Olmstead Annual Report
July 1, 2009 – June 30, 2010

Building Inclusive Communities in West Virginia

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Olmstead

"Power yields nothing without demand. It never did and it never will. Find out just what any people will quietly submit to and you have found the exact measure of injustice and wrong that will be imposed upon them."

-Fredrick Douglass

"Much can be done when we raise our voices and join together. We cannot simply stand by and wait for someone else to take action. We must make our own history."

-the late Ken Ervin,
Olmstead Council Member

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The Olmstead Case

In 1995, the landmark case now known as *Olmstead* was brought by the Atlanta Legal Aid Society on behalf of Lois Curtis and Elaine Wilson, who were confined in a state psychiatric hospital in Georgia. Hospital staff agreed that both women should be discharged to supportive community programs. But no such placements were available. The state of Georgia offered nursing facility placements. Ms. Curtis and Ms. Wilson believed this violated their rights *under Title II of the Americans with Disabilities Act*.

Elaine Wilson (left) and Lois Curtis came to Washington in 1999 for the argument of their case before the U.S. Supreme Court. Today, Ms. Curtis is a successful folk artist in Atlanta, living at home with supportive services. Ms. Wilson lived in her own apartment until she died in 2004, at the age of 53.

Olmstead v. L.C. went through the judicial process. The Georgia Department of Human Resources appealed to the U.S. Supreme Court the lower court's decision that it had violated the ADA's integration mandate by segregating Ms. Curtis and Ms. Wilson in the hospital.

The U.S. Supreme Court found such segregation discriminatory both because it "perpetuates unwarranted assumptions" that people with disabilities "are incapable or unworthy of participating in community life" and because "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

Olmstead has been called the *Brown v. Board of Education* for people with disabilities. And like *Brown*, it is forcing change very slowly, and then only through determined and vigorous advocacy.

Excerpts and photo from "Still waiting…The Unfulfilled Promise of Olmstead" by the Bazelon Center for Mental Health Law, June 24, 2009.

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Introduction

Olmstead v. L.C. is a U.S. Supreme Court decision upholding the rights of people with disabilities to receive supports in the most integrated setting in their community. *Title II of the Americans with Disabilities Act* (ADA) was the basis for this landmark decision. *Title II of the ADA* applies to state and local government entities and the programs funded and administered by them. Two regulations under Title II were fundamental to the Olmstead decision:

1. The **integration regulation** mandates that states "shall administer services in the most integrated setting appropriate to meet the needs of individuals with disabilities." The **most integrated setting** is where people with disabilities are able to engage in the same opportunities to be active members of their community to work, live, socialize, and contribute as other citizens without disabilities.

2. The **reasonable modifications regulation** mandates that states "shall make reasonable modifications in its policies, practices, or procedures when necessary to avoid discrimination, unless modifications would fundamentally alter the nature of the services, programs or activities."

The Supreme Court stated that, "…if the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons…in [most integrated] settings, and a waiting list that moved at a reasonable pace, not controlled by the State's endeavors to keep institutions fully populated, the reasonable modification standard would be met."

On October 12, 2005, Governor Joe Manchin III signed *Executive Order 11-05* formally approving and ordering the implementation of the *West Virginia Olmstead Plan: Building Inclusive Communities* (referred to as the *Olmstead Plan*). *Executive Order 11-05* directs:

1. The implementation of the *West Virginia Olmstead Plan*;
2. The cooperation and collaboration between all affected agencies and public entities with the *Olmstead* Office to assure the implementation of the *Olmstead* decision within the budgetary constraints of the State; and
3. The submission of an annual report by the *Olmstead* Office to the Governor on the progress of implementing the *Olmstead Plan*.

Appendix A provides a list of the 10 goal statements of the *West Virginia Olmstead Plan*.

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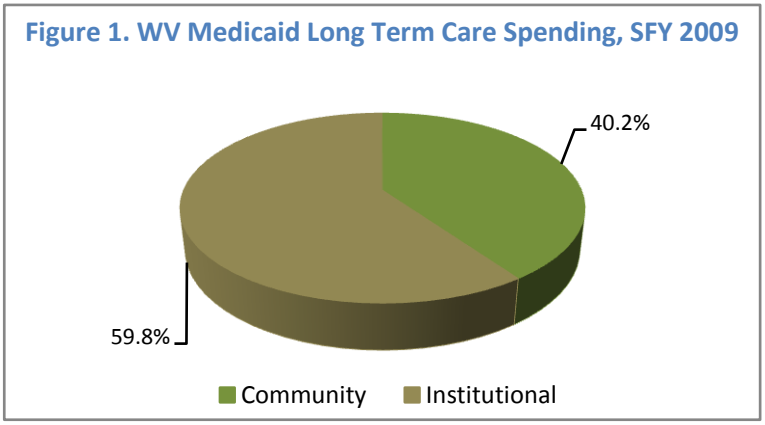
Institutional Bias

One of the major barriers to achieving compliance with the Olmstead decision and Title II of the ADA is the institutional bias of federal and state Medicaid regulations. Historically, Medicaid has covered long term care supports more readily when an individual resides in an institutional setting. However, in response to the Olmstead decision, the Centers for Medicare and Medicaid Services have offered states clarification, guidance, and increased flexibility to implement community-based services, and reduce their reliance on institutions. West Virginia has lagged behind in taking advantage of this flexibility and maintains an institutional bias in implementing and funding long term care supports.

Figure 1 compares Medicaid long term care spending for community-based supports and institutional care in West Virginia for state fiscal year (SFY) 2009. [1]

In SFY 2009, West Virginia spent 59.8% of its Medicaid long term care expenditures on institutional care, and 40.2% on community-based supports.[2]

Figure 1. WV Medicaid Long Term Care Spending, SFY 2009



Thomson Reuters issues an annual report on Medicaid long term care expenditures and compares states nationally for institutional and community-based spending. Since 2004, West Virginia has dropped in the national rankings from 17th to 24th when comparing overall Medicaid institutional and community-based spending. It should be noted that five states were not included in the 2008 rankings due to insufficient data. **Figure 2** shows how West Virginia was ranked in 2008 compared to 2004.

Figure 2. National Rankings Comparing State Medicaid Spending on LTC Services

	2008	2004
MR/DD[3]	17th	19th
AD[4]	24th	18th
TOTAL	24th	17th

[1] Institutional care includes nursing facilities (including state operated) and ICF/MR facilities. Community-based supports include the Aged and Disabled (AD) Waiver Program, MR/DD Waiver Program, home health, and personal care services.
[2] WV Bureau for Medical Services report issued on 05/06/2010.
[3] MR/DD includes costs for ICF/MR facilities and MR/DD Waiver services.
[4] AD includes costs for Aged and Disabled Waiver, Personal Care, and Home Health services.

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Figure 3 shows the distribution of Medicaid long term care expenditures for SFY 2006 through SFY 2009 in West Virginia.[5]

Figure 3. WV Medicaid Long Term Care Expenditures, SFY 06-09				
	Actuals SFY 2009	Actuals SFY 2008	Actuals SFY 2007	Actuals SFY 2006
Institutional LTC Expenditures				
Nursing Facility	$464,023,240	$431,721,537	$413,063,985	$402,903,863
ICF/MR	$63,246,071	$58,149,869	$58,706,822	$53,642,496
Total Institutional Expenditures	**$527,269,311**	**$489,871,406**	**$471,770,807**	**$456,546,359**
Percent of Total LTC Expenditures	**59.8%**	**60.1%**	**61.4%**	**62.3%**
Community-Based LTC Expenditures				
HCBS Waiver (MR/DD)	$233,468,853	$218,374,534	$200,535,722	$185,607,767
HCBS Waiver (Aged/Disabled)	$80,034,343	$65,632,681	$56,417,341	$60,658,000
Home Health Services	$3,918,514	$3,377,822	$3,066,077	$3,513,475
Personal Care Services	$37,675,865	$37,799,505	$36,793,019	$27,037,173
Total HCBS Expenditures	**$355,097,575**	**$325,184,542**	**$296,812,159**	**$276,816,415**
Percent of Total LTC Expenditures	**40.2%**	**39.9%**	**38.6%**	**37.7%**

Since 2007, the United Cerebral Palsy (UCP) annual *Case for Inclusion* seeks to benchmark states actual performance in improving lives for individuals with MR/DD. The report cites West Virginia's drop in the rankings from 16th in 2007 to 22nd in 2010 is "mostly due to not keeping pace with the rest of the country."

Figure 4 shows West Virginia compared to national rankings for key outcomes from the UCP "Case for Inclusion 2010."

Figure 4. UCP "Case for Inclusion" West Virginia Rankings		
Key Outcomes and Data Elements	National Rankings	
	WV 2007	WV 2010
Allocating Resources to Those in the Community (Non-ICF/MR)	22	23
Supporting Individuals in the Community and Home-Like Settings	13	13
Keeping Families Together through Family Support	25	26
Supporting Meaningful Work	45	45
State Ranking of Medicaid Spending for MR/DD	16	22

[5] Ibid.

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The Rehabilitation Research and Training Center on Disability Statistics and Demographics released the *Annual Disability Statistics Compendium, 2009*. This reported ranked West Virginia last in the nation (or 50th) in employment of people with disabilities ages 16-64.

[insert BHHF data]

The Olmstead Office and Council released a report titled, *Long Term Care Institutional Bias in West Virginia, A Working Document* on June 4, 2010. This report highlighted 21 examples of institutional bias and recommendation for balancing the long term care system. The following summarizes the examples of institutional bias in West Virginia:

1. West Virginia spends a greater percentage of its overall funding for institutional care (59.8%) when compared to community-based supports (40.2%).
2. West Virginia has an Aged and Disabled Waiver Program that does not provide a comparable or functional alternative to nursing facility care.
3. West Virginia relies heavily on informal care giving or supports to fill the gaps for inadequate level of support provided by home and community-based supports.
4. West Virginia restricts access to personal care services for recipients of the Aged and Disabled Waiver Program to those receiving services at Level D.
5. West Virginia implemented a waiting list for the Aged and Disabled Waiver Program on July 1, 2010, and implemented a waiting list for the MR/DD Waiver on January 1, 2005.
6. West Virginia employs a more lengthy eligibility process for waiver services when compared to nursing facility and ICF/MR facility care.
7. West Virginia reimburses services for community-based services using a fee-for-service methodology and institutional care using a cost-based comprehensive per diem rate.
8. West Virginia provides fragmented and inadequate services for people with mental illness.[6]
9. West Virginia does not effectively use Targeted Case Management to support people in transitioning from institutional care to the community.
10. West Virginia does effectively use unlicensed, trained personnel to administer medications in the community through exemption and delegation methods.
11. West Virginia does not provide adequate informed choice and options education at the point of institutional placement.

[6] As evidenced by the Hartley Circuit Court Case.

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In the 1980's and 1990's, West Virginia was a leader in the nation for closing institutions for people with MR/DD and downsizing institutions for people with mental illness. Some other positive achievements in West Virginia's long term care system include the following:

1. Moratoriums on the development (net increase) of nursing facility and ICF/MR facility beds and facilities.
2. Implementation of the self-directed option for the Aged and Disabled Waiver Program.
3. Implementation of a pilot transition/diversion program in 22 counties, the West Virginia Transition Navigator Program.
4. Development and expansion of the Aging and Disability Resource Centers.
5. Application to implement a self-directed option for the MR/DD Waiver Program.
6. Implementation of the Ron Yost Personal Assistance Program (RYPAS).
7. Implementation of state-funded senior programs for Lighthouse and FAIR.
8. Increase in Medicaid rate for Assertive Community Treatment from a daily rate of $23.00 per day to $73 per day.
9. Implementation of *Hartley Court Orders* to address community mental health services, overcrowding at state-operated psychiatric facilities, and traumatic brain injury services.

For more information in institutional bias in West Virginia contact the *Olmstead* Office, or go to the *Olmstead* website at www.wvdhhr.org/oig/Olmstead/default.asp.

West Virginia Olmstead Plan Implementation

The *Olmstead Plan* has been in place through *Executive Order 11-05* since 2005. The *Olmstead* Council and the Office continues to work diligently to take proactive steps for its implementation.

West Virginia Olmstead Council

The West Virginia *Olmstead* Council (Council) was established in 2003 to advise and assist the *Olmstead* Coordinator (Coordinator) to develop, implement and monitor West Virginia's *Olmstead* activities. The mission of the Council is to assist all West Virginia citizens with disabilities to have the opportunity to receive supports and assistance in the most integrated setting in the community. The Council has the following responsibilities as outlined in the *Olmstead* Plan:

1. advise the Coordinator in fulfilling the position's responsibilities and duties;
2. review the activities of the Coordinator;

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3. provide recommendations for improving the long term care system;
4. issue position papers for the identification and resolution of systemic issues; and
5. monitor, revise, and update the Plan and any subsequent work plans.

The Council is a 30-member body consisting of: eight (8) people with disabilities and/or immediate family members; eleven (11) advocacy and/or disability organizations; six (6) providers of institutional and community supports; four (4) state agencies; and one (1) representative from federal/local housing. **Appendix B** provides a list of Council members serving during the state fiscal year.

§9-2-6(6). Establish within the Department an Office of Inspector General for the purpose of conducting and supervising investigations and for the purpose of providing quality control for the programs of the Department. The Office of Inspector General shall be headed by the Inspector General who shall report directly to the Secretary. Neither the Secretary nor any employee of the Department may prevent, inhibit, or prohibit the Inspector General or his or her employees from initiating, carrying out or completing any investigation, quality control review or other activity oversight of public integrity by the Office of the Inspector General.

The Council identifies priorities and issues to be addresses each year. The overarching goal remains the implementation of the West Virginia Olmstead Plan. The Council identified the following three (3) priorities for 2010:

1. Implementation of the West Virginia Olmstead Plan: Building Inclusive Communities.
2. Implementation of the Money Follows the Person (MFP) and Long Term Care System Rebalancing study recommendations.
3. Implementation of a statewide transition and diversion program.

West Virginia Olmstead Office

The Olmstead Office provides information, referral and assistance to West Virginia citizens concerning Olmstead-related issues. The Olmstead Office also manages the West Virginia Transition Navigator Program.

The Olmstead Office moved from the Office of the Ombudsman for Behavioral Health to the Office of the Inspector General in October 2009. This move was due to the court action reinstating a Court Monitor and eliminating the Office of the Ombudsman for Behavioral Health.

The Office of Inspector General was very receptive and proactive in supporting the addition of the Olmstead Office. The Office of Inspector General has statutory independence from the Department of

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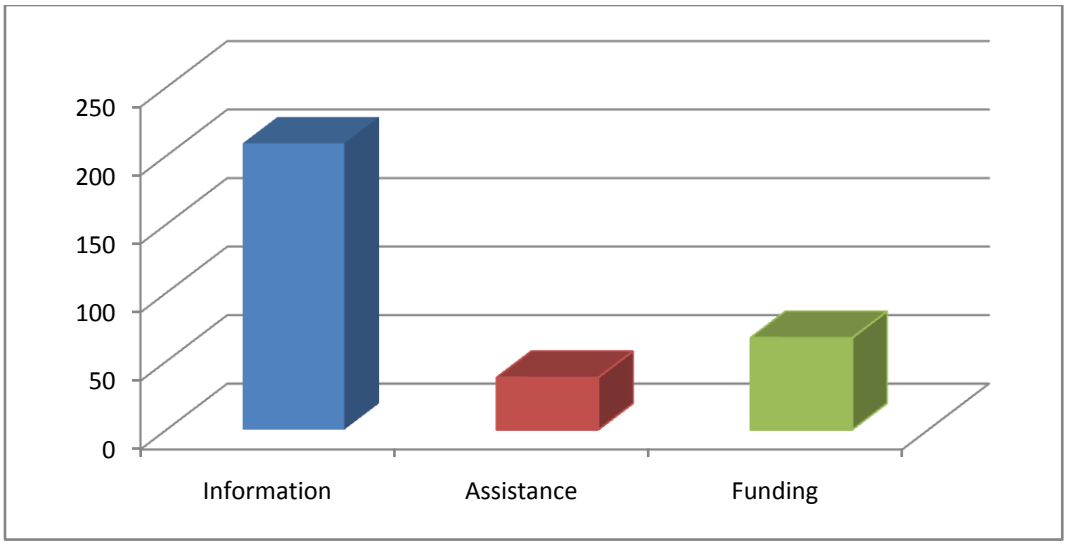
Health and Human Services to carry out their duties and responsibilities. This statutory independence is cited in West Virginia State Code in §9-2-6(6).

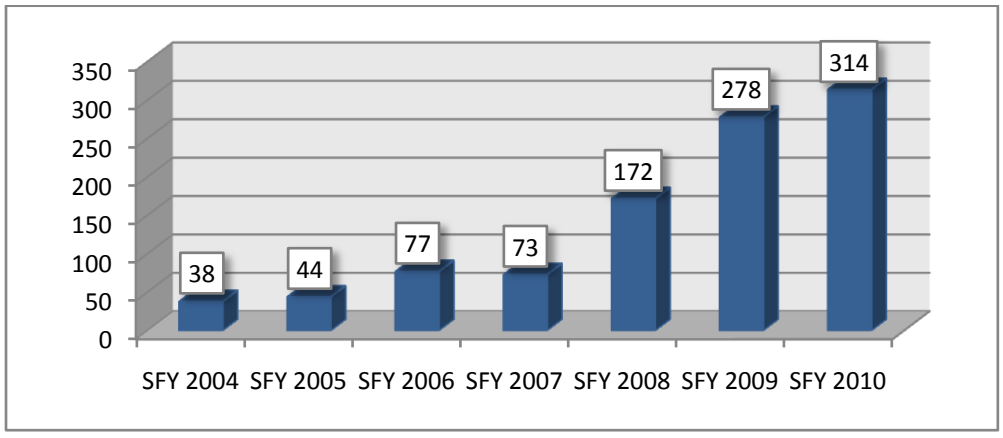
In state fiscal year 2010, the Olmstead Office received 314 documented contacts for information, assistance and funding. **Figure 5** details the number of contacts by category for state fiscal year 2010.

Figure 5. Olmstead Contacts, SFY 2010



The Olmstead Office has been tracking Olmstead-related contacts since the office was established in 2003. **Figure 6** shows the number of contacts for state fiscal years 2003 through 2010.

Figure 6. Total Olmstead Contacts, SFY 2003 - 2010



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Olmstead Council and Office Action Steps

The Olmstead Council and Office have taken a number of proactive steps to address the implementation of the Olmstead Plan. The following provides some examples of these action steps:

1. Developed a comprehensive work plan to direct and guide the implementation of the Olmstead Plan.
2. Administered and monitored the on-going implementation of the Transition Navigator Program through grant agreements with Community Access, Inc., Northern West Virginia Center for Independent Living, and Legal Aid of West Virginia Long Term Care Ombudsman Program.
3. Participated in a series of meetings concerning statutory and regulatory issues related to the Nurse Practice Act and Medication Administration by Unlicensed Personnel. Extensive research was completed and state and national laws and regulations. As a result, the Fair Shake Network, the West Virginia Developmental Disabilities Council, the West Virginia Olmstead Council and the West Virginia Statewide Independent Living Council issues recommendations for statutory and regulatory changes. During the October 2009 interim session, these recommendations were presented to the Legislative Select Committee on Health. During the 2010 regular legislative session was introduced to enact these recommendations. The bill did not pass, nor did a study resolution.
4. Requested an improvement package for additional funding to expand the West Virginia Transition Navigator Program statewide. However, new funding was appropriated for state fiscal year 2012.
5. Monitored the MR/DD Waiver wait list through reports received from the Bureau for Behavioral Health and Health Facilities.
6. Monitored the Aged and Disabled Waiver wait list through reports received from the Bureau of Senior Services.
7. Reviewed the MR/DD Waiver renewal application and provided comments to the Bureau for Medical Services.
8. Reviewed the Aged and Disabled Waiver renewal application and provided comments to the Bureau for Medical Services.
9. Monitored the new contract by APS HealthCare for the MR/DD Waiver by attending Quality Council meetings.
10. Participated on the MR/DD Waiver Self-Direction Work Group.
11. Sponsored the MR/DD Waiver Self-Direction Work Group by funding stipends and meetings.

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12. Participated on the Metro AAA Aging and Disability Resource Center Advisory Council.
13. Participated in the 2010 National Mental Health Block Grant, Data and Olmstead Conference in Washington DC.
14. Presented on the West Virginia Transition Navigator Program at the 2010 National Mental Health Block Grant, Data and Olmstead Conference in Washington DC.
15. Provided funding support and sponsorship to the West Virginia Fair Shake Network and Disability Training Day.
16. Provided funding support and sponsorship to the West Virginia Disability Caucus.
17. Participated on committees and work groups for the West Virginia Disability Caucus.
18. Participated in the Disability Advocacy Day at the Legislature during the 2010 Legislative Session.
19. Managed an annual budget of $493,709 in state general revenue funds for grants programs. Olmstead funding was not subject to budget cuts for the 2010 or the upcoming 2011 state fiscal year.
20. Administered the Olmstead grant provided by the federal U.S. Substance Abuse and Mental Health Services Administration.
21. Participated on the Long Term Care Partnership committees for Home and Community-Based Services and Workforce.
22. Participated in the Long Term Care Partnership Summit Conference.
23. Participated in meetings to discuss changes to behavioral health services through a Medicaid Managed Care system of care.
24. Developed a working report on institutional bias in West Virginia. Examples of institutional bias and recommendations for systems change are presented in this report.
25. Submitted a written request to the Commissioner of the Bureau for Medical Services to participate in changes related to the new Minimum Data Set 3.0.

The Olmstead Office tracks and monitors systemic issues that impede the successful implementation of the Olmstead Plan. The Olmstead Office currently tracks and monitors the following nine (9) systemic issues:

1. Individuals inappropriately placed at the two (2) state-operated psychiatric facilities.
2. Individuals inappropriately placed at the five (5) state-operated long term care nursing facilities.

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3. Implementation of a waiting list for individuals eligible for the MR/DD Waiver services.
4. Implementation of rebalancing initiatives and Money Follows the Person strategies.
5. Individuals inappropriately place in out-of-state nursing facilities, including those who are ventilator dependent.
6. Continued use of and development of ICF/MR facilities.
7. Implementation of medication administration in the community that increases choice, independence, and safety.
8. Development of a work release program at a state-operated nursing facility.
9. Implementation of a waiting list for individuals eligible for the Aged and Disabled Waiver Program.

SAMHSA Federal *Olmstead* Grant

Since 2000, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) have issued state *Olmstead* Initiative grants to states and territories. The purpose of this grant funding is to expand resources and opportunities for adults with serious mental illnesses and children with serious emotional disturbances to live in their home communities. This grant funding offers states and territories up to $60,000 over a three-year grant period. West Virginia has received this grant funding since 2000.

Since 2006, this funding has been granted to Legal Aid of West Virginia to supplement the Children's Legal Advocacy Support Project (CLASP). Legal Aid employees a full-time attorney to provide legal assistance to children (and their families) with severe emotional and/or behavioral health needs. The Olmstead Office will receive this funding until the end of September 2011.

During state fiscal year 2010, the CLASP program achieved the following:

1. Training on "Practical Tips for Parents in Navigating the Special Education Process" was provided in May 2010 and, training on "Special Education Law" was provided in June 2010.
2. CLASP attorney provided legal services to 12 individuals: approximately 3 were between the ages of 0-10; six were between the ages of 11-14; and 3 were between the ages 15-18+. Youth receiving services were involved in the following systems: mental health, education, child welfare, developmental disabilities, child protective services, health services, and family/youth support services.
3. Family receiving services for the following issues: Special Education/learning disabilities (4); discipline, suspensions or expulsions (4); other education issues (1); and minor guardianship/conservatorship (1).

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4. Satisfaction surveys are sent to individuals represented at the time of case closure. Two cases were closed and 2 completed satisfaction surveys were received by Legal Aid citing a high level of satisfaction.
5. The Family empowerment measurement tool will be sent to family receiving assistance with an Individual Education Plan (IEP) issue at the time of case closure. To date, one survey has be mailed, and no completed responses have been received.

Specific examples of legal services provided through this program:

1. A student with ADHD was suspended and the school sought expulsion for an incident occurring at school. The CLASP attorney represented the student at a manifestation meeting, and the incident was determined to be a manifestation of the student's disability. A more structured school schedule was developed as a result and the mother reports the student has been successful and is now enjoying school more.
2. DHHR contacted Legal Aid about a potential expulsion of a foster child after an incident at school. The CLASP attorney provided the DHHR worker technical assistance for the manifestation meeting. The DHHR worker and guardian ad litem successfully prevented the expulsion of the student.
3. The CLASP attorney assisted a woman with obtaining guardianship over her two minor half-siblings (who have developmental disabilities and behavioral health diagnoses) after both of their parents passed away unexpectedly.
4. A teenager, diagnosed with ADHD, ODD, IED, was reported to local authorities after he was involved in a fight. The school failed to provide the authorities with documentation regarding the student with an individualized education plan, as the law requires. The CLASP attorney filed a state complaint on behalf of the family. The County agreed to have an outside attorney provide a training regarding discipline procedures to all school principals in the County.

The West Virginia Transition Navigator Program was one out of five programs chosen by the 2010 National Mental Health Block Grant, Data and Olmstead Conference to be presented as promising practices under Olmstead.

West Virginia Transition Navigator Program

The purpose of the Transition Navigator Program is to assist West Virginians with disabilities residing in institutional facilities to be supported in their home and community. As a pilot program, direct transition assistance is provided in 22 counties through two (2) full-time Transition Navigators.

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Transition Navigators are employed through grant funding by Community Access, Inc. and Northern West Virginia Center for Independent Living.

The remaining 33 counties can access information, referral and assistance through the Olmstead Office, however, direct transition services are not provided in these counties.

Transition Navigators assist people residing in nursing facilities (and their representatives), who want to leave the facility and return to their home and community. Navigators provide: direct transition services; information and referral; outreach and education; assessment and planning; and advocacy.

During state fiscal year 2010, the program supported 134 people through the transition and diversion process. **Figure 7** identifies the number of people the program supported for transition and diversion for state fiscal years 2010 compared to 2009.

Figure 7. People Served by the Transition Navigator Program, SFY 2010

	SFY 2010	%	SFY 2009	%
Total # People Transitioned	38	28%	28	22%
Total # People Diverted	96	72%	101	78%
TOTAL	**134**		**129**	

Figure 7 shows 38 people were transition and 96 were diverted in 2010.

Each participant is eligible to receive up to $2,500 to pay for reasonable and necessary one-time start-up costs. One-time start-up costs associated with: security deposit for housing; set-up fees for utilities; moving expenses; essential home furnishings and supplies; and home accessibility modification. **Figure 8** details the funding allocated for participants during state fiscal year 2010 as compared to 2009.

Figure 8. Transition Navigator Start-Up Funding, SFY 2010 and 2009

Transition Navigator Start-Up Funding	SFY 2010	%	SFY 2009	%
Housing Security Deposit	$9,030.85	3%	$3,748.58	1%
Utility Set-Up Fees or Deposits	$3,420.53	1%	$5,005.34	1%
Essential Home Furnishings and Supplies	$59,441.17	22%	$125,802.34	31%
Moving Expenses	$5,680.13	2%	$8,027.33	2%
Home Modifications	$196,832.00	72%	$266,887.02	65%
TOTAL	**$274,404.68**		**$409,470.61**	
PER PERSON AVERAGE	**$2,063.19**		**$2,844.00**	

In 2010, 133 people received start-up funding and this reflects more people than were identified in the previous chart. This is because some participants have **not** completed the transition/diversion process will be carried over to the next fiscal year. The average start-up funding allocated per participant was $2,063.9.

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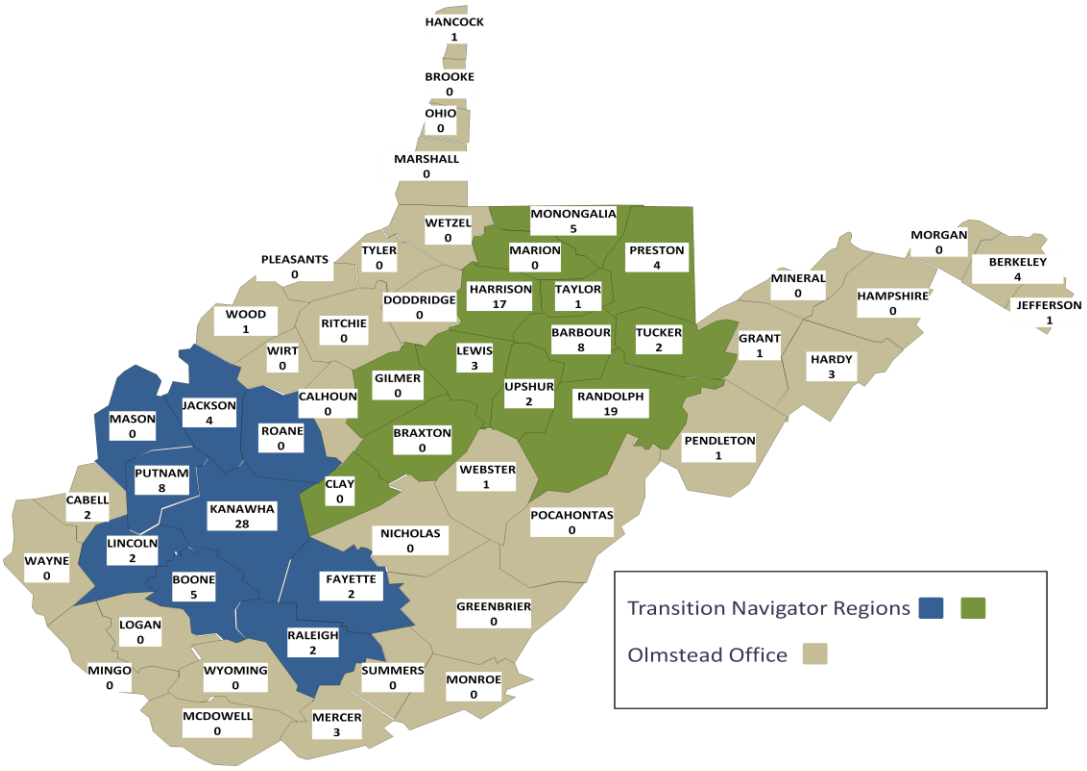
Due to the program starting late in SFY 2008, funding was carried over to 2009 and this accounts for more funding allocated in 2009. **Figure 9** illustrates the number of people supported in each county for start-up funding for state fiscal year 2010.

Figure 9. Participants Receiving Start-Up Funding Per County, SFY 2010



The program served the following counties that were previously unserved: Upshur, Grant, and Pendleton. The Transition Navigators collected data and information for each participant to track trends and monitor for quality improvement needs. **Figure 10** provides some examples of the data and information that is collected:

Figure 10. Transition Navigator Program Data

	SFY 2010	SFY 2009
Age range	20-99	30-94
Average age	66	66
Average transition time	3 months	3 months
Average diversion time	3 months	4 months
Admitted to NF after hospitalization	70%	55%
Admitted to NF due to lack of community supports	30%	45%
Average length of NF stay	8 months	12 months
Received in-home supports prior to NF admission	38%	30%
Received formal in-home supports after transition	46%	78%
Had access to informal supports	85%	70%

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Transition Navigators have identified barriers that prevent or hinder people returning to or remaining in their home and community. As a result of these barriers, many people are forced to leave their home to receive more costly institutional care. The Olmstead Office tracks, monitors and reports on identified barriers to the Olmstead Council and other appropriate entities. **The following lists some of these barriers:**

1. The waiting list for the Aged and Disabled Waiver Program makes it very difficult for people to transition from nursing facilities to their home. The wait list also places more stress on informal caregivers and family.
2. Lack of affordable and accessible housing remains the most critical barrier for people. This includes waiting lists for federal and/or state housing vouchers or lack of adequate funding for housing programs.
3. Lack of funding and programs to meet the needs of people requiring home modifications or home repairs that are essential to remaining at home in the community. Bathroom modifications, access modifications to multi-levels of a home, and ramps are expensive one-time costs. However, they are significantly less costly than nursing facility placements.
4. Lack of community-based supports for people with mental health needs. Waiver, home health and personal care are not always able meet the mental health needs of participants.
5. Lack of comprehensive community-based supports under the aged and disabled waiver program. There is a real disparity between the care provided in a nursing facility and the services offered under the Aged and Disabled Waiver Program.
6. Lack of fast track or presumptive eligibility for home and community-based services results in nursing facility placements often being the only viable option.
7. Lack of timely processing for grant agreements and funding at the state-level creates delays in responsive Transition Navigator services.

The future outlook for this program hinges on securing additional funding to provide statewide implementation. Additional funding will be requested in the amount of $570,000.00 in on-going state general revenue funds. **This funding would allow:**

1. Expansion of Transition Navigator services to the 33 un-served counties by adding coverage to three additional regions. This includes the hiring of three additional full-time Transition Navigators.
2. Expansion of start-up funding services to an additional 100 people within 3 additional regions.

A goal of the program is to compare the costs of caring for people in the nursing facility to supporting people through in-home supports. The first analysis of this data will occur at the end of state fiscal year

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2011. The Bureau for Medical Services is a collaborative partner in the Transition Navigator Program to provide data for this analysis.

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Conclusion

The Olmstead Council continues to work towards full implementation of the Olmstead Plan as directed by Executive Order 11-05.

[need to complete]

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APPENDIX A. Olmstead Plan Goals

The Olmstead Council through extensive public input developed the 10 key goals of the Olmstead Plan. Each goal has a series of specific objectives. The following lists the 10 key goal statements:

1. **Informed Choice:** Establish a process to provide comprehensive information and education so people with disabilities can make informed choice.

2. **Identification:** Identify every person with a disability, impacted by the Olmstead decision, who resides in a segregated setting.

3. **Transition:** Transition every person with a disability who has a desire to live and receive supports in the most integrated setting appropriate in accordance with the three conditions identified in the Olmstead decision.

4. **Diversion:** Develop and implement effective and comprehensive diversion activities to prevent or divert people from being institutionalized or segregated.

5. **Reasonable Pace:** Assure community-based services are provided to people with disabilities at a reasonable pace.

6. **Eliminating Institutional Bias:** Provide services and supports to people with disabilities by eliminating the institutional bias in funding long term care supports.

7. **Self-Direction:** Develop self-directed community-based supports and services that ensure people with disabilities have choice and individual control.

8. **Rights Protection:** Develop and maintain systems to actively protect the civil rights of people with disabilities.

9. **Quality:** Continuously work to strengthen the quality of community-based supports through assuring the effective implementation of the Olmstead Plan, and that supports are accessible, person-centered, available, effective, responsive, safe, and continuously improving.

10. **Community-Based Supports:** Develop, enhance, and maintain an array of self-directed community-based supports to meet the needs of all people with disabilities and create alternatives to segregated settings.

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APPENDIX B. Olmstead Council Members

People with Disabilities and Immediate Family Members	
Karen Davis	
Jeannie Elkins	
Darla Ervin	
Linda Maniak	
Suzanne Messenger	
Kevin Smith	
Vanessa VanGilder	
Advocacy and Disability Organizations	
Libby Collins	EMS-TSN Medley/Hartley Advocacy Program
Jan Derry	Northern West Virginia Center for Independent Living
Nancy Fry	Legal Aid of West Virginia
Clarice Hausch	West Virginia Advocates
Roy Herzbach	Legal Aid of West Virginia Long Term Care Ombudsman Program
Cathy Hutchinson	Mountain State Center for Independent Living
Ted Johnson	West Virginia Mental Health Planning Council
Ann McDaniel	West Virginia Statewide Independent Living Council
David Sanders	West Virginia Mental Health Consumers' Association
David Stewart	Fair Shake Network
Steve Wiseman	West Virginia Developmental Disabilities Council
Providers	
Laura Friend	West Virginia Council of Home Care Agencies
Brenda Hellwig	Job Squad, Inc.
John Russell	West Virginia Behavioral Health Providers' Association
Christina Shaw	Res-Care, Inc.
State Agencies	
Cindy Beane	Bureau for Medical Services
Elliott Birckhead	Bureau of Behavioral Health and Health Facilities
Marcus Canaday	Bureau for Medical Services
Penney Hall	State ADA Coordinator
Vonda Spencer	Bureau of Senior Services

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APPENDIX C. Money Follows the Person Rebalancing Long Term Care Study Recommendations

1. Create an action plan for increasing the availability of home health, adult medical day care, and assisted living services in West Virginia through a review of the existing Certificate of Need (CON) program and Medicaid payment rates.
2. Expand the AD Waiver to provide a wider variety of services to more individuals, and continue to support the self-directed option under the waiver.
3. Replace ICFs/MR with Waiver services and apply for two new Medicaid waivers to incorporate into the West Virginia long term care system: a Traumatic Brain Injury waiver and an MR/DD Supports waiver.
4. Boost the existing Assertive Community Treatment (ACT) program and expand telemedicine services.
5. Continue and expand options for self-direction and individualized budgeting into statewide long term care programs and services.
6. Improve access to community-based services for underserved and unserved populations by expanding home and community-based services.
7. Expand the Transition Navigator Program.
8. Continue to develop a single point of entry system through the Aging and Disability Resource Centers (ADRC) with other community services for improved information accessibility and a streamlined eligibility and assessment process.
9. Change the current assessment process for long term care consumers to: a) ensure providers are not completing individuals' assessments (remove the apparent conflict of interest); b) ensure that options / benefits counseling is occurring at the time of potential facility admission; and c) utilize a presumptive eligibility process or fast track initiative.
10. Modify the Nurse Practice Act.
11. Modify current policies and practices that reinforce institutional bias.
12. Review the medical records of and discuss HCBS options with current LTC facility residents to identify those more appropriately served in and ready for transitioning to the community.
13. Expand the amount of funding resources set aside for assisted living services so that Medicaid and Medicare recipients can access assisted living more equitably.
14. Expand the variety of services and the number of recipients utilizing personal care services by allocating more state-only dollars toward these services.
15. Continue to apply for federal grants to increase funding for LTC services and supports.
16. Promote affordable and accessible housing.
17. Work with the Department of Transportation to provide more affordable and accessible transportation that allows individuals to access recreational, social, medical and spiritual events.
18. Tackle the state's critical workforce shortage by increasing direct care workers' salaries and implementing new methods for recruitment, retention, training and credentialing.
19. Continue to increase consumer and family involvement in the development of policy and the development or redesign of quality improvement / quality assurance activities and processes.

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Office of the Inspector General
Olmstead Office
State Capitol Complex
Building 6, Room 817-B
Charleston, West Virginia 25305
(304) 558-3287 or (866) 761-4628