Community Integration, 2010).
4. Gary Bond, et al from Indiana University: Community integration helps consumers transition out of patient roles, treatment centers, segregated housing, and work enclaves, and toward independence, illness self-management to assume normal adult roles in the community.
5. Sander, et al on community integration after traumatic brain injury: Community integration involves independent living, social and leisure activities, productive activities, and the formation of intimate relationships with others.

Olmstead began with a focus on persons in state psychiatric hospitals who were kept in the hospital after they were deemed ready to live in the community due to a lack of available community resources. The early *Olmstead* cases focused primarily on state psychiatric hospitals for persons with mental illnesses and state schools for persons with development disabilities. Over time, the focus of *Olmstead* cases have expanded to cover additional settings, such as nursing homes, large congregate facilities, non-integrated community housing, and most recently persons living in the community who are "at risk" of needing institutional care because of a lack of appropriate community supports to remain integrated into their own community. More recently, *Olmstead* advocates have turned their focus to increasing availability of day treatment programs and activities that enhance consumers' daily routines.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is funding the development of a State Self-Assessment Pilot and has contracted with AHP and NRI to establish and convene panels of policy and technical experts to develop and pilot the State Self-Assessment. To set appropriate boundaries for what the new SAMHSA State Self-Assessment Pilot of Community Integration should address, the project must determine what types of settings and client populations should be the focus of the effort. Once these decisions are made, then the project can

identify and recommend specific measures of community integration to be used in the state self-assessments.

Settings

The State Self-Assessment Pilot must determine what levels and measures of community integration should be included:

1. Institutional Level: Early *Olmstead* activities focused on state operated psychiatric hospitals and similar facilities for persons with developmental disabilities. Current *Olmstead* activities retain a focus on state psychiatric hospitals, but have expanded to include a variety of other institutional settings, including: nursing homes, residential treatment centers, and other congregate living settings.
2. Community Level: Many *Olmstead* activities now focus on assuring an array of housing, mental health services, and supports are available in the community that either a) allow persons in institutional settings to move into integrated community settings, and/or b) help promote improved community integration for persons living in the community and prevent the need for them to go into an institutional setting to receive services.
3. Person Level: Salzer and others define community integration beyond living in an integrated community setting to include personal assessments of how well integrated consumers are into their community, including contacts with friends and families, social activities, and self-assessments about degrees and level of social connectedness.

Populations

The State Self-Assessment Pilot needs to determine what client population groups should be included:

1. State Mental Health Clients: State Mental Health Authorities (SMHAs) serve almost seven million persons per year, with the majority (over 95 percent) receiving services in the community. SMHAs generally have detailed information about the services provided, living situation, and demographic information for the clients they serve. Should this population be selected, consideration should be given to whether all clients of the SMHA diagnosed with a mental illness, or exclusively those diagnosed with a serious mental illness be included in the Pilot. Consideration should also be given to whether this initiative should focus on adults and children, which would necessitate the inclusion of additional systems involved with each respective age division.
2. State Government Clients: State governments provide mental health services and supports to many more clients beyond the seven million served by the SMHAs. These agencies are often part of current *Olmstead* actions, but the SMHA generally has much less information about the characteristics of the people served by these agencies. Other state government agencies that provide substantial funding and/or services include:
    a. Medicaid (which while a major funder of SMHA services, also pays for many services outside the SMHA system, including nursing homes, general hospital psychiatric services, medications, and mental health services in primary care settings).
    b. State Housing Authorities provide housing supports and subsidies.
    c. Child Welfare
    d. Juvenile Justice
    e. Adult Corrections
    f. Other state agencies, including those that provide older adult services, transportation, education, etc.

3. Total State Population: A broad public health perspective could look at the community integration of all residents of a state, not just those persons currently receiving services from the SMHA or even the broader state system. Since these persons are not receiving state services, information about them would need to come from state and national studies of the overall state population. Potential sources could include SAMHSA's National Survey on Drug Use and Health, the CDC's BRFSS, Medical Expenditure Survey, National Health Interview Survey, HUD's Assisted Housing database among others.

Background

Congress passed the Americans with Disabilities Act (ADA) in 1990 to "end the unjustified segregation and exclusion of persons with disabilities from the mainstream of American life" (DiPolito, 2007). Title II of the ADA, also known as the "integration mandate," specifies "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity" (DiPolito, 2007). In 1995, two women with mental illnesses brought a lawsuit against Tommy Olmstead, the Commissioner of Georgia's Department of Human Resources, for keeping them confined in a psychiatric hospital even though their attending physicians declared them healthy enough to live and receive services in the community (Olmstead v. L.C., 1999). The case reached the Supreme Court of the United States in April of 1999.

In June of 1999, in its decision on *Olmstead v. L.C.*, the Supreme Court interpreted Title II of the ADA to mean that persons with disabilities are entitled to receive services and live in the most integrated setting of their choosing that is appropriate for their care (Department of Justice, 2011). Therefore, any unwanted and unnecessary segregation of individuals with disabilities is considered discrimination. In the 13 years since the Supreme Court's decision, many lawsuits have been brought forth against states for non-compliance with the *Olmstead* decision, and many consumer advocacy organizations argue that too little has been done to ensure the right of community integration for individuals with mental illnesses.

Pilot Test

The Substance Abuse and Mental Health Services Administration (SAMHSA), in collaboration with the Advocates for Human Potential (AHP) and the NASMHPD Research Institute, Inc. (NRI), will conduct a pilot test of the proposed data indicators of community integration within at least five states. The pilot will assist states in conducting a self-assessment using a draft set of measures. The pilot test of the self-assessment measures by states will assist SAMHSA in the development of a self-assessment tool that can eventually be used by all states.

The purpose of this review is to inform the development of the pilot test by 1) helping develop an agreed-upon definition of what constitutes community integration for the self-assessment pilot, and 2) identifying potential populations and settings for consideration for inclusion in the pilot. This literature will then be used, working with a policy expert group and a technical expert group (TEG), to develop a set of proposed data indicators for the state self-assessment.

Defining Community Integration

At present, there is no standard, universally accepted definition of community integration. A review of the literature provides the following definitions:

1. According to the U.S. Department of Justice, the most integrated setting is one "that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible, [and] provide individuals with disabilities opportunities to live, work, and receive services in the greater community" (DOJ, 2011).
2. Salzer and Baron from the UPENN Collaborative on Community Integration define community integration as "the opportunity to live in the community and be valued for one's uniqueness and abilities, just like everyone else," and is comprised of the following components (Salzer, 2006):
    - Housing
    - Employment
    - Education
    - Health status
    - Leisure and recreation activities
    - Spirituality and religion
    - Citizenship and civic engagement
    - Valued social roles, such as marriage and parenting
    - Peer support
    - Self determination
3. The Bazelon Center for Mental Health Law defines community integration as the ability "to live in their own homes, spend time with family and friends, find meaningful work, and enjoy the many small pleasures of being part of a community" (Bazelon – Community Integration, 2010).
4. Gary Bond, et al of Indiana University assert that "community integration entails helping consumers to move out of patient roles, treatment centers, segregated housing arrangements, and work enclaves, and enabling them to move toward independence, illness self-management, and normal adult roles in community settings" (Bond, 2004).
5. Borrowing from the literature on traumatic brain injuries, "community integration encompasses three main areas: independent living, social and leisure activity, and work or other productive activity… Intimate relationships and leisure activity are equally important to a person's wellbeing" and successful integration" (Sander, 2010).

Indicators of Community Integration and *Olmstead* Lawsuits

Public entities violate the ADA integration mandate when they provide services "in a manner that results in unjustified segregation of persons with disabilities" (DOJ, 2011). Violation of the mandate may occur when public entities "directly or indirectly, operate facilities and/or programs that segregate individuals with disabilities; finance the segregation of individuals with disabilities in private facilities; and/or through its planning, service system design, funding choices, or service implementation practices, promotes or relies upon the segregation of individuals with disabilities in private facilities or programs" (DOJ, 2011).

Based on a review of recent lawsuits alleging violation of the integration mandate, the most common indicators the Department of Justice reviewed include the following (DOJ – Participation, 2012, Salzer, 2006):

- Institutional census
- Ratio of people served in the community compared to those served in institutional settings.
- Length of stay of individuals in institutional settings
- Readmission rates, including number of days elapsed between discharge and readmission.

- Number of individuals, in both institutional and community settings, who are on waitlists to receive community-based services
- Ratio of Medicaid dollars spent on community-based services versus funds dedicated institutional services
- Availability of home and community-based services as determined by the amount of funds spent on 1915(c) waivers and other Medicaid Home and Community Based Services HCBS)
- Availability of community-based housing, determined by the existence of supportive housing programs and the number of housing vouchers and subsidies available to consumers
- Existence and effectiveness of comprehensive community crisis services
- Presence of evidence-based practices, including Assertive Community Treatment teams, supported employment programs, and peer support services
- Workforce shortages

Advocacy organizations argue that these measures of community integration do not reach far enough. They argue that to fully understand community integration, one must appreciate the experience of consumers to ensure that integration goes beyond mere exposure to community opportunities to generating opportunities for meaningful social and community inclusion, while at the same time not coercing consumers into placements and services they do not desire.

To improve the wellbeing of consumers, the subjective outcome of social integration, rather than mere physical placement in the community must be considered. Methods to determine social integration include consumer surveys that gather qualitative data, participatory mapping, and other participatory forms of research that allow consumers to express what community integration means to them, rather than testing what researchers think community integration should be (Townley, 2009). Indicators of social integration may include (from Cummins, 2003):

- The number of activities undertaken within the community
- The number and/or objective character of personal relationships
- Frequency of access to community resources
- The number of leisure activities engaged in outside of the home
- Subjective wellbeing

Potential Settings for Inclusion in Pilot

People who are diagnosed with mental illnesses live and receive services in a variety of settings. Such settings include state psychiatric hospitals, nursing homes and other long-term care facilities, adult group homes, correctional facilities, and community settings where people may be at risk of institutionalization.

State Psychiatric Hospitals

Every SMHA operates psychiatric inpatient beds to provide services to persons with high levels of need and who present a risk to themselves or others (Lutterman, 2009). In 2010, state psychiatric hospitals provided services to 157,968 persons (SAMHSA, 2010). The type of services these hospitals provide and the populations they serve vary by state; however, states primarily rely on their state hospitals to provide intermediate and long-term care to adults and forensic consumers (Lutterman, 2009).

State psychiatric hospitals found themselves on the defensive in the *Olmstead* decision, and are still often the target of segregation litigation today. State hospital census numbers, waitlists for discharge, and readmission rates are often used as indicators to determine how well a state is complying with the *Olmstead* decision.

Private Hospitals and other Private Inpatient Facilities

Determining and ensuring that people with psychiatric disabilities receive services in the most integrated setting can be challenging, especially if consumers are receiving treatment in private facilities. Private facilities are rarely included in state *Olmstead* plans because they are not directly operated by the state, and/or they are considered to be integrated as they exist in the community, "even though many are large, segregated facilities serving hundreds of residents with disabilities" (DOJ, 2012; Gruttadaro, 2009).

These types of facilities tend to be for-profit organizations that have little financial incentive to discharge patients into the community. These facilities often argue that they are not subject to the integration mandate of the ADA because they are not public entities; however, courts have rejected this position when the facility "is part of a larger, publicly planned and financial system of services" (Burnim, 2009). Private facilities may include for-profit hospitals, nursing homes, long-term care facilities, and adult group homes.

States will often contract with private psychiatric hospitals to "set aside entire wards or individual beds" to provide services to public mental health clients. These contractual agreements, and even the act of licensing a private facility, leave states culpable for the mental health care clients receive. Therefore, litigation can be brought against states for unnecessary segregation of consumers. Indicators similar to those used for state hospitals may be used to determine violations of the integration mandate in community-based settings.

New York State was recently challenged with an *Olmstead* lawsuit for not enabling residents in private adult board-and-care homes to live in the most integrated setting appropriate. The State's defense was that "it could not be held responsible for segregation of private for-profit adult homes" (SAMHSA Draft, 2012). The court sided in favor of the plaintiffs, citing that "through its various agencies [the State] was involved in licensing and inspecting adult homes" and that "when the State chooses to allocate some of its mental health dollars to support adult homes it was administering services in a manner that violates *Olmstead*" (SAMHSA Draft, 2012).

Services administered through nursing homes are not directly provided by the state mental health authority (SMHA), but are often funded from public sources like Medicaid and Medicare. Many nursing homes provide services to populations with an array of healthcare needs, making it difficult to distinguish how many residents in each facility have diagnosable mental illnesses. A potential source of information about the numbers of persons in nursing homes with psychiatric illnesses comes from the CMS Minimum Data Set (MDS) for nursing homes and information collected through Preadmission Screenings and Resident Reviews (PASRR), a federal initiative that requires new nursing home admissions funded by Medicare and Medicaid to be evaluated

for mental illnesses, and requires all nursing home residents to have an annual review. This dataset could be used in the pilot to determine how many consumers in nursing homes have mental health needs that could be subject to the ADA integration mandate.

Community Mental Health, Persons at Risk of Institutionalization

In honor of the tenth anniversary of the *Olmstead* decision, President Obama announced his Administration's renewed focus on fulfilling the promise of the *Olmstead* decision, and broadened the scope of the target population to include those at risk of institutionalization (DOJ, 2011).

Determining which consumers qualify as "at risk" of institutionalization is a difficult task. If a person living at home or in a community-based setting "requires considerable help from another person to perform two or more self-care activities," then he or she may be considered at risk of institutionalization (Allen, 2001). People living at home who are on waiting lists for community services are also at risk of institutionalization. A case brought against the State of Hawaii in 1999 demonstrates the need to provide community services to those living at home that are at risk of institutionalization.

In *Makin v. Hawaii*, the plaintiffs had been living at home waiting from 90 days to over two years to receive community-based services. Their only choice to receive prompt treatment would have been in a psychiatric institution; however, since they did not want to receive treatment in an institution, they sued the State for failure to provide adequate community services as mandated under the ADA and *Olmstead*. The court upheld the plaintiffs' argument and approved a settlement where Hawaii would provide 700 additional community placements over a period of three years, and work to reduce the time consumers spend waiting to receive community services (Allen, 2001).

More recently, the Commonwealth of Virginia settled a similar case dealing with insufficient community services that may lead to unnecessary institutionalization. A complaint was filed against the Commonwealth to investigate "whether persons with intellectual and developmental disabilities [were] being served in the most integrated setting appropriate to their needs (DOJ, 2012). In a Simultaneous Settlement Agreement, Virginia laid out a plan to "prevent the unnecessary institutionalization of individuals with developmental disabilities who are living in the community, including those on waitlists for community-based services" (DOJ, 2012).

Potential measures for identifying at risk populations include (from DOJ, 2012, and Gruttadaro, 2009):

- The existence and size of waitlists for community-based programs
- Existence of community crisis systems
- Amount of funding to, and existence of culturally competent programs
- Availability of evidence-based practices, such as Assertive Community Treatment teams, Wraparound Services, and Therapeutic Foster Care

Jails and Prisons

Many persons with mental illnesses often end up in jails or prisons due to a lack of institutional beds, and alternative community services and supports. While incarcerated, they are often subject to acts of direct discrimination due to their illness. According to the Human Rights

Watch, "prison staff often punish mentally ill offenders for symptoms of their illness, such as being noisy, refusing orders, self-mutilating [behaviors], or attempted suicide" (Human Rights Watch, 2006).

Reviewing data from 2001 to 2009, NAMI identified a correlation between the closing of state hospitals and reduction of state hospital beds and an increase in the number of inmates with mental illnesses in North Carolina (Akland, 2010). Incarceration may exacerbate symptoms by causing undue stress and trauma, when the person should be receiving mental health services in more appropriate settings, such as an institution or community based program (Bazelon – Diversion, 2010). During times of extreme weather, persons with mental illnesses who are also homeless may be arrested so that they will have shelter from extreme conditions.

Juvenile Detention Facilities

Sixty-six percent of children involved in juvenile justice systems across the United States meet the criteria of having a mental illness (Bazelon – Juvenile Justice, 2010). Their presence in juvenile detention facilities may mean that they are not receiving the appropriate services and may result in the unnecessary institutionalization of a large youth population. Incarceration of juveniles may lead to dangerous, non-rehabilitative conditions that put the health and safety of both the individual and the community at risk (Justice Policy Institute, 2009). A study sponsored by the Justice Policy Institute determined that reduced access to education and disruption in social and familial relationships while incarcerated contributes to a higher recidivism rate for youth treated in institutions, compared with those who receive services in the community (Justice Policy Institute, 2009).

While a review of the literature does not identify past or current litigation against states for failing to provide community-based juvenile justice services, depriving detained youth of community services may put states at risk of violation against the ADA's integration mandate.

Potential Populations for Inclusion in Pilot

Persons with mental illness and other disabilities may receive services from a variety of agencies within state governments. It is often required that these agencies maintain symbiotic relationships with one another to ensure adequate and appropriate service delivery.

State Mental Health Authorities

SMHAs have the responsibility of administering mental health services within a state. In 2009, SMHAs expended nearly $38 billion to deliver institutional and community-based services to more than 6.4 million people (SAMHSA, 2009, NRI, 2009). SMHAs vary widely in how they are organized within state governments, the array of services they deliver, and the way they determine eligibility for services (Lutterman, 2009). One specific characteristic that distinguishes SMHAs from one another is the populations they serve. Some SMHAs only serve consumers who are diagnosed with a serious or serious and persistent mental illness, while others do not limit admission by severity of diagnosis. Over 95 percent of SMHA clients received services through community-based providers, and just over two percent received services in state psychiatric hospitals. Other inpatient providers (both private psychiatric hospitals and general hospitals' psychiatric beds) served more clients (five percent) than state psychiatric hospitals (SAMHSA, 2009).

The following indicators can be used to identify trends in community integration at the SMHA level (DOJ – Participation, 2012, Salzer, 2006):

- The ratio of people served in the community compared to those served in institutional settings.
- Length of stay of individuals in institutional settings
- Readmission rates, including number of days elapsed between discharge and readmission.
- Number of individuals, in both institutional and community settings, who are on waitlists to receive community-based services
- Community involvement in discharge planning
- The number and percentage of patients who receive services in the community within seven to ten days of discharge from the institutions
- Number of supported housing and other housing programs
- Availability of evidence-based practices, including ACT services, and supported employment
- Comprehensive crisis programs, including residential programs and crisis response

Medicaid Agencies

Medicaid funding is crucial to community integration because it is a substantial source of health insurance for disabled people (Tallon, 2011). Historically, Medicaid programs have limited consumers' ability to receive services in the community. However, as Medicaid's role in mental health services has evolved, it has increased its reach to programs in the community to provide alternatives to institutional care (Rowland, 2003).

The Affordable Health Care Act of 2010 (ACA) intends to broaden Medicaid's reach even further by encouraging states to "rebalance" their Medicaid funds toward home and community-based services, and away from institutions by offering matching incentives (Gold, 2010). A report by the Henry J. Kaiser Family Foundation suggests several methods through which states can expand Medicaid home and community-based services: mandatory home health state plan benefit, optional personal care services state plan benefit, and optional 1915(c) waivers.

States are required to offer home health services as part of their Medicaid plans. These services are available to all Medicaid-eligible persons in each state, and "include part-time or intermittent nursing services, home health aide services, medical supplies, equipment and appliances suitable for use in the home; and at state option, physical therapy, occupational therapy and speech pathology and audiology services" (Tallon, 2011).

As part of their Medicaid plan, states may also choose to offer personal care services that "provide assistance with activities of daily living" (Tallon, 2011). According to a study from 2007 to 2009, personal care services were used as frequently as home health services, but were twice as expensive to implement (Tallon, 2011).

1915(c) waivers (often referred to as Home and Community-Based Waivers) were introduced in 1981 and greatly expanded the scope of community-based services available to Medicaid recipients. These waivers allow states to apply to CMS for approval to expand the array of home and community-based services to persons diagnosed with mental illnesses. 1915(c) waivers are also available to people with mental retardation and developmental disabilities, physical disabilities, and older adults (Rowland, 2003). A large number of children also receive services through 1915(c) waivers. Children are considered to be a "family of one;" therefore, there are no income requirements for children to receive services. Eligibility is instead based on a child's need for services at the hospital level of care. Expanding the availability of 1915(c) waivers

requires states to apply to CMS for additional waivers to provide specific services to unique populations (Tallon, 2003).

States may measure their success at "rebalancing" their Medicaid funding through use of the following indicators (from Tallon, 2003):

- Home and community-based services participants per 1,000 of the population
- Home and community-based services expenditures per capita
- Percent of home and community-based services participants compared to the total long-term care population
- Percent of home and community-based services participants compared to total long-term care expenditures

Corrections Agencies

State corrections agencies are responsible for managing the housing and treatment of adult criminal offenders. In 2007, 7.3 million people were incarcerated in U.S. jails or prisons. Of those, more than half of all inmates were identified as having a mental illness (Human Rights Watch, 2006). Programs like assertive community treatment (ACT), intensive case management, crisis Intervention teams, supportive housing have demonstrated success in reducing arrests and incarceration among people with mental illnesses (Bazelon – Diversion, 2010). Jail diversion programs and transition services also reduce the number of mentally ill persons in correctional facilities.

Potential measures to ensure community integration in corrections agency services include:

- Number of persons with mental illnesses residing jails or prisons
- Number of arrests and re-arrests of people involved with the SMHA
- Existence of transition services and jail diversion programs
- Existence of community-based programs that have been proven to reduce arrests and recidivism, including ACT, intensive management, crisis intervention teams, and supportive housing
- Funding dedicated toward mental health training for officers to increase tolerance
- Presence of services in jails and prisons

State Housing Finance Agencies

Affordable, integrated housing is a primary component of all community integration definitions. "State Housing Finance Agencies are state-chartered authorities established to help meet the affordable housing needs of the residents of their states" (National Council of State Housing Agencies, 2012). They provide services to the elderly, homeless, and disabled populations through supportive housing programs, and targeted credits, vouchers, and grants. To identify levels of community integration provided by State Housing Finance Agencies, the following indicators may be used:

- Appropriations for housing programs for people with mental illnesses
- Number of homeless persons living in the state
- Number and type (congregated versus scatter-site) of supportive housing programs
- Number of Housing and Urban Development vouchers received by the state, including Non-Elderly Disabled (NED) Vouchers
- Funding for homeless assistance programs

- Availability of Housing Choice Vouchers and Low Income Tax Credits

Child Welfare Agencies

The child welfare system was established as part of the 1935 Social Security Act "as a last resort attempt to protect children at risk of serious harm at home," and required "states to assume temporary custody of children whose parents were unwilling or unable to care for them" (Bazelon, 1998).

According to the Bazelon Center, nearly half of all children admitted into state child welfare systems "have at least one psychiatric diagnosis," and approximately "one third have three or more mental disorders" (Bazelon – Child Welfare, 2010). Many children are admitted into state child welfare systems because their families have no other options to provide their children with mental health services due to a lack of available community supports and family-centered treatment options. A 2001 Government Accountability Office study identified more than 12,000 instances of children assigned to the juvenile justice or child welfare systems for the sole purpose of accessing mental health services (Bazelon – Child Welfare, 2010). This type of custody relinquishment often occurs when families have exhausted their private insurance coverage and when they are not eligible for funding through Medicaid (Gruttadaro, 2009).

Providing funding and supports for early intervention treatment programs and community-based supports is one way for states to reduce the number of children placed in foster homes and the juvenile justice system when all other avenues have been exhausted by families. Wraparound services have strong evidence supporting their effectiveness at reducing custody relinquishment and institutionalization among youth (Bazelon – Child Welfare, 2010).

Indicators to measure improved community integration in the child welfare system may include:

- Number of instances of custody relinquishment
- Number of children in foster care settings with a diagnosed mental illness
- Funding for wraparound and therapeutic foster care programs
- Funding dedicated to early intervention and family-based treatment programs

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Appendix B:

Community Integration Self-Assessment Tool

A PILOT SELF-ASSESSMENT TOOL FOR STATE MENTAL HEALTH AGENCIES:

AN EFFORT TO PROMOTE COMMUNITY INTEGRATION OF PERSONS WITH SMI AND SED PLACED IN INSTITUTIONAL TREATMENT SETTINGS

July 25, 2012

Version 3.2

FINAL

Prepared for SAMHSA by the NASMHPD Research Institute, Inc. (NRI) in collaboration with members of the Technical Expert Panel and Advocates for Human Potential, Inc. (AHP)

The Pilot Self-Assessment Tool for SMHAs

The tool is comprised of two parts: (1) contextual information and (2) benchmark indicators. Although SMHAs will be relied upon to conduct the pilot self-assessment, the scope is not limited to the SMHA served population. Many community integration indicators that have been identified would require the inclusion of individuals served by Medicaid and other State agencies.

Part I gathers qualitative information that will provide context to the set of indicators that will be piloted. This information will help guide the expert consultants and the State staff in analyzing the trends and values of the indicators as they relate to the overall State system of mental health service delivery and State *Olmstead* activities.

Part II is a set of indicators classified according to dimensions of community integration. Serving as the basic framework for the pilot, this set of indicators will be used as a starting point of discussion with pilot States. Depending on the outcome of this discussion, the overall pilot design process will be finalized --- including the final selection of pilot indicators, agreement on the indicator specifications, identification of applicable institutional settings, and the assessment process.

During the pilot stage, technical expert consultants will work with State staff to access, analyze, and interpret the data that will be collected using the self-assessment tool. Although information from the self-assessment tool will not be submitted to SAMHSA or its contractors, participating States will be asked to submit a report (more details will be spelled out in the pilot protocol) that documents their experiences in the pilot, utility of the self-assessment tool, adequacy or inadequacy of the piloted indicators, and recommendations on how the process and the tool can be further refined.

Part I. Contextual Information

1. ***Role of SMHA in Olmstead implementation.*** Does your State have a current *Olmstead* Plan that addresses mental health? If yes, does that plan cut across multiple agencies, or is it targeted specifically toward the SMHA? What was the SMHA's role in development of the plan? What is the process for evaluating progress in implementing the plan (e.g., do you set targets)? **Please attach your plan (or provide a link to its location on the Web), and be sure to include the last revision date**.
2. ***State Olmstead Investigations.*** Is your state currently, or anticipating coming under an Olmstead investigation? If so, what is the focus of the investigation? What is the service population targeted?
3. ***Identifying and evaluating consumers in institutional settings***. How do you evaluate the status of consumers in institutional settings - please specify which settings are covered (i.e., Is there a mechanism that periodically assesses consumer's readiness for discharge? Do you identify consumers who are ready to leave and receive services in a community setting? Is there a process that facilitates timely discharge? Do you keep a waiting list of consumers ready for discharge, and if so, do you evaluate the waiting list?)
4. ***Interagency collaboration to promote community integration.*** How does the SMHA collaborate with other State agencies in promoting community integration (provide 2 to 3 examples)? For example, how is your SMHA working with State housing agencies to increase available community living settings?

5. ***Use of Medicaid to fund services that promote community integration***. Does your state have a Medicaid HCBS Waiver or Option that is used for mental health services? If yes, please describe. If not, is your state pursuing 1915(i) Option or 1915(c) waivers? Is your state using "Money Follows the Person" or other special Medicaid funding to support community mental health services?
6. ***Follow-up activities to sustain community transition/integration.*** Do you monitor consumers who transitioned from an institutional setting to the community? Do you have specific indicators to determine how well consumers transition from an institutional setting into the community? What specific indicators are used? If so, how often is the measurement activity conducted?
7. ***Diversion programs and related activities to keep consumers in integrated settings and prevent unnecessary institutionalization.*** Does your SMHA engage in any activities, or implement any programs to divert consumers to appropriate mental health services? If yes, please briefly describe these programs, the partnerships necessary to make them work, and how they are sustained.
8. ***Budget development to finance community integration.*** How does your SMHA incorporate community integration to facilitate transition and diversion in its budget development process? What data are gathered and used? How does your SMHA calculate the cost savings that can be achieved and what expenditures are needed?
9. ***Affordable housing.*** Does the cost of living/renting an apartment reduce the number and availability of housing vouchers available to persons with mental illness in your state?
10. ***Use of peer services.*** Does your state rely on peers to assist consumers with transitions into the community? If yes, please describe. What other types of peer support services are offered in your state?

Part II. Indicators of Community Integration

The identified set of indicators applies to persons with SMI and SED receiving services and care from any institutional settings who may potentially experience unjustified segregation. The following institutional settings included in the pilot are defined as follows:

State Psychiatric Hospitals provide services to consumers with high levels of need, including those who are a threat to themselves or others. These facilities provide acute care services, long-term treatment, and forensic services to mental health consumers. For the purpose of this pilot, long-term forensic patients (including sexually violent predators) are excluded from the pilot to the extent that they can be identified. Long-term, forensic patients include defendants in legal cases who were acquitted **not guilty for reason of mental insanity** (NGRI); defendants convicted as **guilty, but mentally Ill**; persons **transferred from prison to the State hospital** for mental health treatment and persons who have been determined **Incompetent to Stand Trial**. Additionally, States that have **Sexual Offender or Sexual Predator** laws that allow for a civil or criminal commitment to psychiatric facilities of convicted sex offenders deemed to need treatment should exclude these patients from the census for this pilot. The care and treatment of forensic patients, particularly the NGRI, is usually long term and their release is subject to more stringent conditions (usually approved by criminal justice courts) compared to patients under civil commitment. If a State's forensic population includes persons admitted for **pretrial competency evaluations** and these pre-trial evaluations are considered long-term, these should also be excluded from this pilot study.

Nursing Homes provide services to persons with significant medical conditions, who have been assessed as needing nursing level of care, but who are not acutely ill enough to require treatment in a hospital. The majority of nursing home residents tend to be older adults, but children and younger adults with disabilities are also served by nursing homes. Studies estimate that nearly 50 percent of those receiving care in a nursing home have a mental illness (Mental Health and Aging, 2012). Nursing homes provide on-site access to staff 24 hours per day.

Adult Care Homes and Other Congregate Living Settings: Each State has different nomenclature for adult care homes. For the purpose of this pilot, adult care homes are defined as any congregate residential settings targeted toward people with low income, where more than half of the residents have psychiatric disabilities. This setting includes group homes for persons with mental illness funded by State or county funds.

Residential Treatment Centers are often used to provide services to children; however, these facilities sometimes provide services to adults and older adults. All licensed residential treatment facilities are included in this pilot.

Jails and Prisons: Many persons with mental illnesses end up in jails or prisons due to a lack of alternative (diversionary) community services and other supports.

On succeeding pages, the set of indicators being considered for the pilot is grouped according to five dimensions of community integration taken from the perspective of a timely and appropriate transitioning of consumers from a segregated setting (institution) to a community setting. The five dimensions are: financing/resources, movement to community and recidivism, community capacity, housing, and well-being. Under each dimension, several indicators are presented. Several of these indicators are highlighted in red indicating that they have been identified as core indicators. All of the core indicators received unanimous support from all six members of the TEP; signifying the importance of these indicators.

Expectations from Pilot States:

SMHAs are expected to perform the following activities related to the piloting of the self-assessment tool:

1. Complete the contextual information outlined in Part 1 of the tool. Specific guidelines for completion of this requirement will be provided in the pilot protocol, which is a separate document.

2. From the set of indicators presented in Part 2, the pilot SMHAs are expected to aggregate, compile and analyze data as may be required to report the indicators. The TEP, in consultation with the pilot SMHAs, will identify the final set of indicators and corresponding applicable institutional settings that participating SMHAs will report at the end of the pilot period. Observing the given timeframe, pilot SMHAs, as they may so desire, will be encouraged to extend the scope by identifying additional indicators and/or institutional settings.

3. To the extent possible, pilot SMHAs will be requested to analyze at least three years' worth of data to allow for trending. When appropriate, the indicators should be applied to both children and adults. There should be a separate analysis of the indicators for each population. Please

note that although no data will be submitted to SAMHSA or to the contractors, the pilot SMHA, with assistance and guidance provided by the technical expert consultants, should be able to interpret the utility of these indicators in their overall effort of advancing community integration. The pilot protocol will include a recommended reporting template for State use.

4. Depending on the selected indicators and corresponding institutional settings, the pilot SMHA may need to reach out to other State agencies or institutions to collect data. This may involve identifying and accessing other available data sources. Along this line, a pilot SMHA with separate mental health systems for children and adults may need to coordinate their effort in order to have a single State reporting. Similarly, SMHAs that do not have direct access to the State hospital database may need to establish a process to facilitate data collection.

5. Track State experience in data collection, reporting, analysis, and interpretation. Submit a report to SAMHSA on their experience with the pilot as it relates to the usefulness of the self-assessment tool in providing guidance to State planning, programming, and allocating resources; effectiveness of the tool in identifying areas where the State shows strength in its capacity and areas where resources, training and technical assistance are needed; barriers and challenges in conducting the pilot and advancing the State community integration efforts; and recommendations to improve the self-assessment tool and process.

Benefits to SMHAs for participating in the pilot:

- Gain a better understanding of the strengths and weaknesses of the State mental health system
- Be able to focus *Olmstead* and MHBG Plans on identified community integration needs
- Help SAMHSA and the mental health field develop a self-assessment tool for use by other States and other systems

Recommended Set of Indicators for Advancing Community Integration

(Refer to notes at the end of this table)

Domain	Indicator	Indicator Specifications		Applicable Settings	Applicable Population	Data Sources	Additional Considerations
		Numerator	Denominator				
Financing/ Resources	Increase in funding for community-based programs	**1.** State MH expenditures on community-based programs	Total State mental health expenditures *(If possible, states should include SMHA, Medicaid, and any other funding sources the SMHA can identify. See Comment under Additional Considerations)*	SMHA/State System	SMHA served population, children and adults Should be reported at a minimum as Children & Adults (using state definitions) Pilot States recommended Reporting using URS age groups: (1) Children (age 0-17) and (2) Young adults 18-20 and (3) Adults 21 and over	Revenues & Expenditures Medicaid claims NDS for nursing homes SMHA MIS	Expenditure data may be collected as: • aggregate • by institution • by population (adults/children) • by service type <u>Comment:</u> If available, additional funding streams may be considered, but should be separated and identified as such.
		2. State expenditures on psychiatric hospital/inpatient care	Total State mental health expenditures *(If possible, states should include SMHA, Medicaid, and any other funding sources the SMHA can identify)*	SMHA/State System By institution (e.g. State Hospital, Nursing homes, RTCs)			
		3. Number of HCBS slots available	State SMI/SED population	SMHA/State System	Adults w/SMI Children w/SED	Medicaid SMHA MIS	<u>Alternate denominator:</u> Medicaid-eligible population or Number of persons with SMI/SED transitioning to the community
Movement to community and recidivism	Decrease in length of time waiting to be discharged	**4.** Number of persons with SMI/SED awaiting discharge by type of institution for more than three months	Institutional census # of persons discharged	By institution (see list of institutional settings)	Adults w/SMI Children w/SED	Institutional databases SMHA MIS Comment: At least one pilot state indicated they have a standardized assessment that identifies patients ready to be discharged. States that	<u>Alternate denominator</u>: # of persons with SMI/SED deemed eligible and ready to transition; Or average daily census, by institution <u>Other time factor</u> may be considered, e.g. awaiting discharge for 30 days or more than 1 year, etc.

Recommended Set of Indicators for Advancing Community Integration

(Refer to notes at the end of this table)

Domain	Indicator	Indicator Specifications		Applicable Settings	Applicable Population	Data Sources	Additional Considerations
		Numerator	Denominator				
						have such a measure should use it. If the state doesn't have such an assessment, they should skip this measure.	
	Decrease in Length of Stay	**5.** Number of Patients in the Institution w/ Length of Stay > One Year (at end of year) **6.** Number/% of Persons w/ LOS > 1 year discharged during year	1, Total Number of Persons in Institution 2. Number of Persons Served w/ LOS greater than one Year	By institution	Adults w/SMI Children w/SED	Institutional databases SMHA MIS	
	Decrease in readmission rate	**7.** Number of persons with SMI/SED readmitted to any (or same) type of institution within six months	Institutional census # of persons discharged	By institution (see list of institutional settings)	Adults w/SMI Children w/SED	Institutional databases SMHA MIS	Other time factor may be considered, e.g. readmission within 30 days Comment: At a minimum, states should look at readmissions to any state psychiatric hospital in their state. However, if states are able to measure readmission to any institutional setting (including jails, prisons, nursing homes, adult care homes, residential treatment centers, etc.) that would be a better measure. States should report which levels of institutional settings they are able to measure readmissions across.
	Decrease in utilization rate of institutional settings	**8.** Number of persons with SMI/SED admitted to institutional care	State SMI/SED population	By institution (see list of institutional settings)	Adults w/SMI Children w/SED	Institutional databases SMHA MIS	Use State definition for SMI/SED

Recommended Set of Indicators for Advancing Community Integration

(Refer to notes at the end of this table)

Domain	Indicator	Indicator Specifications		Applicable Settings	Applicable Population	Data Sources	Additional Considerations
		Numerator	Denominator				
		9. Average daily census (calculated by sum of total patient days during the year/365)	365 (for average daily census)	By institution (see list of institutional settings)	Adults w/SMI Children w/SED	Institutional databases	Alternate denominator: total bed capacity (for an alternate indicator – Percentage of capacity)
		10. Number of licensed psychiatric beds available	State SMI/SED population	By institution (see list of institutional settings)	Adults w/SMI Children w/SED	Institutional databases	Comment: Can be operationalized depending on each state's situation. For example, number of licensed beds available on the Last Day of the Year (each year), or whatever is easiest for states to report.
		11. Number of persons w/ SMI/SED declining transfer into the community	Number of persons awaiting discharge from an institution (see list of applicable settings)	By institution (see list of institutional settings)	Adults w/SMI Children w/SED	Institutional databases	Comment: This is a measure that some states track as part of their Olmstead settlements. If your state has this information, please report it. If your state does not allow patients to decline discharge, please indicate this in the contextual section.
		12. Number of persons w/SMI admitted to nursing homes identified through PASRR Assessments	Nursing Home Census	Nursing homes	Adults w/SMI	CMS Minimum Data Set	
Housing	Increase in percentage of persons with SMI receiving housing support services	**13.** Number of persons w/SMI receiving permanent supported housing	State SMI population Potential alt. denominator: Clients receiving Housing Services/ Supports	SMHA/State System	Adults w/SMI	State Housing Agency SMHA MIS	Number waiting for supported housing services

Recommended Set of Indicators for Advancing Community Integration

(Refer to notes at the end of this table)

Domain	Indicator	Indicator Specifications		Applicable Settings	Applicable Population	Data Sources	Additional Considerations
		Numerator	Denominator				
		14. Number of persons w/SMI receiving Supervised Housing	State SMI population	SMHA/State System	Adults w/SMI	State Housing Agency SMHA MIS	
		15. Number of persons w/SMI receiving Other Housing Services	State SMI population	SMHA/State System	Adults w/SMI	State Housing Agency SMHA MIS	
		16. Number of housing vouchers and slots available by type for persons w/mental illness	State SMI population	SMHA/State System	Adults w/SMI	State Housing Agency SMHA MIS HUD	
	Increase in housing subsidy per capita	**17.** # persons with SMI receiving housing subsidies	State SMI population	SMHA/State System	Adults w/SMI	State Housing Agency SMHA MIS	Housing Subsidies are not included in the vouchers/slots reported above. These are often supplements provided to consumers to help them make rental payments.
	Decrease in length of time on housing waiting lists	**18.** Number of persons with SMI on a housing waiting list	State SMI population	SMHA/State System	Adults w/SMI	SMHA/Provider housing MIS	How many consumers are on a waiting list by the length of time People are waiting: 3 months or less 3 to 6 months 6 months to 12 months 2 years (or more)
		19. Average wait time of for housing (months)		SMHA/State System	Adults w/SMI	SMHA/Provider housing MIS	
Community Capacity	Increase in utilization rate of community-based services	**20.** Number of persons w/SMI/SED receiving targeted	State SMI/SED population	SMHA/State System	Adults w/SMI Children w/SED	SMHA MIS	

Recommended Set of Indicators for Advancing Community Integration

(Refer to notes at the end of this table)

Domain	Indicator	Indicator Specifications		Applicable Settings	Applicable Population	Data Sources	Additional Considerations
		Numerator	Denominator				
		case management services					
		21. Number of persons with SMI receiving Assertive Community Treatment (ACT)	State SMI/SED population	SMHA/State System	Adults w/SMI	SMHA MIS	Alternate numerator: # of persons with SMI receiving ACT who have a history of institutionalization (this demonstrates how it helps with diverting people from institutions)
		22. Number of persons with SMI enrolled in supported employment	State SMI population	SMHA/State System	Adults w/ SMI	SMHA MIS	
		23a. Number of persons with SMI employed **23b.** Number of persons served by SMHA who were employed.	State SMI population	SMHA/State System	Adults w/SMI	SMHA MIS	
		24. Number of children with SED receiving wraparound services	Number of Medicaid-eligible children	SMHA/State System	Children w/SED	Medicaid SMHA MIS	Recommended combining all community services that are an alternative to institutionalization. Alternate numerators: Number of children with SED receiving any evidence-based practices – or – # of children with SED receiving TFC, MST, FFT, etc.
		25. Number of crisis residential beds available for inpatient diversion	State SMI /SED population	SMHA/State System	Adults w/SMI Children w/SED	SMHA MIS	Depends on state operational definition

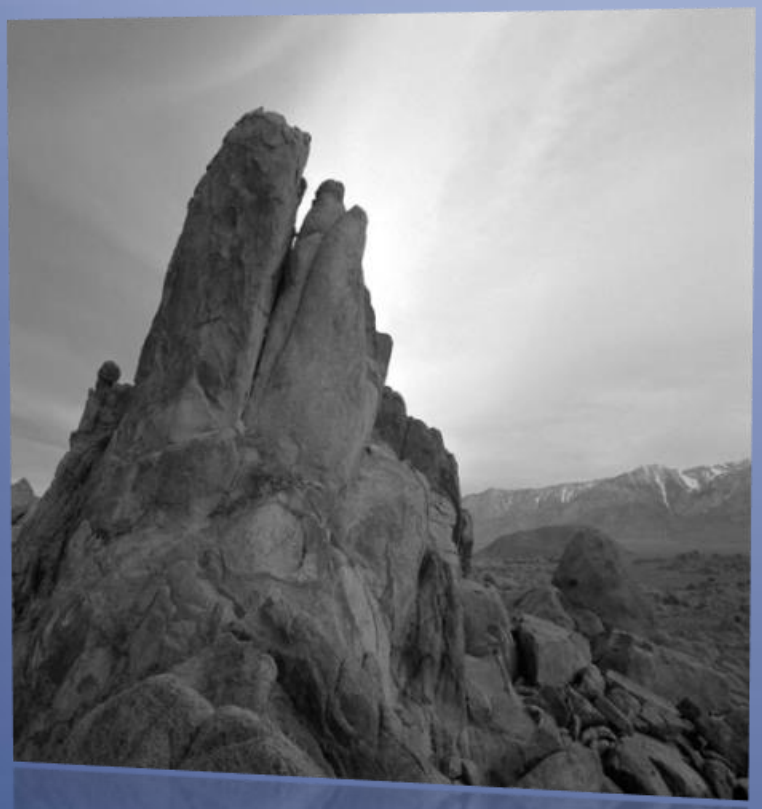
Recommended Set of Indicators for Advancing Community Integration

(Refer to notes at the end of this table)

Domain	Indicator	Indicator Specifications		Applicable Settings	Applicable Population	Data Sources	Additional Considerations
		Numerator	Denominator				
		26. Number of children receiving in-home services	State SED population	SMHA/State System	Children w/SED	SMHA MIS	Look at procedure code modifiers for place of service.
		27. Number of SED persons receiving family-support services	State SED population	SMHA/State System	Children w/SED	SMHA MIS	
		28. SMI emergency room admissions to general hospital	State SMI population	SMHA/State System	Adults w/ SMI	SMHA MIS	
Well-Being	Increase in the percentage of persons expressing social inclusion or connectedness	**29.** Number (%) of consumers reporting positive Social Connectedness (MHSIP Survey module)	State SMI population responding to consumer survey	SMHA/State System	Adults w/ SMI	SMHA MIS	
	Increase in percentage of consumers involved with peer run (self-help) services	**30.** Number of persons involved in peer support programs (including clubhouse programs)	State SMI population	SMHA/State System	Adults w/SMI	SMHA MIS	

Appendix C:

Implementation Tracking Guide for the Community Self-Assessment Pilot Project



Community Integration Self-Assessment Tool for State Mental Health Agencies: Pilot Project Final Report

INTRODUCTION

The Supreme Court decision in *Olmstead versus LC,* which provided a landmark interpretation of Title II of the Americans with Disabilities Act (ADA), determined that persons with disabilities are entitled to receive services and live in the most integrated settings appropriate for their care. Although there is no standard, universally-accepted definition, the Bazelon Center for Mental Health Law defines community integration as the individual's ability to "live in his own home, spend time with family and friends, find meaningful work, and enjoy the many small pleasures of being part of a community[1]." The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) is sponsoring an effort to assist states with *Olmstead* implementation and activities to promote social and community inclusion for adults with serious mental illness (SMI) and children with serious emotional disturbances (SED). The primary objective of this project is to provide CMHS with an evaluation of the Community Integration Self-Assessment Tool, so as to identify the project's strengths and weaknesses, areas for improvement, and assess the potential of expanding the project to include additional states.

Together with Advocates for Human Potential (AHP) and CMHS, NRI developed this implementation tracking guide to help the five pilot states evaluate the Community Integration Self-Assessment Pilot Tool. This guide will be used to evaluate the utility, burden, and amount of effort required by the states to complete the assessment. This is purely an evaluation of effort and usefulness; no data will be submitted by states. This tracking guide should be used in tandem with the self-assessment tool, entitled "A Pilot Self-Assessment Tool for State Mental Health Agencies."

[1] Bazelon. (2010). *Community Integration.*

INSTRUCTIONS

1. This is a free-flowing report form. Your narrative should not be restricted by the space provided on the report layout.
2. Reports should be submitted to Carol Bianco at Advocates for Human Potential (AHP) no later than Friday, August 31, 2012.

PROTOCOL

State: _____ **Phone:** _____

Contact: _____ **Email:** _____

SMHA Pilot Project Structure

1. The following questions document how the pilot project was managed within the SMHA. Which division within the SMHA had the lead in implementing this pilot project?

☐ Olmstead Coordinator ☐ Information Technology ☐ Quality Improvement
☐ Evaluation/Research ☐ Planning ☐ Others, specify:_____

2. Which other divisions within the SMHA participated in the pilot project? Please check all that apply.

☐ Budget/Finance ☐ Evaluation/Research ☐ Consumer Affairs
☐ Olmstead Coordinator ☐ Grants Office ☐ Legal
☐ Clinical/Program Staff ☐ Information Technology ☐ Others, Specify: _____
☐ Commissioner's/Director's Office ☐ Planning _____
☐ Contracts/Procurement ☐ Quality Improvement _____

Collaboration with Other State Agencies

3. Please provide information on the state agencies or organizations that the SMHA engaged/tried to engage in this pilot.

Agencies	Check each agency that the SMHA engaged/tried to engage in the pilot	Please describe briefly how the agency/agencies were engaged (e.g., provided access to agency database). If an agency declined to participate, please describe the reason cited, including if agency was unresponsive to requests.	Please cite 3 factors responsible for successfully engaging these agencies in the pilot
Attorney General	☐ Yes ☐ No		
Corrections	☐ Yes ☐ No		
Housing	☐ Yes ☐ No		
Medicaid	☐ Yes ☐ No		
Intellectual Disability/DD	☐ Yes ☐ No		
Substance Abuse	☐ Yes ☐ No		
Vocational Rehab	☐ Yes ☐ No		
Education	☐ Yes ☐ No		
Early Intervention	☐ Yes ☐ No		
Juvenile Justice	☐ Yes ☐ No		
Child Welfare	☐ Yes ☐ No		
Veterans Affairs	☐ Yes ☐ No		
Other Agency: _____	☐ Yes ☐ No		

4. Of the agencies that the SMHA engaged with for this pilot, please indicate which specific divisions you worked with:

Other State Agencies	Budget/ Finance Staff	Clinical/ Program Staff	Contracts/ Procurement/ Grants Staff	Director's Office	Evaluation/ Research Staff	IT Staff	Planning Staff	Legal	Consumer Affairs Staff	Other, specify
Attorney General	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Corrections	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Housing	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Medicaid	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Intellectual Disability/DD	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Substance Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Vocational Rehab	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Education	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Early Intervention	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Juvenile Justice	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Child Welfare	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Veterans Affairs	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Other Agency: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____

Evaluation of Individual Indicators

Please use the following grid to describe the population, settings, data, and burden to compile of each of the pilot indicators:

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or another initiative?	For what settings were you able to report?	For what populations were you able to report?	What data sources did you use?	If reported, did measure need to be modified?	Please explain modification	Please rank the BURDEN of collecting this indicator (1 = least, 3 = most)
Financing & Resources	Increase in Funding for Community-Based Programs	**1.** State MH expenditures on community-based programs	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3
		2. State expenditures on psychiatric hospital/ inpatient care	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or another initiative?	For what settings were you able to report?	For what populations were you able to report?	What data sources did you use?	If reported, did measure need to be modified?	Please explain modification	Please rank the BURDEN of collecting this indicator (1 = least, 3 = most)
				☐ Prisons ☐ Other_____					
		3. Number of HCBS slots available	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3
		Other: State Specific Measures (specify)	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		N/A	N/A	1 2 3
Movement to Community & Recidivism	Decrease in length of time waiting to be discharged	**4.** Number of persons with SMI/SED awaiting discharge by type of institution for more than three months	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3
		Other: State Specific	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes	☐ Children ☐ Adults		N/A	N/A	1 2 3

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or another initiative?	For what settings were you able to report?	For what populations were you able to report?	What data sources did you use?	If reported, did measure need to be modified?	Please explain modification	Please rank the BURDEN of collecting this indicator (1 = least, 3 = most)
		Measures (specify)		☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____					
	Decrease in length of stay	**5.** Number of patients in the institution with length of stay greater than one year (at end of year)	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		N/A	N/A	1 2 3
		6. Number or percentage of persons with a length of stay greater than one year discharged during the year	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		N/A	N/A	1 2 3
nt to Commun ity & Recidivis	Decrease in length of stay	Other: State Specific Measures (specify)	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms	☐ Children ☐ Adults		N/A	N/A	1 2 3

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or another initiative?	For what settings were you able to report?	For what populations were you able to report?	What data sources did you use?	If reported, did measure need to be modified?	Please explain modification	Please rank the BURDEN of collecting this indicator (1 = least, 3 = most)
				☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____					
	Decrease in readmission rate	**7.** Number of persons with SMI/SED readmitted to any (or same) type of institution within six months	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3
		Other: State Specific Measures (specify)	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		N/A	N/A	1 2 3

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or another initiative?	For what settings were you able to report?	For what populations were you able to report?	What data sources did you use?	If reported, did measure need to be modified?	Please explain modification	Please rank the BURDEN of collecting this indicator (1 = least, 3 = most)
	Decrease in utilization rate of institutional settings	**8.** Number of persons with SMI/SED admitted to institutional care	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3
Movement to Community & Recidivism	Decrease in utilization rate of institutional settings	**9.** Average daily census (calculated by sum of total patient days during the year/365)	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3
		10. Number of licensed psychiatric beds available	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3
	Decrease in utilization rate	**11.** Number of persons with	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or another initiative?	For what settings were you able to report?	For what populations were you able to report?	What data sources did you use?	If reported, did measure need to be modified?	Please explain modification	Please rank the BURDEN of collecting this indicator (1 = least, 3 = most)
	of institutional settings	SMI/SED declining transfer into the community		☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____					
		12. # of persons w/SMI admitted to nursing homes identified through PASRR Assessments		☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____			☐ Yes ☐ No		1 2 3
Movement to Community & Recidivism	Decrease in utilization rate of institutional settings	Other: State Specific Measures (specify)	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		N/A	N/A	1 2 3
Housing	Increase in percentage of persons with SMI receiving	**13.** Number of persons with SMI receiving permanent	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or another initiative?	For what settings were you able to report?	For what populations were you able to report?	What data sources did you use?	If reported, did measure need to be modified?	Please explain modification	Please rank the BURDEN of collecting this indicator (1 = least, 3 = most)
	housing supports	supported housing		☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____					
		14. Number of persons with SMI receiving supervised housing	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3
		15. Number of persons with SMI receiving other housing services	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3
Housing	Increase in percentage of persons with SMI receiving housing supports	**16.** Number of housing vouchers and slots available by type for persons with	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or another initiative?	For what settings were you able to report?	For what populations were you able to report?	What data sources did you use?	If reported, did measure need to be modified?	Please explain modification	Please rank the BURDEN of collecting this indicator (1 = least, 3 = most)
		mental illness		☐ Prisons ☐ Other_____					
		Other: State Specific Measures (specify)	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No	N/A	1 2 3
	Increase in housing subsidy per capita	**17.** Number of persons with SMI receiving housing subsidies	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3
		Other: State Specific Measures (specify)	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No	N/A	1 2 3

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or another initiative?	For what settings were you able to report?	For what populations were you able to report?	What data sources did you use?	If reported, did measure need to be modified?	Please explain modification	Please rank the BURDEN of collecting this indicator (1 = least, 3 = most)
Housing	Decrease in length of time on housing waiting lists	**18.** Number of persons with SMI on a housing waiting list	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3
		19. Average wait time for housing (months)	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3
		Other: State Specific Measures (specify)	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No	N/A	1 2 3

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or another initiative?	For what settings were you able to report?	For what populations were you able to report?	What data sources did you use?	If reported, did measure need to be modified?	Please explain modification	Please rank the BURDEN of collecting this indicator (1 = least, 3 = most)
Community Capacity	Increase in utilization of community-based services	**20.** Number of persons with SMI/SED receiving targeted case management services	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3
Community Capacity	Increase in utilization of community-based services	**21.** Number of persons w/SMI receiving Assertive Community Treatment (ACT)	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3
		22. Number of persons w/SMI enrolled in supported employment	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3
		23a. Number of persons with SMI	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or another initiative?	For what settings were you able to report?	For what populations were you able to report?	What data sources did you use?	If reported, did measure need to be modified?	Please explain modification	Please rank the BURDEN of collecting this indicator (1 = least, 3 = most)
		employed **23b. Alt:** # of persons served by SMHA who were employed		☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____					
		24. Number of children w/SED receiving wraparound services	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3
Community Capacity	Increase in utilization of community-based services	**25.** Number of crisis residential beds available for inpatient diversion	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3
		26. Number of children receiving in-home services	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or another initiative?	For what settings were you able to report?	For what populations were you able to report?	What data sources did you use?	If reported, did measure need to be modified?	Please explain modification	Please rank the BURDEN of collecting this indicator (1 = least, 3 = most)
				☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____					
		27. Number of SED persons receiving family support services	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3
		28. SMI emergency room admissions to general hospital	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3
Community Capacity	Increase in utilization of community-based services	Other: State Specific Measures (specify)	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No	N/A	1 2 3

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or another initiative?	For what settings were you able to report?	For what populations were you able to report?	What data sources did you use?	If reported, did measure need to be modified?	Please explain modification	Please rank the BURDEN of collecting this indicator (1 = least, 3 = most)
Well-Being	Increase in percentage of persons expressing social inclusion or connectedness	**29.** Number or percentage of consumers reporting positively about social connectedness (MHSIP Survey Module)	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3
	Increase in percentage of consumers involved with peer-run/self-help services	**30.** Number of adults with SMI involved in peer support programs (including clubhouse programs)	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		☐ Yes ☐ No		1 2 3
	Other	Other: State Specific Measures (specify)	☐ Yes ☐ No	☐ State Psych. Hospitals ☐ Nursing Homes ☐ RTF ☐ Emergency Rooms ☐ Adult Care Homes ☐ Jails ☐ Prisons ☐ Other_____	☐ Children ☐ Adults		NA	N/A	1 2 3

Notes on responses above (please use extra space as needed):

_____
_____
_____

Expectations, Outcomes, and Recommendations for Future Versions

Please provide a brief narrative that responds to the following questions:

- What did your state find beneficial about this pilot?
- What challenges/barriers did your state encounter as you completed this pilot? How were these barriers addressed?
- How did your state rely on the technical experts? Did you find their availability useful? What other types of technical assistance would be beneficial in the future?
- How does your state intend to use the results of the pilot? Were any policy changes initiated as a result of this initiative?
- Taken as a whole, how do these indicators reflect the work your state is doing to promote community integration?
- Has the SMHA begun to enter into any new data sharing agreements as a result of this initiative?
- Based on your experience with this pilot, what recommendations do you have for improving future versions of this project (e.g., make it more meaningful, more feasible for states to complete, etc.)?

Other Information

Please use the remaining space or add a separate page, if needed, to describe other pertinent information not covered above. This space may also be used to expand on the answers provided above. Please consider implementation factors you considered, or did not consider (but based on hindsight think would be useful) to successfully complete this project. Please share some wisdom from your experience in project implementation and tools that you used, or would like to use in the future, that could be beneficial to the process.

_____
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Appendix D:

Utility Evaluation Form for the Community Integration Self-Assessment

Community Integration Self-Assessment Tool for State Mental Health Agencies: Pilot Project Final Report

INSTRUCTIONS

The purpose of this document is to gather feedback about the usefulness of the Community Integration Self Assessment Tool in identifying strengths and weaknesses in your state's approach to community integration, forming policy around the development and continuance of community integration, and how effective the tool is in pre-empting involvement by the Department of Justice.

To complete this tool, please consult with staff at both the SMHA and other state agencies (when possible), including state Olmstead Representatives, State Mental Health Planners, and any other persons that can help determine whether the tool is helpful in identifying issues related to community integration, and how well the tool can help the state advance initiatives related to community integration and Olmstead compliance.

When completing this form, please provide a review of the following:

- Overall Domains: Are the domains included in this tool adequate to meet your state's needs at assessing community integration? If not, what domains should be included in future versions of the tool? Are there any domains that your state did not find useful that should be eliminated?
- Individual Measures: Please provide feedback on the utility of the measures for which your state was able to collect data. Please also provide feedback on the measures your state attempted to collect, but ultimately could not, as well as the measures your state did not even attempt to gather to help us determine how useful these measures would be assuming your state had the data available for analysis. When analyzing the individual measures, please consider how important and useful the measures are on their own, as well as in relation to other Olmstead measures the state may already be reporting.

The results of this form, along with the feedback from the Implementation Tracking Guide, will be used by NRI to develop a final report. The final report will include an analysis of the utility and burden for each indicator based on the results of the Leichardt scales from this document and the Implementation Tracking Guide. This analysis will be used to recommend measures for future iterations of the Community Integration Self-Assessment Tool.

Reports should be submitted to Kristin Roberts (kristin.roberts@nri-inc.org) at NRI no later than Friday, September 14, 2012.

State: _____

Contact: _____
Phone: _____
Email: _____
Please provide the names and titles of persons who contributed to the writing of this report. Involvement is not necessarily limited to SMHA staff:

_____
_____
_____
_____

Evaluation of Domains

Please answer the following questions to evaluate the utility of each domain:

- How useful is the domain in identifying challenges or successes related to the level of community integration of mental health consumers within your state?
- Are there any indicators that should be added to this domain to make it more meaningful (even if your state does not already collect them)? If so, please describe the additional indicators and what information they would provide that would be helpful to your state.
- Which indicators, if any, should be removed from this domain?
- Please provide any additional comments related to the domain.

Utility Rating of Individual Indicators

Please use the following grid to describe the utility of each of the pilot indicators:

Domain	Indicator	Numerator	Please rank the UTILITY of this indicator (1 = least, 3 = most)	Please provide a brief narrative to support your utility rating. For example, if an indicator is rated the least useful, please specify its weaknesses. If the indicator is important, but the current specifications render it useless, please propose modifications for improvement or an alternative indicator.
Financing & Resources	*Additional comments on overall domain may be entered here.*			
	Increase in Funding for Community-Based Programs	**1.** State MH expenditures on community-based programs	1 2 3	
		2. State expenditures on psychiatric hospital/ inpatient care	1 2 3	
		3. Number of HCBS slots available	1 2 3	
		Other: State Specific Measures (specify)	1 2 3	
Movement to Community & Recidivism	*Additional comments on overall domain may be entered here.*			
	Decrease in length of time waiting to be discharged	**4.** Number of persons with SMI/SED awaiting discharge by type of institution for more than three	1 2 3	

Domain	Indicator	Numerator	Please rank the UTILITY of this indicator (1 = least, 3 = most)	Please provide a brief narrative to support your utility rating. For example, if an indicator is rated the least useful, please specify its weaknesses. If the indicator is important, but the current specifications render it useless, please propose modifications for improvement or an alternative indicator.
		months		
Movement to Community & Recidivism	Decrease in length of time waiting to be discharged	Other: State Specific Measures (specify)	1 2 3	
	Decrease in length of stay	**5.** Number of patients in the institution with length of stay greater than one year (at end of year)	1 2 3	
		6. Number or percentage of persons with a length of stay greater than one year discharged during the year	1 2 3	
	Decrease in length of stay	Other: State Specific Measures (specify)	1 2 3	
	Decrease in readmission rate	**7.** Number of persons with SMI/SED readmitted to any (or same) type of institution within six months	1 2 3	
		Other: State Specific Measures (specify)	1 2 3	

Domain	Indicator	Numerator	Please rank the UTILITY of this indicator (1 = least, 3 = most)	Please provide a brief narrative to support your utility rating. For example, if an indicator is rated the least useful, please specify its weaknesses. If the indicator is important, but the current specifications render it useless, please propose modifications for improvement or an alternative indicator.
Movement to Community & Recidivism	Decrease in utilization rate of institutional settings	**8.** Number of persons with SMI/SED admitted to institutional care	1 2 3	
	Decrease in utilization rate of institutional settings	**9.** Average daily census (calculated by sum of total patient days during the year/365)	1 2 3	
		10. Number of licensed psychiatric beds available	1 2 3	
	Decrease in utilization rate of institutional settings	**11.** Number of persons with SMI/SED declining transfer into the community	1 2 3	
		12. # of persons w/SMI admitted to nursing homes identified through PASRR Assessments	1 2 3	
	Decrease in utilization rate of institutional settings	Other: State Specific Measures (specify)	1 2 3	
o u s i	*Additional comments on overall domain may be entered here.*			

Domain	Indicator	Numerator	Please rank the UTILITY of this indicator (1 = least, 3 = most)	Please provide a brief narrative to support your utility rating. For example, if an indicator is rated the least useful, please specify its weaknesses. If the indicator is important, but the current specifications render it useless, please propose modifications for improvement or an alternative indicator.
	Increase in percentage of persons with SMI receiving housing supports	**13.** Number of persons with SMI receiving permanent supported housing	1 2 3	
		14. Number of persons with SMI receiving supervised housing	1 2 3	
		15. Number of persons with SMI receiving other housing services	1 2 3	
	Increase in percentage of persons with SMI receiving housing supports	**16.** Number of housing vouchers and slots available by type for persons with mental illness	1 2 3	
		Other: State Specific Measures (specify)	1 2 3	
	Increase in housing subsidy per capita	**17.** Number of persons with SMI receiving housing subsidies	1 2 3	
Housing	Increase in housing subsidy per	Other: State Specific Measures	1 2 3	

Domain	Indicator	Numerator	Please rank the UTILITY of this indicator (1 = least, 3 = most)	Please provide a brief narrative to support your utility rating. For example, if an indicator is rated the least useful, please specify its weaknesses. If the indicator is important, but the current specifications render it useless, please propose modifications for improvement or an alternative indicator.
	capita	(specify)		
	Decrease in length of time on housing waiting lists	**18.** Number of persons with SMI on a housing waiting list	1 2 3	
		19. Average wait time for housing (months)	1 2 3	
		Other: State Specific Measures (specify)	1 2 3	
Community Capacity	*Additional comments on overall domain may be entered here.*			
	Increase in utilization of community-based services	**20.** Number of persons with SMI/SED receiving targeted case management services	1 2 3	
		21. Number of persons w/SMI receiving Assertive Community Treatment (ACT)	1 2 3	
Community Capacity	Increase in utilization of community-based services	**22.** Number of persons w/SMI enrolled in supported	1 2 3	

Domain	Indicator	Numerator	Please rank the UTILITY of this indicator (1 = least, 3 = most)	Please provide a brief narrative to support your utility rating. For example, if an indicator is rated the least useful, please specify its weaknesses. If the indicator is important, but the current specifications render it useless, please propose modifications for improvement or an alternative indicator.
		employment		
		23a. Number of persons with SMI employed **23b. Alt:** # of persons served by SMHA who were employed	1 2 3	
		24. Number of children w/SED receiving wraparound services	1 2 3	
		25. Number of crisis residential beds available for inpatient diversion	1 2 3	
		26. Number of children receiving in-home services	1 2 3	
		27. Number of SED persons receiving family support services	1 2 3	
		28. SMI emergency room admissions to general hospital	1 2 3	
Community Capacity	Increase in utilization of community-based services	Other: State Specific Measures (specify)	1 2 3	

Domain	Indicator	Numerator	Please rank the UTILITY of this indicator (1 = least, 3 = most)	Please provide a brief narrative to support your utility rating. For example, if an indicator is rated the least useful, please specify its weaknesses. If the indicator is important, but the current specifications render it useless, please propose modifications for improvement or an alternative indicator.
Well-Being	*Additional comments on overall domain may be entered here.*			
	Increase in percentage of persons expressing social inclusion or connectedness	**29.** Number or percentage of consumers reporting positively about social connectedness (MHSIP Survey Module)	1 2 3	
	Increase in percentage of consumers involved with peer-run/self-help services	**30.** Number of adults with SMI involved in peer support programs (including clubhouse programs)	1 2 3	
	Other	Other: State Specific Measures (specify)	1 2 3	

Please provide any comments or information you want to share regarding your experience in the pilot that may help improve the process and utility of the tool:

Appendix E:

Expert Panel, State Representatives, Project Staff

Policy Expert Panel:

(*Representatives with an asterisk serve dual roles on this project; either as project staff or members of the TEP)

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