Public  Works

OLMSTEAD MENTAL HEALTH PLANNING
REPORT AND RECOMMENDATIONS TO THE STATE OF GEORGIA

DECEMBER 17, 2001

DRAFT

INTRODUCTION

In September 2001, the Georgia Division of Mental Health, Mental Retardation and Substance Abuse Services (MHMRSA), asked **Public Works** to determine future directions for the state's planning process in response to the US Supreme Court's *Olmstead* decision,[1] with particular emphasis on community Mental Health services**.** The Division defined several broad issues to be addressed:

1. What are the priorities of the advocacy community in the way of community mental health planning? What is their perception of what the state is already doing?
2. What are other states doing? How are they conducting their planning processes and what are their results?
3. What are the next steps Georgia should take in planning for community mental health services?

To address these issues, **Public Works** employed a multi-tiered methodology, consisting of primary and secondary research and analysis**.** Specific steps included:

- In-person and telephone meetings and interviews with mental health advocates**.**
- Review and analysis of state planning and budget documents**.**
- Review and analysis of national documents related to Olmstead planning.
- Review and analysis of planning documents and processes from 13 states.
- Interviews with individuals in the mental health field**.**
- Analysis of all of the above to formulate final recommendations**.**

[1] *Olmstead v. United States*, 277 U.S. 438, 478, 48 S.Ct. 564, 2, 72 L.Ed. 944 (1928).

Public Works' research, analysis and recommendations focus on two aspects of Olmstead planning**.** We discuss, first, the planning process itself and, second, the actual content of state plans**.**

This report is presented in four sections:

Section I: What do advocates want and how do they view the current planning efforts of the state?
Section II: State approaches to Olmstead planning
Section III: Findings and recommendations

In addition, the appendices detail the individuals and groups interviewed and the documents reviewed**.**

SECTION I: WHAT DO THE ADVOCATES WANT AND HOW DO THEY VIEW THE CURRENT EFFORTS OF THE STATE?

Public Works sought input from representatives of advocacy groups throughout the state of Georgia in identifying steps that might be taken in response to the Olmstead decision, in particular, mechanisms to improve and enhance the transition to a more defined and effective community-based mental health service delivery system**.**

A. Process for Gathering Information

Public Works met with advocates in Atlanta on October 25 and 26, 2001**.** Advocacy groups were invited by MHMRSA to discuss openly the planning process and related planning needs during face-to-face meetings**.** Representatives of four advocacy groups were present:

- National Alliance for the Mentally Ill (NAMI)
- National Mental Health Association of Georgia (NMH)
- Georgia Parent Support Network
- Consumer Network

Public Works also attended the November 12, 2001, meeting of the Mental Health Planning Coalition to further our understanding of the planning environment and advocates' key concerns**.** Follow-up phone interviews were then conducted with several participants from the Coalition, including representatives from Community Service Boards, the Jail Diversion Program, MATCH providers, and individual advocates**.**

In addition, **Public Works** met with MHMRSA staff during two separate meetings**.** MHMRSA staff was invited to share its perspectives on the planning process and to discuss areas that might be strengthened, changed and improved**.** Staff included regional representatives, administrative and management representatives, and the consumer services representative**.** Geographically remote staff participated by speakerphone**.**

The information gathering process was greatly enhanced by the cooperation and candor of all the individuals who were interviewed**.** It is noteworthy that although the advocates and the state agency staff do not always share the same viewpoint, throughout the entire process there was clear evidence of a mutual respect, a willingness to work together, and a shared sense of purpose**.** While advocates are very concerned about the state planning process, **Public Works** was struck by their dedication, energy, positive attitude and commitment to using their energies to work productively with MHMRSA staff and to strengthen and improve the existing system**.** In turn, MHMRSA staff participated with equal energy and dedication and also demonstrated a commitment to improving the mental health planning process.

Finally, **Public Works** reviewed printed material provided by the Division and by advocacy groups in order to gain a more comprehensive understanding of local, regional and statewide issues. Documents reviewed included:

- State and regional annual reports and plans.
- Provider Manual for Community Mental Health, Mental Retardation and Substance Abuse Providers Under Contract with the Regional Board.
- PERMES-Georgia's Performance Measurement and Evaluation System 2000-2001.
- NAMI planning and advocacy documents.
- Articles and reports on the Georgia mental health system.

A complete list of source materials is attached.

B. Overarching Issues

The goal of the meetings with advocates was to identify shared themes and concerns that could guide the state in its ongoing review of the mental health planning process**.** The next section details the eight specific areas of focus during our meetings. In addition to the many specific issues identified, there

were several overarching concerns that informed all of the identified issue areas**.** Specifically:

- Advocates want to be able to plan for a **needs-based service delivery system oriented toward the individual.** They want a delivery system that has **adequate funding to support creative approaches and programs** rather than a reimbursement-driven approach that is often reactive in nature**.** All advocates agreed that current funding levels were inadequate, system changes were often abruptly cast upon them, and for many years the state has been unable to plan proactively, to develop processes to accurately identify unmet needs, and to develop an appropriate range of effective services**.**

- Advocates point to a need to work with the agency as well as providers and others in the community to **create an environment that promotes flexibility and creativity in the planning and design of service models.** Advocates see opportunities to provide better service at less cost through less reliance on institutional approaches and greater use of consumers as providers of service. They support the maintenance of a planning environment that fosters new ideas**.** They believe that there are vast differences in availability of licensed providers throughout the state, especially in the more rural areas, and endorse a process that promotes the creation and development of new models and non-traditional approaches. For example, advocates expressed great satisfaction that they could work with MHMRSA to successfully obtain a federal waiver enabling qualified consumers to become service providers and to receive reimbursement for their services**.** They believe that these "peer centers" represent a promising example of providing better service to more consumers at an affordable cost**.**

- At the same time, advocates are sophisticated in their understanding of current budget constraints of the agency and the state. They also fully support better planning that is consistent with the department's "rehab option." **They are, however, wary of potentially inconsistent new revenue enhancement approaches ("rev-max") that they believe could compromise optimal consumer services for treatment that qualifies for federal reimbursements.** Advocates also expressed concern about the Division's use of the DACE formula that they feel has an unequal effect on Community Service Boards.

C. Specific Issue Areas of Concern

Eight specific areas were identified by advocates as fundamental to a thorough and effective planning process:

1. Funding
2. Data collection
3. Underserved populations
4. Housing
5. Provider capacity
6. Roles and responsibilities of the regional boards
7. PERMES
8. Interagency cooperation and collaboration

1. Funding

Advocates stressed the importance of obtaining adequate funding both to support a **thorough planning process** and establish a **comprehensive service delivery system** that responds to the findings of the planning process**.** Advocates want a mental health budget that is population based and calculated to grow as documented mental health needs grow**.** Advocates stated that state mental health funding has remained level for more than a decade, despite Georgia's significant growth in population**.**

Advocates emphasized the value to providers, advocates and consumers when services are planned comprehensively and proactively instead of in a reactive mode**.** Many advocates pointed to the emergence of "other" service delivery systems for the mentally ill that have developed over the years (e**.** g**.,** in corrections and juvenile justice), and the lack of proactive planning and coordination with those agencies**.** As a result, advocates state that additional time and dollars are spent after such services are established to coordinate and respond to the changes in the delivery system**.**

In addition, advocates stated that proper planning efforts require taking into consideration "inappropriate" ways of dealing with mental illness, such as incarceration, in order to be comprehensive**.** Additionally, they expressed significant concern that implementation of "rev-max" will compromise the quality and appropriateness of services to consumers**.**

Advocates also recognize that a collaborative approach to planning may help identify and create more flexible treatment approaches that are more cost effective**.** As one advocate stated: *"(t)he money is there, we need to use it better. It's in juvenile justice and corrections, being spent, some of it on mental health (people), but on mental health people in inappropriate ways."*

Advocates articulated two specific examples of concern in hopes that improved planning could yield both better results and additional resources:

- Too few staff and a lack of coordination between agencies, as well as enrollment difficulties, prevent Georgia from identifying many individuals qualified to receive Medicaid and Peach Care benefits.

- While attention is given to identifying best practices and conducting conferences to inform others about effective programs, the planning process does not make funding decisions based on identified best practices. While the state initially helped organize and sponsor the best practice information sharing, advocates are concerned that the best practice findings are not linked to actual planning and funding and, therefore, are hesitant to continue their participation.

Finally, advocates believe that any planning process that changes funding priorities should be well publicized and inclusive in order to be effective and to maximize the use of available dollars. This is especially the case during the current period of transition to the new rehab model. Advocates have concerns that the state is unprepared for implementation of the new model and has not planned adequately for the training of frontline staff or the development of sufficient qualified providers. There were also concerns raised about costs for prescription drugs and the need for a proactive approach to the planning for and funding of providing appropriate pharmaceuticals to clients in need.

2. Data Collection and Use of Information

The most significant concern identified by both staff and advocates was the need to plan adequately to meet the needs of those who should be served by the public mental health system. As one advocate asked, "How do we know how to plan when we don't know what our problem is?" Yet, all felt that it is impossible to plan effectively unless the magnitude of this challenge is more clearly understood.

Assessment of Need

Advocates stressed the need to develop a comprehensive data collection approach that identifies both current users of the public mental health system and those who should use the system, but are unable to do so. Examples include gaining a better understanding of the homeless population as well as their associated mental health and substance abuse and treatment needs. Another example given is Georgia's high school drop out rate, which is second in the nation. While research demonstrates the correlation between youth with mental illness who do not graduate from high school, advocates state that there is no reliable system to identify these youth in Georgia, much less provide appropriate treatment.

Tracking System

Advocates recognize the lack of a data collection and tracking system that reports more than just the beginning and end of treatment. There is vital information lost when patients leave an inpatient setting and then drop out of treatment, or when they receive services in another setting or region. Patients may experience multiple treatment episodes and may not be counted accurately without an effective information system that tracks different episodes of care and services provided over time.

Similarly, advocates state that there is no system to prevent unduplicated counting, therefore, one individual is counted each time they access services. They express concern that this not only leads to a misperception of the number of actual consumers served, but an inaccurate picture of the severity of illness and issues of recidivism. They stated that the inability to accurately count and track users of the mental health system impedes planning for resource allocation and economic forecasting.

Treatment in non-MHMRSA settings

Advocates stressed the difficulties of planning for those with mental illness that are being treated intermittently or on a long-term basis in non-mental health settings, such as the Department of Corrections, the county prisons or the Juvenile Justice System. Advocates find that since communication and collaboration are intermittent, there is no formal mechanism to share client service unit information. Advocates feel that this creates a fragmented delivery system that, in turn, leads to inaccurate planning. They state that since basic data elements such as number of individuals served, severity of condition, discharge status, and co-occurring conditions are not accurately counted in the MHMRSA overall data system, the accuracy of the service delivery plan is questionable.

Prevention

The advocates also stress that strong data collection and use of information are a key to planning for prevention. They believe that lack of an integrated delivery system that crosses all involved agencies impedes effective prevention efforts. Since MHMRSA does not have access to historical data about many consumers, including juvenile offenders and adult prisoners, it is difficult to identify trends or "risk indicators". Advocates state that this leads to ineffective prevention programs and reduces effective use of valuable resources. For example, it is impossible for the established mental health system to gather comprehensive information about pre-prison behavior that is mental health or substance abuse related. Therefore, targeted mental health programs aimed at preventing the onset of criminal behavior cannot be effectively designed. Similarly, advocates cite a lack of reliable information about events leading up to incarceration of

juveniles is a barrier to effective community mental health planning since trends cannot be reliably identified.

Cultural Sensitivity

Advocates state that the current data collection system is not designed to recognize cultural, religious and ethnic differences that are present in the state, particularly in the more remote rural areas and in the high-growth urban areas. This is especially important with those population sub-groups that tend to avoid accessing the public mental health system until a crisis occurs. Advocates believe that demographic data should be carefully reviewed to discern whether sub-populations are being counted and their needs included in the data collection process to make it more inclusive. Advocates suggest an adjustment to the planning process that utilizes individuals trusted by some of these cultural and religious groups to collect valid data.

MHMRIS

The concerns identified above relate directly to the Mental Health Mental Retardation Information System. Advocates state that the MHMRIS is lacking in its ability to provide accurate data back to providers and state agencies in order to promote more effective resource allocation. State agency staff acknowledge that the current data collection system is outdated, but state that budgetary constraints and technical issues impede developing a more useful information system. Providers report that the current use of multiple software programs is not cost effective and does not always allow for a useful exchange of information.

The current data collection approach is also viewed as payment driven rather than accountability driven. As a result, advocates view it as inadequate for determining if there is a greater need for a service than there is an available supply (i. e., a waiting list) and whether consumers are being served effectively.

Finally, advocates state that the current approach is lacking in its attention to local needs-based information. Regions are not required to keep good records of the needs of un- or underserved populations. Some advocates stress the need to incorporate recognized national prevalence data into the management information system, since the use of established benchmarks, such as teen suicide rates, measured against accurate local and state specific data could lead to more effective planning.

Timeliness of data collection and planning

As far back as 1989, advocates recall a needs assessment being done that took so long to complete it was outdated by the time it was finished. Currently, it is felt that data for the regional annual and state biennial plans do not feed into one

another efficiently because of the timing of completion dates. Moreover, advocates state that the plans do not coincide well with the budget process of the legislature. The timetable for submitting individual agency service needs and budgetary information to the governor occurs well in advance of the deadlines imposed on the local boards for submission of their annual plans and service needs. Advocates expressed frustration that there is not a carefully determined schedule for data collection, local and state planning and program and funding decisions.

3. Underserved Populations

A recurring planning challenge woven into discussion of funding and data collection was underserved populations. In general, there was agreement that a better approach needs to be taken to accurately identify all underserved groups, quantify service needs, and properly direct resources.

Certain specific populations surfaced during the course of the discussions that impose particularly challenging planning needs.

Homeless individuals

Everyone interviewed, including agency staff, stressed the importance of addressing the mental health needs of the homeless population and agreed that a method needs to be developed to accurately measure the type and level of services needed. Notably, there was lack of consensus on the percentage of homeless that are mentally ill. Estimates ranged from one-third of the total homeless population to as high as 85 percent. This significant disparity points to a need to identify the size of this population both statewide and regionally.

Older Adults

Special attention needs to be directed at identifying and planning for the needs of older adults. The planning process should identify categories of older adults by age and determine their specific needs. Of specific concern were the subgroup of older males and their needs because they are more prone to substance abuse, particularly alcohol, and suicide.

Incarcerated Individuals

Advocates contend that individuals recently released from incarceration are another group that receives inadequate attention from the mental health system. They state that MHMRSA does not have an established process for obtaining and coordinating information or follow-up needs of individuals coming from other agencies such as corrections. Advocates feel that Georgia develops overall planning guidelines, but expects the regional boards to identify and plan for

localized needs. The regional planning process is unevenly applied to subgroups and to populations currently housed by other agencies, such as prisons or jails.

Young People in Transition

While those interviewed stated that the mental health needs of all younger individuals need to be more accurately studied, they agreed that planning for young people who are in the juvenile justice system is particularly lacking.

Advocates stated that in recent years, the juvenile justice system has addressed some of the mental health needs of incarcerated youth through the use of medication and the hiring of trained mental health providers. In some cases, the services these juvenile consumers receive may be better than what is otherwise available. Advocates are concerned, however, about the appropriateness of the services being provided, since mental health services are not core functions of the juvenile justice system. Moreover, they state that once these juveniles are released from that system, they are not routinely absorbed into the "traditional" mental health system. Many cannot find suitable housing with appropriate support services. Since they are no longer in the justice system, and eventually age out and no longer qualify for children's' services, advocates state that many of these individuals are not effectively linked to the mental health system, and often "drop out." Some speculate that their previous criminal behaviors escalate to more serious crimes or to self-destructive behavior.

Children

Advocates expressed grave concerns about they believe to be "a pattern of abrupt decisions" affecting services for children with mental health needs. They point out the need to take the time to plan for appropriate care settings for children, especially when inpatient beds are removed from service. Advocates voiced concern that the state lacks creativity in its approach to identifying children in need of care and in providing early intervention. For example, they state that most schools have school nurses who are aware of problem behaviors, but these nurses are not actively engaged by the state in identifying needed services.

Other concerns in serving children cited by advocates include:

- The need for better planning to identify and address the relationships between mental illness and co-occurring disorders such as substance abuse and the effectiveness of early intervention and use of proper treatment.

- Inpatient beds removed from service without time to plan and develop appropriate community-based care settings, leading to more and more children in the juvenile justice systems because of the serious nature of

their illness and resultant behavior. Advocates state that this cycle contributes to inaccurate assessment of the need for all levels of care for the seriously mentally ill young person.

- The structure and policies associated with the coordinated MATCH programs and oversight responsibliities of the Division of Services to Families and Children. While many believe that services are fairly well coordinated and are directed at individual needs of children, they are concerned that MHMRSA has limited input into planning, resource allocation and program design.

- Lack of a coordinated approach to planning for services once children are no longer eligible for the Division of Services to Families and Children's oversight. For example, advocates cite situations where providers prevailed upon the state legislature to seek support to expand residential facilities for individuals between eighteen and twenty-two years of age. By one estimate, Georgia had over 6,000 young adults in need of services such as therapeutic foster care and residential care that were unavailable.

- Support for start-up costs for establishing or expanding services or facilities where the state has authorized new care settings and established reimbursement rates. Advocates stress that thorough planning and consideration be given to developing realistic fee schedules especially in the early phases of new facility or program implementation.

Other Special Needs Populations

Advocates stated that since state planning and funding does not address special conditions such as post-traumatic stress disorder (PTSD), often these individuals do not have access to ongoing specialized mental health care. During crises and periods of extreme stress, these individuals may seek treatment in the emergency rooms of general hospitals. Often, when individuals are less symptomatic, they are discharged back to the community without arrangements for follow-up care. Some are referred to the veterans health care system, yet, not all individuals are entitled to receive veterans' benefits. This can be especially difficult in the more rural areas of the state, since often there is a lack of appropriately staffed community services and hospital beds. Often consumers must travel far to access appropriate levels of care if the appropriate levels exist.

4. Housing

While many service needs were mentioned in the course of these interviews, no need was mentioned more often than housing. As one advocate stated, *"The*

biggest problem is housing, or better put, the biggest problem is assessing our needs and housing is a particular area that isn't addressed. "

Advocates state that in addition to lacking a credible inventory of available housing stock to address mental health consumers' needs, there is only one-half of a position at the state level designated to look for possible placements. While there is a state agency responsible for housing procurement and coordination, advocates feel there is little coordination between that agency and MHMRSA regarding overall and local housing needs for people with mental illness. Specific concerns include:

- The lack of a good reliable housing inventory and the incorporation of such an inventory into the planning processes.

- Lack of coordination of transitional housing resources. Transitional housing is the most immediate issue for those leaving inpatient treatment and requires stronger coordination, which could be enhanced through improved tracking, data collection and management and developing a housing inventory by location, type, size, and occupancy level, among other reporting elements.

- A demand for group homes that exceeds availability. Additionally, they cite the need to create a waiting list by geographic area for each type of housing needed.

- Overall, resources are insufficient to identify housing opportunities, identify residents' needs and carefully match resources with clients.

5. Providers and Capacity

Both advocates and staff support a planning approach that accurately identifies available providers throughout the state and that establishes realistic standards for performance measurement, auditing and evaluation. Advocates stated that while consistency and quality must underlie the provision of all care, the planning process should recognize regional and local differences, particularly in manpower needs. They feel that provider advocates should be more involved in the planning process with the regional boards, and state the potential benefit of a more inclusive planning process as annual plans are being prepared and staffing needs are identified.

Advocates expressed concern that providers are currently leaving the system, but there is a need for sound data to more accurately pinpoint the changes in provider patterns and availability. In addition, they state that current state policies exist that prevents providers, such as hospitals, from owning and establishing certain care settings (such as outpatient clinics or group homes) or

from adapting current settings into new uses**,** potentially limiting the ability to maximize the use of existing providers**.**

Advocates' comments about regional boards expanding their menu of non-traditional treatment methods reflect a larger concern as to how well the department's new philosophy will be embraced at the local level**.** This concern is increased by the introduction of "rev-max" and funding uncertainties, a perceived lack of training and the increased importance of a continuum of care for the rehab model to work**.** A number of advocates commented on the accelerated rate of change and "too many things coming at once**.** "

6. Regional Boards

Advocates expressed concern about the categories of representation on the regional boards. They stressed the need to ensure that specific representation of consumers is well understood and that realistic efforts are made to recruit knowledgeable individuals to serve**.** Advocates emphasize that there is a difference between an actual consumer and user of the public mental health system, and a family member or relative of a consumer and the distinction needs to be made when determining representation**.** Boards need both categories of representatives, especially in light of the emphasis placed on developing an annual plan and on performing annual satisfaction surveys**.** Concern was also expressed about barriers to active participation on the boards such as location and timing of the meetings and access to transportation**.** Advocates and consumers believe that regional board diversity will lead to creating a service delivery approach that is both cost effective and recovery based**.**

In addition, both advocates and consumers stressed the need for more consumer involvement in identifying effective approaches to meeting mental health needs, and the importance of their participation in planning and decision-making at the regional and community service board levels**.** As one advocate put it, *"consumers know best what their needs are, we need to make much better use of consumers to help consumers. They will talk to each other, confide in what is working and not. They are the best judge of what providers are doing a good job and which are not. "*

In addition, advocates stress that individuals on the regional boards should be knowledgeable in or represent a broad range of patient categories such as those sensitive to the needs of children, substance abuse, and others**.** Since the regional boards determine and contract for services, there should be members who have an understanding of legal, contracting, and financial matters**.** Finally, and vitally important, advocates state the need to appoint individuals to serve on the boards who have both the time and the investment to serve fully and conscientiously**.**

Advocates feel that the overall annual planning process of the regional boards should be evaluated with specific emphasis on the methods used to solicit public input into the annual plan**.** This includes:

- The format of the public hearings
- The need for new creative and validated methods to survey the public
- The intent to seek broad based information that uncovers all populations in need
- The need for more face-to-face interaction with consumers at locations that are acceptable to the consumer
- The need for collaboration and interaction with other community agencies such as jails and child protection
- The need to more fully integrate information gained from the annual planning process with the overall two-year state agency plan
- The need to evaluate community impact relative to any changes in the delivery system

7. PERMES

Advocates believe that the PERMES, Performance Measurement and Evaluation System, is a first step in developing an effective evaluation process**.** They strongly encourage the continual evolution and refinement of the PERMES approach so needs can be accurately measured and outcomes reliably evaluated**.** They believe that PERMES can be used as an effective planning document to guide the "next steps," but stress that it is only a beginning**.**

Advocates say the current value of PERMES is to provide performance indicators that can be used to draw down federal dollars**.** In their view, PERMES use is limited as a planning instrument because it:

- Does not measure unmet needs.
- Does not have performance standards.
- Captures information only from those already receiving services**.**

Advocates are concerned that PERMES currently has a limited ability to measure quality and continuity of services**.** Some advocates question the appropriateness of the questions asked of consumers and providers. For

example, distinctions between whether consumers are receiving inpatient or outpatient services and whether those asking the questions are providers or professionals or peers of consumers need to be recognized. Advocates feel that the data are limited, since it is collected in a very restricted manner.

While most advocates had hopes that PERMES would one day become an effective planning tool, the project is currently described by a number of advocates *as "a work in progress."* Advocates did express a strong willingness to work with the state to improve PERMES and enhance its applicability as a planning tool.

8. Interagency Coordination and Cooperation

Repeatedly in the course of these interviews, advocates raised concerns about a lack of interagency cooperation as it related to any needs assessment. *"Sharing information is important but rarely happens"* was one comment. *"Department of Corrections inmates get mental health services but don't coordinate with Mental Health (department)"* was another.

Generally, advocates believe the separate mental health "systems" that have developed in corrections, juvenile justice and elsewhere, as well as lack of interagency planning for other services, such as housing, create a confusing mental health patchwork. Poor coordination among agencies leads to wasted resources and makes continuity of service more difficult. Furthermore, it is difficult to plan for and assess resource needs when actual provision of services is scattered among various agencies and included in non-mental health agency budgets. It is even more difficult to compare incidence and prevalence against national recognized or scientifically valid data. Finally, the existence of a non-integrated approach to problem identification and provision of services reduces the effectiveness of advocacy efforts especially with the legislature.

Advocates state the difficulty in measuring the extent and cost to the state's mental health services without timely and accurate information sharing. For example, they asked what percentage of the budgetary increases in the Department of Corrections is directly related to providing mental health and substance abuse services? Conversely, how much of the cost of correction is due to inadequate availability of mental health services that leads to crime? What is the cost of new-generation medications prescribed for teen-agers incarcerated in the Juvenile Justice System? What percentage of public defenders' time is allocated to handling cases for the mentally ill who commit non-violent misdemeanors? These questions only begin to address the issues that they felt must be considered in approaching the interagency planning for an accurate needs assessment of the mental health system.

Advocates contend that the current uncoordinated approach leads to a fragmented service delivery system rather than a fully integrated service delivery approach that could be designed to provide services of value in a cost effective non-wasteful, non-duplicative manner**.** One advocate summed it up by saying, *"Any needs assessment should focus on the entire population and include the need for interagency coordination and all dollars being spent on the 'problem,' both directly and indirectly."*

Case Management

One approach mentioned by advocates to address some of these concerns is to plan for an effective interagency case management system**.** Current case management is viewed as insufficient and advocates stress that there is a need to evaluate and plan for a seamless cross-agency approach**.** Advocates believe that good case management is a building block of planning**.** Without effective case management, individuals cannot be assured of appropriate aftercare or continuity of care**.** Advocates feel that effective case management assists in identifying changing service delivery needs because it is easier to access current service level data and to measure unduplicated consumer utilization**.**

Summary

Interviews with the advocacy community produced a number of recommendations, falling into several broad categories, discussed in detail *infra*, including the need to:

- Recognize the funding constraints that face the state and regions and hamper effective planning and service delivery.
- Improve data collection methods to better inform the planning process and service delivery system**.**
- Focus on underserved populations historically left out of planning and service delivery**.**
- Recognize the role that housing plays in provision of services, and use it as an example of the need for better interagency planning and coordination**.**
- Address the issues around provider capacity in planning for services.
- Implement a non-fragmented, broad-based collaborative approach to planning that crosses state agency boundaries and budgets**.**

SECTION II: STATE APPROACHES TO OLMSTEAD PLANNING

A. Overview

Public Works reviewed Olmstead plans from thirteen states**.** States were selected based on several factors:

- Requests from advocates and MHMRSA staff.
- States mentioned in national literature.
- National geographic distribution.
- Representation of states across the continuum of plan development and implementation.

State Olmstead Plans Reviewed by Public Works
Arkansas
Hawaii
North Carolina
Arizona
Kentucky
Illinois
Iowa
Missouri
New Mexico
Tennessee
Texas
Wyoming
Wisconsin

Public Works focused both on the *planning processes* used to complete the plan (how they were initiated and conducted, and who was included), as well as the components of the *final plan* itself**.** For states that are further along in their plan implementation, we provide some information on their progress.

Key components of the state plans are provided in the chart below**.**

State Plan Key Components

- Involved key stakeholders through formal and informal planning partnerships.
- Established work groups and committees for specific issue areas
- Adopted a consumer-driven plan design
- Has a comprehensive focus tied to most relevant behavioral and physical health components
- Contains "major themes," vision and goals
- Contains narrative charts and support statistics and does not only rely on qualitative data
- Goals and objectives are clearly tied to funding options, budget processes and legislative appropriations
- Contains thorough description of current array of community-based services.
- Contains legal section to address legal issues of Olmstead and other state or federal legal requirements or constraints
- Has clear timeline and recommendations for plan implementation

B. Descriptions of State Planning Processes and Plans

Following are brief descriptions of the thirteen plans that **Public Works** reviewed, including:

1. The process used to create the plan, the planning process, administrative structure and other necessary components**.**
2. The content of the final plan**.**

Arkansas

Process

The Governor of Arkansas directed the Department of Human Services to take the lead in developing a report on Arkansas' response to *Olmstead*. The Olmstead report was submitted to the Governor on February 2001. The actual planning process to create an effective working plan was scheduled to begin in July of 2001 with an October 2001 completion deadline. To ensure broad input into the report, the Governor further directed that an Olmstead Working Group be created to study the issues and recommend future actions. As a result, the report's completion is credited to the Working Group, consumers, advocates and providers. Along with a call for resources and action, central to the report is a call for further planning and further assessment of the needs and desires of people with disabilities. The framework for conducting this planning and evaluation – including involvement from all stakeholders – is a critical component toward developing a comprehensive, effectively working state plan.

There were several different planning committees, task forces, and workgroups that have reviewed the recommendations and report. Although the broad incorporation of stakeholders provides a more comprehensive understanding of the current community-based service system, it slows down the progression of the product as it becomes increasingly difficult to reach a consensus on every issue. As a result, Arkansas has extended the review of implementation and additional proposals to continue until at least 2003 when new supporting legislation will be proposed to the legislature.

Content areas

The report contains a number of recommendations followed by a timeline clearly displaying the steps needed for proper plan implementation. Included in the report are attachments, which provide a more issue-specific focus of planning steps. The attachment issue-areas include:

- Assessments
- Transitions
- Employment
- Public Awareness
- Staffing
- Housing
- Access
- Eligibility and Transportation

The report also contains a substantial legal section. The purpose of this section is to show how Olmstead legislation can be integrated with State legislation in order to optimize service delivery.

The report provides narrative charts and statistics in order to provide a realistic approach to access issues and funding opportunities for necessary community services. Included is a brief explanation of all Olmstead-compliant programs that the State currently provides to consumers.

Arizona

Process

Arizona Health Care Cost Containment System Administration (AHCCCS), Arizona Department of Economic Security/Division of Developmental Disabilities ADES/DDD and Arizona Department of Health Services/Division of Behavioral Health Services ADHS/DBHS convened an initial meeting in June 2000 to discuss the Supreme Court decision and subsequent information from the Centers for Medicare and Medicaid Services. In August 2000, the state agencies identified the process to encourage consumer involvement in the plan development process, which included the following:

- The convening of four regional stakeholder meetings, including one that was conducted via videoconference
- One subcommittee for document review and several additional agency specific planning meetings.

Consumers recommended that the agencies develop a single, consolidated plan because of the issues common to all of the consumers and the three agencies. Based on this input, the State developed a draft consolidated plan and requested review by a group of volunteers from the stakeholder community. Following this review, the state revised the consolidated plan, again based on the consumer responses, and posted a copy of the revised plan on the AHCCCS website for further input from stakeholders. The final plan was published and posted on the AHCCCS website in August 2001. The state's intensive collaborative approach to planning was time intensive, but proved valuable to the overall process.

Content

Central to Arizona's plan is its ability to allow state agencies to have an autonomous vision while working toward achieving an integrated goal.

Content areas and recommendations discussed in the plan include:

- Consumer Directed Service

- Consumer Pay Increases for Home and Community Based Providers
- Re-evaluate the current service matrix that includes services and service reimbursement rates**.**
- Conduct ongoing analysis of the service network through the Regional Behavioral Health Authorities (RBHA)**.**
- Continue with ongoing improvements through the collaborative effort of the RBHAs, Arizona State Hospital, ADHS/DBHS, AHCCCS, and ADES/DDD to meet the needs of special populations**.**

The organization of the plan allows consumers, advocates and providers easy access to specific areas of interest.

Part I provides general background on the Olmstead Decision and Arizona's philosophical base and consumers served**.**

Part II, Common Elements, provides a brief description of the system**.** This includes a discussion of the common components of the community based Medicaid programs in Arizona and the common themes on which the agencies are working**.**

Part III, Agency Specific Actions, provides information about how each agency is addressing the six Olmstead Principles (*Person-Centered Care Management, Consistency of Services, Available and Accessible Services, Most Integrated Setting and Collaboration with Stakeholders)*.

- Services provided by the Arizona Health Care Cost Containment System/Arizona Long Term Care System for persons who are elderly and/or have a physical disability**.**
- Services provided by the Arizona Department of Economic Security/Division of Developmental Disabilities to children and adults with a developmental disability**.**
- Services provided by the Arizona Department of Health Services/Division of Behavioral Health Services to children and adults with behavioral health needs**.**

Part IV, Appendices, provides the reader with more detail regarding the Olmstead Decision principles, populations and programs, services and settings, definitions and acronyms, the work plans for each of the state agencies, and people and organizations that were involved in the development and/or review of this plan**.**

Hawaii

Process

Under the subcontract of Technical Assistance Collaborative (TAC), the Human Services Research Institute (HRSI) conducted Hawaii's needs assessment plan. Specifically, TAC was charged with assisting the Department of Health, Adult Mental Health Division (AHMED) with the enhancement of community services for adults with severe mental illness.

The goal of the needs assessment was to provide the state with information on how persons entered the system and how to best evaluate their treatment needs. This type of information provided the state an opportunity to begin their service plan based on needs of persons who should be served by their functional needs—clinical, personal, social and basic living—rather than just planning by individual services and by perceived needs for a specific service.

Content

The needs assessment contained recommendations on how the State of Hawaii should develop an omnibus plan. The recommendations suggested that the plan should be created through three sets of analysis. The three sets included:

- Determination of what services are already being provided by type and amount of service and by where services are provided;
- Determination what funding sources are being used for each of these services and project potential funding sources that could be utilized by service type; and
- Suggestion that any new state funding to fill gaps identified in the analysis should be spread out over a three to four year period beginning in FY 2001-2.

The plan also recommended that state policy for securing other funds such as Medicaid or other federal funds to fill these gaps should be closely examined and considered.

In addition to background statistics, the State of Hawaii has also included several methodologies either presently employed or scheduled for future implementation on how to measure unmet need or their un- and underserved populations. The methods that the state has outlined throughout their plan suggest that the state, through the usage of past research and recommendations, is able to now progress forward with a sophisticated state-specific tool that might be too progressive or optimistic for the majority of states undergoing similar planning processes. For example, the State is able to assign value to its treatment services. Most states' are unable to fully recognize what their range of service options are or could be, or even estimate their volume of usage. Without being

able to identify the basic elements of service options, a state will not be able to accurately assess service value or even fully grasp the definitions of services delivered.

Illinois

Process

The Illinois' Department of Human Services, as lead agency, assigned six committees that were comprised of stakeholders, people with disabilities, family members, advocates and service providers to present the State with input on how Illinois could modify its service delivery system to comply with Olmstead. The committees were assigned to cover specific areas of the State's delivery system such as financing, universal pre-screening and community integration, housing, service coordination and policy, community infrastructure and best practices. Once the committees reached a consensus, they prepared and submitted a three-page paper providing recommendations to the State. It is important to note that this document is only the first step in the process of Illinois coming into compliance; however, the stakeholders are committed to maintaining a partnership role with the State as the process to comply with Olmstead continues.

Content

The document is clearly written to cater to the consumer. As stated, "The most important factor in our position is: '*What's best for the individual and what do they choose among a range of appropriate options'*." The stakeholders also clearly recognize the cost implications of expanding service options, however, the stakeholders also believe that overtime the actual costs to care for these individuals in community settings will decrease. Therefore, aside from consumer choice driving this plan model, funding (cost) is a key element necessary in order to achieve success. As a result, the finance subcommittee recommended that an annual cost of doing business, an annual Cost of Living Adjustment (COLA) for wages, wage increase above a COLA, a stabilized community infrastructure and rates that cover cost at fair market value should be the State's Budget priorities. In addition, the committee recommended that the State must take the necessary steps to project incidence and prevalence of eligible populations as a method of projecting service costs, including the collection and utilization of the necessary data used in planning and implementation activities.

Immediately following the funding section, the State includes a paragraph explaining steps to increase home and community base services (HCSB) waiver capacities. In order to illustrate whether the State has used its waiver

capabilities to their maximum potential the State listed both the total individuals served and maximum capacity figures**.**

The stakeholders believe that funding could become the primary barrier to access**.** As a result, they are recommending increased consumer control, which includes a "*person centered system"* that provides consumers "*multiple options from which to choose***.** " The plan does not provide detail regarding these recommendations**.**

The stakeholders believe that a critical factor in ensuring high quality and availability of community based programs and services are the recruitment, retention and support of a quality workforce. Moreover, the stakeholders also feel that quality assurance involves improving the capacity of providers to implement continuous quality improvement activities**.** There were no specifics given as to how the State would attain these standards except for a listing of the necessary components needed to carry out the suggested monitoring and quality efforts**.**

Recommended action steps are contained in the document, which are clearly tied to a timeline in order to maintain efficient progression**.**

Iowa

Process

Based on the Lieutenant Governor's commitment to enhance the opportunities of choice for Iowans with disabilities to live and work within the community, Iowa's Olmstead planning process serves as an extension of the state's previous efforts in this area. The actual Olmstead planning process has provided a higher level of service integration for different state agencies and private organizations, which are now working towards attaining a common goal instead of providing fragmented services to segments of the population. Through the recent Olmstead legislation, state agencies and private organizations have been encouraged to combine efforts in providing community-based service options in order to identify current areas of weakness or service gaps within the current community-based system**.** This approach has enabled the state to identify potential barriers to access, which impede the quality of care that can be delivered**.** As a result, Iowa's planning process begins by identifying data that supports underserved or un-served populations**.**

Content

Iowa's plan, which was presented to Governor Vilsack on August 31, 2000 begins by introducing its system's values and presents a short description on each: Choice, Empowerment and Community**.** An ordered description of its

system's principles immediately follows the plan's values, which reemphasizes their importance to the overall plan's success. Encompassed in those system principles are three main components of health care: Access, Cost and Quality in addition to the secondary choice element.

Although many of the initiatives discussed in the plan are not newly implemented as a result of the passage of Olmstead legislation, the plan also lists several initiatives that adhere to many elements the state has outlined exclusively under the Olmstead Plan implementations' section. The initiatives include child mental health, a senior living trust fund, and employment opportunities for people with disabilities.

Even though the plan doesn't site specific funding estimations for plan implementation, it does provide a listing of funding opportunities in which the state recently submitted grant applications.

In assessing the ability to ensure that alternatives to institutional care are available, Iowa believes that there are both population and service gaps throughout the state. In addition the state believes, much like Georgia's advocacy groups identified, that there are several populations that fall into a grouping not specifically targeted for entitlements or discretionary program funding in addition to those offered through traditional Medicaid benefits. Moreover, there is little data available to determine the degree to which these populations are or are not receiving services in the localities or to determine the extent of the need that exists. The State is hesitant to institute a level of flexibility in its planning process to accommodate discrepancies in data collection. Iowa has not included strategies to obtain this needed data. However, it has opted to include data sets in the plan that pertain to state mental institutes' occupation rates, which will be used to track the ability of the state to integrate those individuals to community-based settings.

Finally, the plan includes a section titled: "Current Assessment Process." This section is categorized by facilities (i. e., nursing home, mental institution) and outlines some of the current assessment processes, which are presently being carried out in these facilities. A "Proposed Plan Development Process" section provides next steps for plan implementation suggesting that this is a living document. A timeline is also included in the Future Next Steps section.

Kentucky

Process

Kentucky's Cabinet for Health Services has posted a draft plan on its web page. The plan is organized by section and each section can be downloaded and reviewed. In addition, the web page is designed to accept and view posted

comments. The flexibility of utilizing an interactive web page encourages community involvement and engages a broader range of stakeholders that might have been overlooked in the initial work group and committee organization.

Content

Structurally, the draft plan begins with a recommendations section, which is followed by seven chapters:

- Overview of the *Olmstead* Decision and its Impact on Kentucky
- Climate of Kentucky at the Time of the *Olmstead* Decision
- Kentucky's Response to the *Olmstead* Decision
- Kentucky's Approach for Institutionalized Residents
- Kentucky's Approach for Residents at Risk of Institutionalization
- The Olmstead Executive Planning Committee Workgroup Reports and Kentucky's Next Agenda**.**

Included in the recommendation section is the establishment of an Oversight Committee for the purpose of overseeing compliance in Kentucky with the Olmstead decision and developing any legislation needed to achieve compliance**.** As stated, it's recommended that the Oversight Committee be comprised of legislators, persons with disabilities, family members of persons with disabilities, advocates, and officials with policy-making responsibilities from the Cabinet for Health Services, Workforce Development Cabinet, Transportation Cabinet, Kentucky Housing Corporation and Public Protection Cabinet and Office of the Attorney General**.**

Missouri

Process

Missouri's planning process is designed to demonstrate and implement compliance as interpreted by the Olmstead decision under Title II of the Americans with Disabilities Act (ADA)**.** As a result, the state employed the agencies that are directly affected by the Olmstead decision to develop an effective working plan**.** The state agencies include: Division of Aging, Department of Health, Division of Medical Services, Division of Mental Retardation/Developmental Disabilities, Department of Mental Health Division of Comprehensive Psychiatric Services (State Hospitals), Division of Special Education (State Schools), Division of Vocational Rehabilitation and Division of Sheltered Workshops**.** In addition to this listing, there are several more private non-profit organizations, advocacy groups and active consumers who have also contributed to the planning process**.** The initial planning document was scheduled for review as of July 2000 with subsequent follow-up and updates scheduled for July 2002, and every two years thereafter**.**

Content

The State of Missouri has designed their draft proposed Olmstead plan to resemble either a strategic plan, which address various elements outlined in the Olmstead legislation in question and answer form, or perhaps this draft proposed plan represents an action plan of a much larger strategic plan for a Missouri State Agency. Nevertheless, the draft proposed plan includes established goals and sequential implementation steps.

The plan addresses the need for the State to sponsor a statewide training session on community options, which includes efforts to revise legislation or regulations that in their current form might create barriers to community integration. The State has also identified the necessary components used for individual assessments; however the State only broadly describes the assessment team composition as "qualified treatment professionals" and does not provide a detailed description of the duration of the assessments, nor any legal or resource limitations that might impact the final decision. There is less emphasis on consumer choice except to the extent that a consumer is required to speak to an independent living advocate during the eligibility process. In addition, each consumer will also be informed of the their rights to due process in order to appeal any eligibility decision that individuals perceive to be adverse to their wishes.

The State recognizes many legal and regulatory problems that need to be resolved before actively implementing a plan. For example, the State needs to change legislation in terms of funding opportunities that will be needed to maintain community supports to individuals who are not currently Medicaid eligible, but who are too poor to pay for private attendant or support services.

New Mexico

Process

New Mexico's planning process appears to be an extension of a strategic planning document, which includes specific goals, objectives and priorities. The August 2000 draft plan does not include a specific approach or strategy for designing an effective working plan.

Content

New Mexico has a basic drafting of their preliminary Olmstead Plan. The state chose to discuss some of their beginning implementation steps and recommendations as objectives in a much larger Protection and Advocacy

System's plan. The state has listed implementation steps sequentially, which include training, funding, legal ramifications, assessment or waiting lists and access issues. In order to provide timely access to community-based services the state has requested the collaboration with advocacy organizations, community mental health providers, members of the criminal justice system and consumers in order to assist in evaluating the implementation of initiatives. They have also requested their assistance for the development of a more formalized state Olmstead Plan. The initial objectives included in the Protection and Advocacy System are less focused on addressing consumers needs and more directed at assembling a clear systematic development plan. This perspective is often a secondary initiative for most states as many states have chosen to place the needs of consumers ahead of the system. However, these initial developmental stages will likely be transformed as more advocacy organizations and community representatives begin crafting a more official plan. These introductory steps in the plan's development suggest a new viewpoint that might be worth probing further, since it provides a unique perspective in community services' development that is usually overlooked (i. e., develop a well funded, systematic, regulatory process that will eventually serve to promote state-wide accessibility while providing optimal services).

North Carolina

Process

North Carolina has constructed a comprehensive plan that illustrates the steps necessary to ensure proper implementation of the Olmstead decision. The goal of North Carolina's plan includes the proper administration of publicly financed programs for the disabled and to provide the necessary accommodations for those that can be better served in an integrated setting. Under the direction of North Carolina's Department of Health and Human Services (DHHS) the planning process has been broadened to include agency representatives, providers, advocates and consumers. In addition, the state has initiated four public planning meetings in order to engage a wider audience and increase stakeholder support. As a result, DHHS has designed and interim draft report, which is available for public comment. An interactive version of the draft report can be found on DHHS's website.

Content

North Carolina's plan emphasizes three main areas:

- Informed consumer choice regarding treatment options,
- Expanding public access to community-based support services (i. e. expansion of CARELINE system, and development of the *Going Home* brochure), and

- Carefully customized care plans.

The plan contains detailed assessment and identification processes, which provide a specific range of source information, timelines and assessment protocol for transitional care options.

The assessment protocol is also categorized by an individual's classification. For example, an individual that is considered "at-risk" is assessed using a separate protocol criteria than a person classified as "developmentally disabled." The assessments are conducted systematically and are broken-down by stages depending on individual classification and system admittance (i. e. single portal entry and recidivism rates).

The system's success is based on a centralized process and shared information. Therefore, an individual's assessment will be updated, when appropriate, to account for early discharge or re-admittance to an institution. Individualized care plans are carefully assembled based on appropriate and necessary consumer support, legal restrictions and fair distribution of system resources.

DHHS plans to begin a consistent and standardized data collection method to capture data about the number of qualified people seeking community-based services and the length of time people spend on the waiting list. The plans propose immediate data collection and the development of an automated waiting list. The new system will be integrated with the existing system in order to effectively maintain system continuity.

North Carolina's plan also clearly identifies the need for more community resources. As a result, the State has indicated the need to expand existing services and programs rather than create fundamental alterations of the service delivery system. The State has specified areas that will likely require greater funding to support service expansion. In identifying service expansion needs, the State also recognizes the importance of providing adequate staffing. Potentially helpful recruitment and retention policies have been outlined throughout the State's plan. In addition, DHHS has created a Department-level cabinet to address Olmstead and long-term care issues as well as identify emerging policy issues, work with stakeholders and the general public while assisting coordinating evaluation efforts in this area. Finally, as outlined throughout the plan, the State has indicated the importance of implementing an ongoing monitoring system to sustain quality assurance efforts. The role of an ongoing monitoring system is based on three critical components:

1) To determine if there are ways to streamline and simply the process.
2) To ensure that decisions are made in a timely fashion.
3) To educate consumers about their appeal rights.

South Carolina

Process

In November 2000, Governor Jim Hodges issued an Executive Order establishing the South Carolina Home and Community-Based Services Task Force. The 33-member Task Force was comprised of stakeholders representing state agencies, service providers, consumers, families, advocates, and members of the SC Legislature. The Executive Order charged the Task Force to develop a comprehensive, effective, working plan as recommended under Olmstead. Specifically, the Task Force was instructed to:

- Conduct a comprehensive review that analyzed the availability, application and efficacy of all existing community-based services and support systems available to persons with physical, mental or developmental disabilities in South Carolina. The review focused on identifying affected populations, improving the flow of information about support services in the community, and removing barriers that impede opportunities for community inclusion.

- Ensured the involvement of consumers, parents of consumers, advocates, providers and relevant agency representatives in developing the plan.

- Submit a comprehensive written report of findings to the Governor with specific recommendations on how South Carolina can improve its services for persons with physical, mental, or developmental disabilities by legislative, administrative, or agency action.

- Create a timeline for implementation.

The Task Force was divided into three Workgroups to encompass a broader range of program areas that paralleled three state government organizational units [Department of Disabilities and Special Needs (DSN), The Department of Mental Health (DMH) and Department of Health and Human Services (DHHS)] are the major providers of services to persons with disabilities in institutional and community settings. Each of the Workgroups held formal meetings over a five-month period, reviewed previous studies and data presented by the agencies, and conducted a survey and/or focus groups to gather input statewide regarding needs and recommendations. Once sufficient data was gathered and analyzed each Workgroup submitted a report to the State. The Task Force identified a set of 17 “core principles” to guide the State in implementing recommendations. Most “core principles” are consumer driven and therefore are concentrated in supplying consumers with greater choice, better quality of services and improved access to care.

Content

The work plan provides an overview of the responsibilities of each of the three state government organizational units. Included in the overviews are statistics indicating the amount of consumers utilizing each organization's services. It's in this service utilization section, where the element of cost is discussed. Many of the organizations claim that it's difficult to measure the value of services and resources. In some cases, there is not an accurate method for valuing indirect services and opportunity costs that are incurred, for example, in the case of caregivers. Although the work plan does list difficulties in applying a value to services, it doesn't address methods in which a value could be estimated.

The work plan also includes a gaps and barriers section, which is intended to identify the major current problems in assessing long-term care services. The gaps and barriers' section includes data collection and assessment problems, patient transitional difficulties, financial implications, time delays affecting the continuity of care, lack of precise planning, limited choices, rapid turnover in labor force, labor market shortages, limited housing options, inability to properly coordinate services and the inability to apply outcome measures to track the success of compliance efforts.

Tennessee

Process

Although Tennessee's approach shares many similarities such as assigned Planning and Advisory Councils comprised of a variety of stakeholder groups, defined goals and principles covering a spectrum of important components (e.g., personal care, health care, social services and other services), demographic and background information and a timeline, the plan's principle goal is a seamless, statewide system for people to access needed care. In order to successfully develop a system of this type, the councils decided to coordinate their efforts in a way that encourages maximum advantage of federal financial participation and that coordinates services in a matter that provides the most help with the fewest complications to accessing needed services.

Content

By focusing on the lack of awareness of local level information sources, referral and education about services, the councils placed greater emphasis on system design. Emphasizing system design creates a plan equipped to properly address the lack of providers and other necessary medical resources in some state areas. For example, some rural areas do not even have a general hospital. Therefore, the plan's main purpose is primarily centered on expanding access to services.

The councils decided to recommend a tiered approach in developing the overall plan. In designing the tiered approach the councils used a two-pronged methodology in order to capture two groups of consumers: 1) one serving Medicaid-eligible individuals; and 2) one serving those who would not meet criteria for Medicaid eligibility. There are several core principles defined in the plan. The core principles include: 1) broad-based education and dissemination of information; 2) services in home and community-based settings to those most financially and medically needy; 3) well-coordinated programs; 4) simplified access to services; and 5) ways of encouraging individuals to take responsibility for themselves and their future.

Due to possible funding constraints, legislative or regulatory changes and further administrative infrastructure development the councils recognized that an incremental planning approach is needed. Therefore, the councils recommend a five-year moratorium.

Texas

Process

Texas' draft plan was developed by the Health and Human Services Commission (HHSC) who was directed to enlist the participation of consumers, advocates, providers and relevant agency representatives in a comprehensive review of all services and support systems available to person with disabilities**.**

Content

The draft plan contains a background section, which is used to describe statistical data that explains the current utilization of Texas' support systems**.** The purpose of incorporating service utilization statistics in the beginning of the plan is to provide a more realistic understanding of the broader picture, thereby supporting a consumer driven focus**.**

The draft plan also contains a section dedicated to establishing a consumer value base**.** In this section, the state addresses access, quality and choice values in which the system will be built around**.** A more accurate measurement of need will need to be developed in order for the State to adequately address the values stressed in the draft plan**.** The planning committee, under HHSC direction, recommends that a comprehensive process aimed at identifying affected populations must be developed and implemented in the early stages of plan development**.** To begin this process, the section provides a brief paragraph that addresses each long-term care support system by promoting implementation of an even broader independence initiative. Given the breathe of the support systems, the State believes that developing a successful needs assessment

process will take a considerable amount of time and resources. As a result, the course of the evaluation should begin with a prioritization of programs for review, which reflects the interest and concerns of people with disabilities and their advocates. Program and policy changes that are within the authority of the agency and/or HHSC should be made as necessary to adhere to the value base. HHSC's planning committee also recommends creating a partnership to provide oversight and guidance, and committing the resources to organize and deploy the initiative**.** The following draft report paragraphs, offer a more descriptive account of how the State would staff and proceed with HHSC's recommendations**.**

Although the draft plan does not include any funding implications or necessary future allocations, it does provide a concise and organized method for developing a plan for implementing the initiatives outlined in the draft plan**.**

Wyoming

Process

The State of Wyoming conducted a comprehensive needs assessment and Olmstead plan**.** Through its engagement with stakeholders, the plan very systematically identifies activities that are relevant, specifically to the community at large through a series of advisory groups, as well as specific involvement of family and consumer organization and specific clinical/administrative activities related to the State of Wyoming and community habilitation provider organizations**.**

Content

The plan appears to be a descriptively written strategic plan, which includes action plan components that are linked to proposed completion dates**.** Moreover, the plan displays both the Wyoming Department of Health's strengths as well as the Department's weaknesses in preparation for long-term Olmstead legislation implementation and sustainability**.**

Wyoming places significant importance on customer satisfaction surveys and other performance measurement tools as a means of providing attainable levels of success in eliminating the unnecessary institutionalization of its consumers and identifying states infrastructure's and community 's needs. The plan also displays several charts that provide a visual understanding of workforce development issues as well as the number of people served and waiting for waiver services.

Other elements of the Wyoming plan include:

1) Development of New Community Services and Support Infrastructure.
2) Transition Services to Prepare Individuals for a Change in Placement.
3) Data Collection, which is individualized and tied to the individual program plan.

The plan also contains an extensive literature review discussing several outcome based treatment methodologies. The research is supported through a methodology section that describes Wyoming's position in the parameters of nearby states like South Dakota and Nebraska using a standardize data collection tool**.** Finally, the plan contains a discussion and conclusion paragraph that describes how well the three states' service and support systems have reduced social barriers, increased social activities and helped the person served obtain his or her desired care settings**.**

Recognizing that many of the plans shared key areas, **Public Works**' divided the plans into three categories: basic, intermediate and advanced**.** These determinations were based both on the planning process employed by states, the content of the plan and the steps toward implementation**.**

The state plans and their key components are summarized on the next page:

State Plan Summary Chart			
	Basic	**Intermediate**	**Advanced**
Key Components Of Planning Process and Final Plan	Basic framework; minimal work groups/ committees	Established work groups/committees	Established work groups/committees
		Stakeholder involvement/ partnerships	Stakeholder involvement/ partnerships
	Focus on system process, infrastructure		
		Review committees for specific areas of work	Review committees for specific areas of work
	Legal section	Legal section	Legal section
	Limited in substance		
		Focus usually on single health care component (access, cost or quality)	Comprehensive focus tied to all or most health care components
		Identified plan initiatives	Identified plan initiatives
		Contains major themes, “core principles”	Contains narrative charts and support statistics
		Limited funding emphasis	Goals/objectives are clearly tied to funding options, budget appropriations
		Less flexibility in plan revision	Description of current community-based services
		Future recommendations/ timeline	Future recommendations/ timeline
Model States	Missouri	Illinois	Arkansas
	New Mexico	Iowa	Arizona
		North Carolina	Hawaii
		Texas	Kentucky
			South Carolina
			Tennessee
			Wyoming

In addition to **Public Works'** assessment, *The Arc of Washington State Advocates for Rights of Citizens with Development Disabilities published a (July, 2000) Status Report on States' Development and Implementation of Olmstead Plans*[2] lists the results of a survey used to assess the individual components of states' plans**.** The Arc's survey asked state organizations to check whether or not each state's plan included various planning components recommended by federal officials**.** The survey also asked state officials to rate the overall status of their state's plan and provide an assessment of progress on reducing the waiting list in the state**.** Advocates in 38 states responded to the Arc survey; of these states, 20 had an Olmstead plan or were in the process of developing one**.** The report ranked them as follows:

The Arc of Washington State Advocates for Rights of Citizens with Development Disabilities: Status Report on States' Development and Implementation of Olmstead Plans	
Excellent. Plan is complete and state is taking implementation steps**.**	New York, Arizona
Good. Plan is complete, but much work needs to be done to implement it**.**	Kentucky
Fair. State has initiated, but not yet completed**.**	Connecticut, Delaware, Idaho, Indiana, Louisiana, Maryland, Michigan, Minnesota, New Mexico, Texas, Vermont, Virginia and Washington
Poor. State plan has many gaps**.**	Illinois and North Dakota

This provides an interesting, while subjective, view of other states and their status in responding to Olmstead and developing and implementing state plans.

[2] "Status Report on States' Development and Implementation of Olmstead Plans**.** " The Arc of Washington State Advocates for Rights of Citizens with Development Disabilities (July 2000)

SECTION III: FINDINGS AND RECOMMENDATIONS

This section identifies the components of a responsive planning approach that will begin to address the needs of Georgia's mental health systems**.**

A. General Comments and Recommendations

The advocacy community clearly believes that a sound planning process and needs assessment must include the following:

- Deadlines ensuring that needs analyses are still current and valid when the plan is promulgated.
- With consumer needs growing, funding constraints continuing, and the general population increasing, the state simply cannot delay moving forward until it has a perfect document.
- A process to identify needs with a particular focus on at-risk unserved and underserved populations.
- Input from providers, consumers and their families in setting priorities for funding and service delivery.
- A follow-on plan to use data and other information effectively, once collected, to improve services and access to care.

Public Works concurs with these general conclusions and offers additional recommendations below**.**

Public Works' Recommendations for Community Mental Health Planning
1. Pay as much attention to the planning process is to its outcomes. 2. Recognize the funding constraints that face the state and regions and challenges to effective planning and service delivery. 3. Improve data collection methods to better inform the planning process and service delivery system. 4. Focus on underserved populations historically left out of planning and service delivery. 5. Recognize the role that housing plays in provision of services, and use it as an example of the need for better interagency planning and coordination. 6. Address the issues of provider capacity in planning for services. 7. Implement a broad-based collaborative approach to planning, including an effective evaluation mechanism, at and between the state and regional levels.

1. Pay as much attention to the planning process is to its outcomes.

The process that Georgia undertakes to respond to the Olmstead decision is almost as important as the end product. As the state mental health system has been under great stress over the past few years due to changes in funding and reimbursements, a carefully thought out and implemented planning process is crucial to gaining the support of the advocacy community, providers, consumers and state staff.

Comprehensive planning processes take time, energy, support and constant revision. One issue raised by advocates—that planning documents are outdated by the time they are completed—can be addressed by instituting a fluid, dynamic planning process that constantly revises data, assessment of need, and service availability. At the same time, a balance must be struck between the dynamic and cyclical nature of planning and the need to make accurate service and funding decisions.

- **The process must be uniform and timely.** The depth and breadth of the local planning processes currently varies greatly across Georgia's regions. Additionally, there is variability in the way in which local planning informs state planning and budget decisions. The current process for planning needs to be revisited both to incorporate the issues under Olmstead and to create a planning structure that provides for more uniformity across the state and that is conducted on a schedule that works efficiently with the deadlines for state plans, budget submission and the legislative schedule.

- **Agencies beyond MHMRSA should be included in the planning process and plan implementation.** Mental health services are provided by state agencies other than MHMRSA: Juvenile Justice, Public Health, DFACS, Corrections, etc., are all involved in the provision of behavioral health services and need to be formally involved in any ongoing planning process. In addition, planning efforts for mental health services that take place in other agencies should include MHMRSA representation.

- **The planning process should be well publicized and inclusive.** Particularly in this time of transition to the recovery model, a planning process must involve as many people as possible, not only for their input but also for their eventual acceptance of any new directions in which the plan might take the state in the future.

2. Recognize the funding constraints that face the state and regions and challenges to effective planning and service delivery.

Funding will remain a major obstacle to providing adequate mental health services to many Georgians who need them. Any plan must seek ways to do more with available resources:

- **Coordinate funding sources**. A "universal" state budget for mental health services, including all agencies that provide those services, would facilitate the appropriate distribution of resources within and between those agencies. The plan should set priorities for funding mental health activities and make recommendations on resource allocations in all relevant areas of the state budget.

- **Emphasize interagency collaboration**. Any plan should review opportunities for information sharing and interagency collaboration that could result in cost-savings and better resource allocation, so as to serve more people or to better serve those individuals already in the mental health system.

- **Identify cost-effective service expansion**. The plan should identify ways to expand services in cost-effective ways. For instance, "peer centers" provide needed services at lower cost – with the additional benefit of qualifying for federal reimbursements with a federal waiver. Such creative additions to the service inventory are particularly important given tight budget constraints.

- **Use "best practices" more consistently and tie them to program and funding decisions**. While the gathering of best practice data is clearly supported by the state, a stronger mechanism for incorporating that information into planning and funding decisions needs to be implemented. The planning strategy must be designed to identify, support, follow-up, plan for and fund best service delivery practices.

3. Improve data collection methods to better inform the planning process and service delivery system.

Improved data collection, including tracking individuals who are frequently in and out of the mental health system, is perhaps the most critical shortcoming of the current system. While the recommendations on how a plan can begin to address this challenge are straightforward, implementation will be difficult, complex, and potentially costly.

- **Identify key data elements**. The state, working collaboratively with the regions, should identify relevant data elements that will lead to improved resource allocation and creation of appropriate services in non-institutional settings**.**

- **Insure that data collection is accurate and comprehensive**. The plan's data collection must be comprehensive and include individuals being served in a variety of settings by different agencies, as well as populations that are largely unserved and underserved, such as the homeless**.**

- **Improve information technology**. There should be a collaborative approach between the state and regions to determine what kind of information technology system will best enhance and promote improved identification of mental health needs and the availability of supply**.**

- **Review and expand the MHMRIS**. The plan should review how the existing MHMRIS data collection system, once improved, could be augmented or supplemented with a sister system that can better track individuals as they move in and out of a variety of mental health services over time and in different parts of the state**.**

- **Use of local data**. The plan must identify how better to capture local needs-based data and information and feed them into statewide planning**.**

Model Data Collection Tool

A useful first step in consistent data gathering is a uniform data collection tool. The example on the following page offers a data collection tool provided by the state of Indiana that might serve as a useful model for Georgia:[3] The tool is simple yet thorough, and provides clear instructions to users on how to assess current services, needs, and system responses for each target population.

[3] Source: Tumlinson, A**.** , R**.** Ramchand, D**.** Mendelson**.** Center for Health Care Strategies, Inc**.**, *The Essential Elements of Cost Estimation*, September 2001**.**

State of Indiana: Division of Mental Health
Data Collection Tool

Target Population Served (to be completed for each population selected):

1. Please indicate the target population served by your agency.
2. Please outline/describe the array of services provided to the aforementioned target population.
3. Please indicate the statutory authority (federal and/or state) of each target population served by your agency.
4. Please indicate the total number of consumers (by target population categories) served by your agency.
5. Please indicate the funding source and cost (per consumer) of each of these services provided by your agency.
6. Please describe how consumer choice is considered in determining the appropriate placement of each consumer served by your agency.
7. What data is collected to insure quality services are provided to the target population?
8. Please indicate any services that are not provided statewide (list geographic region).
9. Please describe any measures taken (for each target population) by your agency to prevent unnecessary institutionalization.
10. Please describe any measures used to evaluate the current level care (e. g. deinstitutionalization efforts) for each consumer served by your agency.
11. Please describe any transition services (including any barriers/gaps) provided to the target population by your agency.
12. Please list any needs assessments that have been conducted during the previous three (3) years of this target population.
13. Please provide a brief summary of the priorities, barriers, and assets identified by the aforementioned needs assessment.

Current Initiatives (to be completed for each project):

1. Please provide a brief description of any current project(s)/initiative(s) that your agency is facilitating/managing.
2. Please indicate whether this initiative is being managed by your staff or by a contract agency.
3. Please indicate the funding source (e. g. federal/state/private) and the cost of this initiative.
4. Please indicate any collaborative partners involved in this initiative.
5. Please indicate the target population(s)of this initiative?
6. What are the expected outcomes of this initiative?
7. What is the anticipated completion date(s) of this initiative?

4. Focus on underserved populations historically left out of planning and service delivery.

There are several underserved populations that need particular focus and consideration in the planning process and funding for services. These groups represent consumers that are underserved, hard-to-serve, or cross between several agency boundaries and are therefore difficult to plan for in a comprehensive manner. Some specific recommendations include:

- **Identify and count underserved populations**. The planning process should be designed to count and identify the special needs of unserved and underserved populations, such as the homeless, and begin to develop a delivery system responsive to their needs during non-crisis as well as crisis periods. Such plans must recognize the need to factor in both economic issues (e. g., transportation and housing problems) and non-economic issues (e. g., social taboos and cultural constraints) that are barriers to serving these populations.

- **Focus on prevention and early intervention**. The process should examine the need for appropriate programs designed to reach out and identify mentally ill individuals who may, if untreated, end up in the jail or prison systems. Early intervention and assessment of need may avoid a mental illness growing worse and leading to more serious crimes, and thereby save countless dollars in the corrections budget, not to mention the savings in human dignity. For instance, jail diversion programs can effectively keep people out of jail through monitored participation in a treatment plan.

- **Improve collaboration between the MHMRSA and the Juvenile Justice Agency to address the needs of young people.** These agencies should determine where adjudicated youth are receiving services and the funding streams to meet the service need, including money spent on treatment, medication, emergency care and evaluations, and all other mental health and substance abuse related expenses.

- **Address continuity of care, particularly between systems**. The plan should address continuity of services for special populations, such as youth aging out of juvenile justice, incarcerated mental health consumers released from prison, and children who receive episodic and inconsistent care.

- **Identify "new" populations**. The plan must identify other special needs that are not currently covered by the state's mental health services. An example offered by advocates was post-traumatic stress disorder, but there are likely others. The planning process should identify where the

"holes" are in mental health disorders not recognized by the current system.

5. Recognize the role that housing plays in provision of services, and use it as an example of the need for better interagency planning and coordination.

Insufficient housing for mental health consumers not only represents the lack of a basic need of daily living, but also makes proper treatment less likely and can increase collateral problems caused by further deterioration, such as substance abuse, crime and suicide. Housing, therefore, should become a top priority in any planning process. Some recommendations include:

- **Develop an accurate housing inventory**. The state, through the Agency for Community Affairs working in conjunction with MHMRSA, should develop a reliable housing inventory of mental health consumers' needs and incorporate such an inventory into the planning processes.

- **Fully explore the range of housing needs and availability**. The housing component of the plan must address housing needs resulting from discharges from inpatient settings and recognize that there will be a range of housing services needed to support and encourage varying levels of independence.

- **Focus on interagency collaboration in planning for housing needs**. Determining and planning for sufficient housing needs for the present and future is, once again, largely dependent on an integrated data collection system that tracks individuals as they move through the service delivery system statewide, including those individuals who may be served by agencies other than MHMRSA, including Juvenile Justice, Corrections, Community Affairs, and services for children and the aging. Interagency information sharing and collaboration focused on identifying and planning for a range of housing needs for the mentally ill population will be an important improvement over the current approach.

- **Place a special emphasis on transitional housing**. Transitional housing, which is the most immediate issue for those leaving inpatient treatment, requires special attention. The need for group homes should be a special focus.

- **Create a clear and accurate waiting list.** Waiting lists should be created for each geographic area for each type of housing needed.

- **Increase staff resources to address housing needs and placements**. Additional staff is needed to establish an effective housing inventory,

assess needs, address group homes, and create a useable waiting list. Staff resources allocated to identifying housing opportunities and placing residents must be evaluated to ensure that there is enough staff dedicated to meeting these needs.

6. Address the issues of provider capacity in planning for services.

We cannot overstate the widespread concern expressed about the availability of providers and the capacity of the system to provide services to those in need, particularly in the rural areas of the state. As needs are reinterpreted, service delivery models are changed and the system becomes more community-based. This transition to the "rehab" model presents a new set of circumstances that pose even greater challenges to provider capacity. The magnitude of the problem, however, has not been adequately measured and a clear plan for addressing this issue has not been articulated. Addressing this issue is critical to the success of the state's overall planning and service delivery effort. To begin to address this challenge:

- **Measure the shortage of licensed professionals**. Planning efforts should include survey instruments that can accurately measure the extent of shortages in licensed professionals. This is a particularly important planning concern given the shifts in services required under the new rehab model.

- **Explore ways to increase the supply of licensed professionals**. The state should investigate mechanisms to create a greater supply of qualified professionals to provide services throughout the regions, such as "special needs areas" payment scales, new programs that parallel other efforts to bring doctors to rural areas, telemedicine, and better use of the faith community or other trained lay people. MHMRSA should expand its collaboration with the Public Health Agency on behalf of those with physical health needs to work more closely with agencies that access federal dollars for designated manpower shortage areas.

- **Review policies that may impede recruitment and service expansion**. For example, advocates encourage the Division to review and revise polices that impede service expansion into continuity of care models that could expand consumer choice.

- **Encourage non-traditional treatment methods.** The regional boards must implement a more flexible planning process that enables the design and development of non-traditional treatment methods. Specific examples of less expensive, yet effective, treatment include the use of consumers or peers as providers under the "rehab model" and the new "Peer Center"

approach. Consumers can also help fill the void when traditional mental health providers are unavailable: Advocates believe that consumer-providers can deliver more effective care in some instances.

7. Implement a broad-based collaborative approach to planning, including an effective evaluation mechanism, at and between the state and regional levels.

The current system must be better integrated, requiring effectiveness mechanisms to hold each component part of the system accountable. The budgeting and data collection functions discussed above (Recommendation 3), if planned correctly, can accomplish some of this. In addition, however, other recommendations include:

- **Regional Boards need to be inclusive and knowledgeable.** A process should be established to examine categories of representation on the regional boards to assure that the need for specific representation of consumers is well understood and that realistic efforts are made to recruit knowledgeable individuals to serve. Steps should be taken to remove current barriers to active participation on these boards, such as location and timing of meetings and access to transportation.

- **Emphasize public and consumer input in the planning process**. The overall annual planning process of the regional boards should be evaluated with an eye toward how better to solicit public input, including the format of the public hearings, the need for face-to-face interaction with consumers, the need for better collaboration with other community agencies such as child protection and jails, and the community impact of changes in the delivery system as a result of the transition to the recovery model.

- **Focus on interagency participation and coordination in planning and service delivery**. As discussed throughout, the planning process must include all relevant state agencies, as well as the regions, to accurately reflect all the populations served and the extent of their needs. A critical part of the planning process must be to identify ways to institutionalize the ongoing cooperation and collaboration of these agencies in addressing the changing needs of mental health consumers, budgeting, and other resource allocation.

- **Explore interagency case management.** To better integrate the component parts of the current systems, the planning process should determine how effective an interagency case management system could be in tracking mental health consumer throughout the state on an ongoing basis.

- **A key element to better coordination and collaboration is an effective evaluation tool.** While PERMES is viewed as a good first step, it has a number of deficiencies that can begin to be corrected in a planning process, including measuring unmet need and establishing performance standards**.** PERMES must become established as an independent measure of the quality and appropriateness of services delivered, perhaps by making better use of consumers to collect and evaluate data**.**

B. Potential State Models

Based on our review of state plans, **Public Works** identified three states that offer potential models for Georgia to consider**.** These three states – North Carolina, Arizona, and Kentucky – offer a range of approaches as well as varying degrees of depth and detail**.** We have highlighted some of their key components below; detailed descriptions of each plan are presented in Section 2: State Approaches to Olmstead Planning.

Below we have outlined the key components of each of the three model plans and their successful plan implementation, as well as brief rationales for recommending each state's plan**.** Clearly, Georgia is a unique state and will not be able to easily replicate another state's planning process or plan; nonetheless, we believe that these three models are worth further review and consideration**.**

Key Components Shared by all Three Plans

- A strong overview of the state mental health system, as well as a description of the availability of community services and programs.
- An overview of the Olmstead decision and its applicability to the state, both legally and programmatically.
- Establishment and description of Olmstead taskforces, councils or stakeholder groups.
- A specific public input section.
- A clearly defined vision and core principles, as well as clear goals and objectives.
- Strong detail on consumer statistics, using both currently available data and sound projections where necessary.
- An explanation of the assessment and waiting list process.

- A description of additional resources and other related planning, such as housing, workforce development, and ongoing monitoring of quality of care.

- Clear identification of bureaucratic, fiscal and regulatory barriers to effective planning and service delivery.

- A detailed timeline for plan implementation, revision and ongoing planning.

The North Carolina Model

Public Works selected North Carolina as a model for Georgia for several reasons. North Carolina has implemented a broad based planning process that includes agency representatives, providers, advocates and consumers**.** In addition, the state held four public planning meetings in order to engage a wider audience and increase stakeholder support**.** In keeping with their commitment to public input, the state publicized the plan's availability through multiple media sources, posted their interim draft report on their website for public comment and held a public forum to solicit comments on the draft plan.

North Carolina's plan has a strong focus on consumer assessment and individual classification as a way to plan for service needs. Information is centralized and data mechanisms are relatively sophisticated, allowing for sharing of assessment information across systems. The state plans to begin a consistent and standardized data collection method to capture data about demand for services and waiting lists.

Finally, expansion of community-based services has received strong attention and commitment by the state, along with the development of adequate staffing to meet increased needs and the development of quality assurance mechanisms.

The Arizona Model

Arizona was selected as a model in large part due to their strong emphasis on interagency collaboration, a major priority identified by Georgia's advocates**.** Following input from Arizona's consumers, the state embarked on a single consolidated mental health plan that reached across those agencies involved in planning and service delivery. Arizona has been able to construct a plan that allows state agencies to have an autonomous vision and model of service delivery while working toward achieving an integrated goal of comprehensive service delivery to mental health consumers.

Arizona also demonstrated a strong commitment to consumer and public input into the planning process through stakeholder meetings, videoconferences,

subcommittees and agency specific planning meetings. The plan itself was also subject to extensive agency and public review. This approach was both time and labor intensive. While the comprehensiveness of this approach was extremely well received by advocates and consumers, the time and resources required to carry out such an approach is worthy of careful consideration.

The Kentucky Model

Kentucky's plan, unlike many other states', actually begins with a recommendations section. This supplies the State's intentions upfront while providing the reader the option to continue reviewing the plan's additional seven chapters. Included in the recommendations is a suggestion to establish an Oversight Committee to oversee compliance with the Olmstead decision and developing any legislation needed to achieve future compliance; this is another critical component that sets Kentucky apart from many other State plans.

Although the plan contains many of the same key components as the North Carolina and Arizona models, the detail supplied in Kentucky's plan is much greater. The plan is carefully seamed together to encourage stakeholder support. For example, Kentucky's Cabinet for Health Services has posted a draft plan on its web page; sections and chapters organize the plan, and each section can be downloaded and reviewed. In addition, the web page is designed both for viewing posted comments and posting comments of one's own. This flexibility encourages community involvement and engages a broader range of stakeholders that might have been overlooked in the initial work group and committee organization. Although it is not likely that every demand can be satisfied, the concept of publicizing the plan on the website facilitates more "buy-in," which will likely increase the success of plan implementation.

C. Estimating Costs

Estimating the costs of program or policy implementation can be extremely difficult. Although there are several different methodologies that agencies can employ, deciding the most appropriate valuation and computation techniques can be as important as interpreting the outcome. Appendix 3, modeled after the Center for Health Care Strategies' *The Essential Elements of Cost Estimation Toolkit*, has been developed to provide assistance in determining the costs or establishing Medicaid home and community-based care programs. Contained in this cost allocation summary are the necessary information and the questions that decision-makers and evaluators will likely face in estimating the future costs and savings of a future Georgia Olmstead Work Plan. The information can be used for the purpose of guiding decision-makers and evaluators in reaching the most accurate outcomes, given the State's resources and data indicators.

Appendix I: Interviewees

Advocacy Organizations
NAMI
Georgia National Mental Health association
Georgia Parents Support Network
Consumer Network

Georgia MHMRSA Staff Employees

Regional Executive Directors

Phone Interviews
Executive Directors, Community Service Boards
The Devereux Georgia Treatment Network
NAMI DeKalb Jail Diversion Program

Appendix II: Secondary Data Resource References

Georgia Information

Bridge to Recovery; Georgia Mental Health Consumer Network, Inc**.**

Samples of regional health planning boards annual reports

The Biennial Mental Health Plan of the Division of Mental Health Mental Retardation

The Courage to Change, A Report on Substance Abuse in Georgia, Georgia Council on Substance Abuse, 2001

Provider Manual for Community Mental Health, Mental Retardation and Substance Abuse Providers Under Contract with the Regional Board

PERMES- Georgia's Performance Measurement and Evaluation System 2000-2001

Core Elements Planning Parameters, and Guidelines for the submission of Regional Annual Plan, effective 9-01-00

Core Elements Planning Parameters, and Guidelines for the submission of Regional Plan, effective 2001

Facility System Strategic Plan, 4th Quarter, 2001

Facility System FY 2000 Annual Report

Save state's mental health services, Atlanta Journal-Constitution, letter to the editor, September 10, 2001

Meeting the Need: An Assessment of Georgia's Child and Adolescent Service System, Report prepared by the Mental Health Association of Georgia and the Georgia Parent Support Network, June, 2000

NAMI Georgia, Open Your Mind Treatment Works, descriptive brochure prepared by NAMI Georgia

The NAMI Family-to-Family Education Program, The Keys to Understanding, descriptive brochure prepared by NAMI, Arlington, VA

Our Opinions: Save State's Mental Health Services, Atlanta Journal-Constitution, letter to the editor, October 10, 2001

NAMI Georgia Fact sheet

Moving Forward- a publication of the Georgia Council on Developmental Disabilities, Volume 6, Number 1, January 3, 2001

A Decade of Budget Growth: Where Has the Money Gone? Alan Essig, September 2000

State Plans

Arizona: Arizona's Olmstead Plan (2001). www. ahcccs. state. az. us/publications/olmstead/

Arkansas: Arkansas Department Of Human Services: Report of The Arkansas Olmstead Working Group For the Development of a COMPREHENSIVE, Effectively Working Plan To comply with the United States Supreme Court's holding in Olmstead v. L. C. (2001). www. aradvocate. com/Olmstead_coalition. html

Hawaii: (Final Report) *Hawaii Needs Assessment Project* (2000). www. ehawaiigov. org

Illinois: www. state. il. us/agency/dhs/olmfinancing. html

Iowa: (The Iowa Olmstead Report) www. dhs. state. ia. us/mhdd/MHDDOLMSTEAD,htm

Kentucky: The Kentucky Olmstead Plan: A System of Choice for Citizens with Disabilities, (2001). http://chs. state. ky. us/olmstead/textonly/

Missouri: (Draft Proposed Olmstead Plan) www. dolir. state. mo. us/gcd/Olmstead/Sopdraft-2. htm

New Mexico: New Mexico Protection and Advocacy System. (August 2001). www. nmprotection-advoc…/FY02DraftPriorities8%5B1%5D. 13. 01finalformatforwp. html

North Carolina: (Interim Plan) *Serving Persons with Disabilities in Appropriate Settings*: The North Carolina Plan, North Carolina Department of Health and Human Services. (December 2000). www. dhhs. state. nc. us/docs/draftolmsteadplan-chap1. htm

South Carolina: (Draft Report) *Home and Community Based Services Plan*, (2001). www. state. sc. us

Tennessee: www. state. tn. us/comanaging/tnlongtermcare. pdf

Texas: *Promoting Independence: A Plan to Expand Opportunities for Texans with Disabilities* (2001). www. hhsc. state. tx. us/

Wyoming: (Draft Proposed Olmstead Plan) http://wdhfs. wy. us/OLMSTEAD/DDD%20Element%20Two. htm

Additional Resources

Health Care Financing Administration (HCFA) Guidelines: Developing Comprehensive, Effectively Working Plans http://www. hcfa. gov/medicaid/smd1140a. htm

Status Report on States' Development and Implementation of Olmstead Plans. " The Arc of Washington State Advocates for Rights of Citizens with Development Disabilities (July 2000). www. thearc. org/olmstead_report. htm

Tumlinson, A. , R. Ramchand, D. Mendelson. Center for Health Care Strategies, Inc., *The Essential Elements of Cost Estimation*, September 2001.

Appendix III: Cost Estimation Tool

Beginning the Process

Georgia, like most states, is constrained by the amount and sufficiency of information needed to truly estimate the costs of a model work plan. Despite these limitations, it is possible to use program knowledge, common sense and judgment in order to establish benchmarks for service delivery and costs of providing services. Once these benchmarks are established, the formula for computing costs and benefits will become more standardized over time.

To begin, a few questions will need to be answered:

1. What is the size of the population?

2. Who might qualify for services?

3. How many services will the identified population use?

These answers will produce various results depending on the agency, organization or consumer responding. In order to capture the most accurate responses, the State will likely need to:

1. Determine per person costs for expanding community services.

2. Develop a range of possible estimates, thereby splitting the high and low estimates.

3. Administer surveys of experts and colleagues familiar in the field.

4. Evaluate and compare initial estimates in the context of a larger program.

Estimating Costs

The actual formula for determining total costs is relatively simple: Number of program participants multiplied by the average costs per person equals total costs. It is important for decision-makers and evaluators to understand that there are many factors that could affect participation estimates. For this reason, experts have developed two categories of consumers that need to be calculated: community and institution. Since these two categories typically represent different segments of the population, it will be necessary to calculate these numbers separately. The calculation will likely involve:

1. Determining the number of consumers in the community who might participate in the community-based service option.

2. Determining the number of consumers who might transfer from an institution to a community-based placement.

Since national data are limited, Georgia likely will have to rely on data collected by providers, Regional Boards and Community Service Boards to assist in estimating community eligibility. However, if there are deficiencies in data collection throughout the State, another resource that might be useful is the National Health Interview Survey Disability Supplement (NHIS-E). Although these data have not been updated since 1996, they will provide service criteria that can be adjusted to match more closely the current state system. For example, national disability rates might need to be adjusted before applying them to Georgia county census data, since there are regional disparities that might alter the disability rates. If the State chose to utilize the NHIS-E, it should also combine the information with other sources in order to determine the best possible estimates.

Estimating Savings

Expanding community-based services will probably increase costs to the state in the short-term while decreasing long-term costs as a result of expanding less costly treatment options. The success of Georgia's Olmstead work plan will ultimately dictate the amount of cost-savings that could be generated by expanding community-based services. Therefore, the development of the assessment and waiting list processes are critical components in designing the State's work plan. In order to measure cost-savings, Georgia will need to determine how successful the mental health system is at moving institutional residents into community settings and diverting eligible consumers to community placement. The State will need to determine whether or not the current mental health system infrastructure can provide the necessary services, if its provider network can absorb the additional consumers, and if not, what other service enhancements are required and what state policies and goals are needed to support expanding services.

Determining Average Per Person Net Costs

Determining average per person net costs is fairly straightforward: Average per person costs minus average per person savings equals net per person average costs. There are several questions that Georgia will need to answer before being able to accurately estimate costs and savings. For example, waiver program and administrative costs, non-Medicaid costs (i. e., rent), additional costs for expanding long-term care services due to increases in enrollment and the savings for consumers who would have been served in an institution or other community program in the absence of the newly expanded placement options. Secondly, the State will need to find out how much Medicaid pays for an average person who stays one year or more in an institution, or the institutional per diem

amount. The State might need to modify their estimates if they pay risk-adjustment rates to institutions. In addition, the State will likely need to adjust for the average contribution a consumer may be making to institutional costs through co-payments or through spending down to become Medicaid eligible.

Example Calculation Models

The attached charts illustrate two models to represent what the above calculations might look like if the State chose to develop the same, or a similar cost estimate process. These calculations will need to be repeated on each type of funding source (i. e., waivers), therefore the ratios will vary depending on the total eligible consumers participating in each care option. They are provided as an example only.

Model One		
Hypothetical Calculations for Estimating Total Spending		
Consumers	**Community**	**Institutional**
Eligible	2,000	400
Participation Rate	30%	10%
Total Consumers	600	40
Per Person Costs		
Community-based services	15,000	30,000
One-time costs	1000	8000
Other program costs	2000	4000
Total Per Person Costs	18,000	42,000
Per Person Savings		
Per diem	0	50,000
Case-mix adjustment	0	0
Spend-down adjustment	0	0
Total Per Person Savings	0	50,000
Spending	**$10,800,000**	**0**
Saving	**0**	**-$1,630,000**
Total		**$9,170,000**

Model Two		
Hypothetical Calculations for Estimating Total Spending		
Consumers	**Community**	**Institutional**
Eligible	100	400
Participation Rate	95%	45%
Total Consumers	95	180
Per Person Costs		
Community-based services	65,000	65,000
One-time costs	1500	1000
Other program costs	2000	1750
Total Per Person Costs	68,500	67,750
Per Person Savings		
Per diem	0	40,000
Case-mix adjustment	0	0
Spend-down adjustment	0	0
Total Per Person Savings	0	40,000
Spending	**$6,507,500**	**0**
Saving	**0**	**-$7,132,250**
Total		**-$624,750**