

Report and Recommendations of the Olmstead Cabinet

A Comprehensive Plan for Serving New Yorkers
with Disabilities in the Most Integrated Setting



OLMSTEAD

Community Integration for Every New Yorker

Andrew M. Cuomo
Governor

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“People with disabilities have the right to receive services and supports in settings that do not segregate them from the community; it is a matter of civil rights.”

—Governor Andrew M. Cuomo





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New York State

Andrew M. Cuomo, Governor

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Introduction

Under Governor Andrew M. Cuomo, New York is reclaiming its leadership role in serving people with disabilities. In 2011, the Governor directed a landmark redesign of the state's Medicaid program in order to improve care coordination and the delivery of cost-effective, community-based care. The Governor also established the Justice Center for the Protection of People with Special Needs (Justice Center), which provides the strongest protections from abuse and neglect for people with disabilities in the nation.

To further safeguard the rights of people with disabilities, in November 2012, Governor Cuomo issued Executive Order Number 84 to create the Olmstead Development and Implementation Cabinet (Olmstead Cabinet). The Olmstead Cabinet was charged with developing a plan consistent with New York's obligations under the United States Supreme Court decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999) (Olmstead). Olmstead held that the state's services, programs, and activities for people with disabilities must be administered in the most integrated setting appropriate to a person's needs.

To examine New York's compliance with Olmstead, the Olmstead Cabinet employed a broad and inclusive process. The Olmstead Cabinet received public comment through four public forums and through a dedicated page on the Governor's website. The cabinet met with over 160 stakeholder organizations and received over 100 position papers. Hundreds of state agency personnel across a dozen agencies providing services to people with disabilities participated in multiple discussions and provided data regarding New York's service systems for people with disabilities.

The results of the Olmstead Cabinet's work are contained in this report. This report identifies specific actions state agencies responsible for providing services to people with disabilities will take to serve people with disabilities in the most integrated setting. These actions will:

- Assist in transitioning people with disabilities out of segregated settings and into community settings;
- Change the way New York assesses and measures Olmstead performance;
- Enhance the integration of people in their communities; and
- Assure accountability for serving people in the most integrated setting.

Together, the actions described in this report will ensure that New York is a leader in providing services to people with disabilities in the most integrated setting, consistent with their fundamental civil rights.



Report and Recommendations



I. The Olmstead Mandate

The Olmstead decision addressed the rights of two women who had been confined in a Georgia state psychiatric hospital for five and seven years beyond the time at which they had been determined ready for community discharge. The United States Supreme Court held that the failure to provide community placement for these people constituted discrimination under the Americans with Disabilities Act. The court also held that states are required to provide community-based services to people with disabilities when: (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving disability services from the state.¹

The Olmstead case itself concerned people in a psychiatric hospital. Subsequent cases have addressed developmental centers, board and care homes, and people at-risk of institutional care. Most recently, the Olmstead mandate has been extended to segregated employment services for people with disabilities. Given the breadth and continuing evolution of the Olmstead mandate, in order to develop its specific recommendations, the Olmstead Cabinet sought the views of a broad set of stakeholders regarding the areas in which the cabinet should focus its attention. Through this stakeholder engagement, four areas of focus emerged:

1. The need for strategies to address specific populations in unnecessarily segregated settings, including:
 - a. People with intellectual and developmental disabilities in developmental centers, intermediate care facilities (ICFs), and sheltered workshops;
 - b. People with serious mental illness in psychiatric centers, nursing homes, adult homes, and sheltered workshops; and
 - c. People in nursing homes.
2. The need to increase opportunities for people with disabilities to live integrated lives in the community;
3. The need to develop consistent cross-systems assessments and outcomes measurements regarding how New York meets the needs and choices of people with disabilities in the most integrated setting;
4. The need for strong Olmstead accountability measures.

The following sections of this report discuss each of these areas of focus in turn.

¹ *Olmstead v. L.C.*, 527 U.S. 581. (1999).



II. Transitioning People with Disabilities from Segregated Settings to the Community

In collaboration with state agencies providing services to people with disabilities and a broad set of stakeholders, the Olmstead Cabinet sought to identify specific strategies to assist people with disabilities residing in segregated settings to transition to community-based settings. The specific settings and strategies are described in the sections that follow.

A. People with Intellectual and Developmental Disabilities in Developmental Centers, Intermediate Care Facilities, and Sheltered Workshops

In April 2013, Governor Cuomo announced a comprehensive transformation plan for serving people with intellectual and developmental disabilities in the most integrated setting.² The plan addresses the approximately 1,000 people who resided in developmental centers as of April 2013. The Office for People With Developmental Disabilities (OPWDD) closed its West Seneca Developmental Center in May 2011 and the Staten Island Multiple Disabilities Unit in June 2012, with the individuals residing at these facilities moving to community-based residential services. In addition, OPWDD will close the Monroe and Taconic developmental centers by December 2013, and the 155 people residing at those centers will move to community-based residential settings.

The transformation plan includes the closure of four additional developmental centers in the next four years: Oswald D. Heck (by March 2015); Brooklyn (by December 2015); Broome (by March 2016); and Bernard M. Fineson (by March 2017). It is projected that OPWDD will retain capacity for 150 individuals to receive short-term intensive treatment services in the remaining developmental centers. In addition, over the next few months, OPWDD will finalize its timeline for additional community transition opportunities for other people with intellectual and developmental disabilities residing in community-based ICFs and nursing homes.

OPWDD is also changing the nature of its service system by developing consistent, person-centered intake practices through its Front Door initiative, a comprehensive, person-centered needs assessment process with enhanced, person-centered planning, a fuller menu of community-based supports to better meet a person's needs in community-based settings, and quality oversight that examines individual outcomes as well as systems measures.³

Under its transformation plan, OPWDD will also be exploring new options for community-based housing and has begun participating in the New York State Money Follows the Person (MFP) demonstration. Within the MFP demonstration, people with intellectual and developmental disabilities will transition from institutional settings (developmental centers, community-based ICFs, and nursing homes) to community-based independent housing, supported housing, or supervised residences of four or fewer unrelated people, as appropriate. With this range of housing options and smaller residential service settings, OPWDD anticipates that the people transitioning from institutional settings will lead more integrated lives.

OPWDD's participation in the MFP demonstration began in April 2013. Over the next four years, OPWDD will assist 875 people with developmental disabilities who currently reside in institutional settings to move to community-based settings. This demonstration will require OPWDD to identify people who wish to move to the community and to work with those people to develop transition plans and identify community-based service options to meet their needs in community settings,

² New York. Office for People With Developmental Disabilities. (April 2013). *Road to Reform: Putting People First*. Retrieved from http://www.opwdd.ny.gov/opwdd_about/commissioners_page/OPWDD_Road_to_Reform_April2013.

³ Additional information about OPWDD's Front Door initiative is available at <http://www.opwdd.ny.gov/welcome-front-door/home>.



and to facilitate that transition. OPWDD will utilize peer outreach to identify potential MFP demonstration participants, provide accurate information and referral, and effectively address concerns of participants and family members. Contracted transition coordinators will work closely with OPWDD regional staff to transition MFP demonstration participants to the community through Home and Community-Based Services (HCBS) waiver enrollment.

OPWDD will track all participants' experiences in the MFP demonstration using the Quality of Life Survey to measure the community integration outcomes. This survey will be administered prior to MFP demonstration participants' transition to the community, at 11 months post transition, and at 24 months post transition. This survey measures key integration outcomes for people transitioning from institutional to community-based settings, including living situation, choice and control, access to personal care, respect/dignity, community integration/inclusion, overall life satisfaction, and health status.⁴

OPWDD will also promulgate regulatory amendments to align OPWDD regulations and requirements with the federal Centers for Medicare & Medicaid Services' (CMS) proposed standards for HCBS settings.⁵ These requirements, which largely mirror existing OPWDD regulations, will be implemented throughout OPWDD's service delivery system and will further define the characteristics of a community-based setting that must be present wherever HCBS services are delivered. In addition to the regulations, OPWDD will adopt implementation guidelines and integrate these enhanced standards into its oversight activities.

An important goal of the transformation of the service system for people with intellectual and developmental disabilities is implementation of a self-directed approach in which MFP demonstration participants and/or their designated representatives will be given the option of self-directing by employer authority and budget authority or, at the preference of the individual, either employer authority or budget authority. As part of this effort, OPWDD will offer increased education to all stakeholders by providing a standard curriculum on self-direction to at least 1,500 people and their designated representatives per quarter beginning on April 1, 2013. As a result, OPWDD has set a goal of enabling 1,245 new people to self-direct their services by March 31, 2014.

Recognizing the need to build additional community capacity to support people with developmental disabilities and their families in the community, OPWDD is piloting the national Systemic, Therapeutic, Assessment, Respite, and Treatment (START) program model to provide emergency crisis services and limited therapeutic respite services.⁶ This program will begin as a pilot in the Finger Lakes and Taconic regions, where OPWDD plans to close its developmental centers in 2013.

⁴ Additional information about the Money Follows the Person Quality of Life Survey can be found at <http://apply07.grants.gov/apply/opportunities/instructions/oppCMS-1LI-13-001-cfda93.791-cidCMS-1LI-13-001-013945-instructions.pdf>.

⁵ State Plan Home and Community Based Services under the Act," Proposed Rulemaking, *Federal Register*, 77:86, (May 3, 2012) p. 26361.

⁶ Additional information about the Systemic, Therapeutic, Assessment, Respite, and Treatment program can be found at <http://www.centerforstartservices.com/community-resources/newyorkpublic.aspx>.



OPWDD is also increasing integrated employment opportunities for people with developmental disabilities. On May 31, 2013, New York provided CMS with a baseline count of the number of enrollees receiving supported employment services and the number of enrollees engaged in competitive employment. As of July 1, 2013, OPWDD no longer permits new admissions to sheltered workshops. By October 1, 2013, New York will increase the number of people with developmental disabilities in competitive employment by no fewer than 250 people. Only integrated, gainful employment at minimum wage or higher will be considered competitive employment. New York submitted a draft plan to CMS for review on October 1, 2013, and will submit a final plan no later than January 1, 2014, on its transformation toward a system that better supports competitive employment for people with developmental disabilities.⁷

B. People with Serious Mental Illness in Psychiatric Centers, Nursing Homes, Adult Homes and Sheltered Workshops

The New York State Office of Mental Health (OMH) is implementing the Olmstead mandate in several ways. First, the development of behavioral health managed care will enhance community integrated health and mental health plans of care. Second, the development of Regional Centers of Excellence (RCE) will reorient OMH's state psychiatric center system to focus on high quality, intensive treatment with shorter lengths of stay and enhanced treatment and support in the community.⁸ Third, the implementation of two settlement agreements will assist people in moving from nursing homes and adult homes to integrated community apartments supported by services that focus on rehabilitation, recovery, and community inclusion.

Under Medicaid redesign for managed behavioral health care, New York will create special needs Health and Recovery Plans (HARPs): distinctly qualified, specialized, and integrated managed care programs for people with significant behavioral health needs. Mainstream managed care plans may qualify as HARPs only if they meet rigorous standards or if they partner with a behavioral health organization to meet those standards.⁹ HARPs will include plans of care and care coordination that are person centered and will be accountable for both in-plan benefits and non-plan services. HARPs will interface with social service systems and local governmental units to address homelessness, criminal justice, and employment related issues, and with state psychiatric centers and health homes to coordinate care. HARPs will include specialized administration and management appropriate to the populations/services, an enhanced benefit package with specialized medical and social necessity/utilization review approaches for expanded recovery-oriented benefits, integrated health and behavioral health services, additional quality metrics and incentives, enhanced access and network standards, and enhanced care coordination expectations.

To support the extension of outpatient services to people in their homes and communities, OMH will seek federal approval to provide mental health outpatient services outside of facility-based locations. Providing mobile services will increase access and effectiveness of care for people who cannot or will not access facility-based services. More accessible, consistent, and effective treatment is expected to reduce the need for inpatient care, and will instead serve people with psychiatric disabilities in the most integrated setting.

⁷ The workplan is available at:
http://www.opwdd.ny.gov/opwdd_services_supports/employment_for_people_with_disabilities/draft-plan-increase-employment-ops.

⁸ Additional information about the Regional Centers of Excellence is available at
<http://www.omh.ny.gov/omhweb/excellence/rce/>.

⁹ New York. Department of Health. (June 18, 2013). *MRT Behavioral Health Managed Care Update*. (PowerPoint slides). Retrieved from http://www.health.ny.gov/health_care/medicaid/redesign/docs/2013-6-18_mc_policy_planning_mtg.ppt.



Complementing its transformation of community-based services, in July 2013, OMH announced its plan to transform New York's inpatient psychiatric hospitals into regional centers of excellence (RCEs).¹⁰ RCEs will be regionally-based networks of inpatient and community-based services, each with a specialized inpatient hospital program located at its center with geographically dispersed community service "hubs" overseeing state-operated, community-based services throughout the region. The RCE plan reduces the number of state psychiatric centers from 24 to 15, eliminating 655 inpatient beds in favor of community services. Over the next year, OMH will pursue a regional planning process to guide the development of its RCEs. This planning process will include the assessment of existing community capacity within its five state regions and recommendations for the development of additional community capacity to prevent unnecessary hospitalization and to transition people currently residing in psychiatric hospitals back to their communities. These recommendations will be prepared by December 2013.

Coupled with its community capacity evaluation, OMH will focus on transitioning long-stay patients currently residing at psychiatric hospitals back into the community. OMH has steadily reduced its inpatient psychiatric population from 43,803 in 1973 to 3,876 in 2012 by creating appropriate community placements and supports. As of July 1, 2013, the total number of non-forensic patients in New York's state psychiatric centers was 2,980, 1,328 of whom have stayed longer than one year. Over the next two years, OMH has established a goal to reduce this number of long-stay patients by 10 percent by transitioning these people to appropriate community housing and services.¹¹

In addition to its inpatient psychiatric reforms, in September 2011, New York settled a federal class action lawsuit, *Joseph S. v. Hogan*, concerning people with serious mental illness discharged or at risk of discharge to nursing homes from state-operated psychiatric centers and psychiatric wards of general hospitals. All remedy class members capable of and willing to live in the community will be provided with, or otherwise obtain, community housing and community supports by November 2015. In July 2012, OMH awarded contracts for 200 units of supported housing in order to increase the housing available for qualified people transitioning out of nursing homes. An initial community transition list of remedy class members was developed in December 2012 and will continue to be revised through November 2014. In addition, New York revised its pre-admission screen and resident review process for people with serious mental illness proposed for admission to nursing homes to further prevent unnecessary admissions to these facilities.¹²

New York has also pursued a comprehensive strategy to provide community housing for people with serious mental illness residing in transitional adult homes.¹³ In 2012, New York awarded contracts for 1,050 supported housing opportunities for residents of transitional adult homes. In 2012, the Department of Health (DOH) and OMH finalized regulations regarding residents of

¹⁰ New York. Office of Mental Health. (July 11, 2013). *OMH Regional Centers of Excellence: Today Begins a New Era in New York's Behavioral Health System*. Retrieved from <http://www.omh.ny.gov/omhweb/excellence/rce/docs/rceplan.pdf>.

¹¹ Non-forensic patients are those not on the following statuses: felony defendants found incompetent to stand trial (CPL §730); defendants found not responsible for criminal conduct due to mental disease or defect (CPL §330.20); pre-trial detainees in local correctional facilities in need of inpatient care (CL §508); inmates sentenced to state and local correctional facilities in need of inpatient care (CL §402); civil patients transferred to a forensic facility (14NYCRR §57.2); and people committed to sex offender treatment programs within a secure treatment facility (MHL Art. 10).

¹² *Joseph S. v. Hogan*. No. 06-cv-01042, ECF 232 (E.D.N.Y. Sept. 7, 2011).

¹³ Transitional adult homes are defined in regulations as adult homes with a certified capacity of 80 beds or more in which 25 percent or more of the resident population are people with serious mental illness. See 18 NYCRR §487.13 for more information.



transitional adult homes to assist in their movement to more integrated settings. These regulations were based on a 2012 OMH clinical advisory, which found that such homes “are not clinically appropriate settings for the significant number of people with serious mental illness who reside in such settings, nor are they conducive to the rehabilitation or recovery of such people.”¹⁴

In July 2013, New York reached a settlement with the plaintiffs in longstanding litigation concerning 23 adult homes in New York City serving people with serious mental illness. Over the next five years, New York will provide integrated supported housing to at least 2,000 adult home residents along with appropriate community-based services and supports. The agreement also will ensure that adult home residents have the information they need to make an informed choice about where to live. As these adult home residents choose to move to supported housing, they will participate in a person-centered, transition planning process.

Since January 2011, OMH has shifted its reliance on sheltered workshops to integrated, competitive employment for people with psychiatric disabilities who desire to work. As of December 31, 2013, all OMH funding of community-based sheltered workshops will be converted to funding of programs that support integrated and competitive employment. Agencies received technical support through New York State Rehabilitation Association and the Medicaid Infrastructure Grant to develop sound business plans to transition individuals served in sheltered workshops into integrated, competitive employment. Local government units played integral roles in developing and reviewing plans that were submitted to OMH for review and approval, and agencies operating sheltered workshops were able to reinvest this sheltered workshop funding into one of several alternatives, including assisted competitive employment, transitional employment program, affirmative business, and transitional business programs.¹⁵

C. People in Nursing Homes

New York has pursued a number of policies to support community living for people with disabilities residing in, or at risk of placement in, nursing homes. These include the MFP demonstration, the Nursing Home Transition and Diversion Waiver, the Traumatic Brain Injury Waiver, the Long-Term Home Health Care Plan, and the Care at Home I and II waivers. All of these alternatives provide access to community-based supports for people who meet the criteria for nursing home level of care.

Through its Medicaid redesign initiatives, over the next several years, New York will include all Medicaid-eligible nursing home residents in mandatory managed care. The mandatory “care management for all” initiative is well underway for people receiving Medicaid only, as well as for people who are dually-eligible (Medicaid and Medicare), over the age of 21, and who require at least 120 days of community-based care. New populations and benefits are expected to steadily phase in to mainstream managed care and managed long-term care over the next few years.

Building on the care management for all initiative, reforms in the 2012-2013 budget removed the financial incentives that may have encouraged nursing home placement. Previously, nursing home costs were “carved out” of managed care rates and were instead covered by the state. This policy had the potential to encourage managed care plans to pressure high-cost people served in community-based settings to enter nursing homes. Budget reforms will include the full cost of nursing home care in managed care rates, which is expected to encourage these plans to seek lower cost, community-based services.

¹⁴ L.I. Sederer, MD, memorandum, August 8, 2012, available at http://www.omh.ny.gov/omhweb/advisories/Clinical_Advisory_Adult.pdf.

¹⁵ Definitions of these programs are available at http://www.omh.ny.gov/omhweb/cbr/fy09/section_30.html.



For certain people with significant disabilities, the cost of community-based care will exceed that of nursing home care. For these people, New York is developing financing structures that will permit these people to continue to reside in the community or transition from nursing home to the community, as well as avoid clustering people with significant disabilities in certain plans with preferred benefits. These financing structures will likely include the development of a funding pool to provide supplemental payment to plans serving these people to support their high-cost needs in the community.

To complement these initiatives, DOH is currently exploring mechanisms to enhance existing transition and diversion efforts for people currently residing in nursing homes. DOH will develop and adopt Olmstead performance measures which will be incorporated into its managed care contracts. These measures will evaluate the extent to which plans encourage the transition of people from nursing homes to the community; maintain people in the community; prevent nursing home placement; offer consumer-directed services as the first option for plan enrollees; support the use of assistive technologies; and encourage consumer choice and control.

Additionally, DOH has committed to reduce the long-stay population in nursing homes.¹⁶ As of December 31, 2012, the total number of nursing home residents in New York was 119,987, of which 92,539 have stayed 90 days or more.¹⁷ DOH has set a goal of reducing the long-stay population by 10 percent over the next five years. This target will be coupled with a home and community-based services and housing investment strategy to increase the availability of appropriate community-based housing and services.

¹⁶ Here, long stay is defined as residence in a nursing facility for 90 days or longer, for other than a rehabilitative stay.

¹⁷ Data were derived from the Minimum Data Set 3.0 and include all payment sources. Data include continuing care retirement communities and pediatric facilities, but excludes transitional care Units and four non-Medicaid facilities.



III. Assessment and Outcomes Strategies to Advance Community Integration

In addition to identifying strategies to transition people with disabilities from segregated to community-based settings, the Olmstead Cabinet examined the methods by which the state agencies providing services to people with disabilities understand the needs and choices of the people they serve and how those agencies measure whether those needs and choices are being met in the most integrated setting. The Olmstead Cabinet found inconsistencies in these outcome measures and recommends that state agencies providing services to people with disabilities develop or improve their assessment instruments and processes and Olmstead outcomes measures.

Over the past several years, New York has increasingly standardized its assessments of needs and choice for people with disabilities within its service systems. DOH consolidated eight separate assessment instruments previously used in its home care programs into a single instrument, called the Uniform Assessment System-New York (UAS-NY).¹⁸ OPWDD is developing the Coordinated Assessment System-New York (CAS-NY) for all people served within its service system.¹⁹ Significantly, the CAS-NY shares a common core of clinical items with the UAS-NY, which will permit OPWDD and DOH to assure no-wrong-door access to services and programs administered by these two agencies.

Building upon this initiative, OMH will develop an assessment for its community-based mental health system that shares a common core with both the UAS-NY and CAS-NY. OMH will then explore extending this assessment tool to its inpatient psychiatric hospitals.

Similarly, the State Office for the Aging (SOFA) will revise its Comprehensive Assessment for Aging Network Community Based Long Term Care Services (COMPASS) tool to share a common core with the UAS-NY, CAS-NY, and OMH's revised assessment tool. Currently, while the people and families served by SOFA programs are at high risk of spending down to Medicaid eligibility levels, SOFA's current assessment is not interoperable with the UAS-NY and the Minimum Data Set 3.0, used to assess residents of nursing homes. As a result, opportunities for strategic investment in non-Medicaid services to avoid institutionalization may not be readily identified. The development of consistent, cross-systems core assessments of the service needs and choices of people with disabilities of all ages will address this deficiency. Further, technological interfaces between SOFA and DOH data systems will help facilitate meeting cross-systems needs of people and enhance the ability to follow an individual through different systems and determine their progress in meeting their care plans, goals, and objectives.

The process for conducting assessments will also change. To enhance person-centered planning, New York will implement the Community First Choice Option (CFCO) as an amendment to its Medicaid State Plan. The assessment process will be expected to assess for "community first" service options as the default mechanism, so that every person with a disability is offered services in the most integrated setting and only receives services in a more restrictive setting when necessary. Under CFCO, New York will examine and revise existing assessment processes to ensure that service plans will reflect the services and supports important to the individual, identified through an assessment of functional need and preferences for the delivery of such services and

¹⁸ For more information on the Uniform Assessment System-New York, see http://www.health.ny.gov/health_care/medicaid/redesign/uniform_assessment_system/.

¹⁹ For more information on the Coordinated Assessment System-New York, see http://www.opwdd.ny.gov/people_first_waiver/coordinated_assessment_system/.



supports. This revised assessment process will also seek to minimize conflicts of interest by requiring the assessments be conducted independent of the service delivery system.

Building upon interoperable assessment tools and processes, the agencies providing services to people with disabilities will examine and revise their current outcome measures to incorporate Olmstead measures. To achieve community integration for people with disabilities, New York's service systems must measure whether these services maximize the opportunity for people with disabilities to lead integrated lives. These measures should include whether people with disabilities have control over their own day, whether they control where and how they live, whether they have the opportunity to be employed in non-segregated workplaces for a competitive wage, and whether they have the opportunity to make informed choices about services and supports.

Through design teams and workgroups associated with the People First Waiver, OPWDD explored the best practices for measuring the outcomes that are most important to people with developmental disabilities. After this review, OPWDD selected the Council on Quality and Leadership's Personal Outcome Measures (CQL POMs).²⁰ The 21 measures of the CQL POMs identify the areas of greatest importance to a person receiving supports and the support areas in which improvements may be needed.²¹ OPWDD will incorporate the CQL POMs into the new managed care infrastructure for the developmental disabilities service system.

As part of the implementation of Medicaid managed care, DOH, OMH, OPWDD, and the Office of Alcoholism and Substance Abuse Services (OASAS) are establishing common quality measures across all managed care plan types. Similar to the CQL POMs, these measures will include whether people with disabilities have control over their own day, whether they control where and how they live, whether they have the opportunity to be employed in integrated workplaces for a competitive wage, and whether they have the opportunity to make informed choices about services and supports. These measures will be developed in time for the planned June 2014 implementation of the behavioral health managed care initiative.

In addition, state agencies will enhance the comprehensiveness of their assessment tools. For people with disabilities, true community integration involves the ability to access integrated housing, employment, transportation, and support services. In revising their assessment tools, state agencies will jointly identify relevant items that include these domains and incorporate these items into their assessment tools.

Reforms to New York's assessment of needs and choice and Olmstead outcomes measurement will be sustained by investments made under the federal Balancing Incentive Program (BIP).²² Participation in the BIP will reinforce New York's ongoing efforts to improve access to home and community based long-term care services for those with physical, behavioral health, and/or

²⁰ Additional information about the Council on Quality and Leadership's Personal Outcome Measures is available at http://www.opwdd.ny.gov/opwdd_services_supports/people_first_waiver/documents/POMs_fact_sheet_clean.

²¹ In addition to personal outcomes, the CQL POMs measure community integration outcomes, such as whether the person is connected to natural support networks, has intimate relationships and friends, chooses where and with whom they live, chooses where they work, lives in integrated environments, interacts with other members of the community, performs different social roles, chooses services, chooses and realizes personal goals, and participates in the life of the community.

²² New York received an award letter from CMS on March 15, 2013, to participate in the federal Balancing Incentive Program authorized under the Affordable Care Act. For more information about this program, see http://www.health.ny.gov/health_care/medicaid/redesign/balancing_incentive_program.htm.



intellectual and developmental disabilities throughout the state. Through improved access to information and assistance, people with disabilities will be able to make informed choices regarding services, settings, and related issues. To achieve these goals, New York will implement the three structural changes required under BIP. Specifically, New York will enhance the existing New York Connects network to assure a no wrong door/single point of entry for long-term care services and supports, implement a standardized assessment instrument, and assure conflict-free case management services.^{23,24}

²³ New York Connects is currently operational in 54 counties and serves as an information and assistance system for long term care services. Additional information about New York Connects is available at www.nyconnects.ny.gov/.

²⁴ Conflict-free case management is defined by the Balancing Incentive Program as eligibility determination independent of service provision; case managers and evaluators not related to service recipients; robust monitoring and oversight; accessible grievance process; measurement of consumer satisfaction; and meaningful stakeholder engagement. For more information, see <http://www.balancingincentiveprogram.org/resources/what-design-elements-does-conflict-free-case-management-system-include>.



IV. Supporting Community Integration for People with Disabilities



The Olmstead mandate addresses not only the movement of people with disabilities from segregated to community-based settings, but also the ability of those people to lead integrated lives. Therefore, the Olmstead Cabinet's review sought to identify how New York can further support the integration of people with disabilities in their communities and worked with state agencies to develop policies that would improve community integration.

A. Housing Services

New Yorkers with disabilities need affordable, accessible housing to lead integrated lives. New York has long been a leader in the development of a continuum of housing options for people with disabilities, which include congregate and scattered-site supportive housing, tenant-based rental assistance that enables people with disabilities to lease housing in integrated developments, and apartments specifically set aside for people with various disabilities in mainstream, multi-family housing developments. New York invests over \$900 million annually in supportive housing initiatives, and in the past two years, New York has invested an additional \$161 million in supportive housing as part of Medicaid redesign.

The Medicaid Redesign Team Affordable Housing Work Group is a cross-agency body composed of representatives from multiple state agencies administering and/or funding supportive housing programs, including OMH, OPWDD, OASAS, DOH, Homes and Community Renewal (HCR), and the Office of Temporary and Disability Assistance (OTDA).²⁵ This work group has achieved \$161 million in supportive housing investments over the last two years for high-cost Medicaid recipients. The work group will reconvene in October 2013 to consider further collaborations to increase the number of available and affordable housing options and community supports to increase the availability of integrated housing.

HCR facilitates the availability of community-based supportive housing for people with disabilities through early decision, scoring, and financing incentives for multi-family housing projects. Housing projects may be jointly funded by HCR and a state human service agency, such as OPWDD, OMH, or OASAS. In 2013 (as in past years) early decision incentives are available for multi-family, supportive housing projects that set aside a percentage of units for low-income veterans with special needs and people with intellectual and developmental disabilities. Project developers must also show that they have entered into agreements with human service providers to operate and fund community-based support services. HCR also awards developers applying for New York State low-income housing tax credits additional points in its scoring system for projects which reserve a percentage of units for people with mobility and sensory impairments, and for those that give preference in tenant selection for people with special needs. Additional tax credits, tax-exempt bond financing, and funding in excess of usual program limits are also available for multi-family housing projects with units set aside for special needs populations, depending on ownership and financing circumstances. Beginning in its 2013 annual funding round, HCR will examine new project applications to assess whether new developments are consistent with Olmstead principles.²⁶

²⁵ For more information about the Medicaid Redesign Team Affordable Housing Work Group, see http://www.health.ny.gov/health_care/medicaid/redesign/affordable_housing_workgroup.htm.

²⁶ For more information on the Homes and Community Renewal Annual Funding Round RFP, see http://www.nyshcr.org/Funding/UnifiedFundingMaterials/2013/RFP_MultiFamilyPrograms.pdf.



As part of its monitoring of completed projects, HCR verifies that project units set aside for people with disabilities are occupied by the special needs population intended, as provided for in the developer's regulatory agreement and affirmative marketing plan. In instances where a service provider is unable to provide qualified applicants or has discontinued operations, HCR requires that an acceptable replacement provider be identified and may allow a different special needs population to be targeted.

OTDA engages in a variety of housing initiatives to support the state's implementation of its Olmstead Plan. The agency's Bureau of Housing and Support Services (BHSS) administers both capital and housing programs that are focused on providing supportive housing for homeless people with disabilities and their families in the least restrictive environment possible. OTDA's Homeless Housing and Assistance Program (HHAP), created in 1983, was the first state-funded program in the country to develop supportive housing units for homeless people with disabilities and their families. Among those for whom such housing is provided are homeless people with serious and persistent mental illness, including those with co-occurring substance abuse disorders; people living with HIV/AIDS; people with cognitive impairments such as those caused by traumatic brain injury; and people with other mental and/or physical disabilities. In addition, OTDA's New York State Supportive Housing Program (NYSHHP) provides funding for housing retention services and other supports for formerly homeless people with disabilities who are living in supportive housing programs throughout the state. Many of these supportive housing programs are located in "mixed use" apartment buildings which house people with disabilities along with other community members. Finally, OTDA's Solutions to End Homelessness Program (STEHP) contracts with local not-for-profit agencies to provide eviction prevention services to prevent people at risk of homelessness, including those with disabilities, from losing their housing. STEHP also provides short-term rental assistance and other supports to homeless individuals, including those with disabilities and their families in order to obtain housing available in the general rental market. All of OTDA's housing efforts are aimed at assisting homeless people, including those with disabilities, to obtain and retain housing of their own choosing within the community.

In addition to these programs and incentives, the Olmstead Cabinet examined opportunities for expansion of integrated housing models that will support people with disabilities leaving institutions or at serious risk of institutional care. The Frank Melville Supportive Housing Investment Act of 2010 authorized Section 811 Project Rental Assistance (PRA), specifically designed to support Olmstead implementation efforts by funding developments and subsidizing rental housing with the availability of supportive services for very low income people with disabilities.²⁷ State-level housing (i.e., HCR) and health and human services agencies (e.g., OPWDD, OMH, DOH) partner to meet the housing and support needs of the target population. The health care agency develops a policy for referrals, tenant selection, and service delivery to ensure that this highly-integrated housing is targeted to a population most in need. Through an interagency partnership, New York will develop and submit an application for PRA when the request for proposals (RFP) is released. Subject to the RFP's guidance, this application will target low income people with disabilities transitioning from institutions or at serious risk of institutional placement.

Additionally, New York has expanded the information available to people with disabilities through the www.NYHousingSearch.gov website. HCR maintains this website as a free service to list and find affordable, accessible housing in New York. To expand the listings of affordable housing, HCR requires that owners and managers of multi-family projects developed since 2006 list all adaptable and adapted apartments, as well all special needs/supportive services apartments. Further, HCR requires developers of new multi-family projects to list all units adapted or set aside for people with

²⁷ For more information about Section 811 Project Rental Assistance, see http://portal.hud.gov/hudportal/HUD?src=/program_offices/housing/mfh/progdesc/disab811.



disabilities when advertising new units or accepting tenant applications.

B. Employment Services

The continued strengthening of New York's economic development strategies will help to assure an adequate supply and breadth of jobs available to people with disabilities. Certain reforms implemented under Governor Cuomo's Spending and Government Efficiency (SAGE) Commission have aligned workforce development programs more closely with the New York's economic development efforts. The Department of Labor (DOL) will build upon these reforms for people with disabilities by coordinating disability workforce strategies and assuring that these initiatives are aligned with New York's economic development strategies, such as Regional Economic Development Council priorities.²⁸

DOL will coordinate with state agencies serving people with disabilities (e.g., OMH, OPWDD, OASAS, State Education Department's Adult Career Continuing Education Services – Vocational Rehabilitation (ACCES-VR), and New York State Commission for the Blind (NYSCB)), to better align DOL's disability workforce strategies with the vocational rehabilitation and employment programs administered by those agencies. DOL will increase coordination of disability workforce initiatives by establishing a stronger linkage between disability resource coordination (DRC) activities at One-Stop Career Centers and ACCES-VR. Specifically, DOL regional business services teams, responsible for coordinating One-Stop Career Center business services with regional business strategies and regional labor market information, will include ACCES-VR services in its coordination activities.²⁹ Further, DOL will use disability resource coordinators, established under a federal Disability Employment Initiative pilot program, to provide specialized services designed to increase employment opportunities for people with disabilities through skills upgrading (e.g., on-the-job training, obtaining industry-recognized credentials, entrepreneurial training, and customized training) and community partnerships with agencies that support people in employment, life coaching, and asset development.³⁰

This increased employment coordination will build upon the comprehensive employment supports coordination and data system called the New York Employment Services System (NYESS).³¹ NYESS provides New Yorkers of all abilities with a central point of access to all employment-related services and supports offered by DOL, ACCES-VR, NYSCB, OMH, OPWDD, OASAS, and SOFA. This system connects to the New York State Job Bank, where approximately 90,000 job openings are currently listed each month by employers. Increasing the number of providers and customers in NYESS will allow for comprehensive data analysis of the talent pipeline of people with disabilities. This analysis will include the educational attainment, employment status, and career sectors in which people with disabilities are represented, which will better enable New York to strategically implement effective policy around employment services for people with disabilities.

²⁸ For more information about New York's 10 Regional Economic Development Council priorities, see <http://regionalcouncils.ny.gov/>.

²⁹ For more information about the Department of Labor regional business services teams, see <http://www.labor.ny.gov/workforcenypartners/ta/ta10-12.pdf>.

³⁰ For more information about the federally-funded Disability Employment Initiative in New York, see http://www.labor.ny.gov/workforcenypartners/dpn_dei.shtm.

³¹ For more information about the New York Employment Services System, see <http://www.nyess.ny.gov/>.



DOL and other partner staff will continue to engage Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) beneficiaries with benefits advisement and work incentive counseling in an effort to increase the assignment of tickets to the state under the Social Security Administration's (SSA) Ticket to Work (TTW) program. For people eligible for the TTW program, DOL, ACCES-VR, OPWDD, OMH, and NYSCB will develop a cross-systems assessment protocol to assess each individual's vocational rehabilitation and employment service needs. This protocol will assure that an individual's ticket assignment options are based on individual needs to achieve competitive employment, consistent with the unique strengths, abilities, interests, and informed choice of the individual. This cooperative approach will provide a broad range of employment and career services options for people with disabilities.

Engaging community employers around the benefits of hiring people with disabilities would also improve the opportunities for competitive, integrated employment. Efforts such as the "Think Beyond the Label" advertising campaign help to raise awareness among employers across the state about the benefits of hiring people with disabilities. New York will market various tax credits and incentives, such as the Workers with Disabilities Tax Credit and the Work Opportunity Tax Credit to encourage community employers to hire people with disabilities.

C. Transportation Services

In addition to New York's housing and employment services, transportation services are also fundamental to community living for people with disabilities. New York has conducted a variety of self-evaluation exercises to review its disability transportation strategies (e.g., assessments conducted by the Department of Transportation, Most Integrated Setting Coordinating Council (MISCC), and New York Makes Work Pay^{32,33,34}) in recent years. These reports, and the Olmstead Cabinet's review, show a continued need for coordination of disability transportation services.

A federal executive order was issued in 2004 supporting coordinated transportation planning.³⁵ A cornerstone of such efforts is the establishment of mobility management, a strategic approach to service coordination and customer service to enhance the ease of use and accessibility of transportation networks. Mobility management meets the unique set of transportation needs in each local area by acting as a functional point of coordination for each community's public and private human services organizations and public transportation providers. Mobility management forms and sustains effective partnerships among transportation providers in a community by providing a single, localized source for coordinating and dispatching the full range of available transportation resources to customers. The partnerships formed by mobility management are meant to increase the available travel services for riders and create resource and service efficiencies for transportation providers.

³² For more information about the Department of Transportation review of transportation services, see <https://www.dot.ny.gov/programs/adamanagement/ada-management-plan/appendix>.

³³ For more information about the Most Integrated Setting Coordinating Council review of transportation services, see <http://www.opwdd.ny.gov/node/784>.

³⁴ To access the New York Makes Work Pay report, see http://www.nymakesworkpay.org/docs/Transportation_PWDs_NYS_032010.pdf.

³⁵ Exec. Order No. 13330. 69 FR 9185-9187. (2004). Retrieved from <http://www.gpo.gov/fdsys/pkg/FR-2004-02-26/pdf/04-4451.pdf>.



Under Medicaid redesign, New York implemented a transportation management system, through state-managed contracts, to improve coordination and cost effectiveness for non-emergency Medicaid transportation.³⁶ Non-emergency Medicaid transportation is only available to access medical care covered by Medicaid. Therefore, there remains a need for enhanced coordination of transportation resources to assure the availability of services for people with disabilities who need transportation to work or engage in other non-medical activities.

Prior to Medicaid redesign, a number of local transportation providers had begun to implement mobility management programs for both non-emergency Medicaid and non-medical transportation. New York will review the impacts of Medicaid redesign on these local mobility management efforts. This review will evaluate the cost effectiveness and availability of non-emergency Medicaid and non-medical transportation resources for people with disabilities. Based upon this analysis, New York will consider a pilot program to expand the existing Medicaid transportation management system to non-medical trips.

D. Children's Services

Children with disabilities in residential care and those at risk of placement require strategies capable of specifically addressing their personal, familial, and educational resource needs. New York has long recognized the unique relationships between children and families, the roles of multiple agencies in addressing children's needs, and the need to plan for transitions from childhood to adulthood.

The decision that a student needs out-of-home placement in a residential school must be based on the Committee on Special Education's determination that there is no appropriate alternative available to meet the educational needs of the student. New York adopted Chapter 600 of the Laws of 1994, which was intended to discourage unnecessary out-of-home placements by increasing the connection between families and children at risk of placement with local support services.³⁷ Recognizing that a single system cannot meet all the needs of children with disabilities and their families, CSE membership includes, with the consent of the parent (or student if age 18 or older), representatives from local social service departments, state agencies (e.g., OMH, OPWDD), and local school districts. CSEs provide families with information about in-home and community support services available as alternatives to out-of-home placement to address the unique needs of the child and family. CSEs also consider post-secondary goals and transition services for older students. In 2011, the State Department of Education strengthened its review of proposed out-of-state educational placements to assure adherence with the law.³⁸

The Coordinated Children's Services Initiative (CCSI) is another mechanism for serving children with disabilities in the most integrated setting. This initiative began in the 1990s and is currently operated by the Council on Children and Families. CCSI is an approach to developing individual/family-, county- and state-level mechanisms to identify individual and family needs, coordinate multiple service systems, address barriers to coordinated service delivery, and assure that funding is available to prevent out-of-home placement of children with disabilities.³⁹

³⁶ For more information about the Medicaid transportation management initiative, see <http://www.health.ny.gov/funding/rfp/inactive/1103250338/>.

³⁷ For more information about the changes to New York's Social Services and Education Law as a result of Chapter 600, see <http://www.p12.nysed.gov/specialed/publications/policy/chap600.pdf>.

³⁸ For more information about the updated procedures, forms, and policy regarding a school district's responsibilities under Chapter 600 of the Laws of 1994, see <http://www.p12.nysed.gov/specialed/publications/outofstateplacementsEIP.htm>.

³⁹ For more information about the Coordinated Children's Services Initiative, see <http://ccf.ny.gov/CCSI/index.cfm>.



Recent Medicaid redesign initiatives have further sought to coordinate the unique service needs of children with disabilities and their families to prevent out-of-home placements. In 2011, the Medicaid Redesign Team Children's Work Group was created to redesign behavioral health services for children. This work group focused on early identification of trauma and behavioral health needs via primary care, collaborative, multi-system care models of treatment, specialty care treatment capacity (including clinical and wrap-around services), family engagement, cross-systems care coordination, and funding and administrative alignment.

The children's work group determined that the Medicaid Children's Behavioral Health Care system, currently funded through Medicaid fee-for-service, should be transitioned to Medicaid managed care. Under Medicaid managed care, physical health, behavioral health, and community support services will be coordinated through person- and family-centered care plans. Olmstead outcome measures will be incorporated into managed care plans, and will seek to ascertain whether services for children maximize the opportunity for children with disabilities to lead integrated lives. The transition to this reformed children's managed care system is planned for January 2016.

E. Aging Services

In addition to the Medicaid redesign initiatives to assist people with disabilities residing or at risk of placement in nursing homes, the Olmstead Cabinet reviewed non-Medicaid services for older adults that may delay or prevent institutionalization, hospital utilization, and Medicaid spend down. Federal, state, and local funds sustain a variety of non-medical, long-term services and supports targeted at older people at risk of nursing home placement and Medicaid spend-down, with the goal of avoiding higher levels of care and public financing of such care. In particular, the Expanded In-home Services for the Elderly Program provides case management and non-medical, in-home and ancillary services for people who need assistance with activities of daily living and instrumental activities of daily living.^{40,41,42} Other services, such as congregate and home delivered meals, transportation, and caregiver services, supported through federal, state, and local funds, also assist older New Yorkers to remain in their homes and communities.

As previously noted, SOFA will revise its COMPASS tool to share a common core with the UAS-NY, CAS-NY, and OMH's revised assessment. This revision will help identify opportunities for strategic investment in non-Medicaid services to avoid institutionalization. Further, technological interfaces between SOFA and DOH data systems will help meet cross-systems needs of people with disabilities and enhance the ability to follow a person through different service systems and determine his/her progress in meeting care plan goals and objectives.

SOFA also administers New York Connects, the state's federally-designated Aging and Disability Resource Center to serve as a no wrong door/single point of entry to long-term supports and services for people of all ages with disabilities.⁴³ Using BIP funds, New York Connects will be strengthened to provide better information to people with disabilities and older adults about both private and public community-based services and supports available to meet their needs. This resource center will also provide options counseling to assist with decision making. These services

⁴⁰ For more information about the Expanded In-home Services for the Elderly Program, see http://www.health.ny.gov/health_care/medicaid/program/longterm/expand.htm.

⁴¹ Self-care activities are activities that a person tends to do every day, including feeding, bathing, toileting, dressing, and grooming.

⁴² In addition to activities of daily living, a person must be able to perform instrumental activities in order to live independently, including shopping, transportation, and housekeeping.

⁴³ For more information about New York Connects, see <http://www.nyconnects.ny.gov/nyprovider/consumer/indexNY.do>.



are expected to enhance a person's ability to receive the right service at the right time in the right setting for the right cost.

Further, SOFA will strengthen its Long-Term Care Ombudsman Program to assist residents of nursing homes and adult homes to transition to community-based services and supports.⁴⁴ Ombudsmen currently help residents understand and exercise their rights in facilities and work to resolve problems between residents and facility staff/administrators. Ombudsmen will be trained to assist nursing home and adult home residents to exercise their rights to community placement and to facilitate linkages to community resources, consistent with proposed federal guidelines regarding long-term care ombudsmen.⁴⁵

F. Criminal Justice

The Olmstead Cabinet examined two criminal justice issues concerning people with disabilities and the Olmstead mandate. First, the cabinet sought to assure that people with disabilities who leave correctional facilities are able to access needed community-based services. Second, the cabinet reviewed current state policies to assure that people with disabilities are not unnecessarily incarcerated for minor offenses that are a result of their disability.

Under Medicaid redesign, New York has enhanced its ability to voluntarily engage people with significant behavioral health needs in services and provide strong follow-up upon discharge from institutional settings. For the limited number of people who do not voluntarily access services, the New York Secure Ammunition and Firearms Enforcement (SAFE) Act strengthened assisted outpatient treatment.⁴⁶

OMH works closely with the Department of Corrections and Community Supervision to implement robust statewide policies for screening people in prisons for mental illness, provide mental health services in prisons, and facilitate reentry from prisons to the community. OMH also offers in-reach services to link prisoners with community-based services and employs pre-release coordinators in prisons throughout the state. These coordinators link mentally ill prisoners with appropriate services in the community and assist, where appropriate, in applying for entitlements such as Medicaid and SSI/SSDI.⁴⁷

County-based services for mentally ill jail inmates are supplemented with state funding through the Medication Grant Program to pay for psychotropic medications for released inmates while their Medicaid application is pending. In addition, OMH provides over \$4 million annually to support transition programming in local jails.

The majority of services to divert people with disabilities from the criminal justice system and transition mentally ill inmates back into the community, however, are administered at a local level.

⁴⁴ For more information about the Long-Term Care Ombudsman program, see <http://www.ltombudsman.ny.gov/>.

⁴⁵ "State Long-Term Care Ombudsman Program, Proposed Rules." *Federal Register*, 78:117. (June 18, 2013) p. 36449-36469. Retrieved from <http://www.gpo.gov/fdsys/pkg/FR-2013-06-18/html/2013-14325.htm>.

⁴⁶ Information about the impact of the New York Secure Ammunition and Firearms Enforcement Act on mental health services can be found at http://www.omh.ny.gov/omhweb/safe_act/.

⁴⁷ Recipients of services at OMH forensic facilities are almost always discharged to an OMH civil psychiatric center prior to transitioning back to the community. Residents in OMH secure treatment facilities are transitioned back into the community through the Strict and Intensive Supervision and Treatment program, established by MHL Art. 10.



These local services include law enforcement, courts, jails, and community supervision. Examples of pre-arrest diversion programs that exist across the state are crisis intervention teams, emotionally disturbed people response teams, and mobile crisis teams. In addition, there are currently 28 mental health courts throughout the state, and the Mental Health Connections program shares current mental health court resources with counties that do not have an established mental health court.

A number of recent reforms will further support the diversion of people with disabilities from the criminal justice system and facilitate reentry from the criminal justice system. Notably, OMH has significantly increased the number of supported housing units for parolees with serious mental illness. It also has partnered with the Center for Urban Community Services (CUCS) to develop the Reentry Coordination System in New York City, which operates as a forensic single point of entry for services, including housing, intensive case management, assertive community treatment, and outpatient clinic services. In addition, OMH has collaborated with the New York City Department of Health and Mental Hygiene and with CUCS to establish the Academy for Justice-Informed Practice to cross-train mental health and criminal justice practitioners on best practices for working with justice-involved, mental health service recipients.⁴⁸

The Division of Criminal Justice Services (DCJS) oversees the operation of 19 county reentry task forces and provides \$3 million annually through performance-based contracts with localities to support the reentry of people returning from state prisons. DCJS also provides specialized training to police officers to address the needs of people with mental illness.

DCJS was recently awarded a grant from the Bureau of Justice Assistance to provide training and technical assistance to up to 10 localities with high crime rates and high per member per month Medicaid spending to address the needs of people with serious mental illness in the criminal justice system and coordinate with community-based treatment and supports. Using the Sequential Intercept Model, DCJS will work collaboratively with OMH to assist localities in conducting countywide mapping of mental health and criminal justice resources for planning purposes.⁴⁹ DCJS and OMH also will provide training and technical assistance to identify local service gaps and develop strategies to address unmet need at each interception point. These strategies will help counties address the needs of people with serious mental illness involved in the criminal justice system and connect them to community-based treatment and supports, which is expected to decrease crime rates and the burden on local jails while improving mental health outcomes for the people served. Initial outcome measures for this initiative will seek to identify probationers screened for mental illness, probationers supervised through the joint probation/mental health case management model, probationers with mental illness successfully completing probation supervision, the number of jail admissions screened for mental illness, and the number of police officers completing crisis intervention training.

G. Legal Reform

To promote the full integration of people with disabilities in the community, the Olmstead Cabinet examined legal and regulatory barriers that impact the ability of people with disabilities to achieve

⁴⁸ For more information about the Center for Urban Community Services and the Academy for Justice-Informed Practice, see <http://www.cucs.org/training-and-consulting/training/nyc-training-program>.

⁴⁹ The Sequential Intercept Model, developed by SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, identifies five key points within the criminal justice system where people with serious mental illness can be intercepted and diverted to community-based alternatives: (1) law enforcement, (2) initial detention/initial court hearings, (3) jails/courts, (4) re-entry, and (5) community corrections. For more information, see http://gainscenter.samhsa.gov/pdfs/integrating/GAINS_Sequential_Intercept.pdf.



community integration. The Olmstead Cabinet identified two issues requiring legal reform: access to health-related task assistance in community settings and guardianship laws for people with intellectual and developmental disabilities.

A barrier to community integration for many people with disabilities is their ability to access community-based assistance with health-related tasks, including medication management, medication administration, and other home health treatments. Recognizing these barriers, current law authorizes people with disabilities served by certain programs to receive assistance with these tasks from non-nursing personnel. People receiving home care services under the Consumer Directed Personal Assistance Program (CDPAP) may direct another individual to provide them with health-related task assistance.⁵⁰ Additionally, people with intellectual and developmental disabilities residing in OPWDD certified residences can utilize trained and certified direct care staff for medication, tube feedings, and insulin administration, as well as for other health-related tasks under the supervision of a registered professional nurse.⁵¹

However, for people with disabilities not served by these programs, facility-based care is often the only option for receiving needed assistance with these health-related tasks. For example, while a person with a developmental disability residing in a group home certified by OPWDD may receive assistance with medication administration by an unlicensed direct care staff member, the same person could not receive this level of assistance in an independent apartment. Likewise, people with physical disabilities enrolled in the CDPAP program can receive the assistance of an unlicensed aide in their own homes if they or a designee assumes full responsibility for hiring, training, supervising, terminating the employment of people providing the services, but could not make use of an unlicensed aide if they wish to direct another in the provision of health-related task assistance, but do not wish to assume all responsibilities associated with the CDPAP program. Similar barriers exist for other people with disabilities who need assistance with health-related tasks to live successfully in the community.

In order to fully support community integration for people with disabilities, current restrictions on community-based health-related task assistance require reform. A broader application of the current self-direction exemption of the Nurse Practice Act for CDPAP enrollees should be explored to cover all people with disabilities who are capable of directing others to provide health-related task assistance. For people not capable of directing others to provide this assistance, a broader application of the exemption within the Nurse Practice Act for certified settings, as currently implemented by OPWDD, should be explored to cover all integrated, community-based housing for people with disabilities.

The Olmstead Cabinet also recommends reform to law governing guardianship over people with developmental disabilities. Community integration includes the ability of people with disabilities to make their own choices to the maximum extent possible. Guardianship removes the legal decision-making authority of an individual with a disability and should, consistent with Olmstead, only be imposed if necessary and in the least restrictive manner. New York maintains two separate systems of guardianship for people with disabilities. Article 17A of the Surrogate Court's Procedure Act, adopted in 1969, applies to people with developmental disabilities. Article 81 of Mental Hygiene Law, adopted in 1987, applies to all other people with disabilities.

⁵⁰ For more information about Consumer Directed Personal Assistance Program requirements, see http://www.health.ny.gov/health_care/medicaid/program/longterm/cdpap.htm.

⁵¹ To access the Office for Mental Retardation and Developmental Disabilities and State Education Department's joint Memorandum of Understanding #2003-01 for registered nursing supervision of unlicensed direct care staff in certified residential facilities, see <http://www.op.nysed.gov/prof/nurse/nurse-omrddadminmemo2003-1.htm>.



Under Article 17A, the basis for appointing a guardian is diagnosis driven and is not based upon the functional capacity of the person with disability. A hearing is not required, but if a hearing is held, Article 17A does not require the presence of the person for whom the guardianship is sought. Additionally, Article 17A does not limit guardianship rights to the individual's specific incapacities, which is inconsistent with the least-restrictive philosophy of Olmstead. Once guardianship is granted, Article 17A instructs the guardian to make decisions based upon the "best interests" of the person with a disability and does not require the guardian to examine the choice and preference of the person with a disability.

In contrast, Article 81 imposes guardianship based upon a functional analysis of a person's disability, requires a hearing, requires the presence of the person over whom guardianship is sought at the hearing, requires guardianship to be tailored to the person's functional incapacities, and requires the guardian to consider the person's choice and preference in making decisions. The Olmstead Cabinet recommends that Article 17A be modernized in light of the Olmstead mandate to mirror the more recent Article 81 with respect to appointment, hearings, functional capacity, and consideration of choice and preference in decision making.

In addition to reforming guardianship law, New York should build upon current OPWDD regulations that recognize certain actively involved family members as surrogates for people who cannot provide their own consent.⁵² By extending the authority of these people, OPWDD has minimized those instances in which guardianship is pursued. This outcome could be beneficial to all other people with disabilities to support decision-making activities without pursuing guardianship.

⁵² Among other things, actively-involved family members may give informed consent for major medical procedures on behalf of individuals residing in OPWDD facilities who lack the "capacity to understand appropriate disclosures regarding proposed professional medical treatment" (14 NYCRR 633.11(a)(1)(iii)(a) and (b)), may approve service plans (14 NYCRR 681.13), object to OPWDD-related services on behalf of such individuals (14 NYCRR 633.12), may provide informed consent for behavior support plans that include restrictive/intrusive interventions (14 NYCRR 633.16(g)(6)(i) and (iii)), and make end-of-life decisions on behalf of individuals with developmental disabilities. (Surrogate's Court Procedure Act § 1750-b [1] [a]; see also 14 NYCRR 633.10 [a] [7] [iv]).



V. Ensuring Accountability for Community Integration



Although this report provides the foundation for New York's compliance with the Olmstead mandate, effective oversight is required in order to protect the rights of person with disabilities to live in the community on an ongoing basis.

Since 2011, New York has undertaken significant initiatives to ensure the protection of people with disabilities and other special needs. In June 2013, Governor Cuomo established the Justice Center to investigate and prosecute cases of abuse and neglect against people with disabilities and to provide oversight and monitoring of the systems of care serving these people. Governor Cuomo also designated Disability Rights New York as the state's federally-funded Protection and Advocacy and Client Assistance Program to provide independent oversight of these systems. Additionally, New York initiated independent ombudsman functions through Medicaid redesign to assist people with disabilities served in the Medicaid managed care system. Finally, the Governor created the Olmstead Development and Implementation Cabinet and designated a representative of the Governor's Office to direct its activities. Together, these measures strengthen the oversight of providers and service systems and provide access to independent advocacy to protect the rights of people with disabilities to live in the community.

New York's sustained attention to serving people with disabilities in the community requires continued leadership from the Governor's Office. The legislature created the MISCC in 2002 as the statutory body intended to develop New York's Olmstead plan and hold state agencies accountable.⁵³ As designed, MISCC had a rotating chairmanship among the commissioners of four state agencies. This model has proved challenging because one state agency commissioner does not have the authority to command other state agency commissioners. The creation of the Olmstead Cabinet, with a chair from the Governor's Office, was intended to provide leadership from the Governor's Office in the development of a plan for Olmstead compliance. To sustain this leadership over time and to hold state agencies accountable for Olmstead compliance, a representative of the Governor's Office will continue to provide leadership to the MISCC. MISCC meetings will be a continuing means of public accountability for the state's accomplishment of Olmstead goals.

In addition, the Governor's Office will develop and maintain a dashboard to monitor Olmstead compliance. This dashboard will contain key agency Olmstead initiatives and metrics to measure New York's progress in serving people with disabilities in the most integrated setting. The Governor's Office will also maintain a dedicated website, <http://www.governor.ny.gov/olmstead/home>. This website will provide relevant information regarding New York's implementation of Olmstead and a mechanism for the public to provide feedback regarding New York's Olmstead Plan.

⁵³ Additional information about past MISCC Olmstead proceedings is available at http://www.opwdd.ny.gov/opwdd_community_connections/miscc/press_releases_and_important_documents.



Conclusion

This report and recommendations, developed by the Olmstead Cabinet, provide the framework for New York to serve people with disabilities in the most integrated setting appropriate to their needs and desires. Through implementation of these recommendations, New York will:

- Assist in transitioning people with disabilities into the community from developmental centers, ICFs, sheltered workshops, psychiatric centers, adult homes, and nursing homes;
- Reform the assessment of the needs and choices of people with disabilities;
- Adopt new Olmstead outcome measures for people with disabilities;
- Enhance integrated housing, employment, and transportation services available to people with disabilities;
- Improve services to children, seniors, and people with disabilities involved with the criminal justice system;
- Remove legal barriers to community integration; and
- Assure continuing accountability for serving people with disabilities in the most integrated setting.

The effective implementation of these recommendations will safeguard the fundamental civil rights of New Yorkers with disabilities to lead integrated lives.



www.governor.ny.gov/olmsteadplan