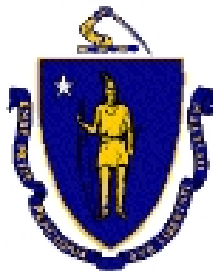


THE COMMONWEALTH OF MASSACHUSETTS
Executive Office of Health and Human Services
Office of Health Services
Department of Mental Health

**DEPARTMENT OF MENTAL HEALTH
INPATIENT STUDY COMMISSION
REPORT AND RECOMMENDATIONS**



James T. Brett
Marylou Sudders
Commission Chairpersons

June 30, 2009

Executive Summary

On April 29, 2009, JudyAnn Bigby, MD, Secretary of the Executive Office of Health & Human Services appointed a 15-member Commission to study the state's psychiatric hospital inpatient system and determine its appropriate capacity. The Commission was co-chaired by James T. Brett, President & CEO of The New England Council and Marylou Sudders, President & CEO of the Massachusetts Society for the Prevention of Cruelty to Children (MSPCC) and a former Commissioner of Mental Health. The Commission was requested to submit its report to the Secretary on or about July 1, 2009.

The principles that have guided the Commission's efforts include:

- *Individuals should live and be served in the least restrictive community settings whenever possible.*
- *Recovery must be a central tenet for this Commission and the Department of Mental Health.*
- *The public mental health system, as funded by both the Department and MassHealth, is the safety net for individuals living with mental illness.*
- *Keeping faith with consumers, families, DMH staff, community providers and other stakeholders is essential.*
- *The community system must be strengthened.*

The Commission understands the Department cannot implement all of its recommendations immediately. Moreover, in order for the system to meet the needs of consumers, family members, and providers, several strategies must be implemented concurrently.

The Commission has endeavored to provide the Department with more than a few short-term recommendations. A road map has been set forth to assist the Department in a methodical examination of the entire public mental health system; to engage with all of its partners

to ensure a seamless system of care, treatment, support and recovery for individuals with serious mental illness.

The Commission's report includes specific recommendations concerning: facility closure; forensic evaluation and treatment; acute inpatient care; community services; and departmental practices.

At the outset, the Commission must acknowledge that the system is strained and that there are insufficient resources to meet the needs of adults with serious mental illness. Thus, when a system is stated to be operating at 97% capacity, one might reasonably ask: Why close any facility?

There are approximately 200 individuals within the public mental health system who are ready for discharge but for whom there are no new community supports available. The inability to discharge adults from the continuing care hospitals to appropriate community placements creates barriers at the "front end" of the system at the emergency and acute inpatient care setting. Any facility closure must be approached in a prudent and cautious manner. As more than one person testified, once a hospital or facility is closed, its beds are lost forever.

Prudence and common sense dictated that the Commission first review the timelines around a facility that is already scheduled to close in 2012 and to determine if that closure could be expedited. Accelerating the closure of Westborough partially addresses the immediate fiscal issues and provides the Department flexibility in the uncertain years ahead.

There are three conditions that are necessary to close the Westborough facility:

- An infusion of \$12 - \$14 million in trust fund or economic stimulus dollars are allocated to commence the deliberate and careful planning and discharge of individuals clinically ready for discharge.
- The annualized dollars for these programs and supports occur from the closure of the inpatient beds.

- The Commonwealth agrees to a maintenance of effort that ensures current levels of resources for adult public mental health services.

The Department needs to conduct a serious review of its state operated mental health centers with the objective of closing at least one 16-bed inpatient unit. The likely candidate is Quincy Mental Health Center, which is the most expensive and the 16 bed unit is the only state operated program within the facility.

However, the Commission acknowledges that the timelines did not allow for a more robust review of each of the state operated community mental health centers. It is acknowledged that these centers contribute to the trust fund revenues that have helped the Department navigate through this economic storm; nonetheless, legitimate questions exist as to whether these 16-bed units have remained true to their original purpose and whether or not quality treatment could be provided at less costly expense. Moreover, reuse plans and any proceeds from the lease or sale of a facility should be dedicated to a fund to ensure maintenance of effort for Department funded or operated community services. In brief, the fact that these centers produce trust fund income should not, standing alone, obviate the necessity of an examination of the entire inpatient system with an eye towards reducing costs and strengthening services.

The Commission urges the Department to ensure that the needs of an increasingly aging inpatient population with both psychiatric and medical needs are addressed in either the new hospital in Worcester or within its existing inpatient facilities.

Finally, this report reflects the opinion of the Commission with one notable dissension. AFSCME is unable to support any report that calls for the closure of inpatient units or for increased privatization of mental health services. AFSCME's statement is included in this report.

All data and documents and testimony submitted to the Commission can be found online at www.mass.gov/eohhs under “Key Resources” on the left-hand side of the web page.

Report of the Department of Mental Health Adult Inpatient Study Commission

On April 29, 2009, JudyAnn Bigby, MD, Secretary of the Executive Office of Health & Human Services appointed a 15 member Commission (see appendix for a full listing of Commission members and their affiliations) to study the state's psychiatric hospital inpatient system and determine its appropriate capacity. The Commission was co-chaired by James T. Brett, President & CEO of The New England Council and Marylou Sudders, a former Commissioner of Mental Health.

The Commission's responsibilities included:

- reviewing the Department's adult inpatient system;
- evaluating the Department's inpatient bed capacity need in light of the Department's goal of Community First (see Appendix III for description) and the Department's budget; and
- recommending an appropriate level of adult inpatient capacity.

Further, the Commission was presented with three stark facts:

- the Department has an immediate structural deficit of \$24M (later reduced to \$13M as a result of the Legislature's FY10 conference committee budget submitted to the Governor;
- a significant reduction to community services as a result of FY09 "9C" cuts; and
- an estimated 200 of 788 adults in DMH inpatient units ready for discharge to community services.

The Commission was requested to submit its report to the Secretary on or about July 1, 2009.

Committed to a public process, the Commission established a link on the EOHHS website for the purpose of posting relevant documents and for eliciting written testimony. In addition, the Commission held five public hearings across the Commonwealth to obtain public input. To help guide its deliberations, the Commission posed four questions:

- How should the Department balance its vision of Community First with the need for adult inpatient capacity?

- Given current budget challenges and realities, should the Department increase community based resources by reducing its adult inpatient capacity?
- In evaluating the Department's statewide adult inpatient system, how should the Department prioritize its inpatient resources?
- How can the Department best serve individuals transitioning from its adult inpatient system to less restrictive, more independent living in the community?

More than 300 individuals attended the public hearings; 66 offered oral testimony and 58 submitted written comments. The Commission's deliberations have been greatly informed and enriched by this powerful verbal and written testimony.

It became apparent that the Commission could not restrict its examination to only the DMH adult inpatient system. Public mental health is complex and complicated; it is not one singular entity with one singular public official in charge. The public adult mental health system is primarily organized and financed by the Department of Mental Health and the Division of MassHealth. However, the system is interrelated with the Departments of Public Health and Correction, the court system, and others. Policy and practice by these state agencies directly impact the admission, length of stay and discharge of individuals receiving treatment and services within the public mental health system. The Commission is aware that any recommendations that are implemented within one component of the public mental health system will have consequences elsewhere.

The Commission is sensitive to the fact that these recommendations are offered at a time of enormous strain within the public mental health system and for our economy. The strains on the adult inpatient system include: a 30% readmission rate for DMH involved adults at acute psychiatric hospitals; 97% capacity in the current DMH continuing care inpatient system; and, between 30 and 50 adults on any given day referred from an acute care inpatient setting to a continuing care bed. Finally, there was a perception that individuals with the most challenging illnesses are not embraced by the current system. It is the express belief of the Commission, that the role of the

public mental health system is the safety net for adults with serious mental illness.

As a result of FY09 “9C” cuts, the Commission heard compelling testimony of the loss of important day services and case management, the impact of cuts on both the outpatient and acute inpatient rates and capacity, and changes in utilization management practices. At the same time, the Department has overhauled its entire adult residential system through a repurchase process that goes into effect on July 1, 2009.

The Commission also received powerful testimony about recovery, advocacy and peer directed services. Supports including peer bridging programs operated through the Genesis and Lighthouse clubhouses, promising practices of the Recovery Learning Communities, and the peer support and self help programs of individuals with lived experience remind the Commission of the importance of the consumer voice in all aspects of the delivery of public mental health services. As one consumer stated in her testimony, “the current system creates a lifelong disability and an impoverished underclass through poverty, crisis focused care, treatment that focuses mainly on medication to the exception of most everything else, and lack of supports in the community such as safe and affordable housing.”

Other promising practices include the development of an outpatient “urgent care” pilot and the repurchase of emergency services programs with an expectation of improved mobile capacity and peer specialists.

The principles that have guided the Commission’s efforts include:

- *Individuals should live and be served in the least restrictive community settings whenever possible.* The Commonwealth’s commitment to Community First must be at the core of any effort to reduce inpatient capacity by moving individuals to community settings.
- *Recovery must be a central tenet for this Commission and the Department of Mental Health.* DMH services, both inpatient

and community-based, must have as a primary goal the recovery of each individual.

- *The public mental health system, as funded by both the Department and MassHealth, is the safety net for individuals living with mental illness.* The Commonwealth has a duty to ensure that the safety net remains effective and secure and funded at appropriate levels. The Department must reaffirm its role as the Commonwealth's Mental Health Authority and be the leader in ensuring that citizens have access to high quality and coordinated mental health services across the spectrum.
- *Keeping faith with consumers, families, DMH staff, community providers and other stakeholders is essential.* Change is challenging. The Department must insure that transitions for individuals from DMH hospitals to community placements are done in accordance with a thoughtful, inclusive planning process that involves all stakeholders and which ultimately presents the best opportunity for each DMH consumer to achieve full recovery. Supports should be provided by a mix of state operated, state contracted and consumer operated services.
- *The community system must be strengthened.* Community-based services have been the heart of the DMH service delivery system for more than 30 years. Previous state hospital closings have succeeded as consumers were transitioned to high-quality services in or near their own communities. The community system, however, experienced significant mid-year "9C" budget cuts in October 2008. An investment of funding for community services is necessary for DMH to replicate the success of earlier hospital closings.

The Commission is cognizant that the Department cannot implement each one of these steps immediately; however, given that in order for the system to meet the needs of consumers, several strategies must be implemented concurrently.

DMH Facility Closure

In fall 2007, the Commonwealth established its Community First Olmstead Plan pursuant to a Supreme Court decision that unnecessary segregation in institutions can constitute discrimination based on disability and that the Americans with Disability Act may require states to provide community based services. This plan and the Commonwealth's Inpatient Study Report for the General Court filed in February 2004 provide the context for the following recommendations.

1. The expected closure of Westborough State Hospital as a result of the opening of a new public mental health hospital in Worcester in 2012 be expedited. The closure of Westborough can be expedited with three conditions:
 - a. that between \$12 - \$14M in trust fund or economic stimulus dollars be allocated for the deliberate and careful planning and discharge of all individuals at Westborough and other facilities who are clinically ready for discharge but for whom there are now no community placements available;
 - b. that the annualization dollars for these new programs be funded from the savings from the closure of inpatient beds; and,
 - c. that the Commonwealth agrees to a maintenance of effort requirement that ensures current (or expanded) levels of resources for adult public mental health services funded by DMH or through MassHealth.
2. The elimination of these continuing care beds is not a 1:1 ratio but lacking other credible information, the Commission would expect a reduction by 60%. Thus if 200 individuals from the state hospital are placed in the community, the Department would expect a reduction in bed capacity by 120.
3. One of the 16-bed inpatient units at a state operated community mental health center should close. The 16-bed unit at Quincy Mental Health Center is the likely candidate. Given the economy of scale, the cost per bed is \$343,221 (based on FY08 cost data provided by the Department). Upon closure of this unit, the Department should engage in a reuse plan for the campus. The campus could be leased by an existing public agency or provider, or the beds converted into another use or transferred to another

facility. Any proceeds from the lease or sale of the campus should be dedicated to a fund to ensure a maintenance of effort for Department funded community services.

4. The Department should replicate the “Western Mass” public mental health model in the Northeast part of the state. The Department currently leases space at Tewksbury Public Health Hospital for a continuing care unit. The “rules” governing this unit are different from all other DMH inpatient units and are limiting and stigmatizing. During public testimony, one person continually referred to individuals with mental illness treated at Tewksbury as “inmates.” In order to accomplish this activity, the Commission recommendations include:
 - a. The Department engage in a concentrated effort to decrease the inpatient beds at Tewksbury State Hospital with the Community First initiative detailed above; and
 - b. The Department should develop either a “continuing care replacement unit” at Tewksbury or with a hospital in the Northeast and purchase forensic evaluation capacity with a private psychiatric hospital or general hospital willing to contract with the Department; and
 - c. The Department shall ensure that individuals receiving inpatient services at Tewksbury State Hospital are afforded the same rights, privileges, and access to community opportunities as individuals elsewhere.

Forensic Evaluation and Treatment

The Department has an important role in the provision of evaluation and treatment of individuals involved with the criminal justice system. Forensic admissions are involuntary admissions to an inpatient facility that originates from the court or place of detention. The most frequent forensic admissions occur for the purpose of pre-trial evaluation, of competency to stand trial or criminal responsibility. Forensic admissions may also occur for aid in sentencing, and for extended periods of treatment of defendants found incompetent to stand trial or not guilty by reason of mental illness. The Department also provides inpatient treatment to inmates from correctional facilities whose mental illness is such that they cannot be safely maintained in a correctional setting. The Commission has several recommendations including:

1. The Department files a bill to revise the current timelines to conduct competency, to stand trial evaluations under M.G.L. c. 123, s. 15(b) from twenty days for the initial evaluation and a total of forty days if extended by the court to ten and twenty days respectively. The statute should be further revised to require the Sheriff to pick up the evaluatee upon the expiration of the evaluation order or within two business days after being notified that the evaluation is completed, whichever is shorter.
2. Assessments under M.G.L. c. 123 s.16 (a) should be for a period no more than 5 business days.
3. In addition, criminal responsibility evaluations M.G.L. c. 123 s 15(b) should only be ordered if the defense either requests it or gives notice of an intention to enter a plea of not guilty by reason of mental disease or defect.
4. The revised language should also clearly provide that the primary purpose of hospitalization of a defendant found incompetent to stand trial under M.G.L. c. 123 s.16(b) and (c) shall be for restoration of competence. DMH should then be required to return the defendant to court for completion of the criminal proceedings as soon as competency is restored.
5. That the Department engage cooperatively with the Department of Correction, the District Courts, the Committee for Public Counsel Services to educate Bridgewater State Hospital staff, court personnel and defense attorneys about the mental health system in order to end the practice of requiring that no individual committed to Bridgewater State Hospital may be discharged directly to the community. The District Court Committee on Mental Health is an appropriate forum or sponsor for these discussions.

Acute Psychiatric Inpatient Capacity

Key partners in the provision of inpatient psychiatric care are the general hospitals with psychiatric inpatient units and private psychiatric hospitals. Operating under a Medicaid waiver, private psychiatric hospitals have been able to provide inpatient psychiatric services for adults with MassHealth. The Commission received strong testimony on the increasing difficulty to provide acute inpatient psychiatric care and the apparent disconnect between the outpatient, acute inpatient and continuing care systems. The Commission is

concerned that the recent closure of acute inpatient psychiatric beds at The Cambridge Health Alliance portends the future if the issues are not addressed. The 30-day readmission rate for adults with DMH involvement was often cited as a clear warning sign that the public mental health system is in trouble. The Commission's recommendations include:

1. Convening a committee composed of hospital representatives, Department staff, consumers and Medicaid managed care staff/providers to review the process for transfers from acute care units to continuing care units with the goal of ensuring consistency and timeliness while acting in the best interest of the consumer.
2. Engaging a third party to update the "Study of Inpatient and Outpatient Behavioral Health Costs to Massachusetts" which was last conducted under authorization of the FY03 General Appropriation Act. The updated report must be utilized to stabilize the fragility of the current acute care system.
3. Requiring MassHealth through its provider Massachusetts Behavioral Health Partnership (MBHP) to conduct a 60-day study detailing the information on each 30-day readmission to determine what led to the readmission, what community supports were in place at the time of discharge, etc. The information should be widely shared for the purpose of improving community connections and reducing the readmission rate.

A Robust Community-based System

A well-funded community-based system must exist to effectively meet the needs of individuals moving from psychiatric inpatient facilities to the community. The community system must offer a full spectrum of services to meet the unique needs of individuals being supported including but not limited to: prevention and diversionary services; mobile crisis services and emergency care; partial hospitalization and day treatment; outpatient care, urgent care and medication management; community based flexible supports and housing support; employment and education; clubhouses and recovery learning communities; respite; peer support and self help programs; and family support. There must be a commitment to and inclusion of

peer specialists across the full spectrum of services. A secure funding stream must be identified to ensure a maintenance of effort that community services are protected to the greatest extent possible.

The Commission's recommendations include:

1. The Department must ensure that the community based system is sufficiently flexible to accommodate the changing needs of individuals to maximize diversions from inpatient units and emergency departments and to minimize lengths of stay in acute and on-going settings.
2. Structuring community based flexible services and reimbursements to allow capacity for clients to receive inpatient care when necessary without losing DMH and MassHealth funded community supports.
3. A strengthened outpatient system of care to improve the link between inpatient and outpatient services, including the development of urgent care capacity to minimize the number of individuals requiring emergency services, thereby reducing likelihood of inpatient admissions.
4. Linking emergency service providers and acute inpatient care services into geographic networks to improve continuity of care.
5. Modifying the existing Medicaid personal care attendant (PCA) model to include, rather than exclude, individuals with mental illness as an aftercare service.

Departmental Policies and Practices

The Department's internal practices must ensure active treatment within its facilities, facilitate continuity of care and treatment, and decrease barriers to discharge. The Commission received much testimony about practices that could be improved upon and possibly have a positive effect on treatment and length of stay. As one family member poignantly testified about their loved one's experience at a state hospital, "there is no apparent sense of urgency in treating patients...court scheduling for treatment plans is not monitored very closely often causing treatment to be delayed....there is little or no continuity of care if a patient is transferred from one ward to another."

1. Policies and practices that should be reviewed and revised include but are not limited to:
 - a. an immediate streamlining of the mandatory forensic review process;
 - b. decreasing the timelines for continuing care inpatient care treatment planning in order to increase active treatment and for community participation as appropriate;
 - c. creating a critical pathway and clear benchmarks for the DMH continuing care system to facilitate active treatment, family and community engagement, and discharge planning.
 - d. eliminating the prohibition on discharging individuals from acute and continuing care inpatient settings on Fridays;
 - e. ending the practice of “stepping down” patients transferring from Bridgewater to Taunton before returning to Tewksbury; and
 - f. streamlining the eligibility process for individuals awaiting transfer from acute care to continuing care units.

Given the charge and timelines of this Commission, it was not possible to examine each and every issue and facility with intensity. However, these recommendations, taken in their totality, should serve as the Department’s blueprint for FY10. The fiscal toll of the past few years up to and including FY09 has resulted in a system that is composed of “component parts” rather than a coherent system that is readily understood by all stakeholders. The Commission believes strongly that it is time for the Department to methodically examine the full public mental health system and to engage with all of its partners to ensure a seamless system of care, treatment, support and recovery for individuals with serious mental illness. The Commission understands that this effort will need to occur deliberatively and in the context of much change and fiscal uncertainty. The Commission is prepared and available to assist the Department in this and any endeavor to strengthen the public mental health system.

Appendices

- I. AFSCME minority report
- II. List of Commission Members
- III. Community First Plan
- IV. Dates of Commission Hearings

I. AFSCME minority report



June 30, 2009

Anthony J. Caso
Executive Director

Donene M. Williams
President

Kenneth Fanjoy
Vice President

Natalie Baker
Recording Secretary

John G. Wagner
Treasurer

Frank Greco
Sgt. at Arms

Dear Co-Chair Sudders and Co-Chair Brett:

On behalf of the 35,000 Massachusetts public employees represented by AFSCME Council 93, we write to state our opposition to recommendations included in the final report of the Department of Mental Health's Inpatient Study Commission.

As one of 15 organizations and individuals with representation on this commission, AFSCME played an active role in the public hearings and discussions related to the commission's work. The process was informative and we applaud the many individuals who attended commission meetings and offered testimony - particularly the individuals and families who had the courage and selflessness to share their life experiences. We also wish to express our appreciation for the work of our fellow commission members. However, we are unable to join them in endorsing this report.

While the report notes that "supports should be provided by a mix of state operated and state contracted consumer driven services," the recommendations on facility closures and bed reductions exclusively target facilities staffed by public, unionized employees and provide a blueprint for guiding the state towards a greater reliance on privately contracted care. As we stated in commission meetings and in written testimony, we strongly believe that a critical component of delivering and maintaining quality services to individuals and families that rely on the state for mental health services is the hiring and retention of qualified and experienced staff. Of course, this is true not only in state human services programs, but in virtually every arena – both public and private. The formula for doing so is simple: Treat workers with dignity and respect and provide them with fair wages and benefits. As members of AFSCME, our workers receive such treatment and as such, the individuals they serve receive a far superior level of care than the care provided in privately operated programs.

In 2007, then U.S. Attorney Michael Sullivan conducted an exhaustive study of state and private community care for the mentally retarded, which strongly supported this point. Sullivan noted a significantly higher incidence of abuse, neglect and sexual assault by staff against residents in privately operated/staffed group homes.

The Sullivan report states in part, *“Unfortunately, after reviewing data from the Disabled Persons Protection Commission our office did note some very disturbing abuse and neglect trends in contract operated community residences as opposed to state intermediate care facilities and state operated community residences. These neglect and abuse trends, particularly sexual abuse, were of great concern to our office and show that residents in these group homes are at a greater risk of being abused or neglected.”*

In addition to the impact privatization has on care, AFSCME also warned commission members of fiscal dangers associated with privatization. While the privatization of public services *may* provide the state with some short-term savings, in many instances privatization ends up costing taxpayers more in the long run. The pattern is always the same: Private vendors secure government contracts with low bids made possible in large-part due to the poor wages and benefits provided to frontline staff. Then, after the state loses the infrastructure and facilities to provide the service “in-house” the private vendors increase their fees and the state has no recourse other than to make enormous capital investments. With these thoughts in mind, the following is an overview of some of our specific objections to the final report:

Commission Recommendation: Reduction of 120 Inpatient Beds

The final report supports the reduction of 120 inpatient beds despite data provided by the state administration indicating a strong current and future need for the limited number of beds currently available. While the commission report states that approximately 200 individuals are currently ready for discharge to community services, no one has disputed the fact that other individuals are waiting to fill these beds now. And unfortunately, future generations will need these beds for many years to come. We cannot – in good conscience – support a measure that would permanently eliminate such an important resource for some of the most vulnerable members of our society.

We urge administration officials to strive to at least maintain the current level of inpatient beds available to those in need. While we fully recognize the scope and depth of the commonwealth’s fiscal crisis, we also firmly believe that the commonwealth has a responsibility to provide a full continuum of professional mental health services. Obviously, the inpatient services provided at our state facilities are a critical part of that continuum of care.

Commission Recommendation: Expedite Closure of Westborough State Hospital

Several years ago, when the Romney/Healey Administration was aggressively pushing for the closure of Worcester State Hospital, AFSCME was a leader in the fight to save the hospital and prevent the scattering of its patients into community-based facilities that

were unable to provide adequate levels of care. The passion and energy devoted to saving Worcester State Hospital was subsequently channeled into the effort to secure approval and funding for construction of the new, state-of-the-art hospital currently in progress on the grounds on the existing hospital in Worcester. We did so with the understanding and knowledge that construction of this new facility would impact the status of the DMH facility in Westborough. While the well documented demand for inpatient beds is a clear indicator that the state and mental health consumers would benefit from maintaining the Westborough facility, we realize that current fiscal realities would make such a scenario extremely unlikely. However, our efforts surrounding the construction of the new facility in Worcester has always been based on the understanding that Westborough and the current Worcester hospital would remain open until the new facility was complete and plans were in place for a smooth transition that minimized impact to the to the patients and the dedicated public employees who care for them. As such, we do not support the recommendation to expedite the closure of the Westborough facility.

Moreover, we object to the recommendation calling for the use of federal economic stimulus money to facilitate this recommendation. AFSCME has been widely recognized on Capitol Hill as a driving force behind passage of the Federal Economic Recovery Act and resulting aid to our states. Therefore, the suggested use of federal economic stimulus funds to essentially facilitate additional unemployment cannot be supported by AFSCME. These funds are designed to create jobs, not continue to eliminate our dwindling supply of jobs with decent wages and benefits.

Commission Recommendation: Close Quincy Mental Health Center

The plan put forward for the closure of this facility is also a measure that we cannot support as it calls for the further elimination of an important and much needed public health resource. Moreover, it calls for using the proceeds from the sale of this state asset to support further privatization of public mental health services. As previously stated, privatization has a negative impact on the quality of care, and has both a short and long-term negative economic impact.

Commission Recommendation: Reduce Beds at Tewksbury State Hospital

The report calls for replicating the western Massachusetts public mental health model in the northeast. Since the nearest DHM inpatient facility to western Massachusetts is in Worcester, one can only conclude that this recommendation is a call for shifting toward privatization of state-operated services in the northeast. Supporting this conclusion is the commission's recommendation that DMH "engage in a concentrated effort to decrease inpatient beds at Tewksbury State Hospital" and "develop either a continuing care replacement unit for the facility or with a hospital in the northeast and purchase forensic evaluation capacity with a private hospital or general hospital."

We oppose this recommendation both for its goal of further reducing inpatient beds and for the negative impact further privatization will have on the quality of care, the workforce, and the economy.

In closing, we thank commission co-chairs Marylou Sudders and James T. Brett for the opportunity to share our points of disagreement with the Patrick Administration and the public. And, we strongly urge administration officials to carefully consider these points as they make decisions that will have a serious impact on thousands of lives for many, many years to come.

Respectfully,

Peter P. Wright
Director of Legislation,
Political Action and Communications

James W. Durkin
Legislative Agent

II. Commission Members

James T. Brett, Co-Chairperson
President and Chief Executive Officer
The New England Council

Marylou Sudders, Co-Chairperson
President and Chief Executive Officer
Massachusetts Society for the Prevention of Cruelty to Children

Nathaniel Baez-Shirley
Mental Health Consumer

Paul J. Barreira, M.D.
Associate Professor of Psychiatry, Harvard Medical School
Director, Behavioral Health and Academic Counseling

John Bove
Member, Department of Mental Health Statewide Advisory Council

The Honorable Harriette L. Chandler
Assistant Vice-Chairwoman, Senate Committee on Ways and Means
Massachusetts Senate

Vicker V. DiGravio III
President and Chief Executive Officer
Mental Health and Substance Abuse Corporations of Massachusetts, Inc.

Jim Durkin
AFSCME Council 93

The Honorable Jennifer Flanagan
Chairwoman, Senate Committee on Mental Health and Substance Abuse
Massachusetts Senate

Robert P. Gittens
Vice President of Public Affairs, Northeastern University and former Secretary of
the Executive Office of Health and Human Services

Philip Hadley
Past President, NAMI-Mass.

Peggy L. Johnson, M.D.
Assistant Professor of Psychiatry
Boston University School of Medicine

Cathy A. Levin
M-POWER

The Honorable Elizabeth A. Malia
Chairwoman, House Committee on Mental Health and Substance Abuse
House of Representatives

The Honorable John W. Scibak
Vice-Chairman, House Committee on Economic Development and
Emerging Technologies
House of Representatives

III. Community First Plan

The Community First **OLMSTEAD PLAN** *A Summary*

A vision for the future

Empower and support people with disabilities and elders to live with dignity and independence in the community by expanding, strengthening, and integrating systems of community-based long-term supports that are person-centered, high in quality and provide optimal choice.

What is an Olmstead Plan?

In 1999, the U.S. Supreme Court rendered a favorable decision in *Olmstead v. L.C.*, a case that challenged the state of Georgia's efforts to keep people with mental disabilities institutionalized. The Court interpreted the Americans with Disabilities Act (ADA) to require states to provide services "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." Additionally, the Court indicated that each state should develop an Olmstead plan to demonstrate efforts to be consistent with the ruling.

Why is an Olmstead Plan important to Massachusetts?

The elder and disabled populations in Massachusetts are growing. They are diverse groups of individuals, many of whom depend on state-supported programs. With a broad array of home and community-based services, including case management, housing supports, and transportation, many can live in less restrictive, and sometimes, less expensive, community-based settings where they would prefer to live.

- Massachusetts has a total population of over 6.4 million people, including approximately 13% (roughly 832,000) who are 65 years and older.
- In Massachusetts' general population, the likelihood of having a disability varies by age. For people between the ages of 16 and 64 years of age, 11 percent (more than 470,000 individuals) report having a disability. For those individuals over the age of 65, the percentage of people who report having a disability is 36 percent (close to 300,000 individuals).ⁱ
- As of August 2008, there were approximately 25,000 kids with disabilities, 203,000 adults under the age of 65 with disabilities, and 107,000 seniors enrolled in MassHealth.
- On any given day, the average number of MassHealth clients (over the age of 18) residing in nursing homes is approximately 28,300.ⁱⁱ
- The current federal and state long-term care financing system was originally designed for institutional rather than community care and as a result, it has tended to favor institutional over community care.
- Among elder and disabled MassHealth members living in the community, as well as among those who are not MassHealth members, there is a desire for more access to home and community-based supports.
- Employment opportunities, critical for supporting elders and people with disabilities in leading self-sufficient and independent lives, are limited in Massachusetts as elsewhere.

- People with disabilities in Massachusetts are almost three times as likely to be unemployed as their non-disabled peers.
- Access to sufficient affordable and accessible housing is often one of the greatest challenges to successful transition from institutional care to independent living.
- The ability of elders and people with disabilities to choose community over institutional care is affected by the availability of community options.

How was the plan developed?

Governor Patrick established an Olmstead Planning Committee in fall, 2007. A large group of representatives including providers, consumers, and advocates, as well as elders and individuals with disabilities (see Appendix), worked collaboratively with state agency staff to develop the current framework and implementation strategies for the Administration's Plan. The original *People's Olmstead Plan*, produced by a group of consumer advocates in 2002, was the starting point for the discussions. Using the goals of the *People's Olmstead Plan* as a foundation, the Olmstead Planning Committee reviewed prior and current EOHHS Olmstead-related initiatives and objectives and identified gaps in service and policy development. The Committee identified six over-arching goals and short-term action steps that are the basis of this eighteen-month implementation plan.

The Community First Olmstead Plan

The overall purpose of the Massachusetts Olmstead Plan ("Plan") is to maximize the extent to which elders and people with disabilities are able to live successfully in their homes and communities.

The following are the six major goal areas included in the Plan. Detailed objectives and timeframes for each area are included in the Community First Implementation Plan, which can be accessed via the World Wide Web at: www.mass.gov/hhs/communityfirst.

1. Help individuals transition from institutional care.

This goal is at the heart of the Supreme Court decision and is the core focus of the Plan. Identifying institutionalized individuals who want to move back home or to other community settings can be challenging. Disability and elder-related organizationsⁱⁱⁱ, in addition to EOHHS staff, currently work to engage individuals in transition processes. However, a more systematic approach would further greater success. Implementation of the Long-term Care Options Counseling process^{iv}, and initiation of the transition services components of the planned Community First 1115 Waiver program^v, the *Hutchinson* settlement, and the alternative *Rolland* settlement^{vi} will provide important ingredients toward

success in moving individuals to community settings. Ongoing assessment of the effectiveness of these transition interventions will provide a basis for continuous quality improvement.

2. Expand access to community-based long-term supports.

Among the efforts to improve access to home and community-based services will be activities to expand access to case management, medication management, behavioral health, caregiver supports, assistive technology and accessible transportation for elders and persons with disabilities. At the same time, efforts will be made to improve transition services for adolescents with disabilities who are leaving the education system.

The Olmstead Plan will also focus on increasing the access that elders and people with disabilities have to community-based long-term resources. The primary means of achieving this objective during the Plan's initial implementation period will be the launch of the Community First 1115 Waiver program. Specifically, by the end of the 18-month implementation period following federal approval, we anticipate that 15,600 people will be enrolled in the Community First Waiver program. In addition, during this same period, EOHHS will also engage in activities to meet the obligations of the *Rolland* court settlement. The state will also work to expand Medicaid community support coverage options by exploring the feasibility of options such as those permitted by the federal Deficit Reduction Act.^{vii}

The Olmstead Plan also refers to several current program review processes which will, when completed, offer solutions to removing other access barriers. For example, one workgroup is focused on identifying and implementing effective ways to improve the MassHealth Personal Care Attendant program's operations. There is also a cross-agency initiative modifying the way EOHHS coordinates planning to assist severely disabled young adults who are turning 22 and "aging out" of educational services.^{viii}

3. Improve the capacity and quality of community-based long-term supports.

A core principle of the Olmstead Plan is choice. To promote choice, agencies will emphasize consumer empowerment and person-centered planning and decision-making. This emphasis on choice will be complemented by improvements in current guardianship, regulatory and administrative practices.

Ongoing and new efforts will concentrate on developing mechanisms to sustain and expand the skills of a high-quality, appropriately trained community workforce. The Personal Care Attendant (PCA) Quality Workforce Council, established by the state Legislature in 2006, is one such mechanism which makes it easier for individuals with disabilities to find and hire PCAs.^{ix} The

objective of initiatives such as the Community First Waiver program will be to increase financing options and service choices, including residential supports that allow people to live in the community in a variety of settings including group homes, foster care and individual apartments. Additional projects will help to define the quality and measure the performance of the long-term support systems.

4. Expand access to affordable and accessible housing with supports.

Affordable, accessible housing is critical to a system that successfully supports elders and people with disabilities who either remain in the community or move to the community from an institutional setting. To develop more accessible housing, EOHHS will collaborate with the Department of Housing and Community Development (DHCD) in efforts to develop affordable housing while renovating existing housing stock. EOHHS will also focus on raising citizens' awareness about accessible housing, promoting the Mass Access Housing registry^x and the state's home modification and assistive technology funding options.

5. Promote employment of persons with disabilities and elders.

Efforts must include greater access to employment opportunities, including employment support services, for elders and individuals with disabilities, increased access to vocational rehabilitation services and career planning for individuals with disabilities, and evaluation of the effectiveness of employment initiatives.

Newly established EOHHS employment goals as well as several federal grant initiatives^{xi} provide both the framework and the support for re-tooling employment services for the target population. Expanded collaborations with the state Department of Elementary and Secondary Education (DESE) and the state Executive Office of Labor and Workforce Development (OLWD) will improve vocational training services for transition-aged youth, employer engagement strategies, market-based skill development, and job retention support. Improved monitoring of employment outcomes holds the promise of continuous quality improvement.

6. Promote awareness of long-term supports (LTS)

A strategy must be developed for educating clinicians in community practices and institutions, as well as residents of the Commonwealth, about availability and viability of community-based LTS options.

Implementation of the Long-Term Care Options counseling processes will go a long way toward ensuring that elders and individuals with disabilities have better information about their options when contemplating long-term support decisions.

Finally, efforts will be made to reach community members to make them more aware of both institutional and non-institutional support options. These efforts will include promotion of available online information resources in addition to a broad outreach and education strategy.

Appendix

Olmstead Planning Committee Members

OLMSTEAD PLANNING COMMITTEE MEMBERS	
Al Norman	<i>Massachusetts Home Care</i>
Annette Shea	<i>Office of MassHealth</i>
Arlene Korab	<i>Brain Injury Association of Massachusetts</i>
Betty Sughrue	<i>Massachusetts Rehabilitation Commission</i>
Bill Allan	<i>Disability Policy Consortium</i>
Bill Henning	<i>Boston Center for Independent Living</i>
Blair Cushing	<i>AIDS Housing Corporation</i>
Carol Menton	<i>Massachusetts Commission for the Deaf and Hard of Hearing</i>
Carol Suleski	<i>Elder Services Plan of the North Shore (Senior Care Options (SCO)/ Program of All Inclusive Care for the Elderly (PACE))</i>
Cindy Wentz	<i>Massachusetts Rehabilitation Commission</i>
Courtney Nielsen	<i>AIDS Housing Corporation</i>
Daniel J. Greaney	<i>Stavros Center for Independent Living</i>
Ed Bielecki	<i>Mass Advocates Standing Strong</i>
Elissa Sherman	<i>Mass Aging Services Association</i>
Elizabeth Fahey	<i>Home Care Alliance</i>
Ellie Shea-Delaney	<i>Department of Mental Health</i>
Gigi Alley	<i>Advocate</i>
John Chappell	<i>Massachusetts Rehabilitation Commission</i>
John Winske	<i>Disability Policy Consortium</i>

Katherine Fox	<i>Briarcliff Lodge Adult Day Health Center</i>
Keith Jones	<i>Soul Touchin' Experiences</i>
Lisa Gurgone	<i>Massachusetts Council for Home Care Aides</i>
Lisa McDowell	<i>MassHealth Office of Long-term Care</i>
Loran Lang	<i>Massachusetts Commission for the Blind</i>
Maggie Dionne	<i>Massachusetts Rehabilitation Commission</i>
Margaret Chow-Menzer	<i>Department of Developmental Services</i>
Maria Russo	<i>The May Institute</i>
Martina Carroll	<i>Stavros Center for Independent Living</i>
Nancy Alterio	<i>Disabled Persons Protection Commission</i>
Pat Kelleher	<i>Home Care Alliance</i>
Paul Lanzikos	<i>North Shore Elder Services</i>
Paul Spooner	<i>MetroWest Center for Independent Living</i>
Rick Malley	<i>Massachusetts Office on Disability</i>
Rita Claypoole	<i>Advocate</i>
Rita Barrette	<i>Department of Mental Health</i>
Robert Sneirson	<i>Disability Policy Consortium</i>
Sue Temper	<i>Springwell</i>
Valerie Konar	<i>Massachusetts Assisted Living Facilities Association (Mass-ALFA)</i>
OLMSTEAD PLANNING COMMITTEE STAFF LEADS	
Eliza Lake	<i>Systems Transformation Grant Lead for Diversion Committee</i>

Jean McGuire	<i>EOHHS-Disability Policies and Programs</i>
Laurie Burgess	<i>EOHHS-Disability Policies and Programs</i>
Mason Mitchell-Daniels	<i>EOHHS-Disability Policies and Programs</i>
Michele Goody	<i>Office of MassHealth</i>
Peter Ajemian	<i>EOHHS-Disability Policies and Programs</i>
Ruth Palombo	<i>Executive Office of Elder Affairs</i>
Sandra Albright	<i>Executive Office of Elder Affairs</i>
Shannon Hall	<i>University of Massachusetts Medical School-Project Management Office</i>

Endnotes:

- ⁱ General population demographic data is based on information from the American Fact Finder, an online tool which reports on the American Community Survey. The American Community Survey is an ongoing survey that provides data on communities every year and is administered by the US Census Bureau. Numbers in this report are estimates for 2007.
- ⁱⁱ MassHealth nursing facility data is from claims paid for state fiscal year 2007.
- ⁱⁱⁱ These organizations include Aging Service Access Points (ASAPs) and Independent Living Centers (ILCs), networks of providers that work with elders and people with disabilities in the community.
- ^{iv} The Long-Term Care Options Counseling process was developed pursuant to a 2006 state statute. This statute, Chapter 211 of the Acts of 2006, specifies long-term care options counseling requirements.
- ^v The Medicaid program is a medical assistance program operated under federal and state law. The Medicaid statute lays out the rules about what can be a covered service and who can be covered. Federal law allows for the federal government to waive some of those statutory rules and provide for different rules requested by the state and specified by the terms of the waiver – i.e., the waiver program. The planned Community First 1115 Waiver is an example of such a Medicaid waiver program, which is intended to reduce barriers to accessing MassHealth-funded home and community-based services (HCBS) in the community and help individuals, who can do so safely and beneficially, to return to

community living from nursing facilities. The Community First 1115 Waiver application is currently awaiting federal approval.

- vi Under the Rolland Settlement, the Commonwealth agreed to either provide certain services to individuals who are Rolland class members and residing in nursing facilities or to place these individuals into community-based programs. Under the Hutchinson Settlement, the Commonwealth agreed to establish a Home and Community Based Waiver program for individuals with Acquired Brain Injuries.
- vii The federal Deficit Reduction Act (DRA) was passed in 2005 and established several law changes related to long-term care. Several of the changes presented new options for states to offer new or expanded programs for people needing long-term care services.
- viii This effort is called the “Turning 22 Initiative.”
- ix Chapter 268 of the Acts of 2006 is the state statute that created the PCA Quality Workforce Council.
- x The Mass Accessible Housing Registry is a free program that helps people with disabilities find rental housing in Massachusetts, primarily accessible and barrier-free housing.
www.massaccesshousingregistry.org
- xi The Medicaid Infrastructure and Comprehensive Employment Grant (MICEO) is intended to increase the number of people with disabilities who are employed while improving the quality of jobs. This grant is intended to build on the work of the previous 2001 Medicaid Infrastructure grant and is defining employment services outcomes by working with the EOHHS Strategic Task Force on Employment.

V. Dates of Commission Public Hearings

Department of Mental Health Inpatient Study Commission Public Hearings

Date	Time	Location
Wednesday, June 3	2:00 p.m. – 4:00 p.m.	<u>Boston</u> The Division of Health Care Finance and Policy China Trade Center Daly Room, 5 th Floor Two Boylston Street Boston, MA
Thursday, June 4	4:00 p.m. – 6:00 p.m.	<u>Central MA</u> Worcester State College Student Center Blue Lounge 486 Chandler Street Worcester, MA
Tuesday, June 9	4:00 p.m. – 6:00 p.m.	<u>Southeastern MA</u> The Conference Center at Massasoit Community College 770 Crescent Street Brockton, MA
Wednesday, June 10	4:30 p.m. – 6:30 p.m.	<u>Western MA</u> Holyoke Community College Kittredge Center 303 Homestead Avenue Holyoke, MA Parking: Lots D & E
Friday, June 12	2:00 p.m. – 4:00 p.m.	<u>Northeastern MA</u> Northern Essex Community College Technology Center TC – 103B 100 Elliott Street Haverhill, MA