Community Integration Self-Assessment Tool

for use in the
2014 Olmstead Community of Practice

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4/16/14

Prepared for SAMHSA through a Task Order with JBS International by Advocates for Human Potential & The NASMHPD Research Institute

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Instructions for State Self-Assessment

The Community Integration Self-Assessment Tool is comprised of two parts: 1) Contextual Information, and 2) Indicators of Community Integration. Although state behavioral health authorities will be relied on to conduct the self-assessment, the scope should not be limited to the population served by the behavioral health authority. Many indicators of community integration require the inclusion of individuals served by other state agencies. Collaborating with these other agencies is crucial, since effective community integration cannot occur in a silo. State behavioral health authorities might consider engaging the following state agencies to help them complete the tool:

- Attorney General
- Corrections
- Housing
- Medicaid
- Intellectual & Developmental Disability
- Substance Abuse
- Vocational Rehabilitation
- Education
- Early Intervention
- Juvenile Justice
- Child Welfare
- Veterans Affairs

Part I, Contextual Information, gathers qualitative information that will provide context to the set of indicators that will be gathered. This information will help states better analyze and understand the trends and values of the indicators as they relate to the overall state system of behavioral health service delivery and state *Olmstead* activities.

Part II, Indicators of Community Integration, contains a set of measures classified according to domains of community integration. The seven domains of community integration included in this tool are:

1. Financing and Resources
2. Movement to the Community and Recidivism
3. Housing (definitions provided in the Appendix)
4. Community Capacity
5. Well Being
6. At-Risk Population
7. Policy

The identified set of indicators contained within this section applies to persons with SMI and SED receiving services and care from any institutional settings who may potentially experience unjustified segregation. The following settings are included in this tool (definitions for each are provided in the Appendix):

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

States participating in the Community of Practice are encouraged to respond to and collect data for as many of the contextual questions and indicators as possible, given the limited amount of time. States should begin by identifying areas of most importance, and accordingly prioritize their data collection efforts.

At the beginning of August 2014, participating states will be asked to submit a report to NRI that documents their participation in the Community of Practice, and generally evaluates the value of the tool at identifying strengths and weaknesses in the state's community integration efforts directed towards persons with mental illnesses. The instructions for completing this report are provided in a separate document. ***It is important to note that NO DATA SHOULD BE SUBMITTED TO NRI, AHP, or SAMHSA. All data are to remain with the state to allow states to conduct internal analyses of their systems.***

Contextual Information

1. Role of SMHA/Behavioral Health Authority in Olmstead Implementation: Does your state have a current *Olmstead* plan that addresses mental health? If yes, does that plan cut across multiple agencies, or is it targeted specifically toward the SMHA? What was the SMHA's role in the development of the plan? What is the process for evaluating progress in implementing the plan (e.g., do you set targets)? Does your state's plan include details as to specific populations (e.g., children with mental health needs, adults with SMI, etc.)?

2. State Olmstead Investigations: Is your state currently, or anticipating coming under an *Olmstead* investigation? If so, what is the focus of the investigation? What is the service population targeted?

3. Interagency Collaboration to Promote Community Integration: How does the SMHA collaborate with other state agencies in promoting community integration (e.g., How is your SMHA working with state housing agencies to increase available community living settings? Is the SMHA working with the state educational system to transition children and youth back to their home communities after a period of institutionalization?)?

4. Use of Medicaid to Fund Services that Promote Community Integration: Does your state use Medicaid options to support community living (e.g., state plan amendments for targeted case management, mobile crisis services, etc.)? If yes, please describe. Does your state have a Medicaid HCBS waiver or option that is used for mental health services? If yes, please describe; if not, is your state pursuing a 1915(i) Option or 1915(c) Waivers? Is your state using Money Follows the Person or other special Medicaid funding to support community mental health services?

5. Use of Housing and Urban Development (HUD) Programs to Fund Housing or Housing Support Services that Promote Community Integration: Please describe the various HUD housing vouchers, subsidies, and other programs that are used to support community living arrangements for mental health consumers. Please describe how your SMHA's involvement/role in providing housing for mental health consumers.

6. Follow-up Activities to Sustain Community Transition/Integration: Do you monitor or track consumers who transitioned from an institutional setting to the community? Do you have specific indicators to determine how well consumers transition from an institutional setting into the community? What specific indicators are used? How often is the measurement activity conducted?

7. Diversion Programs and Related Activities to Keep Consumers in Integrated Settings and Prevent Unnecessary Institutionalization: Does your SMHA engage in any activities, or implement any programs to divert consumers to appropriate community mental health services? If yes, please briefly describe these programs, the partnerships necessary to make them work, and how they are sustained.

8. Budget Development to Finance Community Integration: How does your SMHA incorporate community integration to facilitate transition and diversion in its budget development process? What data are gathered and used? How does your SMHA calculate the cost savings that can be achieved and what expenditures are needed?

9. Affordable Housing: Does the cost of living/renting an apartment reduce the number and availability of housing vouchers available to persons with mental illness in your state? What other barriers to affordable housing exist in your state?

10. Use of Peer Services: Does your state rely on peers to assist consumers with transitions into the community? If yes, please describe. What other types of peer support services are offered in your state?

Domains and Indicators of Community Integration

Financing and Resources Domain

Indicator	Indicator Specifications		Applicable Settings	Applicable Populations	Data Sources	Additional Considerations
	Numerator(s)	Denominator(s)				
Increase in Funding for Community-Based Programs	1. State mental health expenditures on community-based programs	Total state mental health expenditures	SMHA/State System, including: State Psychiatric Hospitals, Nursing Homes, Residential Treatment Facilities, Emergency Rooms, Adult Care Homes, Jails, and Prisons.	SMHA-served population, children and adults. URS age groups should be used to break out age divisions: -Children 0-17 -Young adults 18-20 -Adults 21 and over	-Revenues and Expenditures -Medicaid Claims Data -NDS for Nursing Homes -SMHA MIS	-If possible, states should include SMHA, Medicaid, and any other funding sources the SMHA can identify. -Expenditure data may be collected as aggregate, by institution, by population, by service type
	2. State expenditures on psychiatric hospital/inpatient care	Total state mental health expenditures	SMHA/State System, including: State Psychiatric Hospitals, Nursing Homes, Residential Treatment Facilities, Emergency Rooms, Adult Care Homes, Jails, and Prisons.	SMHA-served population, children and adults. URS age groups should be used to break out age divisions: -Children 0-17 -Young adults 18-20 -Adults 21 and over	-Revenues and Expenditures -Medicaid Claims Data -NDS for Nursing Homes -SMHA MIS	-If possible, states should include SMHA, Medicaid, and any other funding sources the SMHA can identify. -Expenditure data may be collected as aggregate, by institution, by population, by service type
	3. Number of HCBS slots available (only applicable to states with 1915(c) waivers)	-State SMI/SED population -Medicaid-eligible population -Number of persons with SMI/ SED transitioning into the community	SMHA/State System	Adults with SMI Children with SED	-Medicaid -SMHA MIS	

Movement to the Community & Recidivism Domain

Indicator	Indicator Specifications		Applicable Settings	Applicable Populations	Data Sources	Additional Considerations
	Numerator(s)	Denominator(s)				
Decrease in Length of Time Waiting for Discharge	4. a) Number of persons awaiting discharge by type of institution for more than three months 4. b) Does the state have a standardized assessment, update regularly (quarterly, monthly, etc.), to assess readiness for discharge?	-Institutional census -Number of persons discharged -Number of persons with SMI/SED deemed eligible and ready to transition -Average daily census, by institution	By institution. Applicable to all institutions.	-Adults with SMI -Children with SED	-Institutional databases -SMHA MIS	-Other time factors may be considered (e.g., awaiting discharge for 30 days or more than one year, etc.) -States that have standardized assessments that identify patients ready for discharge should use this measure. Those without such an instrument should skip this measure.
Decrease in Length of Stay	5. Number of patients in the institution with length of stay greater than one year at end of year	Institutional census Number of persons discharged	By institution	-Adults with SMI -Children with SED	-Institutional databases -SMHA MIS	
	6. Number or percentage of persons with length of stay greater than one year (discharged during the year)	Institutional census Number of persons discharged	By institution	-Adults with SMI -Children with SED	-Institutional databases -SMHA MIS	
Decrease in Readmission Rate	7. Number of persons with SMI/ SED readmitted to any (or same) type of institution within six months	Institutional census Number of persons discharged	By institution	-Adults with SMI -Children with SED	-Institutional databases -SMHA MIS	-Other time factors may be considered (e.g., w/in 30 days) -At minimum, examine readmissions to any state psychiatric hospital; however, if able, states should measure readmission to any setting.

Movement to the Community & Recidivism Domain, Continued…

Indicator	Indicator Specifications		Applicable Settings	Applicable Populations	Data Sources	Additional Considerations
	Numerator(s)	Denominator(s)				
Decrease in Utilization Rate of Institutional Settings	8. Number of persons with SMI/ SED admitted to institutional care	State SMI/SED population	By institution	-Adults with SMI -Children with SED	-Institutional databases -SMHA MIS	Use state definition for SMI/SED
	9. Average daily institutional occupancy rate	365	By institution	-Adults with SMI -Children with SED	-Institutional databases	For institutions with mixed beds, the measure should specify the occupancy rate of SMI/SED beds only
	10. Number of licensed psychiatric beds available	State SMI/SED population	By institution	-Adults with SMI -Children with SED	-Institutional databases	Can be operationalized depending on each state's situation (e.g., number of licensed beds available on the last day of the year, each year, or whatever is easiest for states to report).
	11. Number of persons with SMI/ SED declining transfer to the community annually	Number of persons awaiting discharge from an institution	By institution	-Adults with SMI -Children with SED	-Institutional databases	-Some states track this as part of an *Olmstead* settlement. If your state has this information, please collect it. If your state does not allow patients to decline discharge, this should be mentioned in the contextual section. -Because many states do not have these data, two policy components are available. Reference measures 46 and 47.
	12. Number of persons with SMI admitted to nursing homes	Nursing home census	Nursing homes	Adults with SMI	-PASRR Assessments -CMS's Minimum Data Set	Cross-system sharing of data is important to assessing compliance with the *Olmstead* decision. For helpful information related to gathering data, visit http://www.pasrrassist.org/resources/quality-monitoring-pasrr-measures-and-new-tool

Background and Guidance for Completing Measures in the Housing Domain

During the first two years of the Pilot, measures under the Housing Domain proved the most challenging to states to complete, especially those that relied on accessing data from the Department of Housing and Urban Development (HUD). Even though most states could not complete many of these measures, each of the housing measures received some of the highest utility ratings in both 2012 and 2013.

To assist states in accessing data for the housing measures, the following approach is recommended (based on an approach used by Vermont to determine the number of persons served in its community mental health system while receiving HUD Section 8 Vouchers for calendar year 2004):

1. Get permission to access the HUD Public Information Center (http://www.hud.gov/offices/pih/systems/pic/). This database includes personal identifying and demographic information (e.g., name, social security number, date of birth, and gender; Form 50058 provides data collection detail) about persons residing in HUD-subsidized programs, including Section 8 and Public Housing. Once access is obtained, relevant data for the state can be downloaded into a file for further processing. Permission will require procedures to assure compliance with HUD's privacy and confidentiality regulations.
2. The HUD files do not include information that would directly identify an individual as seriously mentally ill or psychiatrically disabled; therefore, it is necessary to have a second file with individual data on persons that includes personal identifying information that can be matched to the personal identifiers in the HUD file. The second file might include individuals in the SMHA Client Information System, or selected individuals who are users of mental health services in the State Medicaid Claims System. Vermont employed its mental health client information system.
3. States can undertake procedures for either probabilistic matching or exact matching. Either method will likely require assistance from an outside contractor. Vermont employed the "probabilistic population estimator," a proprietary system available through The Bristol Observatory (http://www.thebristolobservatory.com). Exact matching algorithms are also available. Culhane, Metraux, and Hadley from the University of Pennsylvania employed this strategy in their widely-cited study of housing for homeless individuals in New York City[1].
4. After processing the two files for person matches (or estimates of matches), estimates of the number of persons with SMI who reside in HUD-subsidized housing can likely be developed by program type (e.g., Section 8, Public Housing). Depending upon other data available and the sample sizes, estimates for subgroups of interest can also be developed.

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

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

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

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

Housing Domain

Indicator	Indicator Specifications		Applicable Settings	Applicable Populations	Data Sources	Additional Considerations
	Numerator(s)	Denominator(s)				
Increase in Percentage of Persons with SMI Receiving Housing Support Services	13. Number of persons with SMI residing in HUD-subsidized housing units	State SMI population	SMHA/State System	Adults with SMI	State/Local client-level housing data in combination with SMHA MIS or other client-level data sets	Focus on federally-funded housing programs. Include vouchers, subsidies, public housing and tax credits that require state or local housing authorities to collect individual data following HUD design requirements. Also consider state-funded housing programs outside mental health.
	14. Number of persons with SMI receiving non-HUD permanent supported housing services	-State SMI population -Number of clients receiving housing services or supports	SMHA/State System	Adults with SMI	SMHA MIS	This measure is relevant to those states that subsidize permanent supported housing with state-appropriated funds. See Appendix for definition of supported housing.
	15. Number of persons with SMI receiving non-HUD supervised housing services	State SMI population	SMHA/State System	Adults with SMI	SMHA MIS	This measure is relevant to states that provide licensed housing programs (e.g., group homes, supervised apartments), which are subsidized through state-appropriated funds. See Appendix for definition of supervised housing.
	16. Number of persons receiving other housing services not captured in 13-15	State SMI population	SMHA/State System	Adults with SMI	SMHA MIS	Other housing services refer to anything else the SMHA may do related to housing with state-appropriated funds, or with Federal CMHS funding (e.g., MHBG, PATH, etc.) not already in measures 13-15.
Decrease in Length of Time on Housing Waiting Lists	17. Number of persons with SMI on a housing wait list	State SMI population	SMHA/State System	Adults with SMI	SMHA MIS	
	18. Average wait time for housing (months)		SMHA/State System	Adults with SMI	SMHA MIS	Determine number of consumers on a wait list by length of time: (3 months or less, 3-6 months, 6 months to 1 year, 2 years or more).

Community Capacity Domain

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

Community Capacity Domain, Continued…

Indicator	Indicator Specifications		Applicable Settings	Applicable Populations	Data Sources	Additional Considerations
	Numerator(s)	Denominator(s)				
Increase in Utilization Rates of Community-Based Services	24. a) Number of crisis residential beds available in the community 24. b) Number of people receiving institutional diversion services	State SMI/SED population	SMHA/State System	-Adults with SMI -Children with SED	SMHA MIS	The measure depends on the operational definition of diversion. Diversion services may include crisis residential beds, mobile crisis teams, crisis walk-in centers, crisis stabilization, crisis apartments, transitional planning services, and other diversion services.
	25. Number of persons receiving in-home services	State SMI/SED population	SMHA/State System	-Adults with SMI -Children with SED	SMHA MIS	-In-home services are available to consumers in their own homes, and may include assessment, diagnosis, medication recommendations, individual therapy, medical evaluation and management, social work services, coordination of mental health treatment with medical care, transition services, and telephone crisis services. -Look at procedure code modifiers for place of service. Measure separately for children and adults.
	26. Number of persons receiving family support services	State SMI/SED population	SMHA/State System	-Adults with SMI -Children with SED	SMHA MIS	-Measure separately for children and adults. Services may include family psycho-education, needs assessment, family support groups, family retreats, advocacy training, referrals, and service linkages.
	27. a) ER visits for primary mental health condition 27. b) Number of admissions to general hospitals for psychiatric treatment	-State SMI/SED population -Number of ER admissions within the state	SMHA/State System	-Adults with SMI -Children with SED	SMHA MIS	-These measures are most useful when capturing admissions for psychiatric treatment.

Well-Being Domain

Indicator	Indicator Specifications		Applicable Settings	Applicable Populations	Data Sources	Additional Considerations
	Numerator(s)	Denominator(s)				
Increase in Percentage of Persons Expressing Social Inclusion or Connected-ness	28. Number of consumers reporting positively about social connectedness (MHSIP/YSS-F Survey Modules)	State SMI/SED population responding to consumer survey	SMHA/State System	-Adults with SMI -Children with SED	SMHA MIS	
Increase in Percentage of Consumers Involved with Peer-run (Self-help) Services	29. Number of persons involved in peer support programs (including clubhouse programs)	State SMI population	SMHA/State System	Adults with SMI	SMHA MIS	

At-Risk Domain

Indicator	Indicator Specifications		Applicable Settings	Applicable Populations	Data Sources	Additional Considerations
	Numerator(s)	Denominator(s)				
Measures of Early Intervention Services to Avoid Institutional-ization	30. a) Does your state have 24-hour crisis hotlines? If yes, statewide, or certain regions? 30. b) How many calls were received at the 24-hour crisis hotline in past month/year?	-Trends over time -State SMI/SED population (estimated prevalence)	SMHA-provided services	-Adults with SMI -Children with SED	SMHA MIS	-At minimum, states should report on the existence of these types of programs/interventions designed to reduce institutionalization -If available, SMHAs should track numbers and trends in use of these services
	31. a) Does your state have warm lines operated by mental health consumers to assist persons in crisis? If yes, statewide, or certain regions? 31. b) How many peers staff these warm lines? 31. c) How many calls were received on the warm lines in past month/year?	-Trends over time -State SMI/SED population (estimated prevalence)	SMHA-provided services	-Adults with SMI -Children with SED	SMHA MIS	-At minimum, states should report on the existence of these types of programs/interventions designed to reduce institutionalization -If available, SMHAs should track numbers and trends in use of these services
	32. a) How many 24/7 mobile crisis teams does your state have? 32. b) How many people received services provided by mobile crisis teams in the past year?	-Trends over time -State SMI/SED population	SMHA-provided services	-Adults with SMI -Children with SED	SMHA MIS	-At minimum, states should report on the existence of these types of programs/interventions designed to reduce institutionalization -If available, SMHAs should track numbers and trends in use of these services

At Risk Domain, Continued…

Indicator	Indicator Specifications		Applicable Settings	Applicable Populations	Data Sources	Additional Considerations
	Numerator(s)	Denominator(s)				
Measures that Help Define the Size of the At-Risk Population	33. Number of persons who are homeless and mentally ill, including shelters and transitional programs	-Trends over time -State SMI/SED population -Number of mentally ill on SSI/SSDI rolls -Number in homeless data system				-At minimum, states should report on the existence of these types of programs/interventions designed to reduce institutionalization -If available, SMHAs should track numbers and trends in use of these services
	34. Number of mentally ill involved in the criminal justice system (e.g., discharged from jail programs and/or on probation)	-Trends over time -State SMI/SED population -Number of mentally ill on SSI/SSDI rolls	-Jails -Prisons -Juvenile Justice	-Adults with SMI -Children with SED	-SMHA MIS -State Criminal Justice Data	
	35. Percentage of repeat psychiatric users of the emergency department	-Trends over time -State SMI/SED population -Number of mentally ill on state SSI/SSDI rolls	Emergency departments in general hospitals	-Adults with SMI -Children with SED	-Medicaid Paid Claims Data -Medicaid HCUP Files	Repeat psychiatric users are defined as persons who have had more than one episode over six months or one year.
	36. Individuals with non-fatal suicide attempts	-Trends over time -State SMI/SED population -Number of mentally ill on state SSI/SSDI rolls		-Adults with SMI -Children with SED	Medicaid Paid Claims Data	
	37. Number of persons with co-occurring substance abuse disorders	-Trends over time -State SMI/SED population (est. prevalence) -Number of mentally ill on state SSI/SSDI rolls		-Adults with SMI -Children with SED	-State Substance Abuse Agency Data Set	

At Risk Domain, Continued…

Indicator	Indicator Specifications		Applicable Settings	Applicable Populations	Data Sources	Additional Considerations
	Numerator(s)	Denominator(s)				
Measures that Help Define the Size of the At-Risk Population, Continued…	38. Number of adults with mental illness in board and care homes	-Trends over time -State SMI/SED population (est. prevalence) -Number of mentally ill on state SSI/SSDI rolls		-Adults with SMI -Children with SED	-Medicaid Paid Claims Data -SMHA Data System	
	39. Number of children with SED placed in State Foster Care	-Trends over time -State SED population (est. prevalence) -Number of children in Foster Care	State Foster Care	Children with SED	-State Child Welfare Agency Data System	
	40. Number of children with SED suspended from school	-Trends over time -State SED population (est. prevalence)		Children with SED		
	41. Number of children with SED who have been the subject of a police referral at school	-Trends over time -State SED population (est. prevalence)	Juvenile justice	Children with SED		
	42. Number of children with SED who have been arrested or taken into police custody	-Trends over time -State SED population (est. prevalence)	Juvenile justice	Children with SED		"Taken into police custody" refers to children who may have been taken into custody by the police but either not formally arrested, nor charged, and instead diverted away from juvenile justice or to other child-serving agencies.

Guidance for Completing Measures in the Policy Domain

Measures in the Policy Domain capture information about policies, rules, and procedures in your state that are designed to facilitate community integration and/or prevent unnecessary institutionalization. Policy is defined by SAMHSA as a "document directing an action or event at the state level, including changes achieved through a broad range of mechanisms, including statutes, regulations, directives, contracts, clinical practice guidelines, strategic plans, and mission statements." Policies may also include documents that direct financing or organizational changes. Financing changes include appropriations, billing codes, reimbursement procedures, state Medicaid Plans, and pooling and braiding of funding. Organizational changes may include the creation or elimination of positions, creation of a new reporting structure, or permanent changes in staff composition.

The measures contained within this domain should serve as general category prompts for you to identify specific policies implemented in your state. Therefore, there may be more than one applicable policy, rule, or regulation for each measure.

Policy Domain

Measure	Policy Effect. Date	Type of Policy	Applicable Settings	Applicable Populations	Policy Mechanism	Funding Mechanism	Stage of Implementation	Resp. Agency	Data Sources
43. Does state have policies or rules in place intended to prohibit or reduce discharges from state hospitals or local psychiatric units segregated settings?	M/D/Y	☐Program ☐Financial ☐Org.	☐State psych. hospitals ☐Other psych inpatient	☐Adults w/SMI ☐Children w/SED	☐Statutory ☐Appropriation ☐Regulatory or administrative rule ☐Contract ☐Memorandum of Understanding ☐Executive order ☐Adoption of clinical practice guide./EBP ☐Other	☐Medicaid State Plan ☐Waiver ☐Annual state budget ☐Ongoing ☐Short-term	☐Development ☐Pilot project ☐ Short-term ☐ Long-term ☐Implemented in parts of state ☐Statewide	☐SMHA ☐Health ☐Other	SMHA Rules, Policies, Regs.
44. Has state developed new (in the last two years) funding initiatives that provide community services to help keep people out of institutions?	M/D/Y	☐Program ☐Financial ☐Org.	☐State psych. hospitals ☐Nursing homes ☐Adult care homes ☐Residential treatment centers	☐Adults w/SMI ☐Children w/SED	☐Statutory ☐Appropriation ☐Regulatory or administrative rule ☐Contract ☐Memorandum of Understanding ☐Executive order ☐Adoption of clinical practice guide./EBP ☐Other	☐Medicaid State Plan ☐Waiver ☐Annual state budget ☐Ongoing ☐Short-term	☐Development ☐Pilot project ☐ Short-term ☐ Long-term ☐Implemented in parts of state ☐Statewide	☐SMHA ☐Health ☐Medicaid ☐Housing ☐Other	SMHA Rules, Policies, Regs.
45. Does state employ differential reimbursement rates to discourage admissions of persons w/mental illnesses into segregated settings and/or encourage placement into integrated settings?	M/D/Y	☐Program ☐Financial ☐Org.	☐State psych. hospitals ☐Nursing homes ☐Adult care homes ☐Residential treatment centers	☐Adults w/SMI ☐Children w/SED	☐Statutory ☐Appropriation ☐Regulatory or administrative rule ☐Contract ☐Memorandum of Understanding ☐Executive order ☐Adoption of clinical practice guide./EBP ☐Other	☐Medicaid State Plan ☐Waiver ☐Annual state budget ☐Ongoing ☐Short-term	☐Development ☐Pilot project ☐ Short-term ☐ Long-term ☐Implemented in parts of state ☐Statewide	☐SMHA ☐Health ☐Medicaid ☐Housing ☐Other	SMHA Rules, Policies, Regs.

Policy Domain, Continued…

Measure	Policy Effect. Date	Type of Policy	Applicable Settings	Applicable Populations	Policy Mechanism	Funding Mechanism	Stage of Implementation	Resp. Agency	Data Sources
46. Does state have a standardized assessment of readiness for discharge from institutional care that is regularly updated for all consumers in institutional settings?	M/D/Y	☐Program ☐Financial ☐Org.	☐State psych. hospitals ☐Nursing homes ☐Adult care homes ☐Residential treatment centers	☐Adults w/SMI ☐Children w/SED	☐Statutory ☐Appropriation ☐Regulatory or administrative rule ☐Contract ☐Memorandum of Understanding ☐Executive order ☐Adoption of clinical practice guide./EBP ☐Other	☐Medicaid State Plan ☐Waiver ☐Annual state budget ☐Ongoing ☐Short-term	☐Development ☐Pilot project ☐ Short-term ☐ Long-term ☐Implemented in parts of state ☐Statewide	☐SMHA ☐Health ☐Other	SMHA Rules, Policies, Regs.
47. Does state have other policies or rules that ensure services are provided in the least restrictive setting to avoid unnecessary institutional admissions?	M/D/Y	☐Program ☐Financial ☐Org.	☐State psych. hospitals ☐Nursing homes ☐Adult care homes ☐Residential treatment centers	☐Adults w/SMI ☐Children w/SED	☐Statutory ☐Appropriation ☐Regulatory or administrative rule ☐Contract ☐Memorandum of Understanding ☐Executive order ☐Adoption of clinical practice guide./EBP ☐Other	☐Medicaid State Plan ☐Waiver ☐Annual state budget ☐Ongoing ☐Short-term	☐Development ☐Pilot project ☐ Short-term ☐ Long-term ☐Implemented in parts of state ☐Statewide	☐SMHA ☐Health ☐Medicaid ☐Housing ☐Other	SMHA Rules, Policies, Regs.
48. Does state have a policy or system in place to monitor housing wait lists?	M/D/Y	☐Program ☐Financial ☐Org.	☐State psych. hospitals ☐Nursing homes ☐Adult care homes ☐Residential treatment centers	☐Adults w/SMI ☐Children w/SED	☐Statutory ☐Appropriation ☐Regulatory or administrative rule ☐Contract ☐Memorandum of Understanding ☐Executive order ☐Adoption of clinical practice guide./EBP ☐Other	☐Medicaid State Plan ☐Waiver ☐Annual state budget ☐Ongoing ☐Short-term	☐Development ☐Pilot project ☐ Short-term ☐ Long-term ☐Implemented in parts of state ☐Statewide	☐SMHA ☐Health ☐Medicaid ☐Housing ☐Other	SMHA Rules, Policies, Regs.

Policy Domain, Continued…

Measure	Policy Effect. Date	Type of Policy	Applicable Settings	Applicable Populations	Policy Mechanism	Funding Mechanism	Stage of Implementation	Resp. Agency	Data Sources
49. Does state have a policy or system in place to monitor the amount of time consumers spend waiting for housing?	M/D/Y	☐Program ☐Financial ☐Org.	☐State psych. hospitals ☐Nursing homes ☐Adult care homes ☐Residential treatment centers	☐Adults w/SMI ☐Children w/SED	☐Statutory ☐Appropriation ☐Regulatory or administrative rule ☐Contract ☐Memorandum of Understanding ☐Executive order ☐Adoption of clinical practice guide./EBP ☐Other	☐Medicaid State Plan ☐Waiver ☐Annual state budget ☐Ongoing ☐Short-term	☐Development ☐Pilot project ☐ Short-term ☐ Long-term ☐Implemented in parts of state ☐Statewide	☐SMHA ☐Health ☐Other	SMHA Rules, Policies, Regs.
50. Does state have a standardized methodology to track persons declining discharge to the community?	M/D/Y	☐Program ☐Financial ☐Org.	☐State psych. hospitals ☐Nursing homes ☐Adult care homes ☐Residential treatment centers	☐Adults w/SMI ☐Children w/SED	☐Statutory ☐Appropriation ☐Regulatory or administrative rule ☐Contract ☐Memorandum of Understanding ☐Executive order ☐Adoption of clinical practice guide./EBP ☐Other	☐Medicaid State Plan ☐Waiver ☐Annual state budget ☐Ongoing ☐Short-term	☐Development ☐Pilot project ☐ Short-term ☐ Long-term ☐Implemented in parts of state ☐Statewide	☐SMHA ☐Health ☐Medicaid ☐Housing ☐Other	SMHA Rules, Policies, Regs.
51. Does SMHA have programs to provide education and encouragement to patients about the opportunities and successes they can have in accepting discharge to the community?	M/D/Y	☐Program ☐Financial ☐Org.	☐State psych. hospitals ☐Nursing homes ☐Adult care homes ☐Residential treatment centers	☐Adults w/SMI ☐Children w/SED	☐Statutory ☐Appropriation ☐Regulatory or administrative rule ☐Contract ☐Memorandum of Understanding ☐Executive order ☐Adoption of clinical practice guide./EBP ☐Other	☐Medicaid State Plan ☐Waiver ☐Annual state budget ☐Ongoing ☐Short-term	☐Development ☐Pilot project ☐ Short-term ☐ Long-term ☐Implemented in parts of state ☐Statewide	☐SMHA ☐Health ☐Medicaid ☐Housing ☐Other	SMHA Rules, Policies, Regs.

Appendix: Definitions

- **Adult Care Homes and Other Congregate Living Settings:** Each state has different nomenclature for adult care homes. For the purposes of this Community of Practice, adult care homes are defined as any congregate residential settings targeted toward people with low income, where more than half of the residents have psychiatric disabilities. This setting includes group homes for persons with mental illnesses funded by state or county funds.
- **Jails and Prisons:** Many persons with mental illnesses end up in jails or prisons due to a lack of alternative (diversionary) community services and other supports.
- **Nursing Homes:** Nursing Homes provide services to persons with significant medical conditions who have been assessed as needing nursing-level care, but who are not acutely ill enough to require treatment in a hospital. Nursing homes provide on-site access to staff 24 hours per day. The majority of nursing home residents tend to be older adults; however, children and younger adults with disabilities are also sometimes served by nursing homes. Studies estimate that nearly 50 percent of those receiving care in a nursing home have a mental illness (Mental Health and Aging, 2012).
- **Residential Treatment Centers:** Residential Treatment Centers are often used to provide services to children; however, these facilities sometimes provide services to adults and older adults. All licensed residential treatment facilities should be included in the Community of Practice.
- **State Psychiatric Hospitals:** State Psychiatric Hospitals provide services to consumers with high levels of need, including those who are a threat to themselves or others. These facilities provide acute care services, long-term treatment, and forensic services to mental health consumers. Although protected under *Olmstead* and the Americans with Disabilities Act, for the purposes of the Community of Practice, long-term forensic patients and persons admitted for pretrial competency evaluations (including sexually violent predators) are excluded to the extent they can be identified. Long-term, forensic patients include defendants in legal cases who were acquitted not guilty for reason of mental insanity (NGRI); defendants convicted as guilty, but mentally ill; persons transferred from prison to the state hospital for mental health treatment; and persons who have been determined Incompetent to Stand Trial. Additionally, states that have Sexual Offender or Sexual Predator laws that allow for a civil or criminal commitment to psychiatric facilities of convicted sex offenders deemed to need treatment should exclude these patients from the census for this Community of Practice.
- **Supported Housing:** Supported Housing is a specific program model in which a consumer lives in a house, apartment, or similar setting; alone or with others; and has considerable responsibility for residential maintenance; but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities. Criteria identified for Supported Housing programs include: housing choice, functional separation of housing from the provision of services, affordability, integration with persons who do not have mental illnesses, right to tenure, service choice, service individualization, and service availability.
- **Supervised Housing:** Supervised Housing provides the most care for its residents. Residents generally share another room with at least one other person. Residents have their own bed, dresser, and closet space. Bathrooms and common areas are shared. Depending on the level of supervision these programs provide, supervised housing programs may include: 24-hour (or less) supervision and assistance; assistance in performing basic daily living skills; assistance with medication; food and meals (no less than three per day); assistance with paying bills and managing money; company from other residents and house managers, which can help to ease loneliness; assistance with making doctors'

appointments; assistance with transportation; and day programs. These facilities must be licensed by the state.