DISABILITY RIGHTS
NORTH CAROLINA

November 8, 2021

Submitted via email to ncolmstead@tacinc.org

Re: Draft *Olmstead* Plan

DRNC has, in its fourteen years, consistently fought to move North Carolina toward the promise of the ADA's Integration Mandate. For nearly two years DHHS has promised DRNC and other stakeholders that we were making progress by participating in the State's effort to develop North Carolina's plan to move toward compliance with the ADA and the *Olmstead* ruling. This time was supposed to be different than past false starts. The disability community has – once again – been willing to invest time and hope in a process that was billed as real change. The draft that has been shared changes nothing about the current behavioral health system and does not offer a clear vision or path toward compliance. The following comments are by no means exhaustive, as that would require a near-total rewrite, but they highlight some of the most troubling aspects of the draft.

Reflecting on where the draft plan has diverged from our expectations and, even more so, our hopes, it is useful to what review US DOJ says about *Olmstead* plans.

> "An *Olmstead* plan is a public entity's **plan for implementing its obligation to provide individuals with disabilities opportunities to live, work, and be served in integrated settings**. A comprehensive, effectively working plan…must reflect an **analysis** of the extent to which the public entity is providing services in the most integrated setting and must contain **concrete and reliable commitments** to expand integrated opportunities. The plan must have **specific and reasonable timeframes and measurable goals for which the public entity may be held accountable**, and **there must be funding** to support the plan, which may come from reallocating existing service dollars. The plan should include commitments for each group of persons who are unnecessarily segregated, such as individuals residing in facilities for individuals with developmental disabilities, psychiatric hospitals, nursing homes and board and care homes, or individuals spending their days in sheltered workshops or segregated day programs. To be effective, the plan must have demonstrated success in actually moving individuals to integrated settings in accordance with the plan. **A public entity cannot rely on its *Olmstead* plan as part of its defense unless it can prove that its plan comprehensively and effectively addresses the needless segregation of the**

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> **group at issue in the case. Any plan should be evaluated in light of the length of time that has passed since the Supreme Court's decision in *Olmstead***, including a fact-specific inquiry into what the public entity could have accomplished in the past and what it could accomplish in the future." (Emphasis added, https://www.ada.gov/olmstead/q&a_olmstead.htm)

As TAC noted in its April report, the Minnesota Plan is one of the best in the country and offers a model for NC's work. TAC has held up the Minnesota plan as a model in part because it is data driven, has financial commitments, and measures progress with data. Notably, that plan had several rounds of revisions before it reached the form that we recognize today. Given how far the draft plan is from the requirements of an effective plan set forth by US DOJ that may be North Carolina's path as well.

Timeline

Two years is not enough. It is reasonable for a plan to be a "living document" that gets adjusted when circumstances change or there are different results from what was projected. But planning a paltry two years at a time will reduce the work of *Olmstead* compliance to a constant churn of *planning* with little room for *doing*. Given the time, money, and other resources devoted to the process so far: a contract with TAC for their report, the engagement of stakeholders in OPSA committees and full group meetings, the hours each month that dozens of individuals and organizations contributed, the engagement of TAC for a plan, and the work it will take to get from this draft to a final plan, setting goals two years at a time is unreasonable. **We need at least a five-year plan**, and that plan can acknowledge where the State is not yet prepared to identify yearly or other periodic goals but intends to do so.

Goals

From Innovations Waiver slots to mental health services, to housing, and even transitions supported under MFP, **the goals in the plan are little more than a snapshot of what the State is currently doing and has been doing for years. They reflect little additional effort or commitment to community inclusion**. Where there are concrete numerical goals, they are inadequate. And in many places the essential numerical measures and goals are missing altogether.

Numerical goals in the plan reflect a commitment to the status quo, not progress. The Innovations Waiver slot proposal would barely keep up with recent growth in the RUN much less reduce the waitlist. Similarly, when looking to the MFP model to increase transitions from institutional settings, as recommended by the Transitions to Community committee, the goals just reflect the current level of effort. An expansion would be required to increase the program's impact. In the alternative, if MFP proper cannot grow, the model should be replicated, and DHHS should identify funding to increase transitions. Multiple measures that overlap with the existing settlement between NC and US DOJ would not even bring NC into compliance with that settlement. **People with disabilities can only read this as a**

betrayal of trust. In this draft plan DHHS has effectively communicated to people with serious mental illness that it has no intention of meeting its obligations to them under the DOJ settlement, much less going beyond this bare minimum. What is the value in having advocates at the table for two years only to produce a document that reflects no intent to even meet current obligations much less create more ambitious goals?

Many areas lack concrete measures. Where proposed strategies are mentioned but neither fleshed out fully nor translated to a targeted measure, they are meaningless by the standards of the US DOJ above. Many of those proposed strategies are good ideas like expanding access to mental health supports in schools and primary care settings. But to name them as strategies without then detailing who will carry them out or how and what the size of their impact or their cost will be reduces them to platitudes. The proposed strategies read like the result of brainstorming session without the necessary planning to make those ideas real. It is far too late in the game for that. In multiple places the draft plan identifies needed assessment efforts. It has been the assertion of DHHS previously that the reason for the two-year process and lengthy engagement of TAC was to complete the necessary assessments. Continuing to name the need for assessment without a clear plan to carry out the assessment is not going to move us forward.

Because guardianship affects decisions about housing, health care, and employment, North Carolina will never satisfy its Olmstead obligations without addressing the overreliance on and overly restrictive nature of guardianships. The goals listed in Priority Area 7 are not ambitious enough to meet our state's needs. A five percent increase in restoration petitions over the next fourteen months would still leave hundreds languishing in unneeded guardianships, many of which perpetuate institutionalization. Priority Area 7 also fails to list the most crucial step for data collection on this issue: learning how many North Carolina residents are under guardianship today and keeping statewide records on the number of people affected going forward. Because no such data is collected at this time, it is unclear how the Administrative Office of Courts reached the conclusion that three percent of people under guardianship sought to have their competency restored. The goals included for this priority area are largely dependent on the actions of other entities, without any plan to cooperate with those other entities to achieve the goal. An example of one alternative goal that would be more concrete and within DHHS's control would be to conduct a review of all public guardianships to find people under guardianship who wish to seek and are good candidates for restoration, beginning with those people living in an institution and under public guardianship.

Key Items Missing

Other essential pieces are just plain missing. In children's services there is a commitment to a decrease in utilization of out-of-state PRTFs but no such commitment with respect to NC PRTFs. **The plan should reduce NC's reliance on PRTFs altogether and end placement of children in out-of-state PRTFs.** And

while the state's dependence on emergency departments to hold people experiencing behavioral health crises is noted, there is no targeted measure of commitment to reducing the number of ED admissions or bed days utilized for people in need of behavioral health care. Nor is there any mention of expanding or replicating the ED diversion programs that might help reduce ED utilization. There is no evidence of any plan to increase the pay of the direct support professionals who are so essential to community-based services. It is widely accepted in the behavioral health sector that without pay increases and career path improvement, community-based services will never be able to build the capacity to support deinstitutionalization. Where the draft plan does address pay, it is focused on legislative efforts that increase pay only in institutions, badly missing the mark. It does not even mention the common-sense step of requiring LME-MCOs to assess or report plans for improvement in DSP pay for the providers in their networks. Though TAC's report alluded to the possibility of addressing the needs of waitlist participants outside waivers there is no detail in the draft plan about how or whether DHHS plans to do that. DRNC has for years and continues today to encourage DHHS to require the deployment of in lieu of services by MCOs and their successors that go beyond replacing State dollars to keep in their existing service setting and actually enable people to seek more community-integrated lives with services that substitute for our system's institutional entitlements.

The draft shows no plans of addressing the needs of people with disabilities in our state's criminal justice system beyond the DD Council's current grant to support re-entry efforts. That program, while good, is very small and far from systemic. Since DPS does not appropriately screen for IDD there is a need for a systemic intervention to identify and support people with IDD in prisons as well as jails and throughout the criminal justice system. Additional measures are needed to address the needs of people with other sorts of disabilities in our corrections and criminal justice settings.

There is no mention of in-reach outside TCL in the draft. Successful transition requires that people know what their options are. That is where in-reach is essential. Though in-reach is an essential component of the DOJ settlement it has been unsuccessful to date at generating the transitions from ACHs that could address the heart of the DOJ's findings, that people with mental illness are stuck in facilities with no hope of getting out. In-reach contacts have been too infrequent, too cursory, and too narrow in scope to result in adequate transitions out of adult care homes. NC must learn from that experience and develop improved in-reach practices to help people in ICFs, SNFs, ACHs, and other settings make informed choices about their lives.

In addition to supporting transitions into more integrated settings, NC must also divert people from entering congregate care by default. DRNC made this recommendation during the development of RSVP to replace PASSR for diversion in the DOJ settlement work, and we reiterate here; it is essential to screen for all sorts of disabilities prior to admitting someone into an institutional setting. RSVP, or another tool, must allow for screening of IDD, TBI, and other disabilities prior to admission to a congregate setting to create opportunities for diversion. Diversion requires that people have access to

good information and meaningful choices. It will also require that the service system earn the trust of the community. That can only happen with adequate funding, a commitment to training and professional development, and robust oversight.

The draft shows no commitment to reducing spending on institutionalization. There are no measurable goals identifying the amount by which the State will reduce its reliance on congregate settings for housing, work, and services. This need was noted by TAC in its April 2021 report. They particularly noted the disproportionate amount of state funded services provided in congregate or segregated settings. It is impossible to know how far we have come or still have to go without measuring and reporting on spending on congregate settings. Notably, there should be measures for utilization of settings included but not limited to ICFs, PRTFs, segregated employment, ACHs, and SNFs. TAC also mentioned in its report that it would be essential to assess the need for reducing capacity in state operated facilities. Indeed, that is a basic function of *Olmstead* planning and one that should have been completed already. DHHS staff have raised concerns that to commit to reductions in capacity will raise alarm among family members whose loved ones depend on state operated institutions and also among the legislators whose districts include the facilities. DRNC hears those same concerns. That doesn't make the reductions in capacity less important. In fact, it makes it even more essential that we dig in and identify the hard parts of downsizing and do so in a transparent, publicly accountable way. Lengthening the period of the plan from 2 to 5 years would also help address these concerns by illustrating the multi-year work that would contribute to a stronger community-based system that people with disabilities and their families could rely on and that would employ many North Carolinians. And those community-based supports must be not just in existence but of good quality. There are no quality goals identified in the draft, nor are the services missing from our system identified. For example, the draft calls for children who are at risk of out-of-home placement to receive high fidelity wraparound services. "Wraparound" is a not, in itself, a mental health or developmental disability service; it is a form of case management. In the absence of community services and providers who are competent to provide them, case management has no value.

On employment, goals contained in the draft do not reflect meaningful and lasting changes to how employment services are delivered in North Carolina. They temporarily increase employment outcomes, services, and training for a single fiscal year with no commitment to improve or even maintain these goals in the future. This one-time surge strategy is particularly misleading because the State is currently performing worse than in prior years. For instance, DVRS has relinquished $10.5 million dollars of unspent, allocated money back to the federal government this year. DVRS's goal to increase performance by 5% for next year therefore does not reflect anything more than spending funds that were spent prior to 2021.

DRNC is aware there is a separate housing plan under development. The bifurcation of housing from the *Olmstead* plan reflects a fundamental misunderstanding a "comprehensive, effectively working" Olmstead plan. Housing is integral to Olmstead. Measurable outcomes are crucial to ensuring the State

remains on track and makes meaningful progress to housing persons with disabilities in the community. A final plan must address rental assistance programs as well as the tremendous shortage of housing stock in the state. Vouchers and rental assistance are important resources but are meaningless if there are not available accessible units targeted for residency for individuals with disabilities. Part of this issue could be resolved through a statewide, centralized management system that accounts for all targeted units or waitlists available so that units are filled through referrals when they become available.

Monitoring, Coordination, and Enforcement

Monitoring, coordination, and enforcement responsibilities are unclear in the draft. DRNC has commented previously that ADA and *Olmstead* compliance are obligations borne by all of state government, not just by NC DHHS. As such it is essential that NC's plan address the activities of other state agencies and how those agencies will cooperate to move NC toward compliance. This is especially important given the unique Council of State structure of our executive branch. In Minnesota coordination was structured through the creation of an *Olmstead* Implementation Office and an *Olmstead* Subcabinet that coordinates across state agencies. A similar approach seems appropriate for North Carolina. While the draft does include an Office of Olmstead Plan Implementation, it does not identify what resources or authority that office would have or need and does not address cross-agency work. It was obvious when Governor Cooper proposed committing a substantial amount of ARPA funds to our state operated hospitals just as DHHS was working on the draft *Olmstead* plan that greater coordination was needed. That is even truer where agencies are led by an elected official rather than an appointee of the Governor. The necessary coordination between HHS, DPS, DPI, LEAs, Transportation, Commerce, Agriculture, Labor, and other agencies will not happen without structure and accountability. Just as a final plan must be broader than this draft, so must it be deeper. One request DRNC has made repeatedly throughout this process is for DHHS to identify those things within its control that can be accomplished without legislative or other agency action. That is missing from this draft. In particular, the draft largely ignores the role of LME-MCOs and DHHS's relationship with those entities. Poor management of contracts with LME-MCOs has resulted in numerous failures in the behavioral health space in the past decade. Holding those entities accountable to carry out the responsibilities delegated to them is an essential component of system change. The draft plan also fails to identify those places where DHHS, within its existing authority, can make meaningful change. It notes the good work of others including outside stakeholders and quasi-independent entity NCCDD, without any plan to replicate or expand on that good work system-wide. Indeed, it notes the work of Promise Resource Network whose innovative programs DHHS has not sought to scale or replicate. Where an innovative or promising practice surfaces, whether through LME-MCOs, community partners, or an internal entity like NCCDD, DHHS should take steps to learn from it and, where possible, replicate or scale it.

Final Thoughts

Governor Cooper and Secretary Cohen must take responsibility for getting this process back on course. They can direct their staff that they mean to be truly accountable to the children and adults who languish in NC's institutions, and to the thousands who risk institutionalization. To publicly affirm the rights of all North Carolinians with disabilities under the ADA. DRNC stands ready to continue working toward an Olmstead plan North Carolina can be proud of. We need Governor Cooper, Secretary Cohen, and their teams to do the same.