Community Integration Self-Assessment Tool for SMHAs

2013 Pilot Report

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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 14 years since the *Olmstead* decision, state governments, in particular state 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 employed strategies to prevent lengthy and inappropriate use of restrictive settings.

In Fiscal Year 2012, SAMHSA provided initial funding to develop and pilot a self-assessment tool on community integration designed for use by SMHAs. The original tool was intended to provide SMHAs an opportunity to proactively identify their strengths and weaknesses around community integration for persons with mental illness; however, the tool was not intended to replace a comprehensive outcomes or performance management system. Based on the success of the FY12 pilot, SAMHSA extended funding for this initiative for two more fiscal years (FY13 and FY14) to refine the pilot instrument to address additional community integration concerns and work with additional states.

The FY13 pilot followed a similar format as the FY12 pilot. Guided by a Policy Expert Panel (PEP) of senior federal and SMHA leadership, and assisted by the Technical Expert Panel (TEP), this pilot tested the burden and utility of a set of 54 measures that comprised the pilot self-assessment tool. Five SMHAs (Delaware, Illinois, Minnesota, New Jersey, and Oregon) tested the tool during the Spring, Summer, and Fall of 2013.

This report describes the process for the development of the FY13 Community Integration Self-Assessment Tool, as well as the experiences of the five pilot states testing the tool. More specifically, it contains a process evaluation, an overview of each state's current community integration efforts, and the pilot states' evaluations of the burden and utility of each of the individual measures.

METHODOLOGY

This version of the Community Integration Self-Assessment Tool and Pilot Study is an enhanced version that builds on the original tool and pilot developed under a prior SAMHSA contract to AHP in 2012. As in the 2012 effort, the 2013 pilot relied on two expert panels, the PEP and the TEP, to guide the development and implementation of the tool. The PEP reviewed the results of the 2012 pilot and provided feedback to the project staff and the TEP.

Refining the Tool for 2013

Based on the feedback received from the PEP and original pilot states, project staff collaborated with the TEP and SAMHSA to refine the tool for 2013. Potential measures for the 2013 cycle were divided into three groups: 1) measures that were successfully tested during the initial phase that should be continued in 2013, 2) measures from the pilot that required additional clarification or modification, and 3) new measures identified by SAMHSA and the TEP for the 2013 study. After much consideration, 54 measures were selected for inclusion in the 2013 pilot. These measures were spread across seven domains reflecting important aspects for measuring community integration:

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

Two of the above seven domains were new areas added for the 2013 pilot: At-Risk and Policy. Additional consideration was given to the Housing domain to assist states in collecting data around these measures.

The final tool consisted of two parts: Part I included a set of questions to gather each state's current community integration efforts, and Part II contained 54 recommended measures across the seven domains (see Appendix B).

At-Risk Population

In addition to refining the measures tested in the original phase, SAMHSA also asked the TEP to assess the utility of expanding the focus of the 2013 pilot beyond those individuals living in institutional settings to include persons living in the community who are at risk of needing institutional care. Based on conversations with the original pilot states, the TEP decided to expand the focus to include persons with a mental illness living in the community, who may be at risk of institutionalization, including:

- Persons with a history of repeated prior psychiatric hospitalization
- Persons with high levels of emergency room use
- Persons with a history of homelessness
- Persons who have come into contact with the criminal justice system
- Children placed in foster care
- Children involved in the juvenile justice system

To help states narrow the scope of the at-risk population, the TEP recommended limiting the at-risk population to those persons who have received prior community mental health services from the SMHA.

Housing

In 2012, measures under the housing domain proved the most challenging to states. Of the original seven housing measures, three yielded no results from any pilot states. In order to help states report housing measures in 2013, the measures were refined to provide clarification about their intent, and additional guidance around accessing housing databases was provided. Staff from the Department of Housing and Urban Development (HUD) was very helpful in identifying potential federal reporting systems that SMHAs might access to identify housing supports and subsidies being provided to persons with mental illness.

Policy

The 2013 tool contained 9 new measures aimed to capture policies, procedures, regulations, changes in financing, and other systems states have in place to minimize or eliminate unnecessary institutionalization. The existence of such policies could help states identify potential problems and respond to them before they become pervasive. The adoption of new policies and regulations to promote community integration also reflect tangible actions that states can take to promote community integration. While data from other domains remained with the states, states had the option to share the information collected through the policy domain with SAMHSA.

RESULTS AND KEY FINDINGS

Similar to 2012, states were not asked to submit the data they collected on these measures (with the exception of the policy domain); however, they were asked to submit an evaluation of utility and burden for each of the measures. All five pilot states submitted evaluations of burden; however, only four of the five pilot states provided feedback on the utility of the measures. At the time of publication, Oregon had not submitted their utility evaluation.

Domains

Every state collected data for at least one measure within each domain. Of the seven domains, the housing domain posed the biggest challenge to the most number of states, with two measures only reported by one state. Even with the additional guidance, states expressed difficulty accessing housing data through local housing authorities, and experienced difficulty gaining access to HUD databases due to security restrictions. The financing and resources domain had one measure that none of the states could report (number of HCBS slots available); however, this measure is only applicable to those states with 1915(i) waivers used to provide home and community-based mental health services, which none of the pilot states have.

Community Integration Measures

States tested and evaluated the utility and burden of each measure on a five-point Likert scale (1 = least useful/least burdensome to 5 = most useful/most burdensome). Ideal performance measures have the most utility and are the least burdensome to collect. The following are highlights of the pilot results:

- States varied in the number of measures they were able to collect, ranging from 32 to 37 of the 54 recommended measures. Data collected for each measure varied across states by type of populations, settings, and data sources.
- Fourteen measures were collected by all five pilot sates.
- Fifty-one of the 54 recommended measures received a utility rating higher than 3, indicating high utility (measures were scored on a Likert scale of 1 to 5, with 5 = most useful, and 1 = least useful).
    - Two measures, both in the policy domain, received the highest rating of 5
    - Thirty-one additional measures received a rating of 4 or higher
    - Overall, measures in the policy domain received the highest utility rating, averaging 4.54
    - Overall, measures in the movement to community and recidivism domain received the lowest utility rating, averaging 3.86
- Forty-four of the 54 recommended measures received a burden rating less than 3, indicating a low collection burden (measures were scored by SMHAs regarding the degree of difficulty and burden associated with compiling information for each measure using a five-point Likert scale; 1 = least burdensome, and 5 = most burdensome. Given that states usually only evaluated measures they were able to collect, there may be a skewed bias toward less burdensome, since some measures may have been so burdensome that states did not bother to evaluate).
    - Seven measures received a burden rating of 3 or higher, but less than 4. None of the measures received the highest burden rating of 5 from all reporting pilot states.
    - Overall, measures in the community capacity domain received the highest burden evaluation, averaging 2.45.
    - Overall, measures in the movement to community domain received the lowest burden evaluation, averaging 1. 45.
- Overall, measures that were used in the 2012 cycle of the pilot scored higher on utility evaluations in 2013, and were evaluated as less burdensome in 2013.

NEXT STEPS

Given that the overwhelming majority of measures were rated as highly useful and low burden to states, future iterations of this pilot should not focus on expanding the tool, but rather should focus on helping states use the results to better understand how states use the tool, and how well they are doing comparatively with community integration on a national, regional, and even local level. Potential efforts include:

- Quickly complete work with the TEP and SAMHSA to make any final changes to the tool, including dropping measures of low utility and completing the review of DOJ recommendations/comments.
- Encourage states to develop intra-state regional benchmarks to determine which geographic areas within their states are excelling or struggling with particular aspects of community integration.
- Provide benchmark results from other state and national studies. These benchmarks can help individual states identify whether their results are in the best possible range of performance. These benchmarks could be incorporated into a data dashboard that allows states to enter their data to see how well they align with national and regional rates.
- Create a Community of Practice that expands the number of participating states. Through a series of webinars and other training, SMHAs will be encouraged to use portions of the CISA tool to begin assessing their community integration plans. Rather than repeating the 2013 Pilot, the Community of Practice approach will permit state to have the freedom to use the tool in the most appropriate manner for their state. States will be encouraged to provide feedback on their experience; including how the tool was used, what meaningful results and changes (if any) were witnessed as a result of the tool, and suggestions for improved implementation. The Community of Practice could be enhanced with orientation and training webinars led by members of the TEP and/or prior pilot state staff. In addition, community listservs and periodic conference calls could be established to facilitate state use of the tool.
- Use the experiences of the Pilot states and the Community of Practice participants to develop a toolkit that provides detailed guidance on data collection and interpretation to better understand state efforts related to community integration.
- Targeted work to address the need to improve data on housing supports available to mental health consumers. The one community integration domain where states struggled to get good information was measures of housing subsidies and supports. The project could work with one or two Pilot states to serve as a case study to improve understanding of how to access, link, analyze, and interpret housing data sets (including

HUD data) (e.g., select one or two states to receive targeted technical assistance on all measures within the housing domain to serve as a model for future states).

- Greater collaboration with other government agencies, such as HUD and the DOJ, could be helpful in assisting states collect data for measures they have traditionally had trouble collecting. Such partnerships could encourage greater collaboration between agencies at the state level.

INTRODUCTION

The Supreme Court decision, *Olmstead versus L.C.*, provided a landmark decision that Title II under the Americans with Disabilities Act (ADA) that persons with disabilities are entitled to receive services and live in the most integrated settings appropriate for their care. During the 14 years since the *Olmstead* decision, state governments, mental health systems in particular, 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 appropriate mental health services and supports. SMHAs have also developed alternative services and implemented strategies to prevent lengthy and inappropriate use of restrictive settings.

In fiscal year 2012, SAMHSA sponsored the development and pilot test by five SMHAs of a self-assessment tool on community integration. This pilot community integration self-assessment tool provides SMHAs an opportunity to proactively identify their strengths and weaknesses, and identify problems that may disrupt efforts around community integration in their state prior to *Olmstead* litigation. The measures contained within the pilot tool were specific to community integration and were not intended to replace a comprehensive state mental health outcomes or performance measurement system. The 2012 community integration pilot found most measures to be useful to SMHAs in identifying strengths and gaps related to community integration, as well as areas of the tool needing refinement and enhancement.

This year's Task 6.4 and 6.5 pilot built on the work of the initial phase to revise and enhance the Community Integration Self-Assessment Tool, and to test that tool with at least five states (Delaware, Illinois, Minnesota, New Jersey, Oklahoma and Oregon) over each of the next two years. At SAMHSA's request, the 2013 pilot focused on updating the community integration measures (Task 6.4) to include persons at risk of institutionalization, information about state policies and regulations that support community integration, and enhanced housing information.

As with the initial pilot, AHP and NRI worked with two expert panels to develop the pilot design process, finalize recommended measures, and plan the pilot study. The Policy Expert Panel (PEP) represented a diverse group of stakeholders and experts involved in efforts to advance community integration in public mental health care. The PEP helped identify the scope and populations to be included in the pilot. The Technical Expert Panel (TEP) was comprised of six individuals with expertise in state behavioral health data systems, performance measurement, planning, *Olmstead* issues, and state community integration efforts. At the end of FY12, SAMHSA awarded a new contract to JBS International to continue this effort to refine and expand the Community Integration Self-Assessment Tool with a group of six states: Delaware, Illinois, Minnesota, New Jersey, Oklahoma, and Oregon.

METHODOLOGY

This version of the Community Integration Self-Assessment Tool and Pilot Study is an enhanced version that builds on the original tool and pilot, developed under a prior SAMHSA contract to AHP in 2012.

DEVELOPMENT OF THE SELF-ASSESSMENT TOOL: PHASE I (2012)

A literature review on community integration was conducted in February 2012 to guide the development of the tool (Appendix C). The literature review identified definitions of community integration, potential populations, and appropriate treatment settings, as well as potential state and national data sources that could be used to complete the pilot. Data and performance measures being requested or submitted by SMHAs in recent and ongoing *Olmstead* lawsuits were also considered during the development of the measures.

Together with the PEP, AHP and NRI established the scope and populations for the first year of the pilot. The populations and service settings identified by the PEP included persons receiving care in institutions, persons receiving services in the community at risk of institutionalization, as well as those living in the community with mental illnesses not receiving any mental health services but are also at risk of institutionalization. The PEP recommended that measures for both children and adults, persons served by agencies other than the SMHA (e.g., Medicaid, child welfare, juvenile justice, criminal justice, etc.), and persons who have only received services in the private sector.

Due to limitations in both the time available to states to complete the study, and access to information necessary to test the measures, the TEP recommended limiting the focus of the first pilot to those persons with mental illnesses living in institutional settings and the supports necessary to help move consumers out of these settings into their own communities. SAMHSA and the PEP approved this recommendation. The five primary settings the original tool addresses are:

- State psychiatric hospitals
- Nursing homes
- Adult care homes and other congregate living settings
- Residential treatment centers, and
- Jails and prisons

The final self-assessment tool contained two parts: Part I included a set of contextual questions to better understand each state's current community integration efforts; and Part II contained 30 recommended measures across five domains. Each domain contained from two to nine specific measures. The domains from year one are:

- Financing and resources
- Movement to the community and recidivism
- Community capacity
- Housing, and
- Well-being

DEVELOPING RECOMMENDED MEASURES FOR 2013

At the initial project kickoff meeting with the SAMHSA Task Lead, it was recommended that the development of state self-assessment community integration measures for 2013 build on the measures tested during the 2012 pilot. The TEP, NRI, AHP, and participating SAMHSA staff reviewed the results of the initial pilot study and identified three sets of measures for the 2013 pilot:

1. Measures that were successfully tested during the initial phase that should be continued in 2013,
2. Measures from the pilot that required additional clarification or modification, and
3. New measures identified by SAMHSA and the TEP for the 2013 study.

To better understand the 2012 pilot states' experiences using the community integration tool, NRI staff held brief conference calls with each of the original five pilot states. These calls allowed the pilot state staff to debrief about their experiences with particular measures and get a sense of the utility of the overall pilot process. Based on the summary of individual state comments, the TEP requested additional information from the pilot states for several measures that had variation in utility scores from the pilot states. A conference call that included representatives from each of the original five pilot states, SAMHSA, and the TEP was held that addressed ten particular measures that received wide variation in utility scores by the pilot states, and that elicited recommendations from the pilot states about the utility of these measures.

In addition to refining the measures tested in the original phase, SAMHSA also asked the TEP to assess the utility of expanding the focus of the 2013 pilot beyond a focus on individuals living in institutional settings and the supports needed to integrate them into the community, to include persons living in the community who are at risk of needing institutional care if appropriate community supports and services are not available. The TEP discuss this expanded focus amongst themselves and with the pilot states to explore the availability of data to complete measures that assess at-risk populations. In order to help states participating in the 2013 pilot, the TEP recommended including several groups of consumers currently residing in their own communities as an expanded population for at risk:

- Persons with a history of repeated psychiatric hospitalization
- Persons with repeated emergency room use
- Persons with a history of homelessness
- Persons with criminal justice system contacts
- Children placed in foster care
- Children involved in the juvenile justice system

In January, the PEP met by conference call to review the recommendations of the TEP regarding the scope of population and set of potential measures for the 2013 pilot. The PEP supported the concept of expanding the pilot to include clients at risk of institutionalization and suggested several additional programs that states are implementing to help address at-risk consumer needs, including 24-hour hotlines, warm lines staffed by mental health consumers, 24-hour psychiatric assessment facilities, and crisis/respite beds. The PEP also supported retaining the original pilot measures with modified housing measures to facilitate state reporting for the 2013 pilot.

Modified Measures

Based on the utility and burden evaluations; as well as additional feedback from the original five pilot states, the TEP, PEP and SAMHSA; each of the original measures were determined to be useful and were retained for the second phase of the pilot. However, ten of the original measures were modified. One of the key recommendations that emerged from conversations with the pilot states was that all of the measures could be extremely useful, but only if they are relevant to a particular state's system. Therefore, it was recommended that states only report on measures applicable to their systems. For instance, *Measure 3: Number of HCBS Slots Available* only applies to those states that have HCBS waivers; therefore, only those states with 1915(c) waivers should respond to Measure 3.

Housing Measures

Measures under the housing domain proved the most challenging to the original pilot states. Of the original seven housing measures requested, pilot states were unable to compile information for three. The measures that states were unable to complete in 2012 are:

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

Each of these measures received high ratings of utility from the 2012 pilot states, and would be beneficial to states if the data were made available.

In order to provide guidance for the measure, *Number of Housing Vouchers and Slots Available by Type for Persons with Mental Illness*, several other housing measures, including

number of people receiving permanent supported housing, supervised housing, and other housing services required additional clarification. These measures were intended to reflect the number of people receiving services through housing programs subsidized by, and under the direct control of the SMHA; therefore, they do not receive funding from the Department of Housing and Urban Development (HUD). These measures were modified in 2013 to clarify that there is no overlap with HUD-supported programs, which are separately counted.

HUD-funded programs are likely to represent the bulk of subsidized housing available to the SMI population in most states. All HUD programs can be grouped together, or shown separately. The only other substantial source of subsidized housing identified by the TEP was supervised housing supported by the Department of Veterans Affairs. Veterans' supported housing programs are principally funded through the HUD-VASH (Veterans Affairs Supported Housing) program.

The original pilot states were unable to collect data about the number of housing vouchers and slots available for persons with mental illness due to the limited amount of time states had to complete the pilot, as well as no preexisting data sharing agreements between the SMHAs and local housing authorities. The decentralized nature of housing authorities also presented a challenge to SMHAs trying to capture this information.

Upon further investigation, members of the TEP discovered a potential method for states to operationalize the numerator for the measure, *Number of Housing Vouchers and Slots Available by Type for Persons with Mental Illness*, based on estimates developed by Vermont of persons served in its community mental health system while receiving HUD Section 8 Vouchers for calendar year 2004[1]. The following are the key steps in the process that were recommended to the 2013 pilot states to access such data:

1. *Permission*: Obtain permission to access the HUD Public Information Center (now IMS/PIC; http://www.hud.gov/offices/pih/systems/pic/). This database includes personal identifying and demographic information (e.g., name, social security number, date of birth, and gender; form 50058 provides data collection detail) about persons residing in HUD-subsidized programs, including Section 8 and public housing. Once access is obtained, relevant data for the state can be downloaded into a file for further processing. Permission will require procedures to assure compliance with HUD's privacy and confidentiality regulations.
2. *Source of Mental Health Consumer Data:* The HUD files do not include information that would directly identify an individual as seriously mentally ill or psychiatrically disabled; therefore, it is necessary to have a second file with individual data on

[1] Pandiani, J., & Morabito, S. (2005, January 28). *Vermont Mental Health Performance Indicator Project.* Retrieved January 30, 2013, from http://mentalhealth.vermont.gov/sites/dmh/files/pip/DMH-PIP_Jan_28_2005.pdf.

persons that includes personal identifying information that can be matched to the personal identifiers in the HUD file. The second file might include individuals in the SMHA client information system, or selected individuals who are users of mental health services in the State Medicaid claims system. Vermont employed its mental health client information system.

3. *Matching:* States can undertake procedures for either probabilistic or exact matching. Either method will likely require assistance from an outside contractor. Vermont employed the "probabilistic population estimator," a proprietary system available through The Bristol Observatory (http://www.thebristolobservatory.com). Exact matching algorithms are also available. Culhane, Metraux, and Hadley from the University of Pennsylvania employed this strategy in their widely-cited study of housing for homeless individuals in New York City[2].
4. *Analysis:* After processing the two files for person matches (or estimates of matches), estimates of the number of persons with SMI who reside in HUD-subsidized housing can likely be developed by program type (e.g., Section 8, Public Housing). Depending upon other data available and the sample sizes, estimates for subgroups of interest can also be developed.

HUD has two other publically-available databases that provide information on subsidized housing programs at both state and sub-state levels that may be helpful for states completing the housing measures. The databases are:

- Picture of Subsidized Households (PSH; http://www.huduser.org/portal/picture/picture2009.html)
- Resident Characteristics Report (RCR; http://www.hud.gov/offices/pih/systems/pic/50058/rcr/index.cfm)

Using online tools, aggregated reports showing the number of housing units, as well as tables with demographic characteristics of households and residents can be produced from each database. States can use these to provide a view of the subsidized housing inventory, and the characteristics of occupants. The databases do not provide information that allows the breakdown of data by persons with SMI or psychiatric disabilities. The only way to determine these figures is through matching HUD files with appropriate mental health client files, as described above.

[2] Culhane, D.P., Metraux, S., & Hadley, T.R. (2002). The Impact of Supportive Housing for Homeless People with Severe Mental Illness on the Utilization of the Public Health, Corrections, and Emergency Shelter Systems: The New York-New York Initiative. *Housing Policy Debate,* 13.1. Retrieved from http://works.bepress.com/metraux/16/.

Expanding the Population to Include Persons At Risk of Institutionalization

Persons with a mental illness who are at risk of institutionalization are a priority population for SAMHSA and the Department of Justice, and have been the focus of several recent *Olmstead* settlement decrees. Because of their importance, the at-risk population was included in the expanded population for year two of the pilot. Setting bounds for this population, and selecting indicators to operationalize this population was potentially difficult since persons at risk of institutionalization may have had no prior contact with the state mental health authority, or any other public system that could signify their vulnerability for institutionalization. To make this population more manageable to quantify, it was recommended that Pilot States focus on persons with a mental illness who have had previous repeated psychiatric hospitalizations; multiple interactions with emergency departments at general hospitals; are homeless; and/or have had interactions with the criminal justice, juvenile justice, or child welfare systems. Measures focused on the capacity of the community setting that prevent institutionalization could also serve as indicators about a state's readiness to serve the larger at-risk population in the community.

Risk of institutionalization means persons at risk of going into any institutional setting, including residential treatment facilities, adult care homes, nursing homes, and state hospitals, among other restrictive settings that may be relied upon due to a lack of community resources. To avoid and minimize unnecessary use of institutional settings, SMHAs are providing early intervention, crisis, and other community services and supports that allow persons at risk of institutionalization to instead remain living in their own communities.

Because it is difficult to identify all persons who are at risk of institutionalization, the TEP recommended the inclusion of several measures of services that could help divert at-risk persons away from institutional settings. In developing measures for the at-risk populations, the TEP recommended three potential levels or types of measures:

1. Assuring that persons in at-risk groups (such as homeless, high ER users, persons with repeated hospitalizations, etc.) are addressed in existing measures of community capacity. For example, measuring to make sure that persons who are homeless are accessing Targeted Case Management services (measure 20) or are receiving Assertive Community Treatment (measure 21).
2. Measures of the extent to which SMHAs are offering an array of services and supports designed to provide early intervention or community supports that reduce the need for institutional services. This level of measure would address if SMHAs have certain initiatives, such as 24-hour hotlines, warm lines, crisis services available, rather than creating a measure based on the rate of these service usage.
3. Measures that document the rate of utilization of services designed to help keep at-risk groups out of institutional settings. An example of this third level measure is the number

of consumers served by 24-hour crisis or respite beds in the community during the year, divided by the number of adults with a mental illness on SSI/SSDI roles in the state.

Programs identified as important to help reduce institutional use by persons at risk include:

- 24-hour hotlines
- Warm lines staffed by mental health consumers
- Crisis apartments/respite beds
- 24/7 mobile crisis teams
- Homeless outreach programs

Many individuals considered at risk for institutionalization were also likely to be captured within the existing domains for which performance indicators have already been established. To determine the best approximation of the numbers of persons at risk, states would have to unduplicate the data, after the data for both the existing population and the potential at-risk population have been collected. Key at-risk populations, numerators, and denominators for these populations are listed below.

Numerators for At Risk:

- Measures of the size of potential at-risk population:
    - Number of individuals who are homeless/mentally ill, including shelters and transitional programs (HMIS database)
    - Number of individuals involved in the Criminal Justice system with MI (i.e. individuals who have been discharged from jail programs and individuals on probation). These data would be collected through jail program discharge data, or shared data between systems.
    - Emergency Department repeat psychiatric users (HCUP in some states, Medicaid records)
    - Individuals with non-fatal suicide attempts (CDC reports)
    - Number of individuals with co-occurring substance abuse (i.e., individuals with SMI who have repeated use of detox/IP/residential)
    - Number of adults with mental illnesses in board and care homes
    - Number of children with SED
        - Potential data could be derived from state education systems/specialized programs, and the juvenile justice system
    - Adults on SSI/SSDI rolls with mental illness(MI; information should be available from SSA)
- Measures of Early Intervention/Services to avoid institutionalization
    - Number of individuals using mental health CRISIS programs
    - Warm lines/hot lines
    - Mental health diversion services

- Number of individuals with repeated state hospital use who are not enrolled in community based recovery programs

Denominators for At Risk

There are multiple denominators that would be available for use with the at-risk population; the use of the denominators will vary according to the state system design and the type of indicator.

- SMHA data for individual state programs
- SMI/SED prevalence rate, as defined by SAMHSA, constructed for each state by NRI (which would ensure some construct validity for the determination of the denominator)
- Number of persons with mental health condition served by MA authority
- Number of persons with SMI/SED determined through individual state estimates based on population mental health prevalence rates

Policy Domain: New for 2013

The first version of the self-assessment tool did not include any measures aimed at capturing policies, procedures, or systems in place with the goal to minimize or eliminate unnecessary institutionalization. Policy is defined by SAMHSA as "a document directing an action or an event at the state level, including changes achieved through a broad range of mechanisms, including statutes, regulations, directives, contracts, clinical practice guidelines, strategic plans, and mission statements." Policies may also include documents that direct financing or organizational changes. Such policies, procedures, and systems may help states identify potential problems end efficiently respond before they become pervasive. While data from other indicators remained with the states, states had the option to share the information collected through the policy domain with SAMHSA. Information gathered in the policy domain will be used to establish best practices that other states might find useful to implement in their system.

DEPARTMENT OF JUSTICE REVIEW AND FEEDBACK

Once the self-assessment tool was modified for the 2013 pilot, staff from the Department of Justice was given a chance to review and provide feedback on the draft tool. DOJ staff commented directly on the draft tool and submitted their feedback at the end of May[3]. Some of DOJ's general recommendations include the following:

[3] It is important to note that DOJ staff reviewed a preliminary draft of the tool, and not the final version that was given to the pilot states to use.

- Add language clarifying that *Olmstead* and the ADA protect individuals institutionalized in forensic services.
- Eliminate language that discusses individuals at "high" risk of institutionalization, and replace with reference to individuals "at risk" or at "serious risk," which is consistent with the language used in DOJ case decisions.
- Include children and SED in more measures, and add child-focused inquiries to capture cross-system data for children and youth with SED.
- Add measures that relate to the sustainability of services (i.e., service is provided through a pilot project, special legislative initiative, Medicaid State Plan coverage, etc.).
- Provide an opportunity for states to identify evidence-based practices in use for diversion or to avoid institutionalization.
- Focus inquiries on actual receipt of services, rather than enrollment data.
- Separate measures that are not supported by state services (i.e., independent competitive employment) so as to better gauge the effectiveness of state-sponsored services, while continuing to capture all relevant data.

After DOJ's feedback was received, staff from NRI and AHP reviewed and responded to each of their suggestions. Responses to their comments were divided into five groups: 1) items that needed clarification; 2) items that were already addressed in the working draft of the tool; 3) changes incorporated into the 2013 version; 4) changes that will be considered for future versions; and 5) items that may be very difficult to include without collaboration with other agencies, and may require support from the DOJ. A list of each of DOJ's recommendations, coupled with NRI's responses, is included in Appendix D.

IMPLEMENTATION PROCESS

The 2013 pilot study began with NRI and AHP convening two orientation webinars for the pilot states on May 30 and June 24, 2013. Over the next several months, the pilot states collected data for the set of performance measures outlined in Part II of the elf-assessment tool. Bi-weekly conference calls were held following the two orientation webinars 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.

By the 19th week, states were asked to complete and submit the Utility Evaluation Form (Appendix E) and Implementation Tracking Guide (Appendix F). These documents were used to evaluate the utility and burden of each of the measures, respectively. In order to complete the Utility Evaluation Form, states were 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 they were able to collect, and on these bases, provide a collective utility rating of the tool.

In addition to testing and evaluating the measures, pilot states also completed the contextual information, Part I of the self-assessment tool. These responses were submitted to NRI, which were used to develop the summary characteristics of the pilot states in the following section.

DATA ANALYSIS

Pilot states were asked to evaluate the utility and burden of each of the 54 requested measures in the tool on a five-point Likert scale:

1 = Least Useful / Least Burdensome
2 = Less Useful / Less Burdensome
3 = Neutral
4 = Somewhat Useful / Somewhat Burdensome
5 = Most Useful / Most Burdensome

To evaluate the utility and burden of each measure for 2013, state responses were entered into an Excel spreadsheet. Each measure's respective scores were averaged based on the number of states evaluating a particular measure. Individual measure's scores were also averaged to determine the overall utility and burden of each domain in the tool.

Twenty-four measures were carried over from the 2012 version of the tool. These measures were analyzed for changes in utility and burden scores from 2012 to 2013. Of these 24 measures, four were modified slightly from the original tool based on feedback from the pilot states, expert panels, DOJ, and SAMHSA. The four modified measures are:

Original 2012 Measure:		Modified 2013 Measure:
Average daily census (Total patient days in year/365; Measure 9)	→	Average daily institutional occupancy rate (Measure 9)
Number of crisis residential beds available for inpatient diversion (Measure 25)	→	Number of crisis residential beds available in the community (Measure 24.a)
Number of children receiving in-home services (Measure 26)	→	Number of people receiving in-home services (Measure 25)
SMI emergency room admissions to the general hospital (Measure 28)	→	Emergency room admissions to general hospitals for psychiatric treatment (Measure 27)

Modified measures are highlighted in the Results section of this report, and examined for an increase or decrease in utility and/or burden that may have resulted from the change in language.

The scale used to evaluate the utility and burden of each measure was changed from a three-point Likert scale in FY12 to a five-point Likert scale in FY13 in an attempt to capture more nuances in the evaluations of utility and burden. In order to evaluate the utility and burden of these measures across the two years of the pilot, the five-point scale used in 2013 was adjusted to match the three-point scale used in 2012. SPSS was used to evaluate changes in utility and burden in these measures over time. The conversion of the 2013 scale and the original 2012 scale are provided in table 1 below.

Table 1: Likert Scale Conversions to Allow for Cross-Year Data Analyses

2013 Adjusted Likert Scale for Cross-Year Analysis	2012 Likert Scale
1 = 1 Least Useful / Least Burdensome	1 = Least Useful / Least Burdensome
2 = 1 Least Useful / Least Burdensome	
3 = 2 Neutral	2 = Neutral
4 = 5 Most Useful / Most Burdensome	
5 = 5 Most Useful / Most Burdensome	3 = Most Useful / Most Burdensome

PILOT STATES

Five states participated in the first year of SAMHSA's Community Integration Self-Assessment Pilot: Delaware, Illinois, Oklahoma, Vermont, and Washington. These original states were selected based on the following criteria:

- State has a good mental health data system capable of providing information, not just on persons living in SMHA-operated institutions, but also those receiving services in the community and the capacity of the state's community systems.
- SMHA has existing relationships with Medicaid and other important data systems and sources.
- State has an historical interest and background in *Olmstead* planning or actions.
- Diversity across states in the size and organization of the SMHAs.
- Regional representation.

The same criteria used in 2012 were also used to identify the 2013 pilot states; however, several additional characteristics were added for consideration in selecting the pilot states:

- For purposes of continuity and identification of trends, at least two of the original five pilot states should be included.
- At least two of SAMHSA's *Olmstead* Policy Academy States should be represented to encourage collaboration among state policy and data personnel.
- States that expressed an interest in furthering community integration that had the ability to, or interest in, monitoring housing trends and persons at risk of institutionalization.

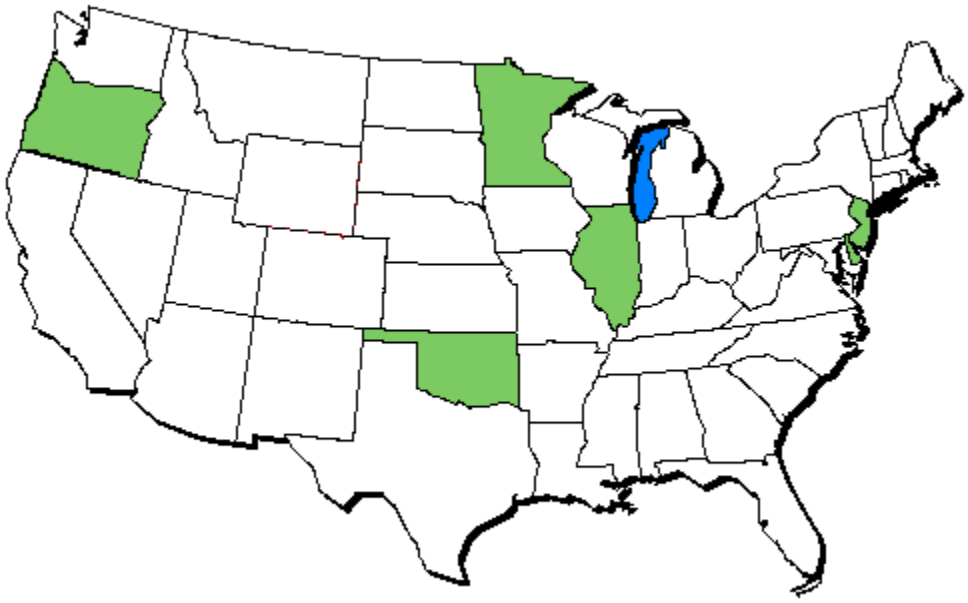
Potential states were then independently consulted to gauge their level of interest in the project. Nine states were submitted to SAMHSA for consideration: Alabama, Colorado, Delaware, Georgia, Illinois, North Carolina, Oklahoma, Oregon, and Texas. SAMHSA recommended that all nine states be invited to participate, with the expectation that several would be unable to commit due to competing priorities at the state level. Six states initially committed to the project: Delaware, Illinois, Minnesota, New Jersey, Oklahoma and Oregon (see Table 2 for a summary of each state's organizational characteristics). Unfortunately, only five states were able to continue the process. Due to the EF5 tornado that struck Moore, Oklahoma on May 20, 2013, the SMHA staff in Oklahoma dedicated their time and resources to tornado recovery efforts. Because of this, Oklahoma did participate in many of the pilot conference calls and discussions, but was not able to complete the compilation of measures or assessments.

Table 2: Pilot State SMHA Summary Characteristics

State	Region	Pop.	2012 Pilot State?	Policy Academy State?	State MH System Features	State MIS Capacities	Current *Olmstead* Involvement	Focus of Settlement Agreement/TA Interests
DE*	East	Small	Yes	No	SMHA-contracted community mental health system	DSAMH pulls Medicaid client eligibility and claims data into its data warehouse (DAMART) for analysis.	Implementing settlement agreement	Improved access to care in community, specifically crisis services & EBPs.
IL*	Mid-west	Large	Yes	Yes	SMHA-contracted community mental health system	Medicaid paid claims data are available to the SMHA on a weekly basis.	Implementing settlement agreement	Use of IMDs for long-term care.
MN	Mid-west	Mid	No	Yes	SMHA funds county mental health authorities statewide	Medicaid paid claims data are available to the SMHA on a semi-annual basis.	Implementing settlement agreement	Unnecessary and improper use of seclusion and restraints.
NJ*	East	Mid	No	Yes	SMHA-contracted community mental health system	The SMHA can access a state-operated data warehouse that combines SMHA and Medicaid data. The SMHA can access and analyze these data on an as-needed basis.	Implementing settlement agreement	Improved access to supportive housing and increasing annual discharges of consumers classified as CEPP (Conditional Extension Pending Placement).
OK	South	Mid	Yes	No	SMHA-operated and contracted community mental health system	Both SMHA and Medicaid are part of the same data system.	MH – none. *Olmstead* case settled in 2003.	N/A
OR	West	Mid	No	No	SMHA funds county mental health authorities statewide	Medicaid paid claims data are available to the SMHA as needed.	MH – none.	State does have lawsuit targeted at equal employment for persons with intellectual and developmental disabilities.

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

Figure 1: Geographic Distribution of Pilot States



CONTEXTUAL INFORMATION & STATE DESCRIPTIONS

Each of the five participating pilot states responded to a series of questions to put their *Olmstead* and community integration activities into context with their state's systems and policies. The contextual questions, Part I of the tool, covered a range of topics, including state *Olmstead* plans, Department of Justice *Olmstead* investigations, interagency collaboration, use of Medicaid to fund services, and housing issues, among others. The table below provides a brief summary of how states responded to each of these questions, with succeeding narratives providing greater detail about how states responded to certain questions.

Table 3: Brief Summary of State Contextual Information

State	Has *Olmstead* Plan?	Collaborates with Other Agencies?	Use of Medicaid for Community Integration			State Monitors those who Transition?	Cost of Living Impact Availability of Housing Vouchers?	Has Diversion Programs?	State Uses Peers to Facilitate Transitions?
			HCBS Waivers	1915(i) Options	Money Follows the Person				
DE	X	X				X	X	X	X
IL	X	X			X	X	N/A	X	X
MN	X	X	X		X	X	X	X	X
NJ	X	X				X	X	X	X
OR	X	X		X	X	X	X	X	X
Total:	**5**	**5**	**1**	**1***	**3**	**5**	**4**	**5**	**5**

** Delaware is in the process of obtaining a 1915(i) Option to provide services that facilitate community integration. Minnesota is considering pursuing a 1915(i) Option as a way to fund community-based services.*

Collaboration with Other State Agencies

Each of the pilot states' SMHAs collaborate with other state agencies to promote community integration for persons with mental illness. Partnerships are common between the SMHAs and the State Housing Authority (DE, IL, MN, NJ, and OR), the State Medicaid Agency (DE, IL, and MN), and the State Department of Labor (DE). Examples of these partnerships are provided below:

- Oregon's SMHA works with representatives from the State Housing and Community Services Division, as well as individuals representing affordable housing providers to develop strategies that improve community integration and independence. Representatives from these stakeholder groups are also involved in the monitoring and progress of the State *Olmstead* Plan.
- Delaware's Division of Medicaid and Medical Assistance works closely with the SMHA to develop the statewide Medicaid Plan, as well as how to best revise the way Managed Care Organizations provide services to clients with severe and persistent mental illnesses.
- Delaware's SMHA also partners with the Department of Labor's Division of Vocational Rehabilitation to monitor and document the provision of supported employment services, 10-day placements of clients, and 90-day employment of consumers.

Monitoring Transitions to the Community

All five of the pilot states monitor consumers who transition to the community. Methods for monitoring transition include quality of life and consumer evaluation of care surveys administered every six months for the first 18 months post-transition (IL); institutional recidivism rates (MN, NJ, and OR); level of client functioning in the community and adult mental health residential programs (OR).

Use of Diversion Programs

Each pilot state also implements diversion programs to prevent unnecessary institutionalization. Strategies include education programs for law enforcement officers (DE), availability of crisis walk-in services (DE, MN, and OR), pre-admission screening (IL), medical emergency room diversion (IL), and the development of peer crisis diversion services (NJ). Illinois's SMHA also has partnerships with two regional corrections systems: the Jail Data Link Project, and the Rockford Crisis Services Collaborative.

The Jail Data Link Project is a pilot program between the Cook County Department of Corrections and the mental health system. This pilot, implemented in 2000, utilizes specialized case managers to ensure continuity of care while a detainee is being held by beginning the immediate discharge aftercare planning process. This process includes linkages back to the consumer's home community agency for mental health and substance abuse services, housing

initiatives, and supportive employment and other community support services. Since 2000, the pilot has expanded to include eight counties, and also encompasses all mental health court data collection initiatives.

The Rockford Crisis Services Collaborative is a partnership between the SMHA's forensic services staff, Janet Wattles Community Mental Health Center, the Singer Mental Health Center, and the Rockford Jail. This initiative launched in 2005, when liaisons developed strategies for providing post-release and emergency mental health services to detainees of the Rockford Jail. The emphasis of services is on detainees with misdemeanors who are known to local mental health providers. As a result, a mental health court was established that provides diversion, discharge planning, and service linkage to the Janet Wattles Community Mental Health Center.

In the succeeding narratives, each pilot state's ongoing efforts in promoting community integration are described in greater detail.

Delaware

Delaware is currently in the third year of a five-year implementation plan that was set forth under an *Olmstead* Settlement Agreement with the U.S. Department of Justice. The plan targets the state-funded adult population with severe and persistent mental illnesses (SPMI), and focuses on redesigning the service delivery system to promote integration of clients with SPMI into the community and enable them to live integrated lives similar to those without disabilities. This effort has entailed a synthesized approach to deinstitutionalization and community integration through the provision of housing, case management, financing, crisis services, judicial reform, and the establishment of a network of community clinical and peer supports.

Upon the implementation of the settlement agreement with the Department of Justice in 2011, one of the first tasks of the Division of Substance Abuse and Mental Health (DSAMH) was to meet with other state agencies whose participation in the compliance effort would be critical. The DSAMH currently partners with the State Housing Authority, the Department of Health and Social Services, Vocational Rehabilitation, the Office of Management and Budget, and the Division of Medicaid and Medical Assistance. Through these partnerships DSAMH funds a State Rental Assistance Program that provides housing vouchers for consumers receiving services, is able to track and document the provision of supported employment services, and has input during the development of the state Medicaid plan.

Another accomplishment to emerge from the settlement agreement was the passage of DE House Bill 311, which was designed to improve the assessment, transport, stabilization, diversion to community-based treatment, and (as necessary) 24-hour detention of clients in

crisis. Complementing the passage of this legislation was the opening of an additional crisis walk-in service, reinforcement of the state's crisis line and 24-hour mobile crisis capabilities, and the conduct of educational activities with law enforcement, the judicial system, emergency rooms, service providers, clients and their families as to their alternatives in the event of a mental health crisis.

Illinois

The Illinois Disabilities Service Plan, developed in 2003 and updated in 2006, contains a broad base of services for persons with disabilities and older adults in compliance with the Americans with Disabilities Act of 1990 and the Supreme Court's 1999 decision on *Olmstead v. L.C.* The Department of Mental Health (DMH) is currently working with the Governor's Office and other state agencies on a rebalancing initiative for state services. The agencies involved in this initiative are the Department of Healthcare and Family Services (which is the State Medicaid Agency), the Department on Aging, multiple divisions within the Department of Human Services (including DMH, Developmental Disabilities, and Rehabilitation Services). To support the rebalancing initiative, the state has appointed a Statewide Housing Coordinator, as well as a Regional Housing Coordinator to work on a Low-Income Housing Tax Credit Targeting Program and other initiatives that expand the availability of integrated housing opportunities for persons with disabilities.

The State of Illinois settled two class-action lawsuits related to the *Olmstead* Decision. The first, filed in 2005, sought "declaratory and injunctive relief to redress violations of Title II of the ADA." In 2010, Illinois entered into a consent decree that assures that the state provides consumers "with the opportunity to receive the services they need in the most integrated setting appropriate and to promote and ensure the development of integrated settings that maximize individuals' independence, choice, opportunities to develop and use independent living skills, and afford the opportunity to live similar lives to individuals without disabilities." The consent decree specifically targets adults with mental illnesses who are institutionalized in privately-owned Institutions for Mental Disease (IMDs).

The second, filed in 2007, alleged that Illinois was unnecessarily segregating and institutionalizing persons with disabilities in nursing facilities, and forcing them to live with numerous other persons with disabilities in violation of the ADA and the Social Security Rehabilitation Act. This suit was settled in November 2012 through a consent decree that provides Medicaid-eligible nursing home residents in Cook County with the array of supports and services they need in the most integrated settings appropriate to their care. The state is improving access to community-based settings, and promoting and use of independent living skills so that people with disabilities have the opportunity to live their lives similar to those

without disabilities. The plan can be accessed online at http://www2.illinois.gov/hfs/PublicInvolvement/Colbert%20v%20Quinn/Pages/default.as.

Minnesota

In December 2011, the Minnesota Department of Human Services (DHS) entered into a settlement agreement that requires the development of a Minnesota *Olmstead* Plan. In 2012, DHS assembled an *Olmstead* Planning Committee to make recommendations to the Commissioner about what should be covered in the plan. This voluntary committee was comprised of individuals with disabilities, family members, providers, advocates, and policy makers from Minnesota's DHS.

In January 2013, Minnesota's Governor, Mark Dayton, issued an Executive Order establishing a sub-cabinet to develop and implement a comprehensive *Olmstead* Plan that supports freedom of choice and opportunity for people with disabilities. The sub-cabinet was chaired by the Lieutenant Governor. The following state agencies were represented by their commissioner or their commissioner's designee: DHS, Housing Finance Agency, Employment and Economic Development, Transportation, Corrections, Health, Human Rights, and Education. This sub-cabinet was tasked with evaluating policies, programs, statutes and regulations of their agencies against the standards set forth in the *Olmstead* decision to determine whether they should be revised, modified, or if they require legislative action to improve the availability of community-based services for people with disabilities. Based on these evaluations, the sub-committee developed a draft *Olmstead* plan that is currently undergoing state review. Recommendations that emerged from the Planning Committee were considered during the development of the draft plan.

In addition to the development of a comprehensive *Olmstead* Plan, Minnesota's SMHA has a number of inter-agency partnerships and programs in place to reduce the use of restrictive settings and address the housing needs of persons with mental illnesses. A primary partnership is between the SMHA and the Housing Finance Agency. Through this partnership, funding for in-home supportive services is linked with rental assistance and capital funding to create integrated housing units and support services in the community. This partnership provides opportunities to persons with intensive barriers to housing by linking housing subsidies, mental health services, and tenancy supports in order to assist people with accessing least restrictive settings.

The SMHA and HFA are also working together with the State Medicaid Agency to implement the Money Follows the Person Initiative, and the Federal PATH (Projects for Assistance in Transition from Homelessness) Program that awards HUD Section 811 funding for persons transitioning out of institutions and those that have experienced long-term homelessness. The SMHA and HFA also work together to support the Bridges Rental Assistance Program, which

provides transitional rental subsidies for adults with SMI who are applying for HUD Section 8 funding. The Bridges Program assists participants with establishing a positive rental history in order to qualify for HUD funding, and provides affordable housing while participants wait for HUD funding to become available.

Minnesota's legislature has dedicated funding to develop community-based services that help individuals remain in the community and receive care in the least restrictive environment. In 2013, the state legislature provided $8.2 million in new funds to strengthen community placement options, and authorized existing funds to support these transitions. Funding has also been dedicated to expand mental health crisis response services, screening for substance abuse through SBIRT (Substance Abuse Screening, Brief Intervention and Referral to Treatment), and the increased use of peer and family specialists.

New Jersey

In 2010, New Jersey entered into a settlement agreement with Disability Rights New Jersey to improve access to supportive housing and increase annual discharges of consumers on Conditional Extension Pending Placement (CEPP) status. The state previously had developed a Home to Recovery (CEPP Plan) which included the states strategy and commitment to community integration.[4] The Settlement Agreement calls for specific annual goals for increasing the number of CEPP consumers discharged within four and six months of attaining CEPP status, depending on any legal involvement. By the end of June 2014, the state is tasked with discharging 95% of non-legally involved CEPP designees within four months and the same percentage within six months for legally-involved consumers.

In addition to increasing discharges from state hospitals, New Jersey's Division of Mental Health and Addiction Services (DMHAS) works with a variety of other state agencies to provide community- based services to individuals with mental illnesses. New Jersey's DMHAS partners with the Department of Community affairs to administer the state rental assistance program (SRAP). Through this partnership, DMHAS is able to provide subsidies to individuals diagnosed with SMI. DMHAS also partners with the State Division of Developmental Disabilities to provide supportive housing for individuals leaving state hospitals who are dually diagnosed with a developmental disability and a mental illness.

New Jersey also has many programs and policies in place to ensure that consumers experience success in the community. DMHAS contracts with providers to ensure that persons recently discharged from the state hospitals are linked with integrated case management, assertive community treatment programs, and supportive housing services. In addition to these contracts, the DMHAS also provides Early Intervention Support Services, and supports a peer

[4] The Home to Recovery CEPP Plan can be accessed online at http://www.state.nj.us/humanservices/dmhs/olmstead/CEPP_Plan_1_23_08_Final.pdf.

crisis diversion program. The peer crisis diversion program supports crisis centers, a 24-hour warm line operated by peers, and intensive outpatient commitment services.

Oregon

Oregon's SMHA collaborates with the State's Housing and Community Services Division to develop strategies to improve community integration and independence. The SMHA also partners with the State's Aging and Persons with Disabilities Division to design, fund, and monitor integrated community placements for eligible individuals with high needs.

Oregon's Adult Mental Health Division works in conjunction with acute care psychiatric hospitals, managed care organizations, and community mental health providers to ensure acute psychiatric patients admitted to the state hospital and stabilized are diverted to more independent and integrated settings when appropriate. Most mid-sized and larger communities in Oregon have non-hospital crisis stabilization settings in a licensed residential program for those who require short-term stabilization.

Oregon has a Medicaid 1915(i) State Plan Option to provide community mental health services. Additionally, Oregon's SMHA uses *Money Follows the Person* (known as Oregon's Community Choice Program) to provide funding for services geared toward children with severe emotional disturbances and adults with severe mental illnesses.

In 2012, Oregon entered into a settlement agreement with the Department of Justice to monitor the effectiveness of initiatives to improve independence and integration for persons with severe and persistent mental illnesses.

RESULTS

PROJECT IMPLEMENTATION

Pilot states were asked which division or office within the SMHA had the primary role in conducting this pilot. Two states indicated the primary responsibility was shared across multiple offices: in Illinois, the Office of Evaluation and Research shared the responsibilities with the Information Technology Department; and in Minnesota, responsibilities were split between the Offices of Evaluation and Research, Information Technology, and Quality Improvement. The *Olmstead* Coordinator's Office had the lead in New Jersey and in Oregon, whereas the Office of the Commissioner oversaw the Pilot efforts in Delaware. The pilot states also involved other divisions within their SMHAs, including the Budget/Finance (three states: IL, NJ, OR), Clinical/Program Staff (three states: IL, MN, NJ), Commissioner/Director's Office (three states: MN, NJ, OR), *Olmstead* Coordinator (two states: DE, IL), and Legal (two states: NJ, OR). The following other divisions were also engaged by New Jersey in the implementation of the Pilot: Contracts/Procurement, Evaluation/Research, Grants Office, Information Technology, Planning, and Consumer Affairs.

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 agreement and/or joint initiatives established prior to this project. The more connections staff at the SMHA had with other agencies generally resulted in a greater ability to collect and interpret data for more of the measures. The agencies SMHA staff collaborated with in 2913 are listed in Table 4 below.

Table 4: Other State Agencies Engaged in the Pilot Implementation

Agency	Delaware	Illinois	Minnesota	New Jersey	Oregon
Attorney General				Y	Y
Corrections			Y		
Housing	Y*	Y	Y	Y	Y
Medicaid	Y*	Y*			Y
Intellectual Disability/DD			Y		
Substance Abuse	Y*		Y	Y	
Vocational Rehab	Y*		Y	Y	
Early Intervention					
Juvenile Justice					
Child Welfare	Y*			Y	

Indicates that the Pilot state worked with this agency in the 2012 Pilot.

EVALUATION OF TOOL STRUCTURE

Domains

The self-assessment tool consisted of seven domains, including Financing and Resources, Movement to the Community & Recidivism, Housing, Community Capacity, Well-Being, At-Risk Groups, and Policy. Five of these domains were carried over from the 2012 cycle of the Pilot. The two new domains for 2013 are the domain for At-Risk Groups, and the Policy Domain. Of the seven domains, the Housing domain posed the biggest challenge to the most number of states, with two measures only reported by one state. States expressed difficulty accessing housing data through local housing authorities (due to their decentralized nature), and experienced difficulty gaining access to HUD databases. The Financing & Resources domain had one measure that none of the states could report (Number of HCBS slots available); however, this measure is only applicable to those states with 1915(c) waivers or 1915(i) options used for mental health, which none of the Pilot states have. Table 5 below shows the frequency distribution of the number of states and the number of measures within each domain that were reported for both the 2012 and 2013 cycle of the pilot.

Table 5: 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	
	2012	2013	2012	2013	2012	2013
Financing & Resources	3	3	2	2	2	2
Movement to the Community & Recidivism	9	10	9	10	6	7
Housing	7	6	4	6	0	0
Community Capacity	9	11	9	11	1	3
Well-Being	2	2	2	2	1	0
At-Risk Groups	N/A	13	N/A	13	N/A	0
Policy	N/A	9	N/A	9	N/A	2

Measures

The tool contained 54 measures (including sub-measures). States varied in the number of measures they collected data for, ranging from 32 to 37 of the recommended measures. However, all five pilot states collected data for 11 measures. For these 11 measures, information on which populations and settings states collected data for, along with the data sources used for each measure are provided below (when available; one state did not provide information on data sources for any measure).

- Financing & Resources Domain:
    - Measure 1: State mental health expenditures on community-based programs
        - Five states already collect this measure through another initiative.
        - Populations: Children (1 state); Adults (5 states)

        - Settings: State Hospitals (2 states); Residential Treatment Facilities (2 states); Emergency Rooms (2 states); Adult Care Homes (3 states); Community (2 states); Other Settings (3 states)
        - Data Sources: SMHA Administrative Data (3 states); Grant-Specific Database (2 states); State General Funds (1 state); State Accounting Database (1 state); State Aid Recommendations (1 state)
    - Measure 2: State expenditures on psychiatric hospital/inpatient care
        - Five states already collect this measure through another initiative.
        - Populations: Adults (5 states)
        - Settings: State Hospitals (5 states); Emergency Rooms (2 states); Community (1 state); Other (2 states)
        - Data Sources: SMHA Administrative Data (3 states); State General Funds (1 state); DSH Medicaid Funds (1 state); State Accounting Database (1 state); Published Budget and Evaluation Data (1 state)
- Movement to the Community & Recidivism Domain:
    - Measure 4a: Number of persons awaiting discharge by type of institution for more than three months.
        - Five states already collect this measure through another initiative.
        - Populations: Adults (5 states)
        - Settings: State Hospitals (3 states); Nursing Homes (1 state); Not Identified (1 state)
        - Data Sources: State Hospital Database (2 states); SMHA Administrative Data (1 state); Special Database to Monitor Consent Decree Process and Outcomes (1 state)
    - Measure 5: Number of patients in the institution with a length of stay greater than one year (at end of year).
        - Four states already collect this measure through another initiative.
        - Populations: Adults (5 states)
        - Settings: State Hospitals (5 states); Residential Treatment Facilities (1 state); Adult Care Homes (1 state); Other (1 state)
        - Data Sources: SMHA Administrative Data (2 states); State Hospital Database (1 state)
    - Measure 6: Number or percentage of persons with a length of stay greater than one year, discharged during the year.
        - Five states already collect this measure through another initiative.
        - Populations: Adults (5 states)
        - Settings: State Hospitals (5 states); Residential Treatment Facilities (1 state); Adult Care Homes (1 state); Other (1 state)

        - Data Sources: State Hospital Database (2 states); SMHA Administrative Data (2 states)
    - Measure 7: Number of persons with SMI/SED readmitted to any (or same) type of institution within six months.
        - Five states already collect this measure through another initiative.
        - Populations: Adults (5 states)
        - Settings: State Hospitals (5 states); Emergency Rooms (1 state); Other (3 states)
        - Data Sources: SMHA Administrative Data (3 states); State Hospital Database (2 states)
    - Measure 8: Number of persons with SMI/SED admitted to institutional care.
        - Three states already collect this measure through another initiative.
        - Populations: Adults (5 states)
        - Settings: State Hospitals (5 states); Nursing Homes (2 states); Residential Treatment Facilities (1 state); Emergency Rooms (1 state); Adult Care Homes (1 state); Other (1 state)
        - Data Sources: State Hospital Database (2 states); SMHA Administrative Data (1 state); Medicaid MIS (1 state)
    - Measure 9: Average daily occupancy rate.
        - Four states already collect this measure through another initiative.
        - Populations: Adults (5 states)
        - Settings: State Hospitals (5 states); Other (1 state)
        - Data Sources: State Hospital Database (3 states); SMHA Administrative Data (2 states); Medicaid MIS (1 state)
    - Measure 10: Number of licensed psychiatric beds available.
        - Four states already collect this measure through another initiative.
        - Populations: Adults (5 states)
        - Settings: State Hospitals (5 states); Residential Treatment Facilities (1 state); Adult Care Homes (1 state); Community (1 state); Other (3 states)
        - Data Sources: Facility Licensure Database (1 state); State Department of Public Health (1 state); SMHA Administrative Data (1 state)
- Community Capacity Domain:
    - Measure 20: Number of persons with SMI receiving Assertive Community Treatment
        - Five states already collect this measure through another initiative.
        - Populations: Adults (5 states)
        - Settings: Nursing Homes (1 state); Community (4 states); Other (1 state)

        - Data Sources: SMHA Administrative Data (1 state); Contracts (1 state); Medicaid MIS (1 state); PACT Monthly Report (1 state); Grant-Specific Databases (1 state)
    - Measure 21: Number of persons with SMI enrolled in supported employment.
        - Three states already collect this measure through another initiative.
        - Populations: Adults (5 states)
        - Settings: Community (3 states); Other (2 states)
        - Data Sources: State Department of Labor (2 states); Providers (1 state); SMHA Administrative Data (1 state); Medicaid MIS (1 state); Contracts (1 state)
    - Measure 24a: Number of crisis residential beds available in the community.
        - Four states already collect this measure through another initiative.
        - Populations: Adults (5 states)
        - Settings: Community (3 states); Other (1 state); Not Identified (1 state)
        - Data Sources: Providers (2 states); Medicaid MIS (1 state); Grant-Specific Databases (1 state); Contracts (1 state); SMHA Administrative Data (1 state)

Table 6: 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	1	5	5
2. State expenditures on psychiatric hospitals/inpatient care	5	0	5	5
3. Number of HCBS slots available	0	0	0	0
4. a) Number of persons awaiting discharge by type of institution for more than three months	5	0	5	5
4. b) Does the state have a standardized assessment, updated regularly, to assess readiness for discharge?	4	0	4	4
5. Number of patients in the institution with length of stay greater than one year (at end of year)	4	0	5	5
6. Number or percentage of persons with a length of stay greater than one year discharged during the year	5	0	5	5
7. Number of persons with SMI/SED readmitted to any (or same) type of institution within six months	5	0	5	5
8. Number of persons with SMI/SED admitted to institutional care	3	0	5	5
9. Average daily inst. occupancy rate	4	0	5	5
10. Number of licensed psychiatric beds available	4	0	5	5
11. Number of persons with SMI/SED declining transfer into the community	3	0	3	3
12. Number of persons with SMI admitted to nursing homes identified through PASRR assessments	3	0	3	3
13. Number of persons with SMI residing in HUD-subsidized housing units	1	0	1	1
14. Number of persons with SMI receiving non-HUD permanent supported housing services	3	0	4	4
15. Number of persons with SMI receiving non-HUD supervised housing services	3	0	3	3
16. Number of persons receiving other housing services not captured in measures 13-15 above	2	0	2	2
17. Number of persons with SMI on a housing waiting list	1	0	1	1
18. Average wait time for housing (mos.)	2	0	2	2
19. Number of persons with SMI/SED receiving intensive targeted case management services	3	0	4	4
20. Number of persons with SMI receiving Assertive Community Treatment	4	0	5	5
21. Number of persons with SMI enrolled in supported employment	3	0	5	5
22. a) Number of persons with SMI employed full time or part time	2	0	3	3
22. b) Number of persons served by the SMHA who are employed full time or part time	3	0	4	4
23. Number of children w/SED receiving wraparound srvcs	1	0	1	1

Measure	States Already Collecting Measure	Number of States Reporting Measure in the Pilot		
		Children	Adults	Total
24. a) Number of crisis residential beds available in the community	4	0	5	5
24. b) Number of people receiving institutional diversion services	3	0	4	4
25. Number of persons receiving in-home services	4	1	4	4
26. Number of persons receiving family support services	1	0	3	3
27. Emergency room admissions to general hospitals for psych. treatment	4	0	4	4
28. Number of consumers reporting positively about social connectedness (MHSIP Survey Module)	3	0	4	4
29. Number of persons involved in peer support programs (including clubhouse programs)	3	0	3	4
30. a) Does your state have 24-hour crisis hotlines? If yes, are they available statewide, or limited to certain regions?	4	2	4	4
30. b) How many calls were received at the 24-hour crisis hotline in the past month/year?	2	1	3	3
31. a) Does your state have warm lines operated by mental health consumers to assist with persons in crisis? If yes, are they available statewide, or limited to certain regions?	2	1	4	4
31. b) How many peers staff these warm lines?	1	1	2	2
31. c) How many calls were received on the warm lines in the past month/year?	2	1	3	3
32. a) How many 24/7 mobile crisis teams does your state have?	3	0	4	4
32. b) How many people received services provided by mobile crisis teams in the past year?	3	0	4	4
33. Number of persons who are homeless and mentally ill, including shelters and transitional housing programs	2	1	4	4
34. Number of mentally ill individuals involved in the criminal justice system	1	1	3	3
35. Repeat psychiatric users of the emergency department	2	0	2	2
36. Individuals with non-fatal suicide attempts	1	0	1	1
37. Number of individuals with co-occurring substance abuse	2	1	4	4
38. Number of adults with mental illness in board and care homes	2	0	2	2

In addition to asking states to report on the applicable populations and settings for measures in the Policy domain, states were also asked to provide information on the date the policy became effective, type of policy, policy mechanism, stage of implementation, and the agency responsible for overseeing the policy. The number of states implementing each type of policy, along with a breakout by policy type, population, mechanism, and responsible agency, is included in Table 7 on the following page.

Table 7: Policy Domain Measures Provided by Pilot States

Policy	# of States	# of Policies	Policy Type			Population		Policy Mechanism								Responsible Agency			
			Prog.	Org.	Financial	SED	SMI	Statutory	Appropriation	Reg/ Admin Rule	Contract	MOU	Exec. Order	Clinical Guide. or EBP	Other	SMHA	Medicaid	Housing	Other
39. Prohibit or reduce discharges from state hospitals/local psychiatric units into segregated settings?	4	16	13	12	2	0	16	6	0	5	5	1	0	1	6	10	0	0	0
40. New funding initiatives to provide community services?	5	21	14	6	17	0	21	5	7	2	6	1	0	0	8	15	4	1	2
41. Employs differential reimburse. rates to discourage placement in segregated settings?	3	6	3	2	4	0	5	1	1	2	3	0	1	0	0	5	2	0	2
42. Standard assessment of readiness for discharge that is regularly updated for consumers in institutional settings?	4	6	1	4	1	0	5	0	1	3	3	0	0	2	0	6	0	0	1
43. Ensures services are provided in least rest. set?	4	17	7	7	3	2	15	2	0	1	5	0	0	0	6	15	2	0	1

Table 7: Policy Domain Measures Provided by Pilot States

Policy	# of States	# of Policies	Policy Type			Population		Policy Mechanism								Responsible Agency			
			Prog.	Org.	Financial	SED	SMI	Statutory	Appropriation	Reg/ Admin Rule	Contract	MOU	Exec. Order	Clinical Guide. or EBP	Other	SMHA	Medicaid	Housing	Other
44. Monitor housing wait lists?	2	3	1	3	0	0	3	0	0	0	1	0	0	0	2	3	0	0	0
45. Monitor amount of time consumers wait for housing?	2	3	0	2	0	0	3	0	0	2	1	0	0	0	0	3	0	0	0
46. Standard method for tracking persons declining discharge to community?	5	2	2	1	0	0	2	0	0	0	1	0	0	0	2	2	0	0	0
47. Programs to provide education and encouragement to patients about opportunities they can have in accepting discharge to community?	1	12	11	4	1	0	10	1	0	0	6	0	0	0	5	12	1	1	0
TOTAL:		**86**	**52**	**41**	**28**	**2**	**80**	**15**	**9**	**15**	**31**	**2**	**1**	**3**	**29**	**71**	**9**	**2**	**6**

Data Sources

Pilot states were asked to report on the data sources used to collect measures of community integration; data sources were requested for all measures except for those included in the Policy domain. Four of the five pilot states supplied information about data sources. As in 2012, states relied heavily on SMHA and Medicaid data systems. Sources of information, by domain, are provided in table 8.

Table 8: Data Sources Used by Pilot States, by Domain

Domain	Primary Data Sources (Number of States)
Financing & Resources	• State General Funds/State Accounting Data (3 States) • SMHA Management Information System (MIS) (2 States) • Grant Data (2 States) • Medicaid MIS (1 State) • State Aid Records (1 State)
Movement to Community & Recidivism	• State Hospital Data (3 States) • SMHA MIS (2 States) • PASRR Evaluations (2 States) • Medicaid MIS (2 States) • Facility Licensure Information (1 State) • *Olmstead* Consent Decree Database (1 State) • State Public Health Database (1 State)
Housing	• *Olmstead* Consent Decree Database (2 States) • SMHA-Sponsored Housing Programs – Application Data (1 State) • State Housing Authority – for Vouchers (1 State)
Community Capacity	• SMHA MIS (4 States) • Medicaid MIS (3 States) • Survey of Providers (2 States) • State Department of Labor (2 States) • Jail Link Database (1 State) • Grant Data (1 State) • NAMI Data (1 State) • State Public Health Database (1 State) • Contract Monitoring Reports (1 State)
Well-Being	• Consumer Surveys (Quality of Life, MHSIP & YSS-F) (3 States) • Self-Help Outcome Utility Tracking System (1 State) • Contact & Visitor Data (1 State)
At-Risk Population	• SMHA MIS (3 States) • Monthly Service Data (2 States) • Grant Data (2 States) • Contract Monitoring Reports (2 States) • State Hospital Data (2 States) • Medicaid MIS (1 State) • *Olmstead* Consent Decree Database (1 State) • County Billing Data (1 State)

UTILITY AND BURDEN RATINGS

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 in enhancing the state's understanding of how effective their efforts are at promoting community integration for people with mental illness. States were requested to rate the utility of each measure using a five-point Likert scale (1 = least useful, to five = most useful), and provide a statement that supports their rating. This same process was used in the 2012 version of the Pilot and states reported this was useful. The only changes for the 2013 pilot was the addition of new measures, and the shifting the Likert scale from a three-point scale in 2012 to a five-point scale in 2013. Utility evaluation forms were received from four of the five participating pilot states; at the time of publication, Oregon had not yet received approval to submit their Implementation Tracking Guide.

Utility of Measures

Each of the four reporting pilot states rated the utility of the measures for which they have data. Additional measures were given utility ratings by three states, despite the absence of collected data, based solely on their collective perspective of the measures' potential use. All 54 requested measures were evaluated for utility by at least one pilot state; three additional state-specific measures were also evaluated by one state each.

Nearly all of the measures were evaluated as having high utility to states: 51 of the 54 requested measures received a utility rating higher than 3. Two measures, each in the Policy domain, received the highest rating of 5 by all responding states:

- *Measure 39: Does the state have policies or rules in place intended to prohibit or reduce discharges from state hospitals or local psychiatric units into segregated settings?* (Three states responding; one state did not respond)
- *Measure 40: Has the state developed new funding initiatives that provide community services to help keep people out of institutions?* (Four states responding)

The three measures that scored a 3 or less are:

- *Movement to the Community & Recidivism Domain – Measure 11: Number of persons with SMI/SED declining transfer into the community* (Average Utility Score = 2.67, three states responding)
- *Housing Domain – Measure 16: Number of persons receiving other housing services not captured in measures 13-15 above* (Average Score = 3.0, two states responding)
- *Community Capacity Domain – Measure 23: Number of Children with SED receiving wraparound services* (Average Utility Score = 2.0, one state responding)

Table 9: State Assessments of the Usefulness of Community Integration Measures

Domain	Indicator	Measure	Please rank the Utility of collecting this indicator (1 = Least Useful to 5 = Most Useful)				States Reporting	Avg.	Number of States scoring measure as Least Utility or Most Utility	
			State	State	State	State			# Least Useful (1)	# Most Useful (5)
Financing & Resources	Increase in Funding for Community-Based Programs	**1.** State MH expenditures on community-based programs	4	3	4	5	4	4.0	0	1
		2. State expenditures on psychiatric hospital/ inpatient care	4	3	4	5	4	4.0	0	1
		3. Number of HCBS slots available	4*	N/R	N/R	N/R	1	4.0	0	0
Movement to Community & Recidivism	Decrease in length of time waiting to be discharged	**4.** a) Number of persons with SMI/SED awaiting discharge by type of institution for more than three months	4	4	3	5	4	4.0	0	1
		4. b) Does the state have a standardized assessment, updated regularly, to assess readiness for discharge?	5	3	3	N/R	3	3.67	0	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)	5	4	3	4	4	4.0	0	1
		6. Number or percentage of persons with a length of stay greater than one year discharged during the year	5	4	3	4	4	4.0	0	1
	Decrease in readmission rate	**7.** Number of persons with SMI/SED readmitted to any (or same) type of institution within six months	5	1	4	5	4	3.75	1	2
	Decrease in utilization rate of institutional settings	**8.** Number of persons with SMI/SED admitted to institutional care	3	4	5	3	4	3.75	0	1
		9. Average daily institutional occupancy rate	3	1	4	5	4	3.25	1	1
		10. Number of licensed psychiatric beds available	4	3	5	5	4	4.25	0	2
		11. Number of persons with SMI/SED declining transfer into the community	1	2	N/R	5	3	2.67	1	1
		12. Number of persons w/SMI admitted to nursing homes identified through PASRR Assessments	3	4*	N/R	N/R	2	3.5	0	0

Domain	Indicator	Measure	Please rank the Utility of collecting this indicator (1 = Least Useful to 5 = Most Useful)				States Reporting	Avg.	Number of States scoring measure as Least Utility or Most Utility	
			State	State	State	State			# Least Useful (1)	# Most Useful (5)
Housing	Increase in percentage of persons with SMI receiving housing supports	**13.** Number of persons with SMI residing in HUD-subsidized housing units	4	N/R	5*	N/R	2	4.5	0	1
		14. Number of persons with SMI receiving non-HUD permanent supported housing services	4	4	5	N/R	3	4.33	0	1
		15. Number of persons with SMI receiving non-HUD supervised housing services	4	1*	5	N/R	3	3.33	1	1
		16. Number of persons receiving other housing services not captured in measures 13-15 above	N/R	1*	5	N/R	2	3.0	1	1
	Decrease in length of time on housing waiting lists	**17.** Number of persons with SMI on a housing waiting list	4	1*	5*	N/R	3	3.33	1	1
		18. Average wait time for housing (months)	4	4	5*	N/R	3	4.33	0	1
Community Capacity	Increase in utilization of community-based services	**19.** Number of persons with SMI/SED receiving targeted case management services	4	3*	4	5	4	4.0	0	1
		20. Number of persons w/SMI receiving Assertive Community Treatment (ACT)	4	3	4*	5	4	4.0	0	1
		21. Number of persons w/SMI enrolled in supported employment	4	5	4	5	4	4.5	0	2
		22. a) Number of persons with SMI employed full time or part time	4	N/R	4	N/R	2	4.0	0	0
		22. b) Number of persons served by the SMHA who are employed full time or part time	4	5	4	N/R	3	4.33	0	1
		23. Number of children with SED receiving wraparound services	N/R	2*	N/R	N/R	1	2.0	0	0
		24. a) Number of crisis residential beds available in the community	5	2	4	4	4	3.75	0	1
		24. b) Number of people receiving institutional diversion services	4*	2	5	5	4	4.0	0	2
		25. Number of people receiving in-home services	3	2	5	N/R	3	3.33	0	1

Domain	Indicator	Measure	Please rank the Utility of collecting this indicator (1 = Least Useful to 5 = Most Useful)				States Reporting	Avg.	Number of States scoring measure as Least Utility or Most Utility	
			State	State	State	State			# Least Useful (1)	# Most Useful (5)
Community Capacity, Cont'd…	Increase in utilization of community-based services, cont'd…	**26.** Number of persons receiving family support services	4*	2*	5	4	4	3.75	0	1
		27. Emergency room admissions to general hospitals for psychiatric treatment	4	2	5	N/R	3	3.67	0	1
Well-Being	Increase in percentage of persons expressing social inclusion or connectedness	**28.** Number or percentage of consumers reporting positively about social connectedness (MHSIP Survey Module)	4*	3	4	4	4	3.75	0	0
		29. Number of adults with SMI involved in peer support programs (including clubhouse programs)	4*	3*	5	4	4	4.0	0	1
Measures for At-Risk Groups	Measures of early intervention services to avoid institutional-ization	**30.** a) Does your state have 24-hour crisis hotlines? If yes, are they available statewide or limited to certain regions?	4	3	5*	5	4	4.25	0	2
		30. b) How many calls were received at the 24-hour crisis hotline in the past month/year?	4	1*	5*	5	4	3.75	1	2
		31. a) Does your state have warm lines operated by mental health consumers to assist persons in crisis? If yes, are they available statewide, or limited to certain regions?	4*	3	5*	5	4	4.25	0	2
		31. b) How many peers staff these warm lines?	4*	1	N/R	5	3	3.33	1	1
		31. c) How many calls were received on the warm lines in the past month/year?	4*	1	5*	5	4	3.75	1	2
		32. a) How many 24/7 mobile crisis teams does your state have?	4*	5*	5	5	4	4.75	0	3
		32. b) How many people received services provided by mobile crisis teams in the past year?	4	3*	5	2	4	3.5	0	1
		33. Number of persons who are homeless and mentally ill, including shelters and transitional housing programs	4*	4	5	5	4	4.5	0	2

Domain	Indicator	Measure	Please rank the Utility of collecting this indicator (1 = Least Useful to 5 = Most Useful)				States Reporting	Avg.	Number of States scoring measure as Least Utility or Most Utility	
			State	State	State	State			# Least Useful (1)	# Most Useful (5)
Measures for At-Risk Groups, Cont'd…	Measures of early intervention services to avoid institutional-ization, Cont'd…	**34.** Number of mentally ill individuals involved in the criminal justice system (e.g., persons discharged from jail programs and/or on probation)	4*	4	5	5	4	4.5	0	2
		35. Repeat psychiatric users of the emergency department	4*	4*	5	N/R	3	4.33	0	1
		36. Individuals with non-fatal suicide attempts	3*	4*	N/R	N/R	2	3.5	0	0
		37. Number of individuals with co-occurring substance abuse (i.e., individuals with repeated use of detox, IP, residential)	4*	4	5	5	4	4.5	0	2
		38. Number of adults with mental illness in board and care homes	4*	2	4	N/R	3	3.33	0	0
Policy		**39.** Does the state have policies or rules in place intended to prohibit or reduce discharges from state hospitals or local psychiatric units into segregated settings?	5	5	5	N/R	3	5.0	0	3
		40. Has the state developed new (in the last two years) funding initiatives that provide community services to help keep people out of institutions?	5	5	5	5	4	5.0	0	4
		41. Does the state employ differential reimbursement rates to discourage admissions of persons with mental illnesses into segregated settings and/or to encourage placement into integrated settings?	5	5*	3*	N/R	3	4.33	0	2
		42. Does the state have a standardized assessment of readiness for discharge from institutional care that is regularly updated for all consumers in institutional settings?	5	5	3	N/R	3	4.33	0	2

Domain	Indicator	Measure	Please rank the Utility of collecting this indicator (1 = Least Useful to 5 = Most Useful)				States Reporting	Avg.	Number of States scoring measure as Least Utility or Most Utility	
			State	State	State	State			# Least Useful (1)	# Most Useful (5)
Policy, Cont'd…		**43.** Does your state have other policies or rules to ensure services are provided in the least restrictive setting to avoid clinically-unnecessary institutional admission?	5*	5	3	5	4	4.5	0	3
		44. Does your state have a policy or system in place to monitor housing wait lists?	4	5	N/R	N/R	2	4.5	0	1
		45. Does your state have a policy or system in place to monitor the amount of time consumers spend waiting for housing?	4*	5	N/R	N/R	2	4.5	0	1
		46. Does your state have a standardized methodology to track persons declining discharge to the community?	2	5	N/R	5	3	4.0	0	2
		47. Does your SMHA have a program(s) to provide education and encouragement to patients about the opportunities and successes they can have in accepting discharge to the community?	4	5	N/R	5	3	4.67	0	2
		Number of Measures Scored:	**52**	**51**	**44**	**32**				

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

Burden to Collect Measures

All five pilot states submitted an assessment of the burden associated with collecting each measure. The pilot states provided burden ratings on 53 of the 54 requested measures (including sub-measures). Forty-four measures received a burden rating less than 3, indicating a low collection burden. Six of these measures received the lowest possible burden rating (burden = 1) by all responding states:

- *Movement to the Community & Recidivism Domain – Measure 12: Number of persons with SMI admitted to nursing homes identified through PASRR Assessments.* (Evaluated by two states)
- *Housing Domain – Measure 14: Number of persons with SMI receiving non-HUD permanent supported housing services.* (Evaluated by three states)

- *Housing Domain – Measure 17: Number of persons with SMI on a housing wait list.* (Evaluated by one state)
- *Measures for At-Risk Groups Domain – Measure 31. a): Does your state have warm lines operated by mental health consumers to assist persons in crisis? If yes, are they available statewide, or limited to certain regions?* (Evaluated by three states)
- *Measures for At-Risk Groups Domain – Measure 31. b): How many peers staff these warm lines?* (Evaluated by two states)
- *Measures for At-Risk Groups Domain – Measure 32. a): How many 24/7 mobile crisis teams does your state have?* (Evaluated by three states)

Five measures received an average burden rating higher than 3; however, none of the measures received an average burden score greater than 4. The five measures evaluated as having the highest burden are:

- Housing Domain – Measure 13: Number of persons with SMI residing in HUD-subsidized housing units (Average Burden Score = 4; one state responding)
- Community Capacity Domain – Measure 22. a): Number of persons with SMI employed full time or part time (Average Burden Score = 4; three states responding)
- Community Capacity Domain – Measure 22. b): Number of persons served by the SMHA who are employed full time or part time (Average Burden Score = 3.25; four states responding)
- Community Capacity Domain – Measure 27: Emergency room admissions to general hospitals for psychiatric treatment (Average Burden Score = 3.5; four states responding)
- Policy Domain – Measure 44: Does your state have a policy or system in place to monitor housing wait lists? (Average Burden Score = 3.33; three states responding)

Table 10 provides a breakdown of states' burden scores for each of the requested measures.

Table 10: State Assessments of the Burden of Data Collection

Domain	Indicator	Measure	Please rank the Burden of collecting this indicator (1 = Least Burdensome to 5 = Most Burdensome)					States Reporting	Avg.	Number of States scoring measure as Least Burdensome or Most Burdensome	
			State	State	State	State	State			# Least Burden (1)	# Most Burden (5)
Financing & Resources	Increase in Funding for Community-Based Programs	**1.** State MH expenditures on community-based programs	3	1	1	2	1	5	1.6	3	0
		2. State expenditures on psychiatric hospital/ inpatient care	3	1	1	2	1	5	1.6	3	0
		3. Number of HCBS slots available	N/R	N/R	N/R	N/R	N/R	0	N/A	0	0
Movement to Community & Recidivism	Decrease in length of time waiting to be discharged	**4.** a) Number of persons with SMI/SED awaiting discharge by type of institution for more than three months	1	2	1	1	1	5	1.2	4	0
		4. b) Does the state have a standardized assessment, updated regularly, to assess readiness for discharge?	3	3	1	N/R	2	4	2.25	1	0
	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	1	1	1	2	5	1.2	4	0
		6. Number or percentage of persons with a length of stay greater than one year discharged during the year	1	1	1	1	2	5	1.2	4	0
	Decrease in readmission rate	**7.** Number of persons with SMI/SED readmitted to any (or same) type of institution within six months	1	1	1	2	1	5	1.2	4	0
	Decrease in utilization rate of institutional settings	**8.** Number of persons with SMI/SED admitted to institutional care	1	2	1	2	1	5	1.4	3	0
		9. Average daily institutional occupancy rate	1	1	2	2	1	5	1.4	3	0
		10. Number of licensed psychiatric beds available	1	2	2	2	1	5	1.6	2	0
		11. Number of persons with SMI/SED declining transfer into the community	4	1	N/R	1	N/R	3	2.0	2	0
		12. Number of persons w/SMI admitted to nursing homes identified through PASRR Assessments	1	N/R	N/R	N/R	1	2	1.0	2	0

Domain	Indicator	Measure	Please rank the Burden of collecting this indicator (1 = Least Burdensome to 5 = Most Burdensome)					States Reporting	Avg.	Number of States scoring measure as Least Burdensome or Most Burdensome	
			State	State	State	State	State			# Least Burden (1)	# Most Burden (5)
Housing	Increase in percentage of persons with SMI receiving housing supports	**13.** Number of persons with SMI residing in HUD-subsidized housing units	4	N/R	N/R	N/R	N/R	1	4.0	0	0
		14. Number of persons with SMI receiving non-HUD permanent supported housing services	1	1	1	N/R	N/R	3	1.0	3	0
		15. Number of persons with SMI receiving non-HUD supervised housing services	3	N/R	1	N/R	N/R	2	2.0	1	0
		16. Number of persons receiving other housing services not captured in measures 13-15 above	N/R	N/R	1	N/R	3	2	2.0	1	0
	Decrease in length of time on housing waiting lists	**17.** Number of persons with SMI on a housing waiting list	1	N/R	N/R	N/R	N/R	1	1.0	1	0
		18. Average wait time for housing (months)	4	2	N/R	N/R	N/R	2	3.0	0	0
Community Capacity	Increase in utilization of community-based services	**19.** Number of persons with SMI/SED receiving targeted case management services	2	N/R	1	1	2	4	1.5	2	0
		20. Number of persons w/SMI receiving Assertive Community Treatment (ACT)	2	1	N/R	2	2	4	1.75	1	0
		21. Number of persons w/SMI enrolled in supported employment	3	1	2	2	2	5	2.0	1	0
		22. a) Number of persons with SMI employed full time or part time	5	N/R	2	N/R	5	3	4.0	0	2
		22. b) Number of persons served by the SMHA who are employed full time or part time	5	1	2	N/R	5	4	3.25	1	2
		23. Number of children with SED receiving wraparound services	N/R	N/R	N/R	N/R	2	1	2.0	0	0
		24. a) Number of crisis residential beds available in the community	2	4	1	4	1	5	2.4	1	0
		24. b) Number of people receiving institutional diversion services	N/R	2	2	2	1	4	1.75	1	0
		25. Number of people receiving in-home services	4	1	2	N/R	2	4	2.25	1	0

Domain	Indicator	Measure	Please rank the Burden of collecting this indicator (1 = Least Burdensome to 5 = Most Burdensome)					States Reporting	Avg.	Number of States scoring measure as Least Burdensome or Most Burdensome	
			State	State	State	State	State			# Least Burden (1)	# Most Burden (5)
Community Capacity, Cont'd…	Increase in utilization of community-based services, cont'd…	**26.** Number of persons receiving family support services	N/R	N/R	4	1	N/R	2	2.5	1	0
		27. Emergency room admissions to general hospitals for psychiatric treatment	5	3	4	N/R	2	4	3.5	0	1
Well-Being	Increase in percentage of persons expressing social inclusion or connectedness	**28.** Number or percentage of consumers reporting positively about social connectedness (MHSIP Survey Module)	N/R	3	1	2	2	4	2.0	1	0
		29. Number of adults with SMI involved in peer support programs (including clubhouse programs)	N/R	N/R	2	2	2	3	2.0	0	0
Measures for At-Risk Groups	Measures of early intervention services to avoid institutional-ization	**30.** a) Does your state have 24-hour crisis hotlines? If yes, are they available statewide or limited to certain regions?	3	1	N/R	4	2	4	2.5	1	0
		30. b) How many calls were received at the 24-hour crisis hotline in the past month/year?	3	N/R	N/R	4	2	3	3.0	0	0
		31. a) Does your state have warm lines operated by mental health consumers to assist persons in crisis? If yes, are they available statewide, or limited to certain regions?	N/R	1	N/R	1	1	3	1.0	3	0
		31. b) How many peers staff these warm lines?	N/R	1	N/R	1	N/R	2	1.0	2	0
		31. c) How many calls were received on the warm lines in the past month/year?	N/R	1	N/R	1	2	3	1.33	2	0
		32. a) How many 24/7 mobile crisis teams does your state have?	N/R	N/R	1	1	1	3	1.0	3	0
		32. b) How many people received services provided by mobile crisis teams in the past year?	4	N/R	1	1	1	4	1.75	3	0
		33. Number of persons who are homeless and mentally ill, including shelters and transitional housing programs	N/R	1	4	2	3	4	2.5	1	0

Domain	Indicator	Measure	Please rank the Burden of collecting this indicator (1 = Least Burdensome to 5 = Most Burdensome)					States Reporting	Avg.	Number of States scoring measure as Least Burdensome or Most Burdensome	
			State	State	State	State	State			# Least Burden (1)	# Most Burden (5)
Measures for At-Risk Groups, Cont'd…	Measures of early intervention services to avoid institutional-ization, Cont'd…	**34.** Number of mentally ill individuals involved in the criminal justice system (e.g., persons discharged from jail programs and/or on probation)	N/R	1	2	2	N/R	3	1.67	1	0
		35. Repeat psychiatric users of the emergency department	N/R	N/R	2	N/R	1	2	1.5	1	0
		36. Individuals with non-fatal suicide attempts	N/R	N/R	N/R	N/R	2	1	2.0	0	0
		37. Number of individuals with co-occurring substance abuse (i.e., individuals with repeated use of detox, IP, residential)	N/R	1	1	3	1	4	1.5	3	0
		38. Number of adults with mental illness in board and care homes	N/R	1	4	N/R	N/R	2	2.5	1	0
Policy		**39.** Does the state have policies or rules in place intended to prohibit or reduce discharges from state hospitals or local psychiatric units into segregated settings?	3	2	2	N/R	N/R	3	2.33	0	0
		40. Has the state developed new (in the last two years) funding initiatives that provide community services to help keep people out of institutions?	1	1	2	3	N/R	4	1.75	2	0
		41. Does the state employ differential reimbursement rates to discourage admissions of persons with mental illnesses into segregated settings and/or to encourage placement into integrated settings?	3	N/R	N/R	N/R	N/R	1	3.0	0	0
		42. Does the state have a standardized assessment of readiness for discharge from institutional care that is regularly updated for all consumers in institutional settings?	3	1	2	N/R	N/R	2	2.0	1	0

Domain	Indicator	Measure	Please rank the Burden of collecting this indicator (1 = Least Burdensome to 5 = Most Burdensome)					States Reporting	Avg.	Number of States scoring measure as Least Burdensome or Most Burdensome	
			State	State	State	State	State			# Least Burden (1)	# Most Burden (5)
Policy, Cont'd…		**43.** Does your state have other policies or rules to ensure services are provided in the least restrictive setting to avoid clinically-unnecessary institutional admission?	N/R	1	2	3	N/R	3	2.0	1	0
		44. Does your state have a policy or system in place to monitor housing wait lists?	4	1	5	N/R	N/R	3	3.33	1	1
		45. Does your state have a policy or system in place to monitor the amount of time consumers spend waiting for housing?	N/R	1	5	N/R	N/R	2	3.0	1	1
		46. Does your state have a standardized methodology to track persons declining discharge to the community?	4	2	N/R	1	N/R	3	2.33	1	0
		47. Does your SMHA have a program(s) to provide education and encouragement to patients about the opportunities and successes they can have in accepting discharge to the community?	3	1	N/R	2	N/R	3	2.0	1	0
		Number of Measures Scored:	**35**	**37**	**37**	**32**	**34**				

Utility & Burden of Measures by Domain

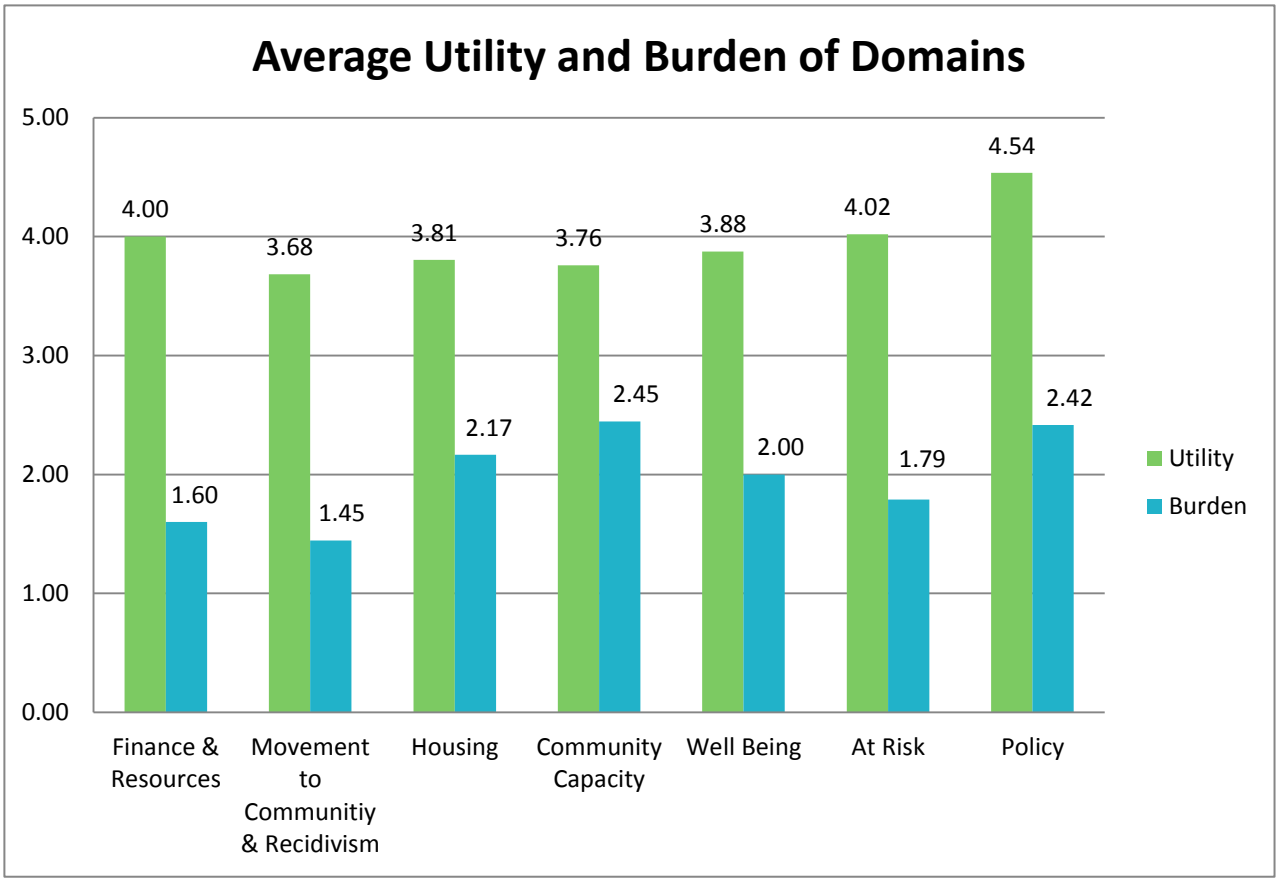
The goal of the TEP was to develop measures that are most useful to state planners and decision makers, while being the least burdensome on staff and fiscal resources to collect. The TEP achieved their goal, as each domain's utility was ranked much higher than the respective burden to collect the measures.

Overall, measures in the Community Capacity Domain are the most burdensome for states to collect, with an average burden score of 2.45. While the average utility for measures within this domain is greater than the data collection burden; the average utility score is the second lowest for all domains.

Measures in the Movement to the Community and Recidivism Domain are the least burdensome for states to collect, with an average burden score of 1.45; however, these measures also have the lowest utility, with an average utility score of 3.68.

Measures in the Policy domain received the highest utility score from pilot states, with an average utility score of 4.54. The policy domain measures also averaged higher burden scores (average = 2.42) than all but one other domain (Community Capacity); however, the burden scores still averaged less than a medium-level of burden Likert score of 3. Figure 2 shows how the average utility and burden scores compare for each domain.

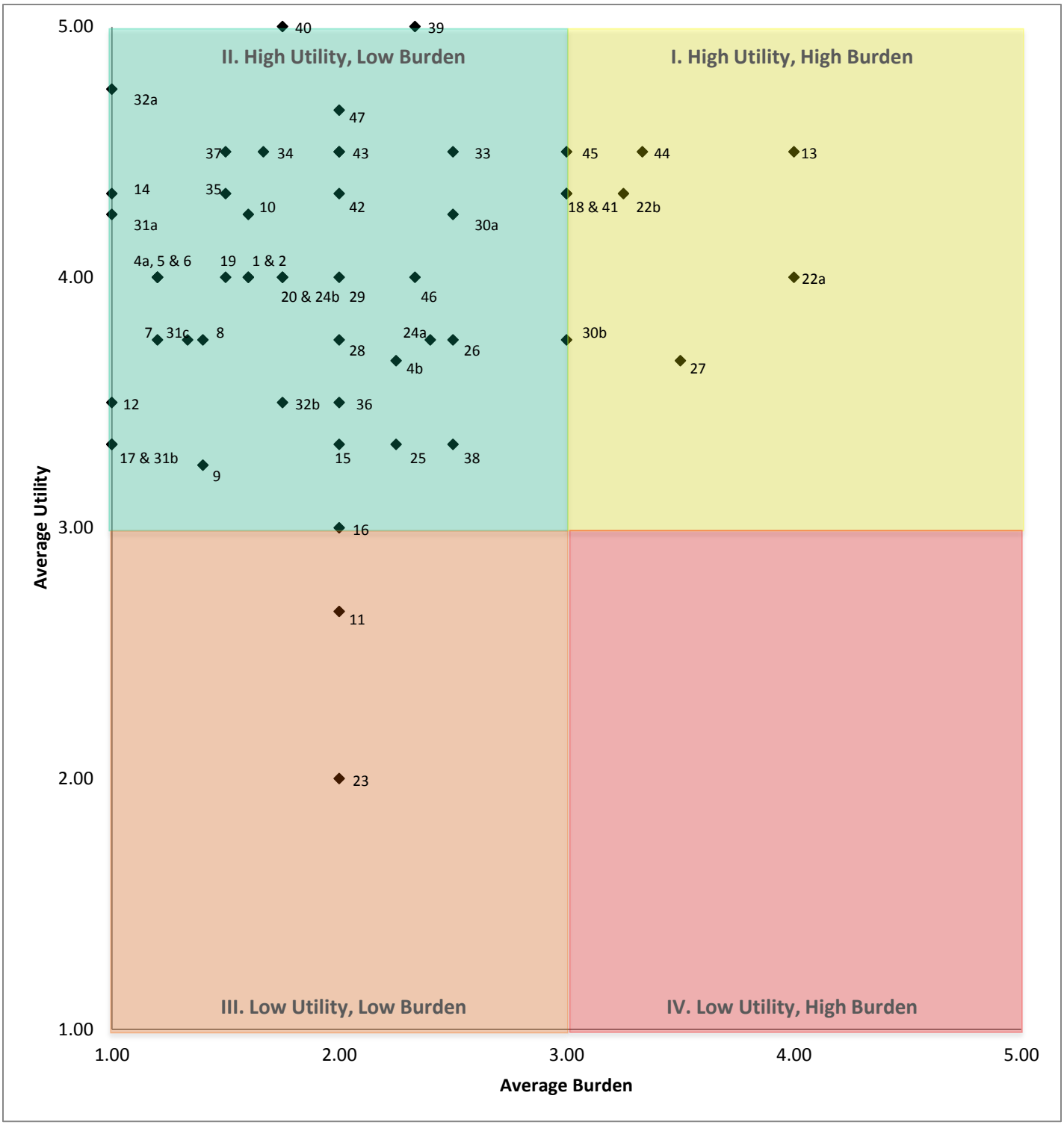
Figure 2: Average Utility and Burden of Domains



Utility and Burden of Measures

Figure 3 shows the correspondence between measures of utility and burden. Measures in the upper left quadrant were rated by states as most useful and least burdensome to collect, while measures in the bottom right quadrant were least useful to states and were most burdensome to collect. Only two measures scored below the mid-range in terms of usefulness (< 3); however, these scores were also not very burdensome for states to collect (average Likert score for burden = 2). None of the scores were rated as least useful and most burdensome.

Figure 3: Relationship of Utility and Burden Assessments of Community Integration Measures



**Numbers next to data points indicate corresponding measure. A list of measures, by number, can be found in Appendix G.*

Table 11 shows the highest rated measures, on average (≥ 4.5 on Likert scale), that also have low average burden scores (≤ 2.5 on Likert scale). State comments provide examples of how state *Olmstead* planners, policy makers, and other key stakeholders rated the utility of the measures for their work in assessing the status of their state regarding community integration.

Table 11: Measures with the Highest Average Utility and Low Average Burden

Measure Number/Name	Average Utility	Average Burden	State Utility Comments
40. Has the state developed new (in the last two years) funding initiatives that provide community services to help keep people out of institutions?	5.00	1.75	This is a key measure of a state's community integration efforts, as this indicator encompasses a wide range of initiatives geared toward the reduction of institutionalization or mental health consumers. This measure demonstrates commitment of the state (beyond the SMHA) to *Olmstead* implementation for persons with SMI. Understanding what resources are available is critical as states develop *Olmstead* plans and data collection initiatives.
39. Does the state have policies or rules in place intended to prohibit or reduce discharges from state hospitals or local psychiatric units into segregated settings?	5.00	2.33	This measure is helpful for states to be aware of the policies that influence the movement of individuals throughout the service system.
32. a) How many 24/7 mobile crisis teams does your state have?	4.75	1.00	This information is useful in looking at available resources in communities that can act as diversion services from hospital-level care. It is also helpful as states continue to grow the use of crisis services in order to have a better idea how many people can access these services, and where (geographically) consumers access them most.
47. Does your SMHA have a program(s) to provide education and encouragement to patients about the opportunities and successes they can have in accepting discharge to the community?	4.67	2.00	Those refusing to be discharged from the state hospital are among the most difficult consumers to place in the community, and the reasons behind these refusals often differ from day to day. The SMHA's ability to examine and respond to the needs of this population is critical, not only to its compliance with any *Olmstead* settlement agreements, but to also further the overall goals of reducing institutionalization and improving community integration.
37. Number of individuals with co-occurring substance abuse (i.e., individuals with repeated use of detox, IP, residential, etc.)	4.50	1.50	Understanding the scope of this population is critical so that the SMHA can tailor services that meet the whole of a person's needs, resulting in better overall health outcomes. This measure also allows for an understanding of the reciprocal impact of substance abuse and mental illness, especially in states with integrated behavioral health systems. The one drawback to this measure is that it is limited in its ability to capture information on individuals beyond the SMHA's purview.

Measure Number/Name	Average Utility	Average Burden	State Utility Comments
34. Number of mentally ill individuals involved in the criminal justice system (e.g., persons discharged from jail programs and/or on probation)	4.50	1.67	Determining the size of this population enables SMHAs to better provide more effective intervention and diversion programs.
21. Number of persons with SMI enrolled in supported employment	4.50	2.00	Employment is a very important indicator of recovery, wellness, and community tenure.
43. Does your state have other policies or rules to ensure services are provided in the least restrictive setting to avoid clinically unnecessary institutional admission?	4.50	2.00	Similar to measure 40, states indicated that this is a key measure of the state's community integration efforts, as it encompasses a wide rage of initiatives directed toward the reduction of institutionalization of mental health consumers.
33. Number of persons who are homeless and mentally ill, including shelters and transitional housing programs	4.50	2.00	This measure is helpful in gaining a broader understanding of the housing and support needs for individuals who are homeless and mentally ill. Determining the scope of this population also allows SMHAs to apply for targeted funding, and to better plan a service continuum to meet the specific needs of this population.

Multi-Year Comparison of Average Utility and Burden Scores

Twenty-four measures were carried over (verbatim, or only very slightly modified) from the 2012 version of the tool. These measures were analyzed for changes in average utility and burden scores from 2012 to 2013. Of these 24 measures, four were slightly modified from the original tool based on feedback from the pilot states, expert panels, DOJ, and SAMHSA. The four modified measures are:

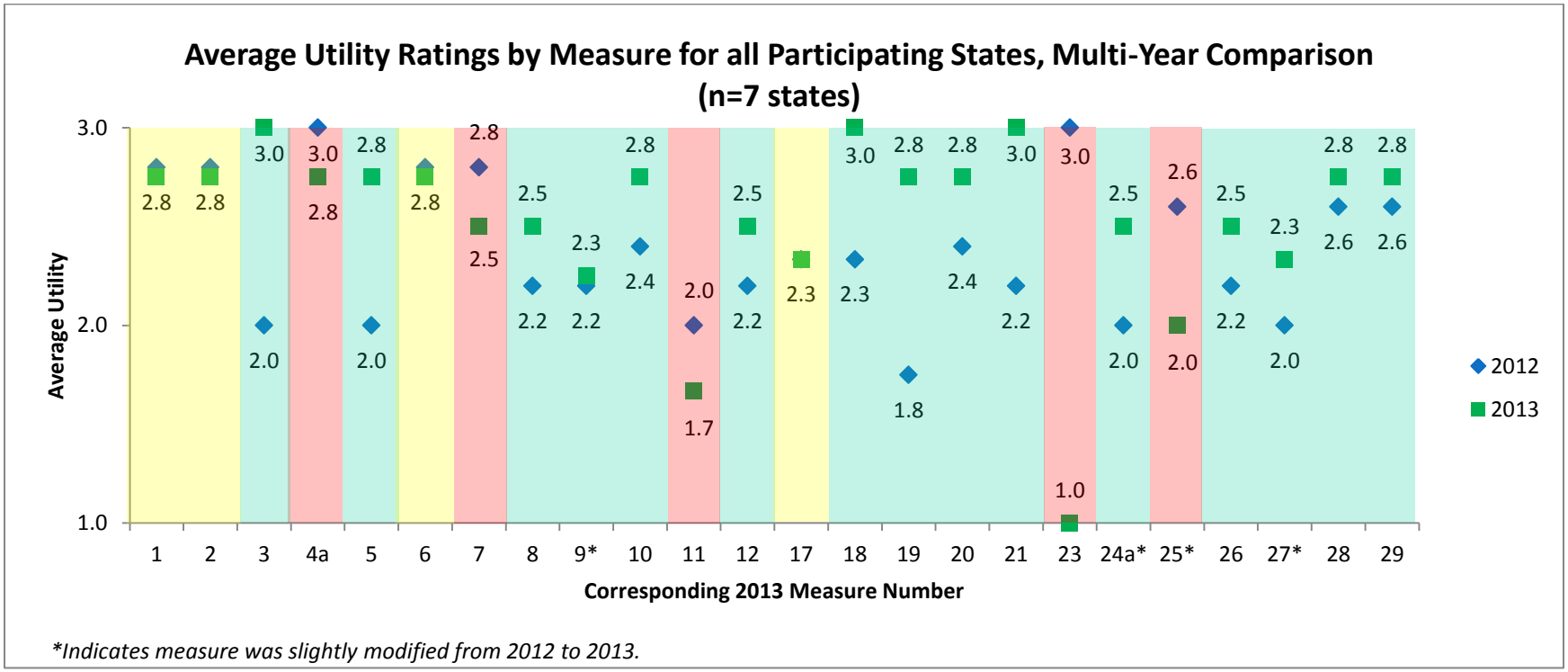
Original 2012 Measure:		Modified 2013 Measure:
Average daily census (Total patient days in year/365; Measure 9)	→	Average daily institutional occupancy rate (Measure 9)
Number of crisis residential beds available for inpatient diversion (Measure 25)	→	Number of crisis residential beds available in the community (Measure 24.a)
Number of children receiving in-home services (Measure 26)	→	Number of people receiving in-home services (Measure 25)
SMI emergency room admissions to the general hospital (Measure 28)	→	Emergency room admissions to general hospitals for psychiatric treatment (Measure 27)

Subsequent paragraphs examine the changes across years, and investigate why some measures may have received higher or lower average utility and burden scores from the prior year.

Utility

With seven states responding to utility across the two years (DE, IL, MN, NJ, OK, VT, and WA), the average utility of the original measures increased from 2.1 to 2.2 on a Likert scale of 1 to 3 (1 = least useful, 3 = most useful). Figure 4 shows the variation in average utility scores for each of the 24 measures across the two years.

Figure 4: Average Utility Ratings for all Participating States, Multi-Year Comparison (n=7 states)



**Indicates measure was slightly modified from 2012 to 2013.*

The majority (15) of the original 24 measures received higher average utility ratings in 2013 than in 2012 (highlighted in green), four had no change in average utility score (highlighted in yellow), and five of the original measures received lower average utility ratings in 2013 (highlighted in red). Of the four measures that were modified slightly for the 2013 pilot, three received higher utility scores

in 2013 than in 2012; the fourth measure received a lower utility score in 2013. A breakdown of differences for each of the measures across years, including potential explanations for variations (when applicable and available), is provided in Table 12.

Table 12: Explanation of Changes in Utility Scores across Two Years of the Pilot

Measure	2012 Average Utility Score	2013 Average Utility Score	Difference	Explanation
1. State mental health expenditures on community-based programs	2.8	2.8	None	N/A
2. State expenditures on psychiatric hospital/inpatient care	2.8	2.8	None	N/A
3. Number of HCBS slots available	2.0	3.0	+1.0	Repeat states rated this measure two points higher in 2013 (from 1 to 3). This increase in score is due to states evaluating the measure from a different perspective: because this measure was not applicable to all states in the 2012 pilot, the utility rating suffered (e.g., "if it does not apply to my state, it is not a useful measure"). In the 2013 version, returning states were encouraged to consider how useful this measure might be if they had the specific waiver in their state.
4. a) Number of persons with SMI/SED awaiting discharge by type of institution for more than three months	3.0	2.8	-0.2	Average utility ratings from repeat states did not change across years (average = 3). New states indicated this measure would be more useful if it got to the reason why people were awaiting discharge, rather than just the number.
5. Number of patients in the institution with a length of stay greater than one year (at end of year)	2.0	2.8	+0.2	Repeat states rated this measure two points higher in 2013 (from 1 to 3). No indication for the increase in utility is provided; however, the increased score may be attributed to one of the returning pilot states having a different group of stakeholders respond to the survey.
6. Number or percentage of persons with a length of stay greater than one year discharged during the year	2.8	2.8	None	N/A
7. Number of persons with SMI/SED readmitted to any (or same) type of institution within six months	2.8	2.5	-0.3	Repeat states rated this measure one point lower in 2013 (from 3 to 2). The decreased score may be attributed to one of the returning pilot states having a different group of stakeholders respond to the survey. This state suggested that the utility of this indicator is hampered by the notion that information produced from this measure is ambiguous. Some readmissions may be helpful, but it would depend on the context and precipitants of the readmission.

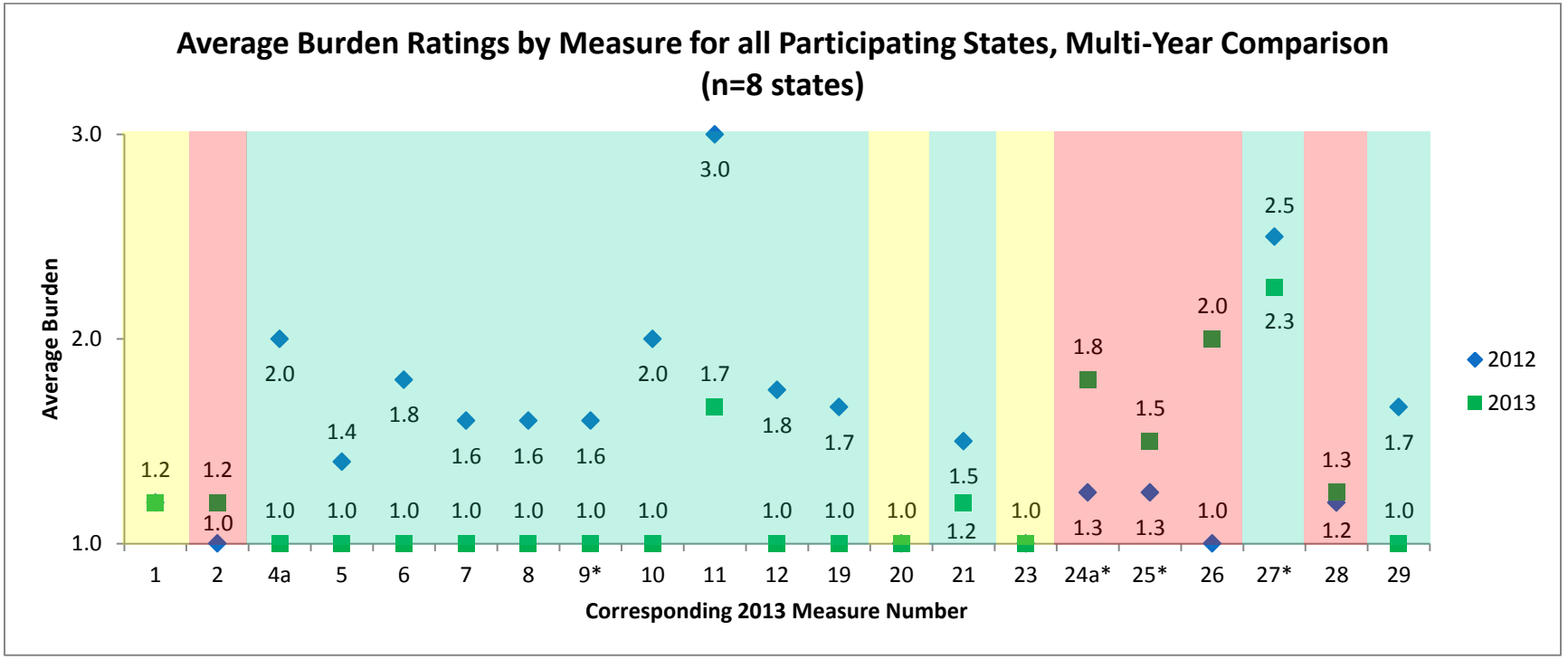
Measure	2012 Average Utility Score	2013 Average Utility Score	Difference	Explanation
8. Number of persons with SMI/SED admitted to institutional care	2.2	2.5	+0.3	Repeat states rated this measure one half point lower in 2013 (from 3 to 2.5). Despite this lower rating, new states evaluated this measure as highly useful in 2013.
9. Average daily institutional occupancy rate*	2.2	2.3	+0.1	Repeat states rated this measure 1.5 points lower in 2013 (from 3 to 1.5). This is likely because one of the states had a different group of people responding to the utility evaluation. Because the returning states rated this measure as less useful in 2013, it appears that the modification was not effective at increasing utility. However, despite the lower rating from one of the returning states, all remaining states rated this measure as highly useful across both years, bringing up the average.
10. Number of licensed psychiatric beds available	2.4	2.8	+0.4	Average utility ratings from repeat states did not change across years (average = 2.5). The average is brought up by all of the new states assigning this measure the highest possible utility score.
11. Number of persons with SMI/SED declining transfer into the community	2.0	1.7	-0.3	Repeat states rated this measure one point lower in 2013 (from 2 to 1). This is likely due to one of the repeating states had a different group of stakeholders responding to the utility evaluation.
12. Number of persons with SMI admitted to nursing homes identified through PASRR assessments	2.2	2.5	+0.3	Repeat states rated this measure one-half point higher in 2013 (from 2 to 2.5), indicating that this is a useful assessment of how the system is working.
17. Number of persons with SMI on a housing wait list	2.3	2.3	None	N/A
18. Average wait time for housing (months)	2.3	3.0	+0.7	Repeat states rated this measure one point higher in 2013 (from 2 to 3) because it addresses system capacity; however, it was suggested that a standard, operational definition of “wait time” be developed.
19. Number of persons with SMI/SED receiving targeted case management services	1.8	2.8	+1.0	Repeat states rated this measure one half point higher in 2013 (from 2 to 2.5). Targeted case management is an important service in the community, and this measure is useful in preventing people from cycling through inpatient stays. The measure also drives needs-based planning via the examination of service utilization.
20. Number of persons with SMI receiving Assertive Community Treatment	2.4	2.8	+0.4	Average utility ratings from repeat states did not change across years (average = 2.5). New states value this measure because it drives development of new placements, allowing for successful community integration, and also enables the SMHA to examine the use of services across systems.

Measure	2012 Average Utility Score	2013 Average Utility Score	Difference	Explanation
21. Number of persons with SMI enrolled in supported employment	2.2	3.0	+0.8	Repeat states rated this measure 1.5 points higher in 2013 (from 1.5 to 3), as it is a valuable and reliable outcome measure of community integration.
23. Number of children with SED receiving wraparound services	3.0	1.0	-2.0	Repeat states rated this measure two points lower in 2013 (from 3 to 1). This is likely due to having a new group of people respond to the evaluation in one state. They indicate a lack of a quality, consistent definition of wraparound services as the reason for their lower evaluation.
24. a) Number of crisis residential beds available in the community*	2.0	2.5	+0.5	Despite repeat states rating this measure one half point lower in 2013 (from 2.5 to 2), the measure's average utility was brought up by new states ranking this measure as highly useful. Because the returning states rated this measure as less useful in 2013 it appears that the modification was not necessarily effective at increasing utility. However, the returning states' lower score in 2013 can likely be attributed to the fact that a different group of stakeholders responded to the utility evaluation in one state.
25. Number of people receiving in-home services*	2.6	2.0	-0.6	Repeat states rated this measure 1.5 points lower in 2013 (from 3 to 1.5). Because the returning states rated this measure as less useful in 2013, it appears that the modification was not effective at increasing utility. A returning state indicated the measure might be more useful if it were more clearly defined in a way that separates these measures from home-based services already included (e.g., ACT, TCM, and ICM)
26. Number of persons receiving family support services	2.2	2.5	+0.3	Repeat states rated this measure one point higher in 2013 (from 1 to 2). New states indicate this is helpful for planning and evaluation purposes.
27. Emergency room admissions to general hospitals for psychiatric treatment*	2.0	2.3	+0.3	Average utility ratings from repeat states did not change across years (average = 2). This indicates that modifications to the measure were ineffective at increasing utility across years.
28. Number or percentage of consumers reporting positively about social connectedness (MHSIP Survey Module)	2.6	2.8	+0.2	Repeat states rated this measure one half point lower in 2013 (from 3 to 2.5). Despite this decrease in score, the overall average utility increased based on support from new states.
29. Number of adults with SMI involved in peer support programs (including clubhouse programs)	2.6	2.8	+0.2	Repeat states rated this measure one half point higher in 2013 (from 2 to 2.5), because it demonstrates capacity to offer peer services in the state.

Burden

With eight states evaluating burden for 21 of the original 24 measures (DE, IL, MN, NJ, OK, OR, VT, and WA), the average burden of reporting the original measures decreased from 1.0 to 0.9 on a Likert scale of 1 to 3 (1 = least burdensome, 3 = most burdensome). Figure 5 shows the variation in average burden scores for each of the 21 measures across the two years.

Figure 5: Average Burden Ratings for all Participating States, Multi-Year Comparison (n=8 states)



The majority (13) of the original 21 measures received lower average burden ratings in 2013 than in 2012 (highlighted in green), three had no change in average burden scores (highlighted in yellow), and five of the original measures received higher average burden ratings in 2013 (highlighted in red). Of the four measures that were slightly modified for the 2013 pilot, two received lower average burden scores, and two received higher average burden scores. A breakdown of differences for each of the measures across years, including potential explanations for variations (when applicable and available), is provided in Table 13.

Table 13: Explanation of Changes in Burden Scores across Two Years of the Pilot

Measure	2012 Average Burden Score	2013 Average Burden Score	Difference	Explanation
1. State mental health expenditures on community-based programs	1.2	1.2	None	N/A
2. State expenditures on psychiatric hospital/inpatient care	1.0	1.2	+0.2	Repeat states measured this one half point higher in 2013 (from 1 to 1.5)
4. a) Number of persons with SMI/SED awaiting discharge by type of institution for more than three months	2.0	1.0	-1.0	Repeat states measured this one point lower in 2013 (from 2 to 1)
5. Number of patients in the institution with a length of stay greater than one year (at end of year)	1.4	1.0	-0.4	Repeat states measured this one half point lower in 2013 (from 1.5 to 1)
6. Number or percentage of persons with a length of stay greater than one year discharged during the year	1.8	1.0	-0.8	Repeat states measured this one half point lower in 2013 (from 1.5 to 1)
7. Number of persons with SMI/SED readmitted to any (or same) type of institution within six months	1.6	1.0	-0.6	Repeat states measured this one half point lower in 2013 (from 1.5 to 1)
8. Number of persons with SMI/SED admitted to institutional care	1.6	1.0	-0.6	Repeat states measured this one half point lower in 2013 (from 1.5 to 1)
9. Average daily institutional occupancy rate*	1.6	1.0	-0.6	Repeat states measured this one half point lower in 2013 (from 1.5 to 1), suggesting that the modification may have made this measure less burdensome to collect.
10. Number of licensed psychiatric beds available	2.0	1.0	-1.0	Repeat states measured this one point lower in 2013 (from 2 to 1)
11. Number of persons with SMI/SED declining transfer into the community	3.0	1.7	-1.3	Repeat states measured this one point lower in 2013 (from 3 to 2)
12. Number of persons with SMI admitted to nursing homes identified through PASRR assessments	1.8	1.0	-0.8	Repeat states measured this one point lower in 2013 (from 2 to 1)
19. Number of persons with SMI/SED receiving targeted case management services	1.7	1.0	-0.7	Repeat states measured this one point lower in 2013 (from 2 to 1)
20. Number of persons with SMI receiving Assertive Community Treatment	1.0	1.0	None	N/A
21. Number of persons with SMI enrolled in supported employment	1.5	1.2	-0.3	Repeat states measured this one half point higher in 2013 (from 1 to 1.5)
23. Number of children with SED receiving wraparound services	1.0	1.0	None	N/A
24. a) Number of crisis residential beds available in the community*	1.3	1.8	+0.5	Repeat states measured this one half point higher in 2013 (from 1.5 to 2)

Measure	2012 Average Burden Score	2013 Average Burden Score	Difference	Explanation
25. Number of people receiving in-home services*	1.3	1.5	+0.2	Repeat states measured this one point higher in 2013 (from 1 to 2)
26. Number of persons receiving family support services	1.0	2.0	+1.0	
27. Emergency room admissions to general hospitals for psychiatric treatment*	2.5	2.3	-0.2	Average burden ratings from repeat states did not change across years (average = 2.5).
28. Number or percentage of consumers reporting positively about social connectedness (MHSIP Survey Module)	1.2	1.3	+0.1	Repeat states measured this one half point higher in 2013 (from 1.5 to 2)
29. Number of adults with SMI involved in peer support programs (including clubhouse programs)	1.7	1.0	-0.7	Returning states did not evaluate burden for this measure in 2013.

STATES' OVERALL ASSESSMENTS

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, three state assessments are presented in verbatim; Delaware and Oregon did not provide responses to these questions. 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.

Illinois

Benefits: The opportunity to discuss what data and information other pilot states found challenging to collect was helpful. It was also helpful to hear about the activities going on in other pilot states.

Challenges: It is a challenge to collect and aggregate data, and meet with program experts in the time allotted for the pilot given other pressing initiatives being addressed by Division staff.

Reliance on Technical Experts: Illinois found it useful to hear the experts' thoughts on the data pilot and indicators.

Plans to Use Pilot Results: Illinois will determine if the indicators will assist in further planning for the two *Olmstead* consent decrees on which they are working.

Utility of Indicators in Promoting Community Integration: There is general consensus that some of the indicators are helpful and could be helpful; however, staff participating in review of indicators thought it would be good to have comparable data. We did discuss the fact that the indicators would be collected at multiple points in time, and that one needs to track progress across time.

Data Sharing Agreements Emerged as a Result of this Pilot: None yet, but we still may.

Recommendations for Future Versions of the Tool: It would be helpful to have more time for planning and data collection. Illinois staff recommended some changes to the indicators for comparison and contextual purposes.

Minnesota

Benefits: It was helpful for us to reevaluate our data system to gain a broader understanding of where we are and where we want to/need to go with regards to the creation of services and/or how to collect data around current services.

Challenges: There is quite a bit of siloed work being done, and it is a barrier to create collaboration and relationships with all the departments offering some level of service to an individual with mental illness.

Reliance on Technical Experts: Bi-weekly calls were helpful.

Plans to Use Pilot Results: We currently use some of the data in assessing the utilization of services within our system statewide and regionally. We will also use the data to consider new treatment services and support services development.

Utility of Indicators in Promoting Community Integration: We typically feel we do a good job with community integration; although this is true the data do reflect what we can be.

Data Sharing Agreements Emerged as a Result of this Pilot: No, we were unable to do so.

Recommendations for Future Versions of the Tool: If there would be ways to give more examples of actual data that would be helpful.

New Jersey

Benefits: The pilot provided a forum for the SMHA to examine relevant measures and outcomes, using the burden and utility rating system to identify the most helpful indicators of the state's performance in providing treatment and support to its mental health consumers.

Challenges: The SMHA was challenged by the short timeframes for completing and submitting the pilot materials, as well as the inherent need to assemble a team of division-wide staff to complete its responses. Additionally, New Jersey's *Olmstead* population is understood as it

relates to a current settlement agreement. This differs from the definition of the pilot, which limited the SMHA's opportunity to examine these measures as they relate to the state's true *Olmstead* population, as well as all efforts of the SMHA to comply with the ADA integration mandate. Further, because many of these data elements were not available via a breakdown of SMI versus non-SMI, the state's overall response to these questions was to compile data on the total population of mental health consumers served by New Jersey.

Reliance on Technical Experts: SMHA staff consulted with the technical experts via the bi-weekly conference calls, as well as via unscheduled calls and emails on an as-needed basis. The staff was very prompt and helpful in the administration of trainings, as well as in answering any questions the New Jersey SMHA had in the process of responding to the pilot's questions as accurately as possible.

Plans to Use Pilot Results: The challenges encountered during the completion of this pilot created a dialogue for developing new initiatives as a means of overcoming these obstacles.

Utility of Indicators in Promoting Community Integration: The indicators measured in this pilot referenced a wide array of areas for evaluation. However, they did not include for examination many of the areas where New Jersey has succeeded in the administration of treatment and services to its mental health consumers. New Jersey continues to expand its community infrastructure via the enhancement of its community placement capacity and diversion programs. This expansion has resulted in a significant reduction in the state hospital census, allowing New Jersey to close one of its state hospitals in 2012. In addition to its community resources, the SMHA has also been improving its data infrastructure with the execution of new database tracking initiatives. New Jersey has already implemented one new data system, and will be rolling out two more over the coming months. These new databases will greatly facilitate the state's capacity for data-driven decision making.

Data Sharing Agreements Emerged as a Result of this Pilot: While not enacted as a result of this initiative, the SMHA has in place a number of agreements to work with other departments throughout the state, including Medicaid and the Housing Mortgage and Finance Agency as the state moves forward with new housing initiatives and the development of the RFP for the coming Administrative Services Organization.

Recommendations for Future Versions of the Tool: Rather than focusing primarily on the SMI population, New Jersey recommends that future assessments call for examination of each state's total population of mental health consumers. A valid alternative to this would be to allow each state to report on any applicable and previously defined *Olmstead* population.

CONCLUSIONS AND NEXT STEPS

During its second phase, the pilot continued to produce significant information towards the initial effort in developing a community integration self-assessment tool for SMHAs. Pilot states expressed enthusiasm about this process because it allows them to gather data to identify strengths and weaknesses in their delivery of community mental health services. The process also encourages people at the state level to talk to others with a stake in community integration efforts, and start examining state-level activities through the lens of community integration. While the pilot's point of contact within the states worked for the SMHA, participants underscored the need to network with staff at other levels of state government as effective community integration for persons with mental illness requires a collaborative approach at the state level.

Highlights of this year's effort are as follows:

- State ratings of utility of the proposed community integration measures confirm that the recommended measures are highly useful to SMHAs in conducting self-assessments of their state's efforts at achieving community integration.
- The greatest challenge in completing this self-assessment tool continues to be the limited time states have to network and collaborate with colleagues in other state agencies to access other data sources, and begin establishing data sharing agreements.

As in the first year of the pilot, a key aspect of the pilot approach approved by SAMHSA was that each pilot state retains all state data collected through this effort, and only share the utility and burden evaluations of specific measures. Pilot states appreciated this level of protection, as it enabled states to explore their results without fear of potential negative external uses of the data. To help states use their own community integration data, the pilot design recommended that states look at trends in their own results over the past several years. While this approach results in better participation among pilot states, it constrains the ability of this process to produce benchmarks or standards that states can use to compare their performance against other states or indices that set a level of national acceptable performance. Based on these limitations, the project staff and the TEP identified several potential approaches that can be used to help states better interpret their data to improve their service systems:

- Encourage states to develop intra-state regional benchmarks to determine which geographic areas within their states are excelling or struggling with particular aspects of community integration.
- Provide benchmark results from other state and national studies. These benchmarks can help individual states identify whether their results are in the best possible range of performance. These benchmarks could be incorporated into a data dashboard that

allows states to enter their data to see how well they align with national and regional rates.

- Provide technical assistance with data experts to help states interpret and apply their community integration results.

During a set of post-pilot debriefing calls with representatives from the pilot states, each of these approaches were recognized as having potential to enhance the utility of the community integration self-assessment tool. In addition to the above suggestions, the following are recommendations for future tool and pilot refinement and next steps:

- Given that the overwhelming majority of measures were rated as highly useful low burden to states, very little measure modification should be done for future versions of the tool; however, consideration should be given to suggestions made by the Department of Justice that were not already incorporated in the 2013 version. If possible, no new measures should be added to future versions to ensure that states are not overwhelmed with data unnecessary collection burden. If anything, perhaps some measures should be considered for elimination (e.g., the two measures that fall into Quadrant III – low utility, low burden).
- Create a Community of Practice that expands the number of participating states. Through a series of webinars and other training, SMHAs will be encouraged to use portions of the community integration self-assessment tool to begin assessing their community integration plans. Rather than repeating the 2013 Pilot, the Community of Practice approach will permit states the freedom to use the tool in the most appropriate manner for their respective state. States will be encouraged to provide feedback on their experience; including how the tool was used, what meaningful results and changes (if any) were witnessed as a result of the tool, and suggestions for improved implementation. The community of Practice will be enhanced with orientation and training webinars led by members of the TEP and/or prior Pilot state staff. In addition, Community listservs and periodic conference calls could be established to facilitate state use of the tool.
- Use the experiences of the Pilot states and the Community of Practice participants to develop a toolkit that provides detailed guidance on data collection and interpretation to better understand state efforts related to community integration.
- Targeted work to address the need to improve data on housing supports available to mental health consumers. The one community integration domain where states struggled to acquire good information was measures of housing subsidies and supports. The project could work with one or two Pilot states to serve as a case study to improve understanding of how to access, link, analyze, and interpret housing data sets (including HUD data

- Greater collaboration with other government agencies, such as HUD, could be helpful in assisting states collect data for measures they have traditionally had trouble collecting. Such partnerships could encourage greater collaboration between agencies at the state level.

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APPENDIX B: 2013 COMMUNITY INTEGRATION SELF-ASSESSMENT TOOL (5/21/13)

PROJECT BACKGROUND

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 appropriate mental health services and supports. State mental health authorities (SMHAs) have also used strategies to prevent lengthy and inappropriate use of restrictive settings.

In fiscal year 2012, SAMHSA sponsored the development and pilot of a self-assessment tool on community integration designed for use by SMHAs. This self-assessment tool is intended to provide SMHAs an opportunity to proactively identify their strengths and weaknesses, and identify problems that may disrupt efforts around community integration in their state prior to *Olmstead* litigation. The measures contained within the tool are specific to community integration and are not intended to replace a comprehensive state mental health outcomes or performance measurement system.

During the first year of the pilot, AHP and NRI worked with two expert panels to develop the pilot design process. The Policy Expert Panel (PEP) represented a diverse group of stakeholders and experts involved in efforts to advance community integration in public mental health care. The PEP helped identify the scope and populations for the pilot. The Technical Expert Panel (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 technical assistance and guidance to states throughout the project. Five SMHAs (Delaware, Illinois, Oklahoma, Vermont, and Washington) tested the tool over 14 weeks during the Spring and Summer of 2012. In September 2012, a report summarizing the results of the pilot study, "Community Integration Self-Assessment Tool for State Mental Health Agencies: Pilot Project Final Report," was submitted to SAMHSA.

At the end of FY2012, SAMHSA awarded a new contract to JBS International to continue this effort to refine and expand the Community Integration Self-Assessment tool with a group of six states over the next two years. This document provides an overview of how the measures were derived for the first year of the pilot, as well as the proposed measures for the new self-assessment tool to be tested this year (FY 2013),

PHASE I (2012) SMHA COMMUNITY INTEGRATION SELF-ASSESSMENT TOOL

A review of recent literature on community integration was conducted in February 2012 to guide the development of the tool. The literature review identified definitions of community integration, potential populations, and appropriate treatment settings, as well as potential state and national data sources that could be used to complete the pilot. Data and performance measures being requested or submitted by SMHAs in recent and ongoing *Olmstead* lawsuits were also considered during the development of the measures.

Together with the PEP, AHP and NRI established the scope and populations for the first year pilot. The populations and service settings identified by the PEP included persons receiving care in institutions, persons receiving services in the community at-risk of institutionalization, as well as those living in the community with mental illnesses not receiving any mental health services 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 as well.

Due to limitations in both the time available to states to complete the study, and access to information necessary to test the measures, the TEP recommended limiting the focus of the first pilot to those persons with mental illnesses living in institutional settings and the supports necessary to help move consumers out of these settings into their own communities. SAMHSA and the PEP approved this recommendation. The five primary settings the original tool addresses are:

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

The final self-assessment tool contained two parts: Part I included a set of contextual 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 specific measures. The domains are:

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

DEVELOPING RECOMMENDED MEASURES FOR 2013

At the initial project kickoff meeting with the SAMHSA Task Lead, it was recommended that the development of state self-assessment community integration measures build on the measures tested during the 2012 Pilot. The TEP, NRI, AHP, and participating SAMHSA staff reviewed the results of the initial Pilot Study and identified three set of measures for this year's pilot: (1) measures that were successfully tested during the initial pilot that should be continued in this new study, (2) measures from the pilot that required additional clarification or modification, and (3) new measures identified by the TEP for the 2013 study.

To better understand 2012 pilot states' experiences using the Community Integration Tool, brief conference calls were held with each of the five pilot states to debrief their experiences with particular measures and get a sense of the utility of the overall pilot process. Based on the summary of individual state comments, the TEP requested additional information from the pilot states for several pilot measures that had variation in utility scores from the pilot states. A conference call that included representatives from each of the pilot states, SAMHSA, and TEP members was held that addressed ten measures that received wide variation in utility scores by the pilot states and that elicited recommendations from the pilot states about the utility of these measures.

In addition to refining the measures tested in the original phase, SAMHSA also asked the TEP to assess the utility of expanding the focus of the 2013 Pilot beyond a focus on individuals living in institutional settings and the supports needed to integrate them into the community, to include persons living in the community who are at risk of needing institutional care if appropriate community supports and services are not available. The TEP discussed this expanded focus amongst themselves and with the pilot states to explore the availability of data to complete measures that assess at-risk populations. In order to help states participating in the 2013 Pilot, the TEP recommends including several groups of consumers currently residing in their own communities as an expanded population for at risk:

- Persons with history of repeated prior psychiatric hospitalization
- Persons with repeated Emergency Room use
- Persons with a history of homelessness
- Persons with Criminal Justice System Contacts
- Children placed in Foster Care
- Children involved in the Juvenile Justice System

On January 18, 2013, the Policy Expert Panel (PEP) met by conference call and reviewed the recommendations of the TEP regarding the scope (including expanding to include some at-risk client groups), and set of potential measures for the 2013 Pilot Study. The PEP supported the

concept of expanding the Pilot to include clients at risk of institutionalization and suggested some additional programs states are implementing to help address at-risk consumer needs, including 24-hour hotlines, warm lines staffed by mental health consumers, 24-hour psychiatric assessment facilities, and crisis/respite beds. The PEP also supported retaining the original pilot measures with modified housing measures to facilitate state reporting for the 2013 pilot.

Modified Measures

Based on the utility and burden evaluations and additional feedback from the original five pilot states, the TEP, PEP and SAMHSA, each of the original measures are useful and should be retained for the second year of the pilot; however, ten of the original measures have been recommended for modification. One of the key recommendations that emerged from conversations with the pilot states is that all of the measures could be extremely useful, but only if they are relevant to a state's system. Therefore, states should only report on the measures applicable to their systems. For instance, Measure 3: Number of HCBS Slots Available only applies to those states with HCBS waivers; therefore, it will only be useful to those states with 1915(c) waivers.

Housing Measures

Measures under the housing domain proved the most challenging to states. Of the seven housing measures requested, three yielded no results from any pilot states. The measures states were unable to complete are:

- 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)

Each of these measures received high ratings of utility from the 2012 pilot states, and would be beneficial to states if the data were made available.

In order to provide guidance for the measure, Number of Housing Vouchers and Slots Available by Type for Persons with Mental Illness, several other housing measures, including number of people receiving permanent supported housing, supervised housing, and other housing services require additional clarification. These measures are intended to reflect the number of people receiving services through housing programs subsidized by, and under the direct control of the SMHA; therefore, they do not receive funding from the Department of Housing and Urban Development (HUD). These measures have been modified to clarify that there is no overlap with HUD-supported programs, which are separately counted.

HUD-funded programs are likely to represent the bulk of subsidized housing available to the SMI population in most states. All HUD programs can be grouped together, or shown

separately. The only other substantial source of subsidized housing identified by the TEP is supervised housing supported by the Department of Veterans Affairs. Veterans' supported housing programs are principally funded through the HUD-VASH (Veterans Affairs Supported Housing) program.

The original pilot states were unable to collect data about the number of housing vouchers and slots available for persons with mental illness due to the limited amount of time states had to complete the pilot, as well as no preexisting data sharing agreements between the SMHAs and local housing authorities. The decentralized nature of housing authorities also presents a challenge to SMHAs trying to capture this information.

Upon further investigation, members of the TEP discovered a potential method for states to operationalize the numerator for the measure, Number of Housing Vouchers and Slots Available by Type for Persons with Mental Illness, based on estimates developed by Vermont of persons served in its community mental health system while receiving HUD Section 8 Vouchers for calendar year 2004 . The following are the key steps in the process that other states may simulate to access such data:

1. Permission: Obtain permission to access the HUD Public Information Center (now IMS/PIC; http://www.hud.gov/offices/pih/systems/pic/). This database includes personal identifying and demographic information (e.g., name, social security number, date of birth, and gender; form 50058 provides data collection detail) about persons residing in HUD-subsidized programs, including Section 8 and public housing. Once access is obtained, relevant data for the state can be downloaded into a file for further processing. Permission will require procedures to assure compliance with HUD's privacy and confidentiality regulations.
2. Source of Mental Health Consumer Data: The HUD files do not include information that would directly identify an individual as seriously mentally ill or psychiatrically disabled; therefore, it is necessary to have a second file with individual data on persons that includes personal identifying information that can be matched to the personal identifiers in the HUD file. The second file might include individuals in the SMHA client information system, or selected individuals who are users of mental health services in the State Medicaid claims system. Vermont employed its mental health client information system.
3. Matching: States can undertake procedures for either probabilistic or exact matching. Either method will likely require assistance from an outside contractor. Vermont employed the "probabilistic population estimator," a proprietary system available through The Bristol Observatory (http://www.thebristolobservatory.com). Exact matching algorithms are also available. Culhane, Metraux, and Hadley from the

University of Pennsylvania employed this strategy in their widely-cited study of housing for homeless individuals in New York City .

4. Analysis: After processing the two files for person matches (or estimates of matches), estimates of the number of persons with SMI who reside in HUD-subsidized housing can likely be developed by program type (e.g., Section 8, Public Housing). Depending upon other data available and the sample sizes, estimates for subgroups of interest can also be developed.

HUD has two other publically-available databases that provide information on subsidized housing programs at both state and sub-state levels that may be helpful for states completing the housing measures. The databases are:

- Picture of Subsidized Households (PSH; http://www.huduser.org/portal/picture/picture2009.html)
- Resident Characteristics Report (RCR; http://www.hud.gov/offices/pih/systems/pic/50058/rcr/index.cfm)

Using online tools, aggregated reports showing the number of housing units, as well as tables with demographic characteristics of households and residents can be produced from each database. States can use these to provide a view of the subsidized housing inventory, and the characteristics of occupants. The databases do not provide information that allows the breakdown of data by persons with SMI or psychiatric disabilities. The only way to determine these figures is through matching HUD files with appropriate mental health client files, as described above.

Expanding the Population to Include Persons at Risk of Institutionalization:

Persons with a mental illness who are at risk of institutionalization are a priority population for SAMHSA and the Department of Justice, and have been the focus of several recent *Olmstead* settlement decrees. Because of their importance, the at-risk population are included in the expanded population for year two of the pilot. Setting bounds for this population, and selecting indicators to operationalize this population is potentially difficult since persons at risk of institutionalization may have had no prior contact with the state mental health authority, or any other public system that could signify their vulnerability for institutionalization. To make this population more manageable to quantify, Pilot States should focus on persons with a mental illness who have had previous repeated psychiatric hospitalizations; multiple interactions with emergency departments at general hospitals; are homeless; and/or have had interactions with the criminal justice, juvenile justice, or child welfare systems. Measures focused on the capacity of the community setting that prevent institutionalization could also serve as indicators about a state's readiness to serve the larger at-risk population in the community.

Risk of institutionalization means persons at risk of going into any institutional setting, including residential treatment facilities, adult care homes, nursing homes, and state hospitals, among other restrictive settings that may be relied upon due to a lack of community resources. To avoid and minimize unnecessary use of institutional settings, SMHAs are providing early intervention, crisis, and other community services and supports that allow persons at risk of institutionalization to instead remain living in their own communities.

Because it is difficult to identify all persons who are at risk of institutionalization, the TEP recommends the inclusion of several measures of services that can help divert at-risk persons away from institutional settings. In developing measures for the at-risk populations, the TEP has discussed three potential levels or types of measures:

1. Assuring that persons in at-risk groups (such as homeless, high ER users, persons with repeated hospitalizations, etc.) are addressed in existing measures of community capacity. For example, measuring to make sure that persons who are homeless are accessing Targeted Case Management services (measure 20) or are receiving Assertive Community Treatment (measure 21).
2. Measures of the extent to which SMHAs are offering an array of services and supports designed to provide early intervention or community supports that reduce the need for institutional services. This level of measure would address if SMHAs have certain initiatives, such as 24-hour hotlines, warm lines, crisis services available, rather than creating a measure based on the rate of these service usage.
3. Measures that document the rate of utilization of services designed to help keep at-risk groups out of institutional settings. An example of this third level measure is the number of consumers served by 24-hour crisis or respite beds in the community during the year, divided by the number of adults with a mental illness on SSI/SSDI roles in the state.

Programs identified as important to help reduce institutional use by persons at risk include:

- 24-hour hotlines
- Warm lines staffed by mental health consumers
- Crisis apartments/respite beds
- 24/7 mobile crisis teams
- Homeless outreach programs

Many individuals considered at risk for institutionalization will also be captured within the existing domains for which performance indicators have already been established. To determine the best approximation of the numbers of persons at risk, a method will have to be established that will permit the states to unduplicate the data, after the data for both the

existing population and the potential at-risk population have been collected. Key at-risk populations, numerators, and denominators for these populations are listed below.

Numerators for At Risk:

- Measures of the size of potential at-risk population:
  - Number of individuals who are homeless/mentally ill, including shelters and transitional programs (HMIS database)
  - Number of individuals involved in the Criminal Justice system with MI (i.e. individuals who have been discharged from jail programs and individuals on probation). These data would be collected through jail program discharge data, or shared data between systems.
  - Emergency Department repeat psychiatric users (HCUP in some states, Medicaid records)
  - Individuals with non-fatal suicide attempts (CDC reports)
  - Number of individuals with co-occurring substance abuse (i.e., individuals with SMI who have repeated use of detox/IP/residential)
  - Number of adults with mental illnesses in board and care homes
  - Number of children with SED
    - Potential data could be derived from state education systems/specialized programs, and the juvenile justice system
  - Adults on SSI/SSDI rolls with mental illness(MI; information should be available from SSA)
- Measures of Early Intervention/Services to avoid institutionalization
  - Number of individuals using mental health CRISIS programs
  - Warm lines/hot lines
  - Mental health diversion services
- Number of individuals with repeated state hospital use who are not enrolled in community based recovery programs

Denominators for At Risk

There are multiple denominators that would be available for use with the at-risk population; the use of the denominators will vary according to the state system design and the type of indicator.

- SMHA data for individual state programs
- SMI/SED prevalence rate, as defined by SAMHSA, constructed for each state by NRI (which would ensure some construct validity for the determination of the denominator)
- Number of persons with mental health condition served by MA authority

- Number of persons with SMI/SED determined through individual state estimates based on population mental health prevalence rates

Policy Domain: New for 2013

The first version of the Community Integration Self-Assessment Tool did not include any measures aimed at capturing policies, procedures, or systems in place or being changed by the SMHA with the goal to minimize or eliminate unnecessary institutionalization. Such policies, procedures, and systems may help states identify potential problems, and efficiently respond before they become pervasive. While data from other indicators will remain with the states, states will have the option to share the information collected through the policy domain with SAMHSA. Information about policies shared with SAMHSA will be used to begin establishing best practices that other states may find useful to implement in their systems.

PHASE II (2013) SMHA COMMUNITY INTEGRATION SELF-ASSESSMENT TOOL

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 measures 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 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 the pilot states.

During the pilot, 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 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 a copy of your plan, or provide a link to its location online, 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. *Interagency collaboration to promote community integration*: How does the SMHA collaborate with other state agencies in promoting community integration (provide two to three examples)? For example, how is your SMHA working with state housing agencies to increase available community living settings?
4. *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 a 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?

5. *Use of Housing and Urban Development (HUD) programs to fund housing or housing support services that promote community integration*: Please describe the various HUD housing vouchers, subsidies, and other programs that are used to support community living arrangements for mental health consumers. Please describe your SMHA's involvement/role in providing housing for mental health consumers.
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. Although protected under *Olmstead* and the ADA, for the purpose of this pilot, long-term forensic patients and persons admitted for pretrial competency evaluations (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.

- *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 of 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

Through participating in this pilot, it is expected that pilot states will:

- 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, and
- Help SAMHSA and the mental health field develop a self-assessment tool for use by other States and other systems.

2013 Matrix of Indicators for Advancing Community Integration

Domain	Indicator	Indicator Specifications		Applicable Settings	Applicable Population	Data Sources	Additional Considerations
		Numerator	Denominator				
Financing and Resources	Increase in Funding for Community-Based Programs	1. State mental health 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 note in Additional Considerations.)	SMHA/State System	SMHA-served population, children and adults. Should be reported at a minimum as children and adults (using state definitions). Pilot states recommended reporting using URS age groups: • Children age 0-17 • Young adults age 18-20 • Adults age 21 and over	Revenues and Expenditures Medicaid Claims Data NDS for Nursing Homes SMHA MIS	Expenditure data may be collected as: • Aggregate • By institution • By population • By service type ***Note:*** 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	SMHA-served population, children and adults. Should be reported at a minimum as children and adults (using state definitions). Pilot states recommended reporting using URS age groups: • Children age 0-17 • Young adults age 18-20 • Adults age 21 and over	Revenues and Expenditures Medicaid Claims Data NDS for Nursing Homes SMHA MIS	Expenditure data may be collected as: • Aggregate • By institution • By population • By service type ***Note:*** If available, additional funding streams may be considered, but should be separated and identified as such.
		3. Number of HCBS slots available (only applicable to states with 1915(c) waivers)	State SMI/SED population	SMHA/State System	Adults with SMI Children with SED	Medicaid SMHA MIS	***Alternate denominators:*** • Medicaid-eligible population • Number of persons with SMI/SED transitioning into the community

Domain	Indicator	Indicator Specifications		Applicable Settings	Applicable Population	Data Sources	Additional Considerations
		Numerator	Denominator				
Movement to the Community and Recidivism	Decrease in Length of Time Waiting for Discharge	4. a) Number of persons awaiting discharge by type of institution for more than three months. 4. b) Does the state have a standardized assessment, updated regularly (quarterly, monthly, etc.) to assess readiness for discharge?	Institutional census Number of persons discharged	By institution Applicable to all institutions.	Adults with SMI Children with SED	Institutional databases. SMHA MIS	***Alternate denominators:*** • Number of persons with SMI/SED deemed eligible and ready to transition • Average daily census, by institution. ***Notes:*** -Other time factors may be considered (e.g., awaiting discharge for 30 days, or more than one year, etc.) -In 2012, at least one pilot state indicated they have a standardized assessment that identifies patients ready for discharge. States with such a measure should use it; those without should skip this measure.
	Decrease in Length of Stay	5. Number of patients in the inst. w/ length-of-stay > 1 yr (end of yr.).	Institutional census # of persons discharged	By institution	Adults with SMI Children with SED	Institutional databases. SMHA MIS	
		6. Number or percent of persons with length-of-stay greater than 1 yr (disch. during year).	Institutional census Number of persons discharged	By institution	Adults with SMI Children with 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 Number of persons discharged	By institution	Adults with SMI Children with SED	Institutional databases. SMHA MIS	***Notes:*** -Other time factors may be considered (e.g., readmission within 30 days) -At a minimum, states should look at readmissions to any state psychiatric hospital; however, if states are able to measure readmission to any institutional setting (e.g., jails, nursing homes, adult care homes, residential treatment centers, etc.) that would be better. States should report which levels of institutional settings they are able to measure readmissions.

Domain	Indicator	Indicator Specifications		Applicable Settings	Applicable Population	Data Sources	Additional Considerations
		Numerator	**Denominator**				
Movement to the Community and Recidivism, Continued…	Decrease in Utilization Rate of Institutional Settings	8. Number of persons with SMI/SED admitted to institutional care.	State SMI/SED population	By institution	Adults with SMI Children with SED	Institutional databases. SMHA MIS	Use state definition for SMI/SED
		9. Average daily institutional occupancy rate	365	By institution	Adults with SMI Children with SED	Institutional databases.	***Note:*** For institutions with mixed beds, the measure should specify the occupancy rate of SMI/SED beds only.
		10. Number of licensed psychiatric beds available	State SMI/SED population	By institution	Adults with SMI Children with SED	Institutional databases.	***Note:*** Can be operationalized depending on each state's situation. Ex:, # of licensed beds available on last day of the year, or whatever is easiest for states to report.
		11. Number of persons with SMI/SED declining transfer to the community annually.	Number of persons awaiting discharge from an institution.	By institution	Adults with SMI Children with SED	Institutional databases.	***Notes:*** -Some states track this 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. -Because many states do not have these data, two Policy Component questions to gather information related to this measure: 1. Does the state have a standardized methodology to track those declining discharge to the community? 2. Does the SMHA have a program(s) to provide education and encouragement to patients about the opportunities and successes they can have in accepting discharge to the community?
		12. # of persons with SMI admitted to nursing homes identified through PASRR assessments.	Nursing home census	Nursing homes	Adults with SMI	CMS Minimum Data Set	

Domain	Indicator	Indicator Specifications		Applicable Settings	Applicable Population	Data Sources	Additional Considerations
		Numerator	Denominator				
Housing	Increase in Percentage of Persons with SMI Receiving Housing Support Services	13. Number of persons with SMI residing in HUD-subsidized housing units.	State SMI population	SMHA/State System	Adults with SMI	State/Local client-level housing data in combination w/ SMHA MIS or other client-level data sets.	***Notes:*** Focus on fed.-funded housing progs, include vouchers, subsidies, public housing and tax credits that require state or local housing authorities to collect individual data following HUD design requirements. Also consider state-funded housing progs outside MH that could be included.
		14. Number of persons with SMI receiving non-HUD permanent supported housing services.	State SMI population	SMHA/State System	Adults with SMI	SMHA MIS	***Alternate Denominator:*** Number of clients receiving housing services or supports. ***Note:*** This measure is relevant to those states that subsidize permanent supported housing with state-appropriated funds. See appendix for def.of supported housing.
		15. Number of persons with SMI receiving non-HUD supervised housing services.	State SMI population	SMHA/State System	Adults with SMI	SMHA MIS	***Note:*** This measure is relevant to states that provide licensed housing programs (e.g., group homes, supervised apartments), subsidized through state-approp. funds. See appendix.
		16. Number of persons receiving other housing services not captured in measures 13-15.	State SMI population	SMHA/State System	Adults with SMI	SMHA MIS	***Note:*** "Other housing services" refers to anything else the SMHA may do related to housing with state-appropriated funds, or with Federal CMHS funding (e.g., the Mental Health Block Grant, Path, etc.) not already counted in measures 13-15.
	Decrease in Length of Time on Housing Waiting Lists	17. Number of persons with SMI on housing wait list.	State SMI population	SMHA/State System	Adults with SMI	SMHA MIS	
		18. Average wait time for housing (months)		SMHA/State System	Adults with SMI	SMHA MIS	***Note:*** If poss., determine how many are on wait list by length of time: • Three months or less • Three to six months • Six months to one year • Two years or more

Domain	Indicator	Indicator Specifications		Applicable Settings	Applicable Population	Data Sources	Additional Considerations
		Numerator	**Denominator**				
Community Capacity	Increase in Utilization Rates of Community-Based Services	19. Number of persons with SMI/SED receiving intensive targeted case management services	State SMI/SED population # of people with SMI/SED waiting for intensive TCM	SMHA/State System	Adults with SMI Children with SED	SMHA MIS	***Note:*** It is likely that all consumers receive some case management service; therefore, the measure is more meaningful if it only encompasses intensive targeted case management services, and/or as a measure of people who need intensive TCM.
		20. Number of persons with SMI receiving Assertive Community Treatment (ACT)	State SMI/SED population	SMHA/State System	Adults with SMI	SMHA MIS	***Alternate Numerator:*** Number of persons with SMI receiving ACT who have a history of institutionalization (which demonstrates how ACT helps divert people from institutions)
		21. Number of persons with SMI enrolled in supported employment.	State SMI population	SMHA/State System	Adults with SMI	SMHA MIS	
		22. a) Number of persons with SMI employed full time or part time. 22. b) Number of persons served by the SMHA who are employed full time or part time.	State SMI population	SMHA/State System	Adults with SMI	SMHA MIS Medicaid	***Note:*** 22. a) focuses on all persons in the state with a mental illness (e.g., persons served by Medicaid or other systems outside of the SMHA). 22. b) focuses on persons with a mental illness served by the SMHA.
		23. Number of children with SED receiving wraparound services.	Number of Medicaid-eligible children	SMHA/State System	Children with SED	SMHA MIS Medicaid	***Note:*** Recommended combining all community services that are an alternative to institutionalization. ***Alternate Numerators:*** • Number of children with SED receiving any evidence-based practice • Number of children with SED receiving TFC, MST, FFT, etc.

Domain	Indicator	Indicator Specifications		Applicable Settings	Applicable Population	Data Sources	Additional Considerations
		Numerator	Denominator				
Community Capacity, Continued…	Increase in Utilization Rates of Community-Based Services	24. a) Number of crisis residential beds available in the community. 24. b) Number of people receiving institutional diversion services	State SMI/SED population	SMHA/State System	Adults with SMI Children with SED	SMHA MIS	***Note:*** The measure depends on the state operational definition of diversion. Diversion services may include: • Crisis residential beds • Mobile crisis teams • Crisis walk-in centers • Crisis stabilization • Crisis apartments • Transitional planning services • Other diversion services
		25. Number of persons receiving in-home services	State SMI/SED population	SMHA/State System	Adults with SMI Children with SED	SMHA MIS	***Notes:*** -Look at procedure code modifiers for place of service. -States should measure separately for children and adults.
		26. Number of persons receiving family support services.	State SMI/SED population	SMHA/State System	Adults with SMI Children with SED	SMHA MIS	***Notes:*** -States should measure separately for children and adults. -Family support services may include: • Family psycho-education • Needs assessment • Family support groups • Family retreats • Advocacy training • Referrals and service linkages • Other family services
		27. Emergency room admissions to general hospitals for psychiatric treatment	State SMI/SED population # of emergency room admissions within the state	SMHA/State System	Adults with SMI Children with SED	SMHA MIS	***Note:*** This measure is most useful when it captures admissions for psychiatric treatment

Domain	Indicator	Indicator Specifications		Applicable Settings	Applicable Population	Data Sources	Additional Considerations
		Numerator	Denominator				
Well Being	Increase in percentage of persons expressing social inclusion or connected-ness	28. Number of consumers reporting positively about social connectedness (MHSIP/YSS-F Survey Module)	State SMI/SED population responding to consumer survey	SMHA/State System	Adults with SMI Children with SED	SMHA MIS	
	Increase in percentage of consumers involved with peer-run (self-help) services	29. Number of persons involved in peer support programs (including clubhouse programs)	State SMI population	SMHA/State System	Adults with SMI	SMHA MIS	
Measures for At-Risk Groups	Measures of early intervention services to avoid institutional-ization	30. a) Does your state have 24-hour crisis hotlines? If yes, are they available statewide, or limited to certain regions? 30. b) How many calls were received at the 24-hour crisis hotline in the past month/year?	Trends over time State SMI/SED population (est. prevalence)	SMHA level	Adults with SMI Children with SED	SMHA MIS	***Notes:*** -At a minimum, states should report on the existence of these types of programs/ interventions designed to reduce institutionalization. -If available, SMHAs should track numbers and trends in use of these services.

Domain	Indicator	Indicator Specifications		Applicable Settings	Applicable Population	Data Sources	Additional Considerations
		Numerator	Denominator				
Measures for At-Risk Groups, Continued…	Measures of Early Intervention Services to avoid institutional-ization, Cont'd…	31. a) Does your state have warm lines operated by mental health consumers to assist persons in crisis? If yes, are they available statewide, or limited to certain regions? 31. b) How many peers staff these warm lines? 31. c) How many calls were received on the warm lines in past month/year?	Trends over time State SMI/SED population (est. prevalence)	SMHA level	Adults with SMI Children with SED	SMHA MIS	***Notes:*** -At a minimum, states should report on the existence of these types of programs/ interventions designed to reduce institutionalization. -If available, SMHAs should track numbers and trends in use of these services.
		32. a) How many 24/7 mobile crisis teams does your state have? 32. b) How many people received services provided by mobile crisis teams in the past year?	Trends over time State SMI/SED population	SMHA level	Adults with SMI Children with SED	SMHA MIS	***Notes:*** -At a minimum, states should report on the existence of these types of programs/ interventions designed to reduce institutionalization. -If available, SMHAs should track numbers and trends in use of these services.
	Measures that Help Define the Size of the At-Risk Population	33. Number of persons who are homeless and mentally ill, including shelters and transitional programs	Trends over time State SMI/SED population # of MI persons on SSI/SSDI rolls # in homeless data system				***Notes:*** -At a minimum, states should report on the existence of these types of programs/ interventions designed to reduce institutionalization. -If available, SMHAs should track numbers and trends in use of these services.

Domain	Indicator	Indicator Specifications		Applicable Settings	Applicable Population	Data Sources	Additional Considerations
		Numerator	Denominator				
Measures for At-Risk Groups, Continued…	Measures that Help Define the Size of the At-Risk Population, Cont'd…	34. Number of MI individuals involved in the criminal justice system (e.g., persons discharged from jail progs and/ or on probation)	Trends over time State SMI/SED population Number of MI persons on state SSI/SSDI rolls	Jails Prisons Juvenile Justice	Adults with SMI Children with SED	SMHA MIS State Criminal Justice Data	
		35. Repeat psychiatric users of the emergency department	Trends over time State SMI/SED population # of MI persons on state SSI/SSDI rolls	Emergency departments in general hospitals	Adults with SMI Children with SED	Medicaid Paid Claims Data Medicaid HCUP Files	
		36. Individuals with non-fatal suicide attempts	Trends over time State SMI/SED population Number of MI persons on state SSI/SSDI rolls		Adults with SMI Children with SED	Medicaid Paid Claims Data	
		37. Number of individuals with co-occurring substance abuse (i.e., individuals with repeated use of detox, IP, residential)	Trends over time State SMI/SED population (est. prevalence) Number of MI persons on state SSI/SSDI rolls		Adults with SMI Children with SED	State Substance Abuse Agency Data Set	
		38. Number of adults with mental illness in board and care homes	Trends over time State SMI/SED population (est. prevalence) Number of MI persons on state SSI/SSDI rolls		Adults with SMI Children with SED	Medicaid Paid Claims Data SMHA Data System	

Domain	Measure	Policy Effective Date	Type of Policy	Applicable Settings	Applicable Population	Policy Mechanism	Stage of Implementation	Agency Responsible	Data Sources
Policy	39. Does the state have policies or rules in place intended to prohibit or reduce discharges from state hospitals or local psychiatric units into segregated settings (e.g., nursing homes, adult homes, shelter, street)? Describe:	M/D/YR	☐ Program ☐ Financial ☐ Org.	☐ State Psychiatric Hospitals ☐ Other Psychiatric Inpatient Settings	☐ SMI Adults ☐ SED Child.	☐ Statutory ☐ Appropriation ☐ Regulatory or Admin. Rule ☐ Contract ☐ MOU ☐ Executive Order ☐ Adoption of Clinical Practice Guideline/EBP ☐ Other, Describe:	☐ In Development ☐ Implemented Parts of State ☐ Statewide	☐ SMHA ☐ Health ☐ Other:	SMHA Rules, Policies, Regs.
	40. Has the state developed new (in the last two years) funding initiatives that provide community services to help keep people out of institutions? Describe:	M/D/YR	☐ Program ☐ Financial ☐ Org.	☐ State Psychiatric Hospitals ☐ Nursing Homes ☐ Adult Care Homes ☐ Residential Treatment Centers	☐ SMI Adults ☐ SED Child.	☐ Statutory ☐ Appropriation ☐ Regulatory or Admin. Rule ☐ Contract ☐ MOU ☐ Executive Order ☐ Clinical Practice Guideline/EBP ☐ Other, Describe:	☐ In Development ☐ Implemented Parts of State ☐ Statewide	☐ SMHA ☐ Health ☐ Medicaid ☐ Housing ☐ Other:	SMHA Rules, Policies, Regs.
	41. Does the state employ diff. reimbursement rates to discourage admissions of persons with mental illnesses into segregated settings (e.g., nursing homes, adult homes, residential treatment centers) and/or to encourage placement into integrated settings (e.g., sup. housing, ind. living)?	M/D/YR	☐ Program ☐ Financial ☐ Org.	☐ State Psychiatric Hospitals ☐ Nursing Homes ☐ Adult Care Homes ☐ Residential Treatment Centers	☐ SMI Adults ☐ SED Child.	☐ Statutory ☐ Appropriation ☐ Regulatory or Admin. Rule ☐ Contract ☐ MOU ☐ Executive Order ☐ Clinical Practice Guideline/EBP ☐ Other, Describe:	☐ In Development ☐ Implemented Parts of State ☐ Statewide	☐ SMHA ☐ Health ☐ Medicaid ☐ Housing ☐ Other:	SMHA Rules, Policies, Regs.

Domain	Measure	Policy Effective Date	Type of Policy	Applicable Settings	Applicable Population	Policy Mechanism	Stage of Implementation	Agency Responsible	Data Sources
Policy, Continued…	42. Does the state have a standardized assessment of readiness for discharge from institutional care that is regularly updated for all consumers in institutional settings? Describe:	M/D/YR	☐ Program ☐ Financial ☐ Org.	☐ State Psychiatric Hospitals ☐ Nursing Homes ☐ Adult Care Homes ☐ Residential Treatment Centers	☐ SMI Adults ☐ SED Child.	☐ Statutory ☐ Appropriation ☐ Regulatory or Admin. Rule ☐ Contract ☐ Memorandum of Understanding ☐ Executive Order ☐ Adoption of Clinical Practice Guideline/EBP ☐ Other, Describe:	☐ In Development ☐ Implemented Parts of State ☐ Statewide	☐ SMHA ☐ Health ☐ Other:	SMHA Rules, Policies, Regs.
	43. Does the state have other policies or rules that ensure services are provided in the least restrictive setting to avoid clinically- unnecessary institutional admissions? Describe:	M/D/YR	☐ Program ☐ Financial ☐ Org.	☐ State Psychiatric Hospitals ☐ Nursing Homes ☐ Adult Care Homes ☐ Residential Treatment Centers	☐ SMI Adults ☐ SED Child.	☐ Statutory ☐ Appropriation ☐ Regulatory or Admin. Rule ☐ Contract ☐ Memorandum of Understanding ☐ Executive Order ☐ Adoption of Clinical Practice Guideline/EBP ☐ Other, Describe:	☐ In Development ☐ Implemented Parts of State ☐ Statewide	☐ SMHA ☐ Health ☐ Medicaid ☐ Housing ☐ Other:	SMHA Rules, Policies, Regs.
	44. Does your state have a policy or system in place to monitor housing wait lists? Describe:	M/D/YR	☐ Program ☐ Financial ☐ Org.	☐ State Psychiatric Hospitals ☐ Nursing Homes ☐ Adult Care Homes ☐ Residential Treatment Centers	☐ SMI Adults ☐ SED Child.	☐ Statutory ☐ Appropriation ☐ Regulatory or Admin. Rule ☐ Contract ☐ Memorandum of Understanding ☐ Executive Order ☐ Adoption of Clinical Practice Guideline/EBP ☐ Other, Describe:	☐ In Development ☐ Implemented Parts of State ☐ Statewide	☐ SMHA ☐ Health ☐ Medicaid ☐ Housing ☐ Other:	SMHA Rules, Policies, Regs.

Domain	Measure	Policy Effective Date	Type of Policy	Applicable Settings	Applicable Population	Policy Mechanism	Stage of Implementation	Agency Responsible	Data Sources
Policy, Continued…	45. Does your state have a policy or system in place to monitor the amount of time consumers spend waiting for housing?	M/D/YR	☐ Program ☐ Financial ☐ Org.	☐ State Psychiatric Hospitals ☐ Nursing Homes ☐ Adult Care Homes ☐ Residential Treatment Centers	☐ SMI Adults ☐ SED Child.	☐ Statutory ☐ Appropriation ☐ Regulatory or Admin. Rule ☐ Contract ☐ Memorandum of Understanding ☐ Executive Order ☐ Adoption of Clinical Practice Guideline/EBP ☐ Other, Describe:	☐ In Development ☐ Implemented Parts of State ☐ Statewide	☐ SMHA ☐ Health ☐ Medicaid ☐ Housing ☐ Other:	SMHA Rules, Policies, Regs.
	46. Does your state have a standardized methodology to track persons declining discharge to the community? Describe:	M/D/YR	☐ Program ☐ Financial ☐ Org.	☐ State Psychiatric Hospitals ☐ Nursing Homes ☐ Adult Care Homes ☐ Residential Treatment Centers	☐ SMI Adults ☐ SED Child.	☐ Statutory ☐ Appropriation ☐ Regulatory or Admin. Rule ☐ Contract ☐ Memorandum of Understanding ☐ Executive Order ☐ Adoption of Clinical Practice Guideline/EBP ☐ Other, Describe:	☐ In Development ☐ Implemented Parts of State ☐ Statewide		SMHA Rules, Policies, Regs.
	47. Does your SMHA have a program(s) to provide education and encouragement to patients about the opportunities and successes they can have in accepting discharge to the community? Describe:	M/D/YR	☐ Program ☐ Financial ☐ Org.	☐ State Psychiatric Hospitals ☐ Nursing Homes ☐ Adult Care Homes ☐ Residential Treatment Centers	☐ SMI Adults ☐ SED Child.	☐ Statutory ☐ Appropriation ☐ Regulatory or Admin. Rule ☐ Contract ☐ Memorandum of Understanding ☐ Executive Order ☐ Adoption of Clinical Practice Guideline/EBP ☐ Other, Describe:	☐ In Development ☐ Implemented Parts of State ☐ Statewide		SMHA Rules, Policies, Regs.

Appendix: Housing Definitions

Supported Housing: Supported Housing is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance, but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities. Criteria identified for supported housing programs include: housing choice, functional separation of housing from service provision, affordability, integration with persons who do not have mental illnesses, right to tenure, service choice, service individualization, and service availability. (Source: 2012 NRI State Mental Health Profiling System.)

Supervised Housing: Provides the most care for its residents. Residents generally share another room with at least one other person. Residents have their own bed, dresser and closet space. Bathrooms and common areas are shared. Depending on the level of supervision these programs provide, supervised housing programs may include: 24-hour (or less) supervision and assistance; assistance in performing basic daily living skills; assistance with medication; food and meals (no less than three per day); assistance with paying bills and managing money; company from other residents and house managers, which can help to ease loneliness; assistance with making doctors' appointments and assistance with transportation; and day programs. These facilities need to be licensed by the state

APPENDIX C: 2012 LITERATURE REVIEW (2/1/12)

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.

To set appropriate boundaries for what the new SAMHSA 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 (at risk) 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 severe mental illness be included in the Pilot.
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 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, and 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 mentally ill women 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 the mentally ill.

PILOT TEST

The Substance Abuse and Mental Health Services Administration (SAMHSA), in collaboration with the Association for Healthcare Philanthropy (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 the technical expert group (TAG), to develop a set of proposed data indicators for the self-assessment (Task 7.4).

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 around 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
- 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
- The ratio of Medicaid dollars spent on community-based services versus funds dedicated institutional services

- The availability of home and community-based services as determined by the amount of 1915(c) waivers
- Availability of community-based housing, determined by the existence of supportive housing programs and the number of housing vouchers and subsidies available to consumers
- The existence and effectiveness of comprehensive community crisis services
- The presence of evidence-based practices, including Assertive Community Treatment teams, supportive 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 a feeling of social and community inclusion.

To improve the wellbeing of consumers, the subjective outcome of social integration, rather than physical exposure 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 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 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 the clients receive. Therefore, litigation can be brought against states for unnecessary segregation of consumers. Indicators similar to state hospitals may be used to determine violations of the integration mandate.

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 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 mentally ill persons 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 mentally ill inmates 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, mentally ill persons 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 severe 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 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 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 mentally ill persons 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 D: DEPARTMENT OF JUSTICE FEEDBACK AND PILOT RESPONSE

NRI and AHP received the suggestions from the Department of Justice (DOJ) to the March 6, 2013 draft version of the 2013 Community Integration State Self-Assessment Pilot report. These comments and recommendations were very helpful and supported the measures being included in the 2013 Community Integration Pilot. NRI and AHP worked with the Technical Advisory Panel (TEP) to review all of the DOJ comments and suggestions and to incorporate them into the 2013 Community Integration Pilot whenever possible.

Many of the DOJ comments/suggestions had been addressed in the final 2013 Tool or were addressed for the 2013 Pilot with minor changes to the tool and were tested by states. Since the DOJ comments were received while Pilot States were already working on their data, some DOJ suggestions were received too late to add to the 2013 Pilot and were deferred for inclusion in the 2014 Pilot. A few DOJ suggestions require substantial work and will be reviewed by the TEP and SAMHSA to determine how to best include them in future work.

DISPOSITION OF DOJ COMMENTS/EDITS TO DRAFT TOOL

DOJ Comments addressed in 2013 Pilot

Most of the DOJ comments/edits were addressed or already reflected in the final version of the 2013 Olmstead State Self-Assessment Tool pilot, including:

- Separate indicator for persons admitted to institutional care into SMI and SED populations
- Clarify that indicator for number of persons enrolled in supported employment reflects people actually receiving services
- Separate indicator for persons employed into independent competitive employment and supported employment
- Simplify language in indicators for number of crisis residential beds and people receiving institutional diversion services
- Re-organizing measures so that HUD-related questions are placed up front
- For measures related to early intervention and services related to reducing the need for institutional services, capture limitations on services such as limited hours or regional availability
- Recommend that states use Medicaid hospital billing records to help assess the size of the at-risk population
- Include children in several measures in the At-Risk domain.
- Modify one measure to solicit new funding initiatives or policies developed by the state.
- Re-format conceptual questions to encourage more open-ended responses.
- Move Targeted Case Management into a new domain.

- Incorporate specific DOJ definition of in-home services.
- Include a measure for the number of children with admitted to emergency rooms in general hospitals for psychiatric treatment.
- Change measures for "Persons with high levels of Emergency Room Use" to be "Persons with repeated Emergency Room Use."
- Incorporate specific changes in language related to people who are at high risk of institutionalization.
- Change language regarding individuals using mental health crisis programs.
- Include "SED prevalence rate" as a denominator for risk.
- For one measure, change the word "disorder" to "condition."
- Remove children with SED from the measure related to adults with mental illness in board and care homes.
- Recommend that states use hospital medical claims data as a source of information regarding the number of individuals with non-fatal suicide attempts.
- Clarify language related to segregated settings.
- Encourage states to collect data from housing-related agencies, such as local housing authorities.
- Incorporate specific edits under the Psychiatric Hospital section.
- Include definitions for supported and supervised housing services.

DOJ Comments that will be included in 2014 Pilot

The following DOJ comments/edits will be included in the 2014 data pilot instrument:

- Remove the word "clinically" from the measure for "clinically unnecessary institutional admissions."
- Include a measure regarding whether the state's Olmstead plan includes details related to specific populations (such as children with SED or adults with an SMI).
- Include a measure regarding whether the SMHA is working with the state educational system to transition children and youth back to their home communities after institutionalization.
- When measuring the use of Medicaid to fund community integration, include regular Medicaid options that support community living, including state plan amendments for targeted case management, mobile crisis services, etc.
- Add the word "track" to the measure for "follow-up activities to sustain community transition/integration.
- Clarify that only community-based services are included in measures related to diversion programs.
- Modify questions related to affordable housing to ask about barriers to independent living.

- Include a question about Medicaid-funded group homes in the section regarding adult care homes and other congregate living settings.
- Encourage states to track the URS age populations in tandem with related Medicaid EPSDT requirements.
- When measuring state expenditures, ensure that the numerator reflect the applicable settings.
- Clarify that readmission rates should include all institutional settings where such data is available.
- Clarify language regarding the number of people with SMI receiving ACT.

DOJ Comments the TEP will Address and Consider for 2014

The following DOJ comments/edits will be reviewed by NRI, AHP and the TEP to determine how to best include them in the 2014 data pilot:

- Include new measures reflecting the access questions asked on the MHSIP survey
- Encourage the use of multiple data sources to determine the number of people with SMI admitted to nursing homes. (PASRR already is included; additional data sources will be included if they can be identified).
- Change the measure for "ER admissions to general hospitals" to more specifically target "ER visits for primary mental health condition."
- Collect and analyze data on ER visits, not just hospital admissions via the ER.
- Provide a definition of repeat psychiatric users of ER services and for repeat hospitalizations.
- Include the state foster care system and Medicaid records in assessing the at-risk population.
- Measure not just the number of mobile crisis teams in a state but also the regional availability of these services.
- Include new measures for (1) children with SED who have experienced multiple foster care placements; (2) children with SED who have been suspended from school or subject to a police referral at school; (3) children with SED who have been arrested or taken into police custody.
- Remove repeated use of detox as a possible indicator for the number of individuals with co-occurring substance abuse, as it may lead to under-reporting.
- Track the sustainability of programs reported under the Policy Domain by inquiring whether or not the program is a pilot project; is funded through the Medicaid State Plan; is funded through a waiver; is funded through the state's annual budget; or is a program of limited duration.
- Separate measure related to policies intended to prohibit discharges into segregated questions into two measures, one for state hospitals and one for local psychiatric units.

- Encourage states to provide length of stay data if they are unable to report the length of time people wait for discharge.

The following DOJ suggestion will be considered but may be *difficult for most* SMHAs to implement, since the data generally are not available to SMHAs:

- Include individuals in jails with SMI and youth with SED in detention centers within the At-Risk Domain.

APPENDIX E: UTILITY EVALUATION FORM

INSTRUCTIONS

The purpose of this document is to gather feedback about the usefulness of the 2013 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 Neylon (kneylon@nri-inc.org) at NRI no later than **Friday, August 9, 2013**.

State: _____
Contact Name: _____
Telephone: _____
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, 5 = 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 ☐4 ☐5	
		2. State expenditures on psychiatric hospital/ inpatient care	☐1 ☐2 ☐3 ☐4 ☐5	
		3. Number of HCBS slots available (only applicable to states with 1915(c) waivers)	☐1 ☐2 ☐3 ☐4 ☐5	
		Other: State Specific Measures: _____	☐1 ☐2 ☐3 ☐4 ☐5	
Movement to Community & Recidivism	*Additional comments on overall domain may be entered here.*			
	Decrease in length of time waiting to be discharged	**4. a)** Number of persons awaiting discharge by type of institution for more than three months.	☐1 ☐2 ☐3 ☐4 ☐5	
		4. b) Does the state have a standardized assessment, updated regularly to assess readiness for discharge?	☐1 ☐2 ☐3 ☐4 ☐5	
		Other: State Specific Measures _____	☐1 ☐2 ☐3 ☐4 ☐5	

Domain	Indicator	Numerator	Please rank the UTILITY of this indicator (1 = least, 5 = 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 the Community & Recidivism	Decrease in length of stay	**5.** # of patients in the institution with length of stay greater than one year (at end of year)	☐1 ☐2 ☐3 ☐4 ☐5	
		6. Number or percentage of persons with a length of stay greater than one year discharged during the year	☐1 ☐2 ☐3 ☐4 ☐5	
		Other: State Specific Measures _____	☐1 ☐2 ☐3 ☐4 ☐5	
	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 ☐4 ☐5	
		Other: State Specific Measures _____	☐1 ☐2 ☐3 ☐4 ☐5	
	Decrease in utilization rate of institutional settings	**8.** # of persons with SMI/SED admitted to institutional care	☐1 ☐2 ☐3 ☐4 ☐5	
		9. Average daily institutional occupancy rate	☐1 ☐2 ☐3 ☐4 ☐5	
		10. # of licensed psychiatric beds available	☐1 ☐2 ☐3 ☐4 ☐5	
		11. Number of persons with SMI/SED declining transfer into the community	☐1 ☐2 ☐3 ☐4 ☐5	
		12. Number of persons w/SMI admitted to nursing homes identified through PASRR Assessments	☐1 ☐2 ☐3 ☐4 ☐5	
		Other: State Specific Measures _____	☐1 ☐2 ☐3 ☐4 ☐5	

Domain	Indicator	Numerator	Please rank the UTILITY of this indicator (1 = least, 5 = 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.
Housing	*Additional comments on overall domain may be entered here.*			
	Increase in percentage of persons with SMI receiving housing supports	**13.** Number of persons with SMI residing in HUD-subsidized housing units	☐1 ☐2 ☐3 ☐4 ☐5	
		14. Number of persons with SMI receiving non-HUD permanent supported housing services	☐1 ☐2 ☐3 ☐4 ☐5	
		15. Number of persons with SMI receiving non-HUD supervised housing services	☐1 ☐2 ☐3 ☐4 ☐5	
		16. Number of persons receiving other housing services not captured in measures 13-15 above	☐1 ☐2 ☐3 ☐4 ☐5	
		Other: State Specific Measures: _____	☐1 ☐2 ☐3 ☐4 ☐5	
	Decrease in length of time on housing waiting lists	**17.** Number of persons with SMI on a housing waiting list	☐1 ☐2 ☐3 ☐4 ☐5	
		18. Average wait time for housing (months)	☐1 ☐2 ☐3 ☐4 ☐5	
		Other: State Specific Measures _____	☐1 ☐2 ☐3 ☐4 ☐5	
Community Capacity	*Additional comments on overall domain may be entered here.*			
	Increase in utilization of community-based services	**19.** # of persons with SMI/SED receiving intensive targeted case management services	☐1 ☐2 ☐3 ☐4 ☐5	
		20. # of persons w/SMI receiving Assertive Community Treatment	☐1 ☐2 ☐3 ☐4 ☐5	
		21. Number of persons w/SMI enrolled in supported employment	☐1 ☐2 ☐3 ☐4 ☐5	

Domain	Indicator	Numerator	Please rank the UTILITY of this indicator (1 = least, 5 = 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.
Community Capacity	Increase in utilization of community-based services	**22. a)** Number of persons with SMI employed full time or part time	☐1 ☐2 ☐3 ☐4 ☐5	
		22. b) Number of persons served by the SMHA who are employed full time or part time.	☐1 ☐2 ☐3 ☐4 ☐5	
		23. Number of children with SED receiving wraparound services.	☐1 ☐2 ☐3 ☐4 ☐5	
		24. a) Number of crisis residential beds available in the community.	☐1 ☐2 ☐3 ☐4 ☐5	
		24. b) Number of people receiving institutional diversion services	☐1 ☐2 ☐3 ☐4 ☐5	
		25. Number of persons receiving in-home services.	☐1 ☐2 ☐3 ☐4 ☐5	
		26. Number of persons receiving family support services.	☐1 ☐2 ☐3 ☐4 ☐5	
		27. Emergency room admissions to general hospitals for psychiatric treatment.	☐1 ☐2 ☐3 ☐4 ☐5	
		Other: State Specific Measures	☐1 ☐2 ☐3 ☐4 ☐5	
Well-Being	***Additional comments on overall domain may be entered here.***			
	Increase in percentage of persons expressing social inclusion or connected-ness	**28.** Number of consumers reporting positively about social connectedness (MHSIP Survey Module	☐1 ☐2 ☐3 ☐4 ☐5	
		Other: State Specific Measures: _____	☐1 ☐2 ☐3 ☐4 ☐5	

Domain	Indicator	Numerator	Please rank the UTILITY of this indicator (1 = least, 5 = 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	Increase in percentage of consumers involved with peer-run/ self-help services	**29.** Number of persons involved in peer support program (including clubhouse programs)	☐1 ☐2 ☐3 ☐4 ☐5	
		Other: State Specific Measures _____	☐1 ☐2 ☐3 ☐4 ☐5	
Measures for At-Risk Groups	***Additional comments on overall domain may be entered here.***			
	Measures of early intervention services to avoid institutionalization	**30. a)** Does your state have 24-hour crisis hotlines? If yes, are they available statewide, or limited to certain regions?	☐1 ☐2 ☐3 ☐4 ☐5	
		30. b) How many calls were received at the 24-hour crisis hotline in the past month/year?	☐1 ☐2 ☐3 ☐4 ☐5	
		31. a) Does your state have warm lines operated by mental health consumers to assist persons in crisis? If yes, available statewide, or limited to certain regions?	☐1 ☐2 ☐3 ☐4 ☐5	
		31. b) How many peers staff these warm lines?	☐1 ☐2 ☐3 ☐4 ☐5	
		31. c) How many calls were received on the warm lines in the past month/year?	☐1 ☐2 ☐3 ☐4 ☐5	
		32. a) How many 24/7 mobile crisis teams does your state have?	☐1 ☐2 ☐3 ☐4 ☐5	
		32. b) How many people received services provided by mobile crisis teams in the past year?	☐1 ☐2 ☐3 ☐4 ☐5	
		Other: State Specific Measures	☐1 ☐2 ☐3 ☐4 ☐5	

Domain	Indicator	Numerator	Please rank the UTILITY of this indicator (1 = least, 5 = 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.
Measures for At-Risk Groups	Measures that help define the size of the at-risk population	**33.** Number of persons who are homeless and mentally ill, including shelters and transitional housing programs	☐1 ☐2 ☐3 ☐4 ☐5	
		34. Number of mentally ill individuals involved in the criminal justice system (e.g., persons discharged from jail programs and/or on probation)	☐1 ☐2 ☐3 ☐4 ☐5	
		35. Repeat psychiatric users of the emergency department	☐1 ☐2 ☐3 ☐4 ☐5	
		36. Individuals with non-fatal suicide attempts	☐1 ☐2 ☐3 ☐4 ☐5	
		37. Number of individuals with co-occurring substance abuse (i.e., individuals with repeated use of detox, IP, residential)	☐1 ☐2 ☐3 ☐4 ☐5	
		38. Number of adults with mental illness in board and care homes	☐1 ☐2 ☐3 ☒4 ☐5	
		Other: State Specific Measures: _____	☐1 ☐2 ☐3 ☐4 ☐5	

Domain	Measure	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.
Policy	*Additional comments on overall domain may be entered here.*		
	39. Does the state have policies or rules in place intended to prohibit or reduce discharges from state hospitals or local psychiatric units into non-segregated settings (e.g., nursing homes, adult homes, shelters, street)?	☐1 ☐2 ☐3 ☐4 ☐5	
	40. Has the state developed new (in the last two years) funding initiatives that provide community services to help keep people out of institutions?	☐1 ☐2 ☐3 ☐4 ☐5	
	41. Does the state employ differential reimbursement rates to discourage admissions of persons with mental illnesses into non-segregated settings (e.g., nursing homes, adult homes, residential treatment centers) and/or to encourage placement into integrated settings (e.g., supported housing, independent living)?	☐1 ☐2 ☐3 ☐4 ☐5	
	42. Does the state have a standardized assessment of readiness for discharge from institutional care that is regularly updated for all consumers in institutional settings?	☐1 ☐2 ☐3 ☐4 ☐5	
	43. Does the state have a standardized assessment of readiness for discharge from institutional care that is regularly updated for all consumers in institutional settings?	☐1 ☐2 ☐3 ☐4 ☐5	
	44. Does your state have a policy or system in place to monitor housing wait lists?	☐1 ☐2 ☐3 ☐4 ☐5	
	45. Does your state have a policy or system in place to monitor the amount of time consumers spend waiting for housing?	☐1 ☐2 ☐3 ☐4 ☐5	
	46. Does your state have a standardized methodology to track persons declining discharge to the community?	☐1 ☐2 ☐3 ☐4 ☐5	

Domain	Measure	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.
Policy	**47.** Does your SMHA have a program(s) to provide education and encouragement to patients about the opportunities and successes they can have in accepting discharge to the community?	☐1 ☐2 ☐3 ☐4 ☐5	
	Other State Specific Policy Measures: _____	☐1 ☐2 ☐3 ☐4 ☐5	

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 F: IMPLEMENTATION TRACKING GUIDE (BURDEN EVALUATION)

INSTRUCTIONS

The purpose of this document is to better understand the processes used to collect data, and to gather feedback about the burden your staff experienced while collecting data for the measures contained in the 2013 Community Integration Self-Assessment Tool.

This is a free-flowing report form. Your narrative should not be restricted by the space provided in this report layout. Responses are due to Kristin Neylon (kneylon@nri-inc.org) at the NASMHPD Research Institute, Inc. by Friday, August 9, 2013.

PROTOCOL

State: _____
Contact Name: _____
Telephone: _____
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	_____

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

Agency	Did your SMHA attempt to engage this agency?	Please briefly describe how the agency was engaged (e.g., provided access to agency database). If an agency declined to participate, please describe the reason cited, including if the agency was unresponsive to requests.	Please cite the factors responsible for successfully engaging the agency in this 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:	☐Yes ☐No		
Other:	☐Yes ☐No		

Comments:

_____

_____

_____

_____

_____

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

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

Comments:

_____

_____

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Evaluation of Burden: Individual Indicators

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

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or other 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 this indicator (1 = least, 5 = most)
Financing and 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: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		2. State expenditures on psychiatric hospital/ inpatient care	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		3. Number of HCBS slots available (only applicable to states with 1915(c) waivers)	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or other 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 this indicator (1 = least, 5 = most)
Financing & Resources	Increase in funding for community-based programs	Other: State Specific Measures (specify): _____ _____ _____	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
Movement to the Community & Recidivism	Decrease in length of time waiting to be discharged	**4. a)** Number of persons 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: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		4. b) Does the state have a standardized assessment, updated regularly to assess readiness for discharge?	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		Other: State Specific Measures (specify): _____ _____ _____	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or other 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 this indicator (1 = least, 5 = most)
Movement to Community & Recidivism	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: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		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: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		Other: State Specific Measures (specify): _____ _____ _____	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
	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: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or other 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 this indicator (1 = least, 5 = most)
Movement to Community & Recidivism	Decrease in readmission rate	Other: State Specific Measures (specify): _____ _____ _____	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
	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: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		9. Average daily institutional occupancy rate	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		10. Number of licensed psychiatric beds available	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or other 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 this indicator (1 = least, 5 = most)
Movement to the Community & Recidivism	Decrease in utilization rate of institutional settings	**11.** Number of persons with SMI/SED declining transfer into the community	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		12. Number of persons w/SMI admitted to nursing homes identified through PASRR Assessments	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		Other: State Specific Measures (specify): _____ _____ _____	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
Housing	Increase in percentage of persons with SMI receiving housing supports	**13.** Number of persons with SMI residing in HUD-subsidized housing units	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or other 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 this indicator (1 = least, 5 = most)
Housing	Increase in percentage of persons with SMI receiving housing supports	**14.** Number of persons with SMI receiving non-HUD permanent supported housing services	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		15. Number of persons with SMI receiving non-HUD supervised housing services	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		16. Number of persons receiving other housing services not captured in measures 13-15 above	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		Other: State Specific Measures (specify): _____ _____ _____	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or other 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 this indicator (1 = least, 5 = most)
Housing	Decrease in length of time on housing waiting lists	**17.** 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: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		18. Average wait time for housing (months)	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		Other: State Specific Measures (specify): _____ _____ _____	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
Community Capacity	Increase in utilization of community-based services	**19.** Number of persons with SMI/SED receiving intensive targeted case management services	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or other 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 this indicator (1 = least, 5 = most)
Community Capacity	Increase in utilization of community-based services	**20.** 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: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		21. 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: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		22. a) Number of persons with SMI employed full time or part time	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		22. b) Number of persons served by the SMHA who are employed full time or part time.	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5

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Community Capacity	Increase in utilization of community-based services	**23.** Number of children with SED receiving wraparound services.	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		24. a) Number of crisis residential beds available in the community.	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		24. b) Number of people receiving institutional diversion services	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		25. Number of persons receiving in-home services.	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or other 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 this indicator (1 = least, 5 = most)
Community Capacity	Increase in utilization of community-based services	**26.** Number of persons receiving family support services.	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		27. Emergency room admissions to general hospitals for psychiatric treatment.	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		Other: State Specific Measures (specify): _____ _____ _____	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
Well Being	Increase in percentage of persons expressing social inclusion or connectedness	**28.** Number 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: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or other 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 this indicator (1 = least, 5 = most)
Well-Being	Inc. in %of persons expressing social inclusion or connectedness	Other: State Specific Measures (specify): _____ _____ _____	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
	Increase in percentage of consumers involved with peer-run/self-help services	**29.** Number of persons involved in peer support program (including clubhouse programs)	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		Other: State Specific Measures (specify): _____ _____ _____	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
Measures for At-Risk Groups	Measures of early intervention services to avoid institutionalization	**30. a)** Does your state have 24-hour crisis hotlines? If yes, are they available statewide, or limited to certain regions?	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or other 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 this indicator (1 = least, 5 = most)
Measures for At-Risk Groups	Measures of early intervention services to avoid institutionalization	**30. b)** How many calls were received at the 24-hour crisis hotline in the past month/year?	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		31. a) Does your state have warm lines operated by MH consumers to assist persons in crisis? If yes, available statewide, or limited to certain regions?	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		31. b) How many peers staff these warm lines?	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		31. c) How many calls were received on the warm lines in the past month/year?	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or other 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 this indicator (1 = least, 5 = most)
Measures for At-Risk Groups	Measures of early intervention services to avoid institutionalization	**32. a)** How many 24/7 mobile crisis teams does your state have?	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		32. b) How many people received services provided by mobile crisis teams in the past year?	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		Other: State Specific Measures (specify): _____ _____ _____	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
	Measures that help define the size of the at-risk population	**33.** Number of persons who are homeless and mentally ill, including shelters and transitional housing programs	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or other 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 this indicator (1 = least, 5 = most)
Measures for At-Risk Groups	Measures that help define the size of the at-risk population	**34.** Number of mentally ill individuals involved in the criminal justice system (e.g., persons discharged from jail programs and/or on probation)	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		35. Repeat psychiatric users of the emergency department	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		36. Individuals with non-fatal suicide attempts	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		37. Number of individuals with co-occurring substance abuse (i.e., individuals with repeated use of detox, IP, residential)	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5

Domain	Indicator	Numerator	Does your state already collect this measure as part of an Olmstead Settlement or other 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 this indicator (1 = least, 5 = most)
Measures for At-Risk Groups	Measures that help define the size of the at-risk population	**38.** Number of adults with mental illness in board and care homes	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5
		Other: State Specific Measures (specify): _____ _____ _____	☐Yes ☐No	☐State Psych. Hospitals ☐Nursing Homes ☐RTF ☐Emergency Rooms ☐Adult Care Homes ☐Jails ☐Prisons ☐Other: _____	☐Adults ☐Children		☐Yes ☐No		☐1 ☐2 ☐3 ☐4 ☐5

Domain	Measure	Please rank the BURDEN of collecting this indicator (1 = least, 5 = most)	Comments
Policy	39. Does the state have policies or rules in place intended to prohibit or reduce discharges from state hospitals or local psychiatric units into non-segregated settings (e.g., nursing homes, adult homes, shelters, street)?	☐1 ☐2 ☐3 ☐4 ☐5	
	40. Has the state developed new (in the last two years) funding initiatives that provide community services to help keep people out of institutions?	☐1 ☐2 ☐3 ☐4 ☐5	
	41. Does the state employ differential reimbursement rates to discourage admissions of persons with mental illnesses into non-segregated settings (e.g., nursing homes, adult homes, residential treatment centers) and/or to encourage placement into integrated settings (e.g., supported housing, independent living)?	☐1 ☐2 ☐3 ☐4 ☐5	
	42. Does the state have a standardized assessment of readiness for discharge from institutional care that is regularly updated for all consumers in institutional settings?	☐1 ☐2 ☐3 ☐4 ☐5	
	43. Does the state have a standardized assessment of readiness for discharge from institutional care that is regularly updated for all consumers in institutional settings?	☐1 ☐2 ☐3 ☐4 ☐5	
	44. Does your state have a policy or system in place to monitor housing wait lists?	☐1 ☐2 ☐3 ☐4 ☐5	
	45. Does your state have a policy or system in place to monitor the amount of time consumers spend waiting for housing?	☐1 ☐2 ☐3 ☐4 ☐5	
	46. Does your state have a standardized methodology to track persons declining discharge to the community?	☐1 ☐2 ☐3 ☐4 ☐5	
	47. Does your SMHA have a program(s) to provide education and encouragement to patients about the opportunities and successes they can have in accepting discharge to the community?	☐1 ☐2 ☐3 ☐4 ☐5	
	Other State Specific Policy Measures: _____ _____	☐1 ☐2 ☐3 ☐4 ☐5	
	Other State Specific Policy Measures: _____ _____	☐1 ☐2 ☐3 ☐4 ☐5	

NOTES ON RESPONSES TO BURDEN RANKINGS:

Expectations, Outcomes, and Recommendations for Future Versions:

1. What did your state find beneficial about this pilot?

   _____
   _____

2. What challenges/barriers did your state encounter as you completed this pilot? How were these barriers addressed?

   _____
   _____

3. 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?

   _____
   _____
   _____

4. How does your state intend to use the results of the pilot? Were any policy changes initiated as a result of this effort?

   _____
   _____

5. Taken as a whole, how do these indicators reflect the work your state is doing to promote community integration?

   _____
   _____

6. Has your SMHA initiated any new data sharing agreements as a result of this initiative? If yes, please describe these endeavors.

   _____
   _____

7. Based on your experience with this pilot, what recommendations do you have for future versions (e.g., make it more meaningful, more feasible for states to complete, etc.)?

   _____
   _____

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 G: SIMPLIFIED LIST OF 2013 MEASURES

PART I: CONTEXTUAL QUESTIONS:

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 a copy of your plan, or provide a link to its location online; 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. Interagency collaboration to promote community integration: How does the SMHA collaborate with other state agencies in promoting community integration (provide two to three examples)? For example, how is your SMHA working with state housing agencies to increase available community living settings?

4. 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 a 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?

5. Use of Housing and Urban Development (HUD) programs to fund housing or housing support services that promote community integration: Please describe the various HUD housing vouchers, subsidies, and other programs that are used to support community living arrangements for mental health consumers. Please describe your SMHA's involvement/role in providing housing for mental health consumers.

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: MEASURES OF COMMUNITY INTEGRATION

Domain: Financing & Resources

1. State mental health expenditures on community-based programs / Total state mental health expenditures

2. State expenditures on psychiatric hospital/inpatient care / Total state mental health expenditures

3. Number of HCBS slots available / State SMI-SED population

Domain: Movement to the Community & Recidivism

4. a) Number of persons awaiting discharge by type of institution for more than 3 months / Institutional census

4. b) Does the state have a standardized assessment, updated regularly, to assess readiness for discharge?

5. Number of patients in the institution with length-of-stay greater than 1 year (at end of year) / Institutional census

6. Number or percent of persons with length-of-stay greater than 1 year (discharged during year) / Institutional census

7. Number of persons with SMI-SED readmitted to any type of institution w/in 6 months / Institutional census

8. Number of persons with SMI-SED admitted to institutional care / State SMI-SED population

9. Average daily institutional occupancy rate / 365

10. Number of licensed psychiatric beds available / State SMI-SED population

11. Number of persons w/SMI-SED declining transfer to the community annually / # awaiting discharge from an institution

12. Number of persons w/SMI admitted to nursing homes identified through PASRR assessments / Nursing home census

Domain: Housing

13. Number of persons w/SMI residing in HUD-subsidized housing units / State SMI population

14. Number of persons w/SMI receiving non-HUD permanent supported housing services / State SMI population

15. Number of persons w/SMI receiving non-HUD supervised housing services / State SMI population

16. Number of persons receiving other housing services not captured in measures 13-15 / State SMI population

17. Number of persons w/SMI on a housing waiting list / State SMI population

18. Average wait time for housing (in months)

Domain: Community Capacity

19. Number of persons w/SMI-SED receiving intensive targeted case management / State SMI-SED pop. or # waiting for ITCM

20. Number of persons w/SMI receiving ACT / State SMI population

21. Number of persons w/SMI enrolled in supported employment / State SMI population

22. a) Number of persons w/SMI employed full time or part time / State SMI population

22. b) Number of persons served by the SMHA who are employed full time or part time / State SMI population

23. Number of children w/SED receiving wraparound services / Number of Medicaid-eligible children

24. a) Number of crisis residential beds available in the community / State SMI-SED population

24. b) Number of people receiving institutional diversion services / State SMI-SED population

25. Number of persons receiving in-home services / State SMI-SED population

26. Number of persons receiving family support services / State SMI-SED population

27. ER admissions to general hospitals for psychiatric treatment / State SMI-SED population or # of ER admissions w/in the state

Domain: Well Being

28. Number of consumers reporting positively about social connectedness / State SMI-SED pop. responding to MHSIP/YSS-F

29. Number of persons involved in peer support programs (including clubhouses) / State SMI population

Domain: Measures for At-Risk Groups

30. a) Does your state have 24-hour crisis hotlines? If yes, are they available statewide, or limited to certain regions?

30. b) # of calls received at the 24-hour crisis hotline w/in the past month/year / Trends over time or State SMI-SED population

31. a) Does your state have warm lines operated by peers to assist persons in crisis? If yes, are they available statewide?

31. b) How many peers staff these warm lines?

31. c) How many calls were received on the warm lines in the past month/year / Trends over time or State SMI-SED population

32. a) How many 24/7 mobile crisis teams does your state have? / Trends over time or State SMI-SED population

32. b) # of people who received services provided by mobile crisis teams in past year / Trends over time or State SMI-SED pop.

33. # of homeless & mentally ill persons, include shelters & transitional programs / State SMI-SED pop. or # in homeless data system

34. # of individuals with MI involved in the CJ system / State SMI-SED pop. or # of persons with MI on SSI/SSDI rolls

35. Repeat psych. users of the ED / State SMI-SED population or Number of persons with MI on SSI/SSDI rolls

36. Individuals with non-fatal suicide attempts / State SMI-SED population or Number of persons with MI on SSI/SSDI rolls

37. # of individuals with co-occurring substance abuse / State SMI-SED pop. or Number of persons with MI on SSI/SSDI rolls

38. Number of adults with MI in board & care homes / State SMI-SED pop. or Number of persons with MI on SSI/SSDI rolls

Domain: Policy

39. Have policies or rules in place to prohibit discharges from state hospitals/local psych. units into segregated settings?

40. Have new funding initiatives to provide community services?

41. Does the state employ differential reimbursement rates to discourage placement in segregated settings?

42. Have a standard assessment of readiness for discharge that is regularly updated for consumers in institutional settings?

43. Have policies to ensure services are provided in the least restrictive settings?

44. Does the state have policies to monitor housing wait lists?

45. Does the state have policies to monitor the amount of time consumers wait for housing?

46. Does the state have a standard method for tracking persons declining discharge to the community?

47. Does the state have programs to provide education and encouragement to patients about opportunities they can have in accepting discharge to the community?