POST-SASA SUSTAINABILITY PLAN

SECOND AMENDED SETTLEMENT AGREEMENT

CABINET FOR HEALTH AND FAMILY SERVICES
Curated and Monitored by the Office of Legal Services

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Introduction

The Second Amended Settlement Agreement (SASA), signed on October 22, 2018, was entered into between the Cabinet for Health and Family Services (CHFS) and Kentucky Protection and Advocacy (P&A) in the interest of Kentuckians with Serious Mental Illness (SMI) currently residing in free-standing Personal Care Homes (PCHs), who receive State Supplementation pursuant to KRS 205.245 and 921 KAR 2:015, and who are not opposed to community placement; or those with SMI at risk of entry into a PCH, who would be eligible for State Supplementation, and who are not opposed to community placement. In the Agreement, the Cabinet acknowledged that PCHs are institutions covered by the Americans with Disabilities Act (ADA), 42 U.S.C. §12131, *et seq.*, *Olmstead v. L.C.*, 527 U.S. 581 (1999), and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794(a), and agreed to provide Housing Assistance as defined in the SASA to 1,275 persons by September 30, 2021.

The services and supports required to meet the terms of this Agreement, the integration mandate of Title II of the ADA, and Olmstead compliance are primarily provided through contractors of the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID). The DBHDID contracts with fourteen Community Mental Health Centers (CMHCs) throughout the Commonwealth contain a Direct Intervention: Vital Early Responsive Treatment System (DIVERTS) section for adults with SMI who are institutionalized or are at risk of institutionalization. The DIVERTS services assist persons with SMI in transitioning to integrated housing while receivingappropriate community-based treatment and support services. These services assist with recovery while preventing admission and/or re-admission to psychiatric institutions or other congregate settings that qualify as institutions.

The DIVERTS services are provided in conjunction with the SASA; but, are also part of the Cabinet's overall Olmstead efforts. Since 2002, the DBHDID has implemented an Olmstead process to assist adults with SMI who have long-term stays at state psychiatric hospitals to transition to living in integrated settings in the community. At the conclusion of the SASA, the DBHDID intends to integrate the direction of SASA-related services under the existing Olmstead process thereby continuing to offer opportunity for persons in PCHs or at risk of PCH placement to transition to living in integrated settings in the community. The DBHDID intends to maintain

contracts with providers and partners for the provision of services and programs and plans to continue contract-monitoring processes. Reporting requirements remain and include plans to expand post-SASA.

In addition to efforts made by the DBHDID, other Cabinet departments have significantly contributed to the implementation of SASA goals and objectives. The Office of Inspector General, Department of Medicaid Services, Department of Aging and Independent Living, and Department of Community-Based Services have also developed sustainability plans to continue and improve upon integration efforts post-SASA. These plans are presented in the following pages.

Department for Behavioral Health, Developmental and Intellectual Disabilities

1. Access to Affordable Housing in the Community

The SASA defines "Housing Assistance" as assistance in gaining access to housing in the community that meet the following criteria:

a. Permanent housing with Tenancy Rights;
b. Tenancy support services that are flexible and available as needed but not required as a condition of tenancy, and enable residents to attain and maintain integrated, affordable housing;
c. Housing and tenancy support services that enable individuals with disabilities to interact with individuals without disabilities to the fullest extent possible;
d. Housing and tenancy support services that do not limit individuals' ability to access community activities at time, frequencies and with persons of their choosing;
e. Housing and tenancy support services that are scattered site housing, where no more than 25% of the units in any development are occupied by individuals with a disability known to the Cabinet;
f. Housing and tenancy support services that afford individuals choice in their daily life activities, such as eating, bathing, sleeping, visiting and other typical daily activities; and
g. Housing priority is for single-occupancy housing.

The DBHDID contracts with CMHCs and other supportive housing providers to make available services which support community-based housing. Specifically, the DBHDID funds services and programs that are designed to assist individuals having SMI designation with living successfully in the community. Fidelity to a nationally sponsored toolkit is required of all programs funded by the DBHDID to ensure quality of housing services and programs.

At the conclusion of the SASA, the DBHDID will continue these programs which are aimed at serving persons with Serious Mental Illness (SMI) including persons residing in personal care homes (PCHs) and persons at risk of institutionalization or homelessness.

A. Provide assistance in gaining access to community-based supportive housing.

Contracts with the CMHCs provide funding through the DIVERTS and SMI sections to cover

services and staff that provide pre-tenancy and tenancy support services, including:

- Targeted Case Management – Assisting clients in accessing all needed services providedby a variety of agencies and other resources, including housing resources.
- Assertive Community Treatment – A multidisciplinary team that provides a comprehensive approach to services that includes housing services.
- Housing Specialist – Provides housing resource development, dissemination of information, and assistance in securing housing for individuals with SMI.

The DIVERTS and SMI sections also cover more intensive support services such as:

- Supportive Housing – Activities necessary to assist adults with SMI to live with maximum independence in community integrated housing with the goal of increasing community tenure. Skills training is designed to reduce functional disabilities and restorean individual to their best possible functional level. Areas addressed may include support to improve daily living skills, the self-monitoring of symptoms and side effects, emotional regulation skills, crisis coping skills, and enhancing interpersonal skills.
- Community Residential Support – Provides supportive housing services such as skills training, assistance with activities of daily living, and assistance with community living skills to assist participants to live with maximum independence in community housing with the goal of increasing community tenure. This service ensures up to twenty-four (24) hours per day, seven (7) days per week, 365 days a year on-site support, as appropriate, dependent upon individual resident needs.

The lack of affordable housing units in the community is one of the identified barriers to transitioning to integrated housing in the community. To address that issue, CMHCs utilize housing services which include:

- Residential Support – projects with on-site staff in permanent housing settings owned and managed by local CMHCs.
- Housing Development – generating new housing options at the local level, with the CMHC building/constructing new units.

Additionally, the DBHDID maintains contracts with supportive housing providers. These programs assist adults with SMI who are transitioning to integrated community housing from an institutional setting or who are at risk for institutionalization. Activities include linking clients to

services and activities of their choosing, accessing subsidies, locating suitable housing, negotiating leases, acquiring household items, moving the individual into the residence, teaching basic life skills and other skills that strengthen recovery and promote community integration. Wellspring provides supportive housing assistance in the Louisville/Jefferson County area. New Beginnings provides supportive housing assistance in the Lexington/Fayette County area.

B. Provide access to ongoing programs for rental assistance

For many adults with SMI, Supplemental Security Income (SSI) and/or Social Security Disability Insurance is the only source of income, thus they may qualify for low-income rental assistance programs. These programs include the Housing Choice Voucher (HCV) program, also known as Section 8, which provides rental assistance directly to applicants; and Project- Based Rental Assistance, which provides rental assistance to specific complexes for low-income residents. Persons can apply for these programs through their local Housing Authority or through the Kentucky Housing Corporation in areas that do not have a local Housing Authority.

In addition to the programs named above, the following rental assistance programs set-aside for adults with SMI:

Olmstead Housing Initiative (OHI) – The DBHDID, in partnership with Kentucky Housing Corporation, created the OHI in response to the 1999 Supreme Court Olmstead decision. This initiative is a uniquely designed rental assistance program which prioritizes the housing needs of persons with SMI who are residing in institutions or who are at risk of institutionalization. The OHI may pay for moving expenses, basic furnishings, security and utility deposits, provide an ongoing rental subsidy, and cover other housing-related expenses that are barriers to transitioning to the community. Referrals to OHI may be made by staff of state operated or state contracted psychiatric hospitals, Community Mental Health Centers (CMHCs), or other contractors of the DBHDID.

Olmstead Set-Aside Vouchers – Through an agreement with Louisville Metro Housing Authority, these vouchers are available to individuals meeting Olmstead eligibility that are referred by Seven Counties Services, Wellspring, Central State Hospital, and the Center for Accessible Living.

C. Provide supportive housing services in accordance with the Substance Abuse and Mental Health Services Administration (SAMHSA) Permanent Supportive Housing Toolkit

The DBHDID contracts with CMHCs and supportive housing providers include requirements to incorporate the principles of Permanent Supportive Housing and provide services in accordance with the SAMHSA Toolkit. These principles include:

1. Choice and Self-Determination

   People shall have choice in all aspects of their lives,including the planning and delivery of services, and housing and living support arrangements. Individuals shall be free to choose housing from the same living environments available to the general public.
2. Safety

   People shall have the opportunity to live in housing that is decent and safe, in neighborhoods free from problems of drugs and crime.
3. Affordable

   People shall have the opportunity to live in housing that is affordable – where no more than thirty percent (30%) of their income pays for their housing costs(rent/mortgage and utilities).
4. Integrated

   People are entitled to have available to them housing options that are integrated into neighborhoods and are typical of the housing in the neighborhood.
5. Consumer and Family Involvement

   People and their family members shall play a role inthe development of new housing and support opportunities and in promoting the availability of housing alternatives for people with disabilities.
6. Permanent

   People shall be provided needed support in obtaining housing where they lease, own, or otherwise control the housing. Decisions regarding housing tenure shall beseparate from decisions about needed supports and services.
7. Accessible

   People shall have access to housing with needed physical modifications orother accommodations to support them in daily living. Individuals shall receive necessary assistance in requesting and accessing such housing and supports.

8. Flexible and Individualized Services and Supports

    People shall have support services available to them regardless of where they choose to live. Services and supports shall be person-centered, and shall enable people to live in their own homes. Supports shall include community supports (congregations, schools) and natural supports (family, friends, and neighbors).

D. Monitoring access to affordable housing in the community – reporting requirements

The DBHDID contract monitoring processes include corrective action planning when contract deliverables are not met. In addition to the contract monitoring process, the DBHDID requires data reports to assure provision of quality services and financial accountability.

OHI - The DBHDID will continue monitoring expenditures and use of vouchers associated with the contract with Kentucky Housing Corporation, Inc. Monitoring includes, but is not limited to, utilization of vouchers and expenditures.

Supportive Housing - The DBHDID intends to continue monitoring the CMHCs and other DBHDID-funded supportive housing providers for fidelity to the SAMHSA Permanent Supportive Housing Toolkit.

Data report requirements for the provision of services within the DIVERTS program include reports on the population served, the services provided, and compliance with staffing requirements. The DBHDID intends to continue collecting the following data reports related to services from the CMHCs with which it contracts:

- Annual planning summary for service provision
- Annual summary reports on services provided and staffing requirements

2. Support for a Community-Based System of Care

As part of the Adult System of Care, the DBHDID intends to continue funding the DIVERTS program to promote deinstitutionalization. These funds are allocated to CMHCs and other partners through contracts, which include expectations for service provision and data reporting.

The service expectations include provision of a variety of quality, community-based services designed to increase community integration and personal independence.

A. Community-based services and supports are available, evidence-based, person-centered, and recovery-focused

Contracts with the CMHCs provide funding through the DIVERTS and SMI sections to cover services and staff which provide evidence-based practices. Fidelity reviews are conducted to ensure programs are providing services that meet the practice guidelines listed below.

- Assertive Community Treatment (ACT) – An evidence-based practice that uses a multidisciplinary team that may include psychiatrists, psychologists, nurses, targeted casemanagers, therapists, peer support specialists, and others. ACT is a comprehensive approach to services that include assessment, treatment planning, case management, psychiatric services, medication management, psychotherapy, and other services; including family support, employment services and housing services that support the teaching of basic living skills in the community environment.
- Individual Placement and Support (IPS) Supported Employment – An evidence-based practice designed to assist individuals with SMI to obtain employment in a competitive environment using the supports of their behavioral health treatment team, an employment specialist and benefits counselor. IPS Supported Employment services include: person-centered job selection, job development and analysis, rapid job search and job acquisition with support, and long-term support and follow-up.
- Permanent Supportive Housing (PSH) – Decent, safe, and affordable community-based housing hat provides tenants with the rights of tenancy under state and local landlord tenant laws and is linked to voluntary and flexible support and services designed to meet tenants' needs and preferences.

Contracts also specify the development of a Person-Centered Recovery Plan (PCRP). A PCRP is a treatment/recovery plan that is developed collaboratively with an individual, based on the strengths of each individual and clearly identifies planned interventions, both billable and not, and the frequency and purpose of treatment interventions.

Other contracted services that assist in community living include:

- Comprehensive Community Support Services (CCS) uses a variety of psychiatric rehabilitation techniques to improve daily living skills (hygiene, meal preparation, medication adherence), self-monitoring of symptoms and side effects, emotional regulation skills, crisis coping skills and developing and enhancing interpersonal skills.
- Peer Support Services (PSS) offer emotional support, which is provided by persons with lived experience of a behavioral health disorder, to others who experience the symptoms of a behavioral health disorder in order to bring about a desired social or personal change.
- Targeted Case Management (TCM) is provided by a qualified professional and assist the targeted population with attaining needed medical, educational, social and other support services.

B. Crisis services are timely and accessible

Contracts with the CMHCs require maintenance of a crisis response system with a central point of contact for crisis coordination, which provides the following components twenty-four (24) hours per day, seven (7) days per week, and 365 days a year.

- Screening
- Behavioral health crisis assessments, including involuntary hospitalization evaluations
- Counseling and intervention to stabilize the situation
- Psychiatric medication/consultation
- Information and referral services
- Observation and/or follow-up to ensure stabilization
- Other therapeutic and supportive services to prevent, reduce, or eliminate a crisis situation
- Coordination of transportation services for individuals needing an involuntary hospitalization
- Safety planning for self-harm or suicide risk
- Assessment and coordination of referral to appropriate level of care for SUD

Contracts also require CMHCs to ensure individuals experiencing a behavioral health crisis have access to a team of professionals, which includes a prescriber of medications (Psychiatrist/Advanced Practice Registered Nurse) and other staff trained in crisis response risk

assessment and management.

Access/eligibility requirements for individuals experiencing a behavioral health emergency are divided into three categories based on severity:

Emergency care – Services that are required to be delivered within three (3) hours of notification and shall meet the needs of an individual who is experiencing an onset of a behavioral health condition that becomes apparent by an immediate and significant possibility of serious harm to oneself or others, which is at the level of severity that would meet the requirements for involuntary hospitalization and who, in the absence of asuitable alternative or psychiatric medication, would require hospitalization. This includes services for individuals who need drug or alcohol withdrawal management services.

Urgent care – Services that are required to meet the needs of an individual experiencing an onset of a behavioral health condition not constituting an immediate risk of harm but that, if left untreated, may worsen into a behavioral health emergency or cause the person to become overwhelmed and unable to function without assistance.

Routine care – Preventive care or medical management provide following an episode of urgent treatment or an emergency. Routine care shall occur within seven (7) calendar days.

To increase public access to crisis services, Kentucky intends to participate in the 988 initiative. In July 2022, 988 intends to become the national three-digit dialing code for the National Suicide Prevention Lifeline, replacing the current number of 1-800-273-TALK (8255). Americans needing support should continue to call 1-800-273-TALK (8255) until July 2022. The new 988 number, once implemented, intends to be America's mental health safety net, providing emotional support for people in distress, reducing suicides and mental health crises, and providing a pathway to well-being for all. This new three-digit national number represents an opportunity to ensure that those in a suicide and/or substance use crisis are connected directly with behavioral health providers, bypassing the need for law enforcement or justice system interaction and in turn decreasing the growing stress on the 911 system as well. As this is a nationwide number, Kentucky intends to implement the infrastructure needed to answer and respond to 988 calls originating in the state.

C. Community-based services and support are of good quality and are sufficient to help

individuals achieve increased independence and gain greater integration into the community

Monitoring of the evidence-based services covered under the DIVERTS and SMI contract sections include fidelity reviews to assure programs are providing services that meet practice guidelines. These include particular fidelity tools, processes, and follow-up.

Assertive Community Treatment (ACT) - The DBHDID collaborates with the regional ACT Team Leaders to address issues, provide training and information, and discuss the progress of the regional programs.

The DBHDID conducts a biennial ACT review process using the Dartmouth Assertive Community Scale (DACTS). This 28-item fidelity tool assesses how close in implementation a CMHC ACT team is to the model using specific observational criteria. The DACTS assesses the degree of fidelity along three dimensions:

- Human Resources (e.g. small caseload, psychiatrist on staff);
- Organizational Boundaries (e.g. explicit admission criteria); and
- Nature of Services (e.g. in-vivo services).

Following each fidelity review, the CMHCs must provide an Action Plan for maintaining high scores or improvement for lower scores. The CMHCs with a score falling below fair implementation receive additional consultation and support.

Individual Placement and Support (IPS) Supportive Employment - An IPS Implementation Team works collaboratively to address issues, plan fidelity reviews, and discuss the progress of the regional programs. The team includes staff from DBHDID, UK Human Development Institute, Vocational Rehabilitation, and National Alliance on Mental Illness (NAMI).

Fidelity monitoring begins six months after a new program starts. The monitors follow up every six months until program scores are acceptable and thereafter reviews occur annually. Fidelity assures the best outcomes for employment, which is a critical contributor to attaining and maintaining recovery from mental illness, substance use, and co-occurring disorders.

The fidelity review index assesses the degree of fidelity along three dimensions:

- Staffing
- Organization
- Services

After each fidelity review, the monitors send a report to the agency and schedule a conference call with the fidelity monitors, the coach/trainer for that area, and the site IPS supervisor. The IPS site drafts an action plan to address ay items that need improvement or any areas they want to enhance. The scores serve as a "road map" for the program to succeed.

Permanent Supportive Housing - CMHC and all DBHDID-funded supportive housing providers are contractually required to conduct an annual self-assessment of supportive housing services using the SAMHSA Permanent Supportive Housing Fidelity Scale and submit the results to the DBHDID. The fidelity scale evaluates the following dimensions:

- Choice of housing
- Separation of housing and services
- Decent, safe and affordable housing
- Housing integration
- Rights of tenancy
- Access to housing
- Flexible, voluntary services

The scores on the dimensions indicate areas in need of further development to improve program operations. Any areas that need improvement are addressed with the CMHC Housing Coordinator and, when necessary, an action plan may be requested to address any items that need improvement.

Person-Centered Recovery Planning - In 2015, the DBHDID contracted with consultants Janis Tondora, Psy.D., and Diane Grieder, M.Ed., to provide training and coaching calls with the CMHCs on PCRP. Additional training,technical assistance, and coaching calls were provided through 2019. The consultants also worked with the DBHDID staff to create sustainable tools including a Quality Indicators Tool used to monitor the implementation of person-centered plans, and a toolkit that is available online to contracted providers. The Quality Indicators Tool evaluates thirteen (13) key PCRP documentation indicators, including:

- Objectives and Interventions include strengths of the individual
- The Plan actively incorporates direct input from the individual
- Objectives go beyond service participation
- The Plan helps the individual connect with chosen activities in their community

Following each fidelity review, CMHCs with a score below basic/minimum adherence must provide an action plan for improvement. Further, those CMHCs receive additional consultation and support.

D. Monitoring Support for a Community-Based System of Care

The DBHDID intends to continue monitoring service provision by the CMHCs with which it contracts. In addition to monitoring fidelity to service models, service utilization is monitored. Service utilization is accomplished by collecting specific data on services provided and the population receiving the services. This information is analyzed at the regional and statewide level. Service utilization reporting includes and is not limited to the following data processes:

Provision of Services

Service utilization reports are reviewed by DBHDID leaders and program administrators. Regional information is analyzed to guide decisions and planning for the provision of community based services statewide. The information informs contract compliance monitoring and the evaluation of programmatic and geographic service provision. Service utilization reports include the following services:

- Assertive Community Treatment (ACT)
- Individual Placement and Support (IPS) Supported Employment
- Permanent Supportive Housing (PSH)
- Comprehensive Community Support Services (CCSS)
- Peer Support Services (PSS)
- Targeted Case Management (TCM)
- Crisis Service
- Service Planning

The DBHDID plans to add reporting of inreach/outreach services to the CMHC contracts in State Fiscal Year 2023. This expectation includes the provision of inreach to personal care homes and other institutional living arrangements.

Reporting Requirements

Data report requirements for services provided within the DIVERTS program include reports on the population served, the services provided, and compliance with staffing requirements. The DBHDID intends to continue collecting the following data related to services from the CMHCs with which it contracts:

- Annual planning summary for service provision plans include collecting inreach/outreach service in SFY23.
- Annual summary reports on services provided and staffing requirements plans include collecting inreach/outreach service information in SFY23.

As indicated above, the DBHDID intends to expand the data collection processes in State Fiscal Year 2023, which begins July 1, 2022. The expansion includes reporting of inreach/outreach services as part of the array of services in the Adult System of Care. Expanding data reporting requirements is intended to increase accountability of the funds allocated by the DBHDID to the CMHCs specifically for service provision within the DIVERTS program which serves persons at risk for institutionalization.

3. Requests for Community-Based Services Including Transition Processes

The DBHDID intends to continue to support processes through which referrals for inreach/outreach services can be made by a variety of sources. Specifically, processes are intended to receive referrals through state psychiatric hospital discharges and through access points available to the general public, guardians, and professionals.

The DBHDID plans to expand Olmstead Transition Committee work, which already focuses on deinstitutionalization efforts. Specifically, plans include discharge planning and Olmstead Transition Committee follow-up for persons discharged from a state psychiatric hospital and placed in personal care homes.

Additional avenues of accountability include meetings between the DBHDID and state hospital directors and through the development of specific, new performance indicators.

A. State Psychiatric Hospital Discharge Placements to Personal Care Homes

The DBHDID intends to continue monitoring placements to personal care homes upon state psychiatric hospital discharge through process evaluation and data reporting. Plans include maintaining and expanding existing processes such as discharge planning, follow-up through the Olmstead Transition Committees, and reporting requirements.

Discharge Planning

The DBHDID owned and operate state psychiatric hospitals are required to practice person-centered and collaborative discharge planning; a process that requires placement consideration. Patients are informed of independent living options in the community, and efforts are taken to reduce the discharge of patients to specific settings including personal care homes, shelters, board and care homes or other institutional settings. The hospitals also work with managed care organization (MCO) staff to ensure a successful transition back into the community.

- Hospital Requirements
  At discharge, the hospitals identify outpatient resources and schedule a follow-up appointment with a community service provider within two (2) weeks of discharge. The hospitals are also required to convene a quarterly Continuity of Care Committee, which is composed of hospital staff, CMHC staff, and one (1) or more individuals representing consumers, family members, and/or peer support staff, and representatives from the DBHDID. Items discussed include referral and aftercare follow-up by the CMHC by professional type (i.e. therapist, psychiatrist, and case manager), and efforts to ensure successful transition from the hospital to the community.

- CMHC Requirements
  The CMHCs are required to provide an appointment with a qualified professional for each person referred to the CMHC upon discharge from a state psychiatric hospital within fourteen (14) calendar days from discharge. The CMHCs are also required to assign a targeted case manager prior to or on the date of discharge and provide targeted case management services within fourteen (14) calendar days of discharge.

Olmstead Transition Committees

The DBHIDID requires that each state psychiatric hospital maintain an Olmstead Transition Committee, which focuses on deinstitutionalization. Traditionally, the committees' efforts focus on the Olmstead population. This population includes persons whose hospital stay is longer than 90 days. Members of the committee work collaboratively to create individualized plans for individuals meeting Olmstead criteria. Designated representatives include:

- DBHDID staff
- Psychiatric hospital staff
- CMHCs in the hospital catchment area
- Community organizations that serve the population

Processes are designed to ensure continuity of care for persons institutionalized as defined by the DBHDID Olmstead Plan. Activities include regularly scheduled meetings of the Olmstead Transition Committees at each hospital, the development of transition plans, and collaboration between the hospitals, the respective CMHCs and other partners. Current Olmstead transition plans are an extension of the hospital's discharge plan with an emphasis on the preferences of the individual and a delineation of the services and supports that will be needed in the community. The transition plan addresses efforts to provide informed choice as to community living arrangements and choice of services.

Plans to expand the committee's attention include continuity of care for persons being discharged to personal care homes regardless of their hospital length of stay. The collaboration, which is currently accomplished under the SASA Regional Transition Committees, is intended to be managed by expanding the population served by the Olmstead Transition Committee. The Committee collaboration is designed to facilitate the timely delivery of post-discharge, outpatient services provided by the CMHCs. This includes follow-up reporting and planning for a seamless continuum of care that is person-centered, trauma informed, and recovery oriented.

New Olmstead Transition Committee Reporting Requirements

The DBHIDID requires CMHC engagement with the Olmstead Transition Committees. The DBHDID intends to add new requirements that guide the committee to expand the population it

serves. Activities related to the expanded population include:

- The CMHCs provide inreach service to persons discharged to PCHs.
- The CMHCs update the Olmstead Transition Committee with progress and current status of these individuals.
- The CMHC staff report to the Olmstead Transition Committee when these individuals move out of a personal care home.
- Reporting on the items above are intended to be recorded in the meeting minutes of the Olmstead Transition Committees.

Additional Reporting Requirements Related to Hospital Discharge Placements to Personal Care Homes

Performance Indicator

The DBHDID has developed a performance indicator that requires maintenance of a minimum rate of state-owned and operated psychiatric hospital discharges to a personal care home where the admission living arrangement was not a personal care home. This indicator, which includes financial risk, has been submitted for approval by the SAMHSA for use in Kentucky's 2022/2023 Behavioral Health Assessment and Plan. The SFY23 target is supported by expanding the Olmstead Transition Committee work that is intentional collaboration on persons discharged to personal care homes and required follow-up reporting. This work is further supported by the provisionof a data report which indicates the reasons for discharges to personal care homes. The data report is intended to inform performance improvement initiatives through the Olmstead Transition Committee.

Rate of Discharge Placements to Personal Care Homes

The DBHDID intends to continue collecting and monitoring data about state-owned and operated psychiatric hospital discharges to personal care homes. Plans include continuing to update existing reports on rates of discharge placements including personal care homes. This information informs discussions between the DBHDID and hospital directors. This allows the DBHDID to address concerns at the executive management level which functions above the continuity of care work completed by the hospital Olmstead Transition Committee.

Reason for Discharge

The DBHDID intends to continue hospital data reporting requirements which include the reason for discharge placement to personal care home. Monitoring this data allows refinement of collaborative processes named above; particularly, with the Olmstead Transition Committees.

B. Community Referrals and Requests for Transition Assistance

Access

In addition to the discharge process and follow-up related to state psychiatric hospitals, the DBHDID will continue to support processes through which persons can request assistance directly through the CMHCs. The CMHCs may be contacted directly when someone wants to refer a person to inreach/outreach services. Access is available to the public, including family members, guardians or other professionals through online/web-based means, phone contact, and in-personwalk-ins. The DBHDID maintains on its public website the physical addresses and telephone numbers for each CMHC including 1-800 phone numbers for setting up appointments.

- The DBHDID maintain a publicly available search tool for accessing CMHC services in all 120 counties CMHC locations per county
- A map of Kentucky counties and their associated CMHCs
  CMHC Locations
- A list of crisis hotlines for all 120 counties
  Crisis Hotlines per County

To expand access, the DBHDID intends to make available on its public website CMHC contact information through which referrals to inreach/outreach services may be made. Once a request for inreach is received by the CMHC, the CMHC is expected to conduct the inreach/outreach service per contract requirements with the DBHDID. Also, as mentioned above, the DBHDID plans to continue supporting Kentucky participation in the 988 initiative which increases public access to crisis services.

Reporting Requirements

Accountability for the provision of inreach/outreach services occurs through the CMHC contract

monitoring process. This process includes compliance review of contract data reporting requirements. The contract monitoring process requires corrective action plans when contract requirements are not met. The DBHDID will monitor inreach/outreach services through reporting requirements, specifically:

- Annual planning summary for service provision including collection of inreach/outreach service data in SFY23
- Annual summary reports on services provided and staffing requirements including collecting inreach/outreach service information in SFY23

Office of the Inspector General

Personal Care Home Regulation

In accordance with Section III.B.1. of the SASA, the Office of Inspector General promulgated an amendment to 902 KAR 20:036 which required instruction in activities of daily living (ADLs) and instrumental activities of daily living (IADLs) for residents of personal care homes who are transitioning to community living. With the goal of facilitating a coordinated transition to the community for residents who desired to move, additional requirements were included for personal care homes that care for the SMI population. The amendment to the regulation was filed on July 15, 2019 and became effective July 20, 2020. The SASA-related changes included in the regulation are set out below:

- Created a definition of “specialized personal care home” or “SPCH” to mean a personal care home that participates in the mental illness or intellectual disability supplement program pursuant to 921 KAR 20:015, Section 13, or serves residents with thirty-five
- (35) percent or more with an SMI designation;
- Required each SPCH to develop and implement written transition procedures to ensure cooperation with an individual or entity that assists with transitioning residents with an SMI designation to a community living arrangement;
- Required the administrator of an SPCH and at least one (1) direct care staff member to complete the MI/ID training workshop established by 921 KAR 2:015, Section 14, no later than January 29, 2021 (six (6) months from the effective date of the administrative

regulation) and every two (2) years thereafter;

- Required a PCH or SPCH to complete the SMI Screening Form for each resident at the time of admission;
- Required a summary of, or a copy of the resident's records to be provided to the resident and the resident's guardian if the resident transitions to a community living setting;
- Required an SPCH to collaborate with the agency or team that is working with residents transitioning to community living pursuant to 908 KAR 2:065 to offer basic instruction in activities of daily living (ADL) and instrumental activities of daily living (IADL) to each resident who is identified as working to transition to independent community living. The requirement for assistance with ADLs was not a new change and had been in effect for allresidents prior to July 29, 2020; and
- Required SPCHs to maintain monthly documentation of ADL and IADL skills instruction provided to, or made available to and refused by, residents who are transitioning to living independently in the community. The regulation further clarified that ADL and IADL skills training would include instruction that is integrated into the normal rhythms of life.

These requirements will remain in the regulation and compliance will continue to be monitored as part of the annual survey inspections conducted by the Office of Inspector General. As with any other regulatory requirements, if a provider is found to be out of compliance with these requirements, the deficient practices are noted and the provider is required to correct them.

Serious and repeated violations can lead to licensure revocation. In addition to the annual surveys, OIG will continue to investigate and respond to complaints as they arise. Just as OIG has done in the past, if the SASA coordinator or other cabinet agencies alert the office to a pattern of non-compliance by providers, the IG will issue a letter or notice to providers reminding them of the regulatory requirements.

Department for Medicaid Services

SMI/SED Initiatives

The Department of Medicaid Services will continue to support initiatives aimed at providing

treatment and other services to the SMI/SED population. Although Kentucky does not currently have an SMI/SED waiver, initiatives surrounding this population include:

- DMS began researching the possibility of a Severely Mental Illness (SMI) and Severe Emotional Disturbance (SED) waiver at the end of 2020. Research has included:
    - Research on other states (1915c, 1915i, and 1115 waivers
    - Participated in Trainings and Collaborations
- On-going conversations with CMS
    - CMS Communication and guidance related to KY pursuing SMI/SED Waiver
    - CMS has recommended adding the SMI/SED authority to our approved 1115 waiver authority
- DMS reached out to the Robert Wood Johnson Foundation & the State Health and Value Strategies Administration, SHVS, in January 2021 and applied for SMI/SED waiver TA.
    - TA is for 6 weeks only and starts with the first call
    - DMS reached out again in early September after hiring a dedicated staff to SMI/SED in Medicaid and the Kickoff is October 20, 2021.
- Related SMI/SED Initiatives
    - Certified Community Behavioral Health Clinics (CCBHC)
- Agencies required to be certified
- Provide comprehensive range of mental health, substance use disorder,and physical health services
- Available to any individual in need of care, including but not limited topeople with SMI, SED, long-term chronic addiction, mild or moderate mental illness, substance use disorders, and complex health profiles
- Care for individuals regardless of ability to pay including those underserved, low income, insured/uninsured, on Medicaid, as well asactive-duty military or veterans
    - CMS Housing Collaborative
- Kentucky is one of the ten states selected to develop or expand innovativehousing-related activities, supports and care coordination targeted to individuals with substance use disorders
- DMS and other Kentucky partners also looking at housing issues related toSMI and SED
    - Mobile Crisis Planning Grant

- DMS, in collaboration with Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), recently appliedto CMS for a Mobile Crisis Planning Grant funded by the American Rescue Act Plan (ARPA)
- Grant awarded on September 18
- Opportunity to research enhancements and/or expansion of existing crisis services and explore one Kentucky Crisis Model for members with any behavioral health crisis
    - Home and Community Based Services Enhanced FMAP Request
- Conduct a feasibility study of the current waiver structure to include transformation or reconfiguration of the waivers including the possibilityof an SMI/SED waiver to focus on supports of individuals with a seriousmental illness and serious emotional disability including housing and employment supports
- 2018, added primary care services to CMHCS
- 2018, SUD 1115 demo waiver, can cover up to 30 days stays
- 2019, allowed the prescriber to bill outside of the per diem of ACT
- FFS and MCO PA for all Medicaid covered substance use and behavioral health services continue as not required.
- DMS is reinstating the ability for MCOs and FFS to require prior authorization (PA) for inpatient medical and surgical services, including concurrent review, effective Aug. 13,2021.
- PA will not be required for all covered behavioral health and SUD services until further notice.
- DMS will continue to evaluate.

Department for Aging and Independent Living

Guardianship

The Cabinet for Health and Family Services, Department for Aging and Independent Living, is appointed as guardian and/or conservator for 4,489 individuals throughout Kentucky. Of that total there are 637 individuals currently residing in a Licensed Personal Care Home.

Deputy Commissioner, Lala Williams, facilitated training on Person Centered Service Planning in July 2021 for guardianship field staff throughout the state. DAIL enlisted the assistance of Laura Butler with the Human Development Institute through the University of Kentucky to

provide training on Supportive Decision Making to Guardianship field staff in May/June 2021. All new guardianship field staff receive person centered and supportive decision making training within the first 60 days of employment.

The Division of Guardianship will continue to utilize the SASA online referral system for individuals under guardianship that meet referral criteria and would benefit from placement in the community. Staff will encourage individuals under guardianship to participate in the planning and decision making process to the best of the individual's ability within the bounds of the guardianship court orders.

Department for Community Based Services

Community Integration Supplementation Program

In accordance with Section [placeholder] of the Second Amended Settlement Agreement, the Department for Community Based Services has engaged in several actions to help provide ongoing support to DCBS staff serving the SMI population in determining eligibility for the Community Integration Supplementation (CIS) program:

- In April 2021, DCBS updated State Supplementation Policy Manuals to better outline the application and recertification process, explain what the CIS program is, and make the eligibility requirements for CIS more clear and easier to understand.
- DCBS presented, and will continue to provide, Family Support Memos, tip sheets, user guides, and specialized trainings to DCBS staff to address any issues that arise regarding the eligibility process for CIS. Specifically, eight training sessions were held in June 2021 for all DCBS staff who complete applications for the CIS program. In these training sessions, DCBS leadership discussed all of the eligibility requirements for CIS, misconceptions and common errors found, and a question and answer session to help DCBS field workers better understand and be able to explain the CIS program requirements to applicants. The sessions were followed-up with a FAQ document containing all questions received over the eight (8) training sessions and the answers provided during the trainings. This document was disseminated to all training participants.
- DCBS leadership participated in a training session facilitated by DBHDID in which

similar information and questions answered on the CIS program as described was provided. DCBS will continue to provide similar trainings as needed to CMHC providers including, but not limited to, ACT Teams, Housing Coordinators, Case Managers, Peer Support Specialists, and Program Directors.

- DCBS is currently in the process of making a change to the CIS eligibility system to provide better information to both DCBS staff and CIS applicants. The system updates have been changed to notify applicants and providers exactly what specific CIS information is needed and the types of documentation that can provide that information. Specifically, this system change will have separate questions for each specific requirement for the statement from the Mental Health Provider. Specifically, this system change will have separate questions for each specific requirement for the statement from the Mental Health Provider. For example, if the statement lists the SMI diagnosis, type of activity of daily living the SMI is affecting, and that it is unlikely to improve without treatment but does not state that the SMI does not include a primary diagnosis of Alzheimer's disease or dementia, the client would receive a Request for Information (RFI) only requesting a written statement from the medical provider stating the SMI does not include that primary diagnosis.
- Similarly, if the written verification of care and support includes all of the necessary information but is missing a statement that the services prevent institutionalization, DCBS staff will be able to see that specific need in the eligibility system and the client would receive an RFI only requesting that missing information. Currently the eligibility system can be difficult to determine what missing documentation is being requested which can result in different, potentially incorrect or confusing, information being provided based on with whom the client was speaking with.
- This change is scheduled to be implemented on the evening of February 4, 2022.

Office of Legal Services

SASA Administrator/Chief Compliance Officer

In 2018, pursuant to the terms of the SASA, the CHFS created a SASA Administrator position within the Office of Legal Services to monitor progress toward achieving SASA goals and objectives. Under the Sustainability Plan, this role will continue as a Chief Compliance Officer

responsible for monitoring the Commonwealth's compliance with the Olmstead decision, the ADA, and the Rehabilitation Act of 1973. The Chief Compliance Officer's primary responsibility is to ensure programs and benefits which support individuals with developmental disabilities, intellectual disabilities, as well as individuals with serious mental illness are available and accessible to those that qualify. The CHFS will maintain this position within the Office of Legal Services as part of the Sustainability Plan.

Summary

Since October 2013, the Cabinet for Health and Family Services (CHFS) has worked diligently to develop programs that provide individuals with serious mental illness access to affordable community-based housing and the necessary community supports needed for successful and lengthy community tenure. By the end of the Second Amended Settlement Agreement, the CHFS met its goal of creating a state-wide plan that provides individuals with SMI the opportunity to reside in integrated housing while receiving treatment in the community. To maintain its compliance with Olmstead, ADA, and Section 504 of the Rehabilitation Act of 1973, the CHFS will continuously monitor and adapt the programs described within this Sustainability Plan in order to meet the needs of individuals with SMI and improve their quality of life.