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Opportunities for South Carolina to Strengthen Home and Community-Based Services for People with Disabilities



About Disability Rights South Carolina

Disability Rights South Carolina (DRSC) is the federally mandated Protection and Advocacy (P&A) system and the Client Assistance Program (CAP) for South Carolina. P&As are the only legally based advocacy organization established by Congress to protect the rights of all individuals with disabilities. DRSC helps people with disabilities understand and defend their rights. DRSC provides a variety of services, including client assistance, training, abuse and neglect investigations, legal assistance and advocacy for change. The DRSC mission is to protect and advance the legal, civil and human rights of people with disabilities.



South Carolina Institute of
Medicine & Public Health

About the South Carolina Institute of Medicine and Public Health

The South Carolina Institute of Medicine and Public Health (IMPH) is an independent entity serving as an informed nonpartisan convener around the important health issues in our state, providing evidence-based information to inform health policy decisions.

Disclaimer

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Opinions represented in this report are those of individuals interviewed for this project and do not necessarily represent the opinions of Disability Rights South Carolina or the South Carolina Institute of Medicine and Public Health. All suggested objectives listed are based on interviews with participants and evidence-based materials recommended by interview participants. To protect participant privacy, direct quotes are being reported anonymously in the following pages.

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Introduction

In 2020 an estimated 64 million Americans lived with a disability.¹ This total included 1,304,480 South Carolinians living with traumatic brain injuries (TBI), vision or hearing impairments, mental illness, intellectual disabilities, developmental disabilities, physical disabilities and co-occurring disabilities such as (mental illness and intellectual disability or mental illness and TBI).²

People with disabilities have historically been segregated from the rest of society and unable to participate in everyday life that most of us take for granted, and this segregation was noted as a severe and pervasive problem upon the passing of the Americans with Disabilities Act (ADA) in 1990.³ The Integration Mandate set by the ADA began a process of desegregation which further extended into deinstitutionalization by the *Olmstead v. L.C.*, 527 U.S. 581 Supreme Court ruling in 1999. The *Olmstead* ruling states that people with disabilities are entitled to comprehensive services in a community-integrated setting.⁴ However, 23 years after the order, South Carolinians with disabilities still struggle to receive support services in their community.

Disability Rights South Carolina and The South Carolina Institute of Medicine and Public Health conducted interviews to identify barriers to *Olmstead* compliance in South Carolina. Interviewee participants included state agencies, community organizations and South Carolinians with disabilities and their families and caregivers. We asked participants to identify what they believed were barriers to meaningful community integration. The barriers identified were included in the following themes: Waiting Lists for Medicaid Waivers, Health Care Workforce Crisis, Employment, Housing, Transportation, Assistive Technology and Care Coordination of Services. South Carolina risks continued non-compliance with the *Olmstead* decision and a future with no *Olmstead* Plan. The United States Department of Justice Civil Rights Division is currently investigating South Carolina to determine if adults with mental illness are being subjected to unnecessary institutionalization and risk of institutionalization in Community Residential Care Facilities (CRCFs) due to South Carolina's failure to provide integrated community-based mental health services.⁵

The *Olmstead* decision clearly defines the responsibility of South Carolina to develop an *Olmstead* Plan. Although many states have created *Olmstead* Plans in the years following the decision, South Carolina has not. Without an *Olmstead* Plan, it is difficult for South Carolina to prove that it comprehensively and effectively addresses the needless segregation of individuals with disabilities.⁶ This report outlines recommendations for South Carolina to develop and implement an *Olmstead* Plan that reflects the extent to which the state provides services in the most integrated setting and concrete commitments to expand integrated opportunities.



Account of Lois Curtis and Elaine Wilson^{7, 8, 9, 10}

Lois Curtis and Elaine Wilson

OLMSTEAD V. L.C., 527 U.S. 581 (1999)

Lois Curtis was diagnosed with mental and intellectual disabilities early in her life. She was institutionalized when she was thirteen years old. By the time she was released, Lois had spent most of her life in a state-run institution in Georgia. Elaine Wilson, another Georgia woman with an intellectual disability, was institutionalized 36 times spending a significant part of her adolescence and young adulthood confined to institutions across the state. Both women spent years advocating for their independence while housed in different facilities. Despite recommendations from their doctors and the women's desire to live in the community, the state repeatedly denied their requests to leave the facility. Lois, Elaine and their attorney Sue Jamieson eventually filed a case to end their cycle of institutionalization. They stated that the state of Georgia violated their rights as recognized in the Americans with Disabilities Act of 1990 (ADA). Their case received national attention when it reached the United States Supreme Court and led to a decision impacting many people with disabilities living in institutions.

Implications of the Integration Mandate

Title II of the Americans with Disabilities Act of 1990 (ADA) prohibits discrimination against individuals with disabilities and “requires that each service, program, or activity conducted by a public entity, when viewed in its entirety, be readily accessible to and usable by individuals with disabilities.”¹¹ In *Olmstead v. L.C.*, 527 U.S. 581 (1999), the Supreme Court ruled that unnecessary segregation of people with disabilities is a form of discrimination and violates provisions set by the ADA.^{12, 13} In their decision, the Supreme Court acknowledged that unnecessary segregation perpetuates unjustified assumptions that institutionalized persons are incapable of living in the community and confirmed that continued confinement to an institution severely diminishes an individual's ability to maintain the connections and activities necessary for independent living, such as family relations, social contacts, work, educational advancement and cultural enrichment.¹⁴ For this reason, programs must be developed and administered “in the most integrated setting appropriate to the needs of individuals with disabilities.”¹⁵ Community integration provides an opportunity for people with disabilities, especially those with mental illness, intellectual disabilities and developmental disabilities, to join the workforce, pursue an education, volunteer, worship and participate in the community free from unnecessary limitations.¹⁶ For this to be fully realized, we cannot stop with deinstitutionalization. People with disabilities must have appropriate supports and services to live successfully in the community. This requires systemic adjustments in how South Carolina allocates resources and the beliefs surrounding the safety and efficacy of community integration.¹⁷

South Carolina's Response to the Olmstead Decision

Following the Olmstead decision, Governor Jim Hodges established the South Carolina Home and Community-Based Services Task Force in 1999.¹⁸ This taskforce, comprised of 33 members representing various state agencies, providers, advocacy organizations and the disability community, produced a comprehensive report in 2001 outlining recommendations for supporting people with disabilities living in the most integrated settings.¹⁹ These recommendations centered on establishing an independent assessment process to identify people who might benefit from home and community-based services, developing a standardized transitioning protocol for individuals in institutions, identifying gaps in service delivery and improving care coordination and accountability.²⁰ The report offered an in-depth analysis of the status of community-based services in South Carolina. Many barriers to community integration identified in the report are still present today. However, this report never transitioned into an Olmstead Plan for South Carolina.

Across the American Southeast, individuals with mental and cognitive disabilities are consistently and unnecessarily institutionalized by the state. This institutionalization results from a lack of community-based alternatives provided for those individuals who are often ill-fitted for traditional adult-care homes. Advocacy groups, individuals and the Department of Justice (DOJ) have challenged states that do not comply with the Olmstead decision. These challenges have led to settlements where the states must meaningfully progress on an Olmstead Plan. There are currently 53 Olmstead cases in the Circuit Courts of Appeal across the country.²¹ Court cases currently in the Fourth Circuit Courts of Appeal, which has jurisdiction over the district courts of Maryland, North Carolina, South Carolina, Virginia and West Virginia, involve people with mental illness, intellectual disabilities and developmental disabilities who are at risk for institutionalization, due to a systemic lack of community-based alternatives.²² For example, in the recent case of *Samantha R., et al. v. North Carolina 2022*:

Disability Rights North Carolina filed a lawsuit in 2017 on behalf of individuals with intellectual and developmental disabilities (I/DD) who were institutionalized or at risk of institutionalization due to the state failing to make sure those individuals could get essential services in the community. It was established that people with intellectual and developmental disabilities enter and remain in institutions when there is no viable community-based alternative. North Carolina was over-reliant on institutions and did not have adequate community-based services, including Direct Support Professionals, for all individuals with I/DD who prefer a community-based setting to an institution. There were thousands of people living in institutions, including over 4,000 in public and private Intermediate Care Facilities, with the remainder in Adult Care Homes. The waiting list for the Innovations Waiver, a 1915(c) Home and Community-Based Services Waiver, exceeded 16,000 people. In November 2022, the court ordered that North Carolina must: 1) provide services to the 16,314 people currently on the Innovations Waiver waiting list within 10 years, 2) effectively address and resolve the direct care worker shortage, 3) assist 3,000 people who want to leave or avoid institutional settings and cease new admissions after six years except for purposes of respite or short-term stabilization and 4) provide quarterly reports about each measure the judge outlined in the order and post data to its website, so everyone gets timely information about the state's progress. North Carolina must also report progress to Disability Rights North Carolina and the judge for verification and tracking.^{23, 24}

Without an Olmstead Plan, South Carolina is in violation of the Olmstead decision and risks systemic litigation such as that in North Carolina. South Carolina's current service system relies heavily upon institutional settings and does not adequately encourage or support community engagement, violating the ADA and the Olmstead decision. For instance, South Carolina uses

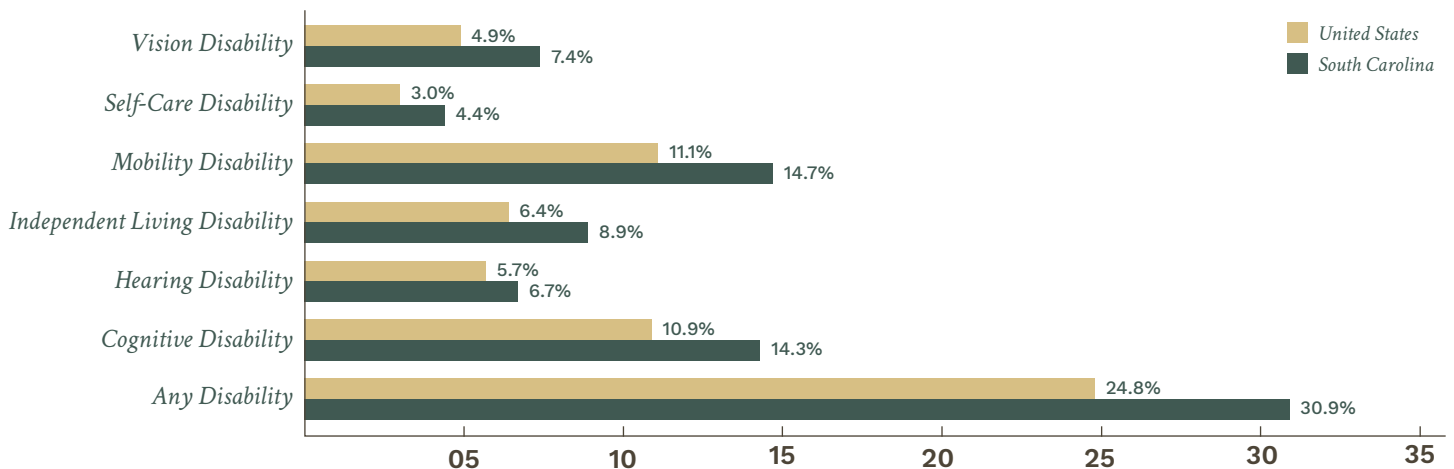
a system of state hospitals (two) and community residential care facilities (CRCFs), commonly called assisted living facilities, to serve many individuals with mental illness. These settings provide services but also have strict regimens for residents, isolating them from the larger community. Individuals in these settings rarely interact with the outside world. They do not routinely attend community activities or events or work in the community but spend most of their time with the other residents and staff. They rarely move into less restrictive settings. The United States Department of Justice Civil Rights Division is investigating South Carolina to determine whether South Carolina unnecessarily institutionalizes adults with mental illness in CRCFs, violating Title II of the ADA and the Olmstead decision.²⁵

Community Integration Barriers: Olmstead Compliance in South Carolina

In 2020 an estimated 64 million Americans lived with a disability, which included 1,304,480 South Carolinians.²⁶ The prevalence of disability in adults 18 years and older in the United States and South Carolina is illustrated in the following graph. According to a 2021 American Community Survey, the distribution of individuals with disabilities in South Carolina by race and ethnicity was 14.5 percent Non-Hispanic White, 15.4 percent Non-Hispanic Black, 10.6 percent Non-Hispanic Other and 8.2 percent Hispanic/Latino.^{27, b}

Disabilities considered in this report include traumatic brain injuries (TBI), vision or hearing impairments, mental illness, intellectual disabilities, developmental disabilities, physical disabilities, and co-occurring disabilities such as mental illness and intellectual disability or mental illness and TBI. To identify barriers to Olmstead compliance in South Carolina, interviews were conducted with executive directors, commissioners, assistant directors, independent living advocates, general counsels, human service coordinators, ombudsman and public health advocates. Participants were asked to identify what they believed were barriers to meaningful community integration, which are summarized below.^c Interviews were also conducted with South Carolinians with disabilities and their families and caregivers. Their stories are shared throughout the report. A unifying theme throughout the interviews with the state and community organizations was the lack of explicit metrics or defined methods to ensure accountability. Confirming that without clear metrics to define success, detailed guidelines with responsible parties and defined implementation strategies, South Carolina risks continued non-compliance with the Olmstead decision and a future with no Olmstead Plan.

Graph 1: Prevalence of Disability Types in Adults 18 Years and Older, South Carolina and the United States, 2020



Source: United States Census Bureau, 2022²⁸

b. Native Hawaiian and Other Pacific Islander populations were not reported due to low sample size.

c. Qualitative interviews were transcribed and analyzed thematically using Dedoose version 8.0.35, a web application for managing, analyzing and presenting qualitative and mixed methods research data.

TABLE 1:

State Agency and Community Organization Interviewee Participants

ABLE South Carolina	South Carolina Department of Disabilities and Special Needs
AccessAbility	
Alzheimer’s Association South Carolina Chapter	South Carolina Department of Mental Health
Brain Injury Association of South Carolina	South Carolina Department of Social Services
Center for Disability Resources	South Carolina Department on Aging
NAMI South Carolina	South Carolina Developmental Disabilities Council
South Carolina Appleseed Legal Justice Center	South Carolina Long Term Care Ombudsman Program
South Carolina Autism Society	South Carolina Statewide Independent Living Council
South Carolina Commission for the Blind	South Carolina Vocational Rehabilitation Department
South Carolina Department of Children’s Advocacy	The ARC of South Carolina
	Walton Options for Independent Living

Barrier One: Waiting Lists for Medicaid Waivers

“We have an adult son with CP [Cerebral Palsy] who lives in a Pennsylvania residential facility. When my husband got a job in South Carolina, we contacted the state agency about services for our son. We were told he would qualify for benefits, but the waiting list is 3-4 years. When we lived in Pennsylvania, we lived a few miles from our son. Now we live 8 hours away. We would love to have him close, but he wants to live in the community, and that is not an option right now.” -Parent

Since the Olmstead decision, the federal government has introduced several Medicaid waivers and expanded community-based services at the state level. Medicaid waivers and incentive programs allow health care providers to provide care within the home or community settings rather than solely in a long-term care facility.²⁹ Congress authorized the Medicaid Home and Community-Based Services (HCBS) Waiver program under Section 1915(c) of the Social Security Act.³⁰ States develop waivers to meet the needs of people who prefer to receive services or support in the home or community rather than in an institution.³¹ The home and community-based services include home health, personal care and other services provided through Medicaid. HCBS waivers allow states to waive specific Medicaid requirements to offer individuals who otherwise would require institutional care the opportunity to remain in the community.^{32, 33} South Carolina operates eight waivers, and each waiver has its eligibility criteria and available service options.^{34, d}

- Intellectual Disability/Related Disabilities Waiver (ID/RD)
- Community Supports Waiver (CS)
- Head and Spinal Cord Injury Waiver (HASCI)
- Community Choices Waiver (CC)
- Medically Complex Children’s Waiver (MCC)
- Mechanical Ventilator Dependent Waiver
- HIV/AIDS Waiver
- Palmetto Coordinated System of Care Waiver (PCSC)^{35, 36, 37}

d. The SCDHHS Home and Community Based Services Waiver Summary Chart lists the groups served, level of care, available services and other information.

The South Carolina Department of Health and Human Services (SCDHHS) serves as the administrative authority for the waivers. SCDHHS also serves as the operating authority for Community Choices, Medically Complex Children's, Mechanical Ventilator Dependent and HIV/AIDS waivers. The South Carolina Department of Disabilities and Special Needs (SCDDSN) serves as the operating authority for Intellectual Disability/Related Disabilities, Community Supports and Head and Spinal Cord Injury waivers.^{38, 39, 40} The SCDHHS Home and Community Based Services Waiver Summary Chart summarizes groups served, level of care and services provided.⁴¹ States choose the number of HCBS waivers to operate and the maximum number of people to serve under a specific HCBS waiver program.⁴² When there are no available slots, individuals are added to a waiting list, and according to an interviewee, "waiting lists are a key issue."

The federal government developed incentives to expand home and community-based services, and South Carolina has utilized some to increase waiver capacity and reduce waiting lists.⁴³ ⁴⁴ For instance, Money Follows the Person (MFP) focuses on promoting and funding home and community-based services at the state level to replace institutional care. MFP provides supplemental services to assist individuals in transitioning from an institution.^{45, 46} As of January 2022, supplemental services are fully covered by MFP grant funds at a federal reimbursement rate of 100 percent.⁴⁷ Allowable benefits include up to six months of short-term rental assistance and utility expenses, food pantry stocking for up to 30 days and payments for activities needed before transitioning such as home accessibility modifications and vehicle adaptations.⁴⁸ South Carolina's Home Again Program, an MFP-funded program, is a transition service program that helps residents of skilled nursing facilities and hospitals return to their homes and communities.⁴⁹ Support services vary depending on the needs of the participants but may include home-delivered meals, utility deposits, basic furniture, groceries and limited home modifications.⁵⁰ In response to the Coronavirus pandemic, the American Rescue Plan Act (ARPA) of 2021 included investments to strengthen existing home and community-based services. Through ARPA Section 9817, South Carolina receives an additional 10% in the federal match for home and community-based services resulting in a projected \$80 million.⁵¹ This investment will go toward workforce support and training and enhance access to home and community-based services. It will also support infrastructure and sustainability.⁵²

Appendix K is available to states during emergencies to request approved 1915(c) waiver amendments and includes actions states can take to respond to emergencies. The South Carolina Department of Health and Human Services (SCDHHS) received approvals between April 2020 and July 2022 to amend 1915(c) waiver services.^{53, 54} Among amendments approved in April 2020 were the addition of respite and personal care service hours to replace hours lost due to displacement from Day Programs and Adult Day Health Care Services for Intellectual Disability/Related Disabilities Waiver (ID/RD) waiver participants, as well as the removal of limits on Adult Attendant Care/ Personal Assistance for ID/RD and Head and Spinal Cord Injury Waiver (HASCI) waiver participants due to closure of South Carolina Department of Disabilities and Special Needs (SCDDSN) Day Programs.^{55, 56} Among amendments approved most recently in July 2022 included utilizing ARPA funds to temporarily increase payment rates through March 2025 (or until funds are exhausted) for Respite, Adult Day Health Care, Residential Habilitation, Home Delivered Meals, Care Coordination, Career Preparation and Employment Services (group and individual), In-Home Support and Waiver Case Management.^{57, 58} In May 2022, SCDHHS announced its intent to make permanent the rate increases for respite and adult day health care that was previously implemented through Appendix K.⁵⁹ Beginning January 1, 2023, specific reimbursement rates for waivers operated by the South Carolina Department of Disabilities and Special Needs (DDSN) increased, including Intellectual Disability/Related Disabilities (ID/RD), Community Supports (CS) and Head and Spinal Cord Injury (HASCI).⁶⁰ These provider rate increases have been made to enhance the network of providers rendering services to members enrolled in the state's Home and Community-Based Services (HCBS) waiver programs.⁶¹ Rate increases for these waivers range from 6.4% to 61.1%. These increases will continue until SCDHHS American Rescue Plan Act funding is depleted or through March 2024.⁶²

Table 2: Provider Rate Increases for Intellectual Disability/Related Disabilities (ID/RD), Community Supports (CS) and Head and Spinal Cord Injury (HASCI) Waivers. Effective January 1, 2023.

Service and Waiver	Previous Rate	New Rate	Percent Change
<i>Adult Attendant Care (ID/RD)</i>	\$4.21/15 min	\$4.48/15 min	6.4%
<i>Adult Companion Services (ID/RD)</i>	\$3.76/15 min	\$4.50/15 min	19.7%
<i>Medicaid Nursing-LPN (ID/RD & HASCI)</i>	\$29.80/hr	\$35.00/hr	17.4%
<i>Enhanced Nursing Services (ID/RD & CS)</i>	\$8.75/15 min	\$9.50/15 min	8.6%
<i>Personal Care I (ID/RD & CS)</i>	\$3.70/15 min	\$5.50/15 min	48.6%
<i>Personal Care II (ID/RD & CS)</i>	\$4.85/15 min	\$6.25/15 min	28.9%
<i>Respite in Home (ID/RD, CS & HASCI)</i>	\$4.21/15 min	\$6.25/15 min	48.5%
<i>Medicaid Nursing-RN (ID/RD & HASCI)</i>	\$39.40/hr	\$42.00/hr	6.6%
<i>Attendance Care – Agency (HASCI)</i>	\$5.02/15 min	\$6.25/15 min	24.5%
<i>Attendant Care – Boards (HASCI)</i>	\$3.88/15 min	\$6.25/15 min	61.1%
<i>Attendant Care – UAP (HASCI)</i>	\$4.21/15 min	\$4.48/15 min	6.4%
<i>In Home Support (CS)</i>	\$16.82/hr	\$17.90/hr	6.4%

Source: South Carolina Department of Health and Human Services, 2022^{63, e}

South Carolina still faces challenges to providing comprehensive community-based services that meet the standard of care provided in an institutional setting. As one interviewee stated, “It should be anything but institutionalization and it seems like you’re home without much of anything or institutionalized.”

^e. Respite in Home service increase only applies to agency-based respite. It does not apply to self-directed respite.

Barrier Two: Health Care Workforce Crisis

“My daughter is authorized for 60 hours of personal care assistance hours a week. However, we only receive about 10-12 hours of care a week because we can’t find people to do the work. The pay is not competitive. Restaurants and food service are paying more than what we pay for personal care assistants. We live in the Charleston area. I can’t imagine how hard it is to find care in rural communities.” -Parent

In 2016 the American Association on Intellectual and Developmental Disabilities and the National Alliance of Direct Support Professionals declared that: “If the charge to address the workforce crisis is not acted upon, the entire disability service system is at risk of going back to days of institutionalization, segregation and stigmatization, turning the clock back on decades of advocacy.”⁶⁴ Interviewees confirmed the dire consequences of the lack of qualified staff on service provision for South Carolinians with disabilities. One confirmed, “There’s [a] national crisis, and we have that problem in South Carolina too.” Direct care workers provide daily support to people with intellectual or developmental disabilities who require assistance in “learning, language, self-care, making decisions, independent living and finding and keeping employment,” all of which help them become more independent and integrated into the community.⁶⁵ Direct care workers also provide needed support to caregivers allowing them to take a necessary respite from their daily responsibilities of caring for their loved ones.^{66, 67} The impact of the Coronavirus pandemic further impacted workforce composition and service provision.⁶⁸ In 2020, South Carolina had 396 home and personal care aides and 344 nursing assistants per 100,000 residents.⁶⁹ Interviewees also expressed shortages in qualified providers of psychiatric and counseling services, skilled professionals who understand and know how to work with people with traumatic brain injuries, neurologists and neuropsychologists and early intervention specialists. South Carolina had 524 psychologists in 2019, and in 2020 there were only 564 psychiatrists. Fourteen counties had no psychologists or general psychiatrists.⁷⁰

Low wages, limited or lack of benefits and insufficient training and professional development are some factors that have contributed to the shortage in the direct care workforce and posed significant challenges in recruiting and retaining qualified staff.⁷¹ The mean annual wage for home and personal care aides in 2020 was \$23,560 in South Carolina.⁷² The median annual wage for nursing assistants in 2020 was \$27,760 in South Carolina.⁷³ Overall, between 2010 and 2020, the median annual salaries for direct care workers only increased by twenty cents across South Carolina, with the average wage being \$11.73 an hour in 2020.⁷⁴ Compared to North Carolina, Georgia, Tennessee and the United States, South Carolina had the highest percentage of direct care workers living in poverty in 2019.⁷⁵

The shortage in the direct care workforce available to provide support services contributes to long waiting lists and increased workload on existing staff.⁷⁶ As one interviewee indicated, “Without being able to invest in the direct care workforce, I don’t know how you can get the care that you need to be in a community.” The shortage of qualified staff also results in the underutilization of approved services, and families are left to supplement the care. This is the case with Pattison (“PJ”), who is approved for 60 hours per week of home nursing services and 40 hours per week of respite care but only receives 10-20 hours of nursing services and no respite care due to an inability to find someone for respite. An interviewee stated, “We pay our respite workers \$8 an hour. I mean, you’re not getting people. So, the services are not being used because you can’t find anybody to do it.”



Pattison “PJ”

“Expanding services for Personal Care Assistants and Respite workers and providing more training and certification for Personal Care Assistants would help.”

Photo is provided courtesy of PositiveExposure.org

Pattison “PJ” is a 19-years old woman who lives at home with her mother, Pam. She was diagnosed with Cerebral Palsy (CP) and Intellectual Disability at age nine months. PJ is quadriplegic, legally blind, incontinent and has significant hearing loss and a gastrostomy tube (G-Tube). Pam has been PJ’s primary caregiver.

PJ has been on the Intellectual Disability/Related Disabilities Waiver (ID/RD) since age three. She now attends an adult daycare program where she receives nursing services. Transportation to the program is provided through her waiver but is inconsistent. In addition to the adult daycare program, PJ is authorized to receive 60 hours per week of nurse services at home. Typically, she only receives 10 to 20 hours per week due to staffing shortages. She is also authorized for 40 hours of respite care, but her mother has not found anyone to provide respite care. This lack of service utilization is not new for PJ. According to Pam, PJ has never received the hours she is authorized to receive, leaving her mother to provide care in the evenings and weekends. Pam questions who is responsible for tracking hours for people with disabilities. She believes someone needs to pay attention to the hours people with disabilities are authorized to receive versus how many they can get. Pam wants to keep PJ at home and does not want her daughter to be placed in a facility. Pam shared that her home is the only home that PJ knows.

Workforce conditions that deter entry into the direct support profession.



Source: President’s Committee for People with Intellectual Disabilities, 2017⁷⁷

A lack of competitive wages and other factors have resulted in a high turnover of support service staff. According to the President's Committee for People with Intellectual Disabilities, a "tightening pool of potential employees, along with greater competition from other businesses and industries that pay more competitive wages, results in businesses being forced to consider applicants they would not have previously considered."⁷⁸ The urgency to fill vacancies can foster a culture that fails to place emphasis on recruiting and retaining a workforce with the desire and qualifications to work with people with disabilities.⁷⁹ As one interviewee reminds us, "We need to be mindful that people want that service, but they also want to make sure it's somebody who's qualified." Further, turnover rates impede opportunities for advanced training. One interviewee acknowledged that "training and having folks who are well trained to support people with disabilities appropriately is a huge issue. When you have turnover taking place, then you're continually training, and it's basically to keep. We keep to the basics instead of continually building on their level of expertise."

The instability in the workforce disrupts service provision, exposes clients and families to negative experiences in care and leaves families questioning if they will ever receive consistent quality care. This inconsistency of service provision places those with disabilities who prefer to be in the community at risk of being institutionalized, especially when families cannot supplement the care because the necessary support services for them to live in the community are lacking.⁸⁰ "Without the workforce to do the services, you'll have more people who need to be in group care settings because they can't be served individually. Anytime you have the intensive service array that we need for families to be able to stay together, for people to stay in their homes and their communities, that requires more one-on-one attention. With more one-on-one attention, you need more bodies, more people to do the work," one interviewee acknowledged.

The South Carolina Department of Health and Human Services (SCDHHS) has identified "workforce support and training" as a spending priority for funds received from the American Rescue Plan Act (ARPA).⁸¹ The agency plans to consider one of the following to support the Home and Community-Based Services (HCBS) workforce: "1) signing bonuses and retention payments for direct service professionals and nursing staff, 2) retainer payments for providers, 3) training and certifications or 4) strengthening assessments and person-centered training."⁸² According to the spending plan, methods to provide hazard pay and shift differential pay to direct care workers will also be considered.⁸³ Implementing a combination of strategies may prove to be a more effective approach than solely focusing on increasing pay given that multiple factors contribute to the difficulty of recruiting and retaining staff.

A stable, robust and qualified workforce is essential to providing the support services needed for people with disabilities to live in community-integrated settings. To build up and maintain this type of workforce, "substantial ongoing investments in recruitment and training of staff is needed"⁸⁴ because a limited workforce, as one interviewee expressed, "limits your ability to be able to provide the best type of services you want to provide."⁸⁵ In 2017, the President's Committee for People with Intellectual Disabilities (PCPID) recommended several strategies to address the shortage in the direct care workforce such as "1) creating grant programs and financial incentives to expand the pool of direct care workers through recognition programs, grassroots campaigns and training efforts designed to expand awareness about the profession and encourage greater participation by people with disabilities, men, retirees and young adults across diverse racial, ethnic and cultural groups, 2) expanding utilization of self-direction in long-term services and supports so that family, friends and neighbors can be hired as direct care workers, 3) engaging community colleges and job centers to develop and invest in career training and credentialing for direct care workers and 4) providing technical assistance and financial or programmatic incentives to promote the use of technology solutions in long-term services and supports, such as remote monitoring, sensors, robotics and smart homes, to create efficiencies, reduce costs and support community living for people with disabilities."⁸⁶ Flexibility in the procurement of service providers to extend beyond currently contracted providers, utilizing existing organizations that have demonstrated an interest and expertise in serving those with disabilities and employing individuals with disabilities as peer support workers are other strategies.^{87, 88}

Barrier Three: Employment for People with Disabilities

“I want to find a full-time job. I want to work full-time like my sister and have healthcare benefits. I don’t want to be on SSDI all my life. I want to be independent. I just don’t know where to start. All of my jobs have been part-time jobs. This is not what I want. I want to work and be independent so my mom does not have to worry about me.” -Person with a disability

“I worry about keeping my job. I live on my own and have a great support network, but I need my job to stay in my apartment. If I lose my job, I don’t know what would happen.” -Person with a disability

According to a 2019 Disability Status Report^f, the employment rate of non-institutionalized working-age (ages 21 to 64) people with disabilities in South Carolina was 34.6 percent, compared to 79.4 percent of people without disabilities, resulting in an employment gap of 44.8 percent.⁸⁹ Among those with disabilities not employed, 6.2 percent were actively looking for employment.⁹⁰ Access to work reduces the risk of institutionalization, homelessness, and incarceration for people with disabilities, especially those with intellectual disabilities, developmental disabilities and mental health diagnoses. The Workforce Innovation and Opportunity Act (WIOA) aims to improve coordination between the public workforce system and industry to help businesses meet their workforce needs by recruiting, hiring, and training individuals with disabilities. Administered in South Carolina through the Department of Employment and Workforce and 12 Local Workforce Development Areas (LWDA) throughout the state, WIOA significantly limits the use of sub-minimum wage sheltered workshops and focuses on the direct placement of students with disabilities in jobs after high school.^{91, 92, 93, 94} WIOA sets the parameters for employment for people with disabilities and requires state agencies to enter into a cooperative agreement to prioritize competitive integrated employment (CIE). CIE means that people with disabilities are paid the same wages as people without disabilities and interact with and get the same opportunities for career advancement as non-disabled coworkers.^{95, 96, 97, 98, 99}

^f. The Annual Disability Status Reports are produced by the Yang Tan Institute on Employment and Disability at Cornell University. Status Reports are based on data from the US Census Bureau’s American Community Survey (ACS) which samples the population and therefore may differ from actual population values.

Anonymous in SC

This South Carolinian is a 27-year-old man diagnosed with Schizophrenia shortly after graduating from college. He lives hours away from his parents, who take turns living with him so that he can attend a day program because there is nothing similar where they live. His mother wants to close the distance between them and hopes that he will be able to get an apartment using a Section 811 voucher. Obtaining a voucher is very difficult and the state opens up applications for the waiting list randomly and without notice. Even if individuals are able to apply for the waitlist, the process is very confusing and hard to navigate. Because of the high number of people in need statewide, it can take a very long time to receive a voucher.[†]

He is interested in getting a job but has been out of the workforce for five years. The only jobs available in his programs are in food service, but he is interested in front desk work. He attends a day program that offers a community-based approach to treating serious mental illness. This program offers opportunities to increase social and vocational skills, build relationships and obtain employment. Through this center, he is on a waiting list for a job, but the waiting list is long, and he has lost motivation to continue going to the program.

When he was in crisis and having issues with medication following a hospital discharge, his mother had difficulty getting treatment for him even though he was hurting himself. Sometimes his mother feels very alone when dealing with her son's mental health crises. She loves him and wants the best for him, but it has been six years, and she is losing hope. She wonders what it takes to get medical treatment for someone in a crisis and wishes for more support for families. He wants to live independently in the community, and his parents want the same thing but worry about his safety.

[†] There is an application process to be placed on the waiting list for housing vouchers. The application for the waiting list can be closed and reopened periodically by Public Housing Authorities. The application may open randomly, and with no list of "potential eligible applicants" to pull from, individuals must apply before the application closes again. Public Housing Authorities have the authority to establish their policies regarding the waiting list application process and policies vary even within the same state. How PHAs submit notifications of open application periods varies and may include posting on websites and local newspapers.

Code of Federal Regulations (2022 November-Last Amended) Title 24 Housing and Urban Development: Subpart B HUD Requirements and PHA Plan for Administration of Program. Retrieved on December 19, 2022 from <https://www.ecfr.gov/current/title-24/subtitle-B/chapter-IX/part-982/subpart-B>

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The Office of Disability Employment Policy has identified 10 areas to increase competitive integrated employment:

- **Employment First Policy:** Includes legislation, executive orders and state plans that define competitive integrated employment and describes the roles of state agencies to achieve competitive integrated employment.
- **Rate Reimbursement Restructuring:** Determines which employment services are incentivized and which are not, and revises rates as needed to promote employment services that result in competitive integrated employment.
- **Capacity Building:** Creation of policy and funding priorities that promote competitive integrated employment along with the development of community agencies with skilled personnel to deliver supported and customized employment.
- **Interagency Coordination:** Collaboration of state agencies and other partners serving those with disabilities.
- **Provider Transformation:** Realignment of a service provider's business model to promote competitive integrated employment.
- **14(c) Phase Out:** The phase-out of Section 14(c) of the Fair Labor Standards Act which allows providers to pay people with disabilities subminimum wages.
- **Employer Engagement:** Engagement with businesses and employers on employing those with disabilities, emphasizing individuals with learning/developmental disabilities or other significant disabilities. As well as implementing marketing strategies that include highlighting businesses that successfully recruit, hire and retain employees with disabilities so that those businesses can share their experiences.
- **Mental Health:** Identifying specific funding applications and joining other services to provide the necessary mental health support for individuals to pursue and retain employment. With a focus on utilizing Individual Placement and Support (IPS) and identifying and addressing barriers to facilitating IPS.
- **Seamless Transition:** Transition of youth with disabilities from school to competitive integrated employment and those with a clear career path.
- **Data Collection:** Identify and implement methods to collect data on employment and integration outcomes to help a state identify where they are and where they want to be.^{100, 101, 102}

South Carolina is poised to make strides in competitive employment. In May 2022, Governor Henry McMaster signed S533 prohibiting employers receiving certificates under section 14(c) of the Fair Labor Standards Act of 1938 from paying wages less than the federal minimum wage.^{103, 104} This legislation includes the Employment First Initiative Act, which encourages state agencies to “ensure state programs, policies, procedures and funding to support competitive integrated employment; share data and information to track progress toward full implementation and adopt rules and promulgate regulations to implement provisions for competitive integrated employment.”¹⁰⁵

Employment for people with disabilities still lags considerably behind the general population.¹⁰⁶ Interviewees identified a lack of appropriate employment opportunities and access to appropriate support services contributing to the unemployment rate. The perspectives of some employers on hiring people with disabilities have been identified in focus groups. They offer some explanations for the hesitancy or refusal of some employers to hire people with disabilities. Employers perceived people with disabilities would “require extra time to learn new job tasks, require accommodations to do the job, have trouble getting the work done and need help from others, tend to call in sick more, have trouble getting along with others and make co-workers uncomfortable.”¹⁰⁷ These employers lacked awareness of disability and accommodations and were concerned with costs and legal liability.¹⁰⁸ However, there are employers like Randy Lewis, former Walgreens executive and disability employment advocate, who, according to an interviewee, “recognized that people with disabilities had incredible abilities to do tasks. And so he made it part of the company’s mission to employ people with disabilities.”^{109, 110, 111} The distribution center

built in Williamston, South Carolina (Anderson County) opened in 2007, and it became the site for a more inclusive program where one-third of the workforce were people with disabilities.^{112, 113} Working side by side, team members with disabilities and without disabilities did the same jobs, were held to the same standards and earned the same pay.¹¹⁴ After analyzing 400,000 hours of work, Walgreens concluded that people with disabilities worked the same or better than team members with no disabilities, had 20 percent better retention rates, had less absenteeism and had lower costs of Workmen’s Compensation.^{115, 116} Today, there are more employers like Walgreens who are expanding their commitment to hiring a more diverse workforce, including people with disabilities, such as Dominion Energy, which scored a 100 on the Disability Equality Index (DEI) and was recognized as one of the 2021 Best Places to Work for People with Disabilities.^{117, 118}

Appropriate transition planning to ensure students with disabilities have a set plan for employment after graduation is essential. An interviewee indicated that “all students exiting school in the state of South Carolina should have a definitive plan for what they’re going to do when that school bus doesn’t come. And it shouldn’t be sitting at home. Their plan should include a job.” Project Search is a national model that prepares high school students with intellectual disabilities and developmental disabilities for competitive integrated employment.¹¹⁹ Vocational Rehabilitation implements the program here in South Carolina.¹²⁰ The model includes extensive skills training, career exploration, long-term coaching and internships.¹²¹

Supported employment services help people with disabilities gain access to competitive employment that meets their interests and abilities and pays a fair wage. As one interviewee stated, “Being employed in the community is the best way to reach full community integration.” Inclusion of strategies to continue to support advancements toward competitive integrated employment is essential to South Carolina’s Olmstead Plan.



Barrier Four: Housing for People with Disabilities

One of the most often cited barriers to community integration is the lack of safe, accessible and affordable housing. Loss of access to housing is also one of the primary reasons people with disabilities find themselves at risk of institutionalization. For an individual to receive services in a more integrated setting, there must be a more integrated setting available, whether that setting is a group home, with their extended family, or on their own. Nationally, there is a critical shortage of affordable housing, and South Carolina is no exception. It is not unusual for an individual to overcome the almost monumental task of getting approved for services and securing a provider only to remain in their current living situation because there is simply no physical space for them to go. This is an even more difficult barrier for people with disabilities who are coming out of incarceration. Interviewees cited a lack of sufficient affordable housing as a barrier to people with disabilities living in the community. One interviewee stated that “housing is a huge barrier because you have folks who may have a record or may not have a stable income, and we don’t have quality, affordable housing that’s out there to allow people to be in their home.” Another interviewee suggested that the reason South Carolina does not have enough housing available is that “we did not build a system so we have enough housing, so that our individuals that we are now sending out into the world and not being institutionalized have somewhere to go rather than being homeless.” With fixed or limited incomes, people with disabilities are unable to afford housing in the current market “even with the stipends,” as one interviewee confirmed. The basic monthly Supplemental Security Income (SSI) benefit is \$841.00 for one person and \$1,261 for a couple.¹²²

According to a 2022 analysis of the federally defined housing market in South Carolina, a person receiving a monthly SSI benefit of \$841.00 would have to pay a sizable portion of their SSI to rent a one-bedroom unit across the state.¹²³ This would range from spending 76 percent of their SSI in Clarendon County to spending 161 percent of their SSI in Charleston-North Charleston.¹²⁴ As people continue to face the challenge of securing affordable housing, one interviewee indicated that the risk of homelessness increases and “more people are living on the street, panhandling and living in their cars.” For some, living with their family has been an option, but as their parents are aging, not having affordable housing options increases their risk of institutionalization because, as one interviewee stated, “there are not enough services in place to consider people who may be in situations where their parents are taking care of them but are soon approaching end of life.” Individuals are on waiting lists for lengthy periods awaiting housing. An interviewee recounted the length of time an individual awaited housing stating, “Fifteen years was on the list, and he just got housing last month... [it took] 15 years for him to get into an apartment.” The Housing Choice Voucher Program (“Section 8”) provides housing assistance that does not limit individuals and families to subsidized housing projects and allows them to choose single-family homes, townhouses and apartments that meet the program’s requirements.¹²⁵ However, an interviewee noted that there are not enough vouchers for Section 8, and individuals with criminal records are ineligible for the program. The South Carolina State Housing and Development Authority (SC Housing) provides up to 2,000 vouchers in Clarendon, Colleton, Dorchester, Fairfield, Kershaw, Lee and Lexington counties, and waiting lists are currently three to five years long.¹²⁶

In addition to affordability, housing must have reasonable accommodations to ensure accessibility; as an interviewee emphasized, “It’s accessible housing also...accessible, affordable housing.” There have been occurrences where housing options have not been compliant with the Americans with Disabilities Act (ADA). As one interviewee stated, individuals are having trouble getting housing because “some of the places that say that they’re ADA compliant turn out not to be as compliant as they claim to be.” This is true with Ebony, who worked with AbleSC to make home accommodations, including removing the door to her bedroom so she can move her wheelchair into the bedroom. Still, she wishes her apartment were more accessible. Ebony believes more housing should be designed with accommodations such as walk-in showers, wider doorways and low counters for people with disabilities and older adults so that they can age in place.

Developing and implementing strategies to ensure various housing options are integrated in the community is necessary to meet the needs of people with disabilities. For an Olmstead Plan to be complete, comprehensive and valuable to the state and people with disabilities, programs for affordable and accessible housing must be included.



Alex

“If something happens to me, Alex will remain in a group home and may never be able to live independently.”

Alex is 29 years old and wants to live in an apartment with limited case management. Alex has made a lot of progress toward living independently. He manages household duties, exercises regularly, and makes his meals. He is interested in a Supported Living (SLP 1) housing option. This program allows individuals to live in an apartment or home, where staff provides support based on the client’s needs and preferences. There is an excessive waiting list, and the available apartments are not in safe neighborhoods. Alex had his first psychiatric hospitalization at age five and is currently on the Intellectual Disability/Related Disabilities Waiver (ID/RD). He lives in a Community Training Home (CTH-2), a 4-bedroom group home with full-time staff who administer medications, assist with transportation and prepare meals. Alex’s mother, Kelly, says the staff is not trained to call the 988 Suicide and Crisis Lifeline or Mobile Crisis Unit to de-escalate situations but instead call law enforcement. The frequent calls to law enforcement have “tagged” the group home as a community disturbance but have not resulted in positive outcomes. When a resident gets out of control, the police take the resident to the hospital. No treatment occurs, but the resident is returned to the group home. Kelly believes the resources spent on hospitalization would be better utilized in the creation of individualized plans of treatment, which, if implemented correctly, could reduce crisis events.

Alex receives Social Security Disability Insurance (SSDI), which benefits adults with a qualifying disability and limited income and resources. Alex relies on the ID/RD waiver and SSDI to live in the community and receive the mental health services he needs.

Barrier Five: Transportation for People with Disabilities

“As a person with a disability who can’t drive, transportation is an issue for me daily.” -Interviewee

According to a 2017 report from the Bureau of Transportation Statistics on travel patterns of adults with disabilities, over 20 percent of non-workers and 12 percent of workers between 18 to 64 lived in households with no vehicle. Further, seven out of ten individuals indicated reducing their day-to-day travel because of their disabilities.^{127, g} Access to work, education, medical care, religious services and other cornerstones of community living is predicated on reliable transportation. Adults with disabilities often require supportive transportation services to travel to medical and dental appointments, grocery stores, pharmacies, schools and social settings. In the absence of comprehensive, reliable public transportation, adults who are unable to drive themselves or who lack a vehicle must rely on caregivers, relatives and friends for transportation. Limited or no public transportation has been noted as the most frequently reported problem for people with disabilities.¹²⁸ An interviewee stated “You can’t have community integration without quality public transportation throughout all areas of the state. It’s just impossible to participate in employment, social activities, civic organizations, faith-based organizations if they can’t get to them.” While people in urban areas indicate problems with utilizing public transportation services, those in rural areas may not have public transportation services and must rely on other methods.¹²⁹ However, interviewees indicated that private services such as Uber and Lyft also may not be feasible due to increased costs, being outside the service area, or the vehicle’s inaccessibility.

According to interviewees, the impact a lack of reliable transportation has on employment is significant. Despite wanting to work, individuals find it challenging to obtain and maintain employment without a reliable source of transportation. An interviewee described this perpetual cycle of unemployment individuals face due to a lack of reliable transportation while recounting an individual’s challenge stating, “It becomes very cyclical, and it prevents him from the next level reaching his goals.”

Accessibility is also a significant factor because an individual’s disability may prevent them from being able to ride in certain vehicles. An interviewee recalled an individual “who had the worst time being able to get out to go to a doctor’s appointment because she needed accessible transportation. Her family could not afford a vehicle for her to ride in, and it was very difficult for her to be able to get anywhere and do anything.” An individual’s disability can also make utilizing public transportation difficult when you consider the “complexities of schedules and transfers, inaccessible sidewalks and other barriers.”¹³⁰

Access to safe and reliable transportation is critical to community integration, as transportation is needed to conduct daily activities. As an interviewee emphasized, “Having options that work for people at all levels and with all disabilities and needs is important.” Access to public and private transportation expands their options and provides more control over how and when people with disabilities move throughout the community. However, transportation options must be “equipped to suit the physical, sensory, and cognitive needs of all people,” as lack of accessibility and negative experiences with transportation providers contribute to those with disabilities not fully participating in transportation options.^{131, 132, 133}

g. Report was updated in January 2022.

Barrier Six: Assistive Technology

“When you talk about workforce composition, it impacts Olmstead because the idea with Olmstead is to put more people in the community and we want to do that. But we also have to have the staffing ratios or the assistive technology needed to put somebody in the community.” -Interviewee

The United Disabilities Services Foundation (UDSF) categorizes assistive technology and adaptive equipment into the following categories: cognitive devices, communication devices, daily living devices, hearing devices, mobility devices, positioning devices and vision devices.¹³⁴ It has been suggested that assistive technology lessens the direct support workforce needed to help support community integration when you consider the benefits of remote monitoring, computer-assisted devices, electronic medication dispensers, smart homes and personal computerized assistants (Siri and Alexa).¹³⁵ Such technology can supplement direct support professionals or, in some cases, be used in the absence of the professionals if the client has less need for on-site direct support, thus facilitating greater independence and community integration.¹³⁶ An interviewee stated, “Assistive technology is so important for composition because we can get less people involved in people having more independence.” However, lack of awareness and trained personnel have been identified as barriers to more individuals accessing assistive technology.¹³⁷ Interviewees emphasized that it is necessary to educate the community on how assistive technology supports community integration and makes it more possible for individuals with disabilities to live independently. According to an interviewee, “There’s a lack of awareness of the types of assistive technology that can make employment possible, and so there’s a lack of folks understanding how people with disabilities can work and live in the community with the support of the technology.” For instance, an interviewee recalled an example where a workstation in the Walgreens Distribution Center was modified to accommodate an employee with Cerebral Palsy who couldn’t push a button in his workstation with his hand. The interviewee stated that “Vocational Rehabilitation came in and developed a component to cover the button that he’s supposed to push, so he could hit it with his palm or closed fist.”



Ebony

**“A good support system is necessary.
It does take a village.”**

Ebony, 40, lives by herself in an apartment and has done so for over a year. After graduating college in 2009, she lived with her parents but set a goal to live independently by 40. Ebony has Cerebral Palsy (CP) and is on the MA Community Long-Term Care Waiver. Before living alone, her mother provided most of her direct care. While in college, she received 25 hours a week of care through the school’s attendant care program. Ebony realized that she would need good caregiving services when she moved into her apartment and having a concrete plan for services would be essential. She is authorized for 40 hours of services per week, and caregivers come at various times in the morning and afternoon. Ebony wishes her apartment were more accessible, but she is making it work. She has worked with AbleSC to make home accommodations, including removing the door to her bedroom so she can access the room with her wheelchair. However, Ebony believes more housing should be designed with accommodations such as walk-in showers, wider doorways, and low counters for people with disabilities and older adults so that they can age in place.

Ebony works full-time from home and has been with her company for six months. Her employer has provided equipment and accommodations so she can perform her job. She says the key has been open communication with her employer about expectations. Ebony uses technology to make grocery lists and order items through Instacart. She uses Dial-A-Ride-Transit (DART), a curb-to-curb, shared-ride transportation service for people with disabilities that prevent them from riding public transportation. Ebony appreciates having DART because the county she lived in before did not have this option.

Ebony continually works to be independent. She has a good support system, including her family, close friends nearby, a great case manager, AbleSC and Disability Rights South Carolina. She enjoys the privacy, peace, quiet and autonomy of having her own home. She says, however, that what is most rewarding is that her parents see she is okay.



Yvette

“I always believed people with disabilities are the most underserved in the country. They can’t speak for themselves, and their family members are so worn out they can’t either.”

Yvette is 78 years old. She and her husband have a 54-year-old son who has an Intellectual Disability (ID) and mild Cerebral Palsy (CP), which affects his speech. Their family moved from Indiana to South Carolina in the late 1990s, and Yvette says the support available in South Carolina was not comparable to the support her son had in Indiana. Once they moved to South Carolina, her son got a job at a restaurant and was doing well until his job coach left. He was eventually let go, which Yvette says is because he does not have a full-time job coach. Yvette’s son worked at a chocolate factory for eight years in Indiana with the support of a consistent job coach.

Yvette’s son has been on the Intellectual Disability/Related Disabilities Waiver (ID/RD) since 2000. He currently receives case management and companion care services but not respite services. They were given a list of companies all over the state that provide respite services, but no one was a good fit and Yvette is unsure of how to find other options. They are also having trouble finding a provider for companion care, and Yvette worries he will lose his waiver due to a lack of meeting the service requirements when their current companion caregiver can no longer provide for them. Finding, interviewing, hiring and managing caregivers is a complex and overwhelming task for parents who are already exhausted.

While taking care of her son, Yvette has had three hip replacements, two brain aneurysms, a shoulder replacement and knee replacement. She has advocated for her son to get a residential placement for 20 years and always thought that things would get better when he got older, but it never has. She and her 79-year-old husband are plagued with the question of what will happen to their son when they are no longer there. He needs a residential placement, and the longer it takes to get him one the harder it will be for him to transition. Yvette believes that she and her husband would have to die or become disabled for him to get housing. The uncertainty about her son’s future is overwhelming according to Yvette: “It’s draining, you have no control over your life. You can’t plan for the future, or for yourself. It’s just stress and fear.”

Barrier Seven: Care Coordination of Services

“I think the system is just designed at this point for agencies just to be working in [silos]. It’s just not set up to be a collaborative approach. We have this old mindset regarding how we do business in these silos. We’ve got the same population, but we’ve all got a different mission on how we are going to address it. So that, I think, creates problems.”
-Interviewee

Components of effective care coordination include communicating and sharing information and knowledge, establishing accountability and agreeing on responsibility.¹³⁸ Interviewees indicated a lack of care coordination in the system that serves people with disabilities. Organizations working in silos and not sharing information contribute to gaps in service provision and a delay in care. An interviewee asserted that “we need to get out of the mindset of silos and of parents having to be in trouble to get help or kids having to be in trouble to get help or having to go through this huge maze of state, government and Medicaid and insurance and MCOs [Managed Care Organizations] and three different case managers and three different doors.” This fragmented system has disrupted the continuum of care and favors institutionalization over community integration because for an individual to obtain intensive services, they would have to be institutionalized since such services are not available or not easily assessable in the community. An interviewee expressed that changes to the system would allow individuals to “access a longer and more robust array of services to keep children in our homes, schools and communities.”

According to interviewees, there are issues with information sharing. One interviewee pointed out that information sharing should be an integral part of the system, noting that “if it’s going towards the child’s continuum of care, information needs to be able to quickly and efficiently move from place to place without everyone taking a time out, scheduling a meeting, deciding whether or not this information can be shared to someone, or having seventeen steps in between.” The interviewee further expounded on the need for interagency collaboration by specifying that organizations should not have a mindset of “this is our data, this is their data,” but functioning with a collaborative mindset and working together more effectively. Developing an integrated health information exchange system can increase efficiency and improve reporting and monitoring to enable individuals to receive services promptly.^{139, 140, 141} Further integrating health information to include group homes, private therapy practices, schools and home and community-based service encounters would foster effective care coordination.¹⁴² As one interviewee confirmed, “If we had better-coordinated data and systems, there would be a lot fewer individuals who sit in the gaps of service until they’re in crisis.” Data sharing is also essential for families, especially when accessing resources. Brandon’s parents expressed that education on what services existed and what the services meant was what they needed throughout Brandon’s life but didn’t receive, stating that “the system is a maze not meant for typical people to navigate.”

Interviewees also revealed that a lack of clarity on who’s responsible for the care of individuals and other competing issues negatively impacts care, especially for those with multiple disabilities. For example, when people are diagnosed with an intellectual disability and mental illness, an interviewee noted that during a mental health crisis, their behavior is perceived to be due to their intellectual disability, so they are not treated accordingly for the mental health crisis. An interviewee noted that “if you have a dual diagnosis, meaning you have an intellectual disability, but you also have a mental illness, and you live in the community, then you should be able to access appropriate mental health services just like everyone else in the community. But that is a barrier in South Carolina.” Another interviewee noted that practically all individuals that have a brain injury go through depression. A barrier to receiving mental health services is that “people in the mental health field want to say that the person doesn’t have a mental health issue.”

Individuals with traumatic brain injury (TBI) and mental illness have been shown to have unmet care needs due to limited evidence-based interventions, lack of knowledge about TBI among mental health professionals and concurrent conditions affecting their eligibility for services.¹⁴³ In a study that highlighted the challenges individuals with a TBI and mental illness face in receiving support services, providers who worked solely in mental health noted being uncertain about their knowledge of TBI, making it challenging to determine appropriate services and assess whether services were adequate.¹⁴⁴ Further, the providers indicated that working in a fragmented system diminished their ability to tailor services because they lacked access to medical and service use history which would have assisted them in building service supports around the person instead of starting from scratch.¹⁴⁵

An interviewee confirmed that collaboration among organizations is “needed to have a successful Olmstead Plan.” The need for an Olmstead Plan that would state which agencies are responsible for services regularly emerged throughout the qualitative interviews. Without the South Carolina Olmstead Plan, many state agencies will continue to work in silos to provide community-based services. Resulting in an overlap in services and, as one interviewee put it there is no “clear, seamless way of putting things together.”



Brandon

“Brandon has a whole new life. He can grow and live his own life with the supports he needs. He is happy and thriving.”

Brandon is 29 years old. He has Cerebral Palsy (CP), a seizure disorder and hydrocephalus. Early in his life, Brandon received early intervention home therapy services through BabyNet, South Carolina’s early prevention system for infants and toddlers with developmental delays. Once he aged out of BabyNet, he continued to receive services through the school district. When he was finishing high school, a teacher suggested the family apply for waiver services and job coaching. Brandon applied for the Intellectual Disability/Related Disabilities Waiver (ID/RD) and was placed on the waiting list. In the blink of an eye Brandon went from being a full-time happy student with support services to spending years unhappy with nothing to do and no support. Had his parents been informed earlier that there would be a multiple year waiting list for services, they would have applied much earlier. He did not get a waiver until October 2021 when his mother died and his family conveyed that they needed urgent help. Now Brandon receives services under the Intellectual Disability/Related Disabilities Waiver (ID/RD). His family notes a stark difference. Brandon is in a supervised living program and has an apartment of his own. He is at a work training center and is learning life skills. He even invited his father and stepmother over for dinner for the first time. Brandon’s father finally feels that Brandon is not only happy but has the support he needs. The road has been challenging and Brandon’s family wished they had more education on available services. Noting that the “system is a maze not meant for typical people to navigate,” Brandon’s family says they had no idea where to go for information. They found that information websites were confusing and used words and terms that they did not understand.

Recommendations for an Olmstead Plan for South Carolina

The Olmstead decision clearly defines the responsibility of states to develop an Olmstead Plan. The United States Justice Department (DOJ) summarizes several requirements for an Olmstead Plan and emphasizes that it must be a working plan that reflects an analysis of the extent to which the state is providing services in the most integrated setting and contains concrete and reliable commitments to expand integrated opportunities.¹⁴⁶ An Olmstead Plan is a commitment to inclusion and community integration for each group of persons unnecessarily segregated. It should outline goals with reasonable timeframes and implementation strategies for moving individuals to integrated settings and providing support services. Lastly, the plan should have metrics for defining success and be evaluated annually to measure progress.^{147, 148} Without an Olmstead Plan, South Carolina will find it difficult to show that it is moving individuals out of institutions, providing services in integrated settings and actively supporting community integration.

Olmstead Compliance Coordinator and Olmstead Implementation Council

Assign an Olmstead Compliance Coordinator and Olmstead Implementation Council to develop and implement a comprehensive Olmstead Plan for the state. The Olmstead Compliance Coordinator would oversee the development, implementation and evaluation of the South Carolina Olmstead Plan. Responsibilities would include:

- Providing direction and oversight for the plan’s development.
- Controlling and monitoring the performance and modification of the compliance activities.
- Developing and implementing quality assurance and accountability processes.
- Overseeing and managing communication about the Olmstead Plan and the compliance activities of the Olmstead Implementation Council.¹⁴⁹

The Olmstead Implementation Council would assist with developing and implementing the South Carolina Olmstead Plan. Responsibilities would include developing specific work plans to implement the strategies articulated in the Olmstead Plan, engaging and communicating with the community and conducting the annual Quality of Life Survey.¹⁵⁰ The council would include representatives from the following state agencies and community organizations as well as other stakeholders (people with disabilities and immediate family members of a person with a disability, providers and legislators).

- | | |
|---|--|
| <ul style="list-style-type: none"> AbleSC AARP South Carolina AccessAbility Alzheimer’s Association South Carolina Chapter Brain Injury Association of South Carolina Consumers and Providers Disability Rights South Carolina Family Connection of South Carolina NAMI South Carolina South Carolina Autism Society South Carolina Bar Association South Carolina Commission for the Blind South Carolina Department of Children’s Advocacy South Carolina Department of Disabilities and Special Needs South Carolina Department of Corrections South Carolina Department of Education South Carolina Department of Employment and Workforce South Carolina Department of Health and Human Services | <ul style="list-style-type: none"> South Carolina Department of Juvenile Justice South Carolina Department of Mental Health South Carolina Department of Social Services South Carolina Department on Aging South Carolina Access to Justice South Carolina Developmental Disabilities Council South Carolina Institute of Medicine and Public Health South Carolina Legal Services South Carolina Legislators South Carolina State Housing Financing and Development Authority South Carolina Long Term Care Ombudsman Program South Carolina Statewide Independent Living Council South Carolina Vocational Rehabilitation Department South Carolina Department of Transportation South Carolina Department of Veteran’s Affairs The ARC of South Carolina University Center of Excellence in Developmental Disabilities Walton Options for Independent Living |
|---|--|

In 2003, the governor of West Virginia “directed the establishment of an Olmstead Coordinator to develop, implement and monitor Olmstead activities. The Olmstead Coordinator was placed under the supervision of the Office of Ombudsman for Behavioral Health.¹⁵¹ To be effective, South Carolina’s Olmstead Compliance Coordinator needs to be independent of state agencies that provide services and have the backing and support to implement the plan.

Development of the South Carolina Olmstead Plan

South Carolina should:

- Develop the South Carolina Olmstead Plan to reflect the extent that the state is providing services in the most integrated setting.^{152, 153}
- Include identified barriers to integration and commitments to expand integrated opportunities.^{154, 155}
- Outline goals with reasonable timeframes with implementation strategies for moving individuals to integrated settings and providing support services.

Each goal should identify the extent to which people with disabilities are currently in the most integrated settings with support services and be accompanied by strategies to produce improved outcomes over a defined number of years.¹⁵⁶ Addressing the extent of available funding to support the goals should also be outlined in the South Carolina Olmstead Plan.¹⁵⁷

The barriers identified in this report should be the primary focus areas in the initial development of the South Carolina Olmstead Plan. However, it is not intended to be a static document and must be updated and extended accordingly as new data and other information arise. The Olmstead Plan should include measurable goals and specific strategies to address the following barriers. Work plans developed by the state agencies should outline the proposed actions to support the strategies and goals.

The South Carolina Olmstead Plan should include measurable goals and specific strategies to:

- Increase the number of slots for waivers and shorten the time people with disabilities are on waiting lists.
- Employ a multifaceted approach that leverages various recruitment and retention strategies to increase the number of qualified home and community-based service staff.
- Support current advancements toward competitive integrated employment (CIE), such as Employment First and the Elimination of Subminimum Wage.
- Increase accessible and affordable housing in the community for people with disabilities.
- Increase accessible transportation options for people with disabilities.
- Increase access to assistive technology in the homes of people with disabilities and workplaces to support employment. Strategies should include investments in building awareness of available assistive technology options and training in utilizing the equipment for individuals with disabilities and the family and staff that support them.
- Increase the use of person-centered practices, organize care activities and improve information sharing across providers.

South Carolina Olmstead Plan Implementation Responsibilities

The Olmstead Implementation Council would develop specific work plans to implement the strategies identified in the South Carolina Olmstead Plan. The work plans describe the actions that state agencies will take to support the strategies and goals of the South Carolina Olmstead Plan. Work plans will include key activities, expected outcomes, deadlines and the agency or agencies responsible for implementation. Each work plan should include anticipated action items over one to two years to ensure actions are concrete and realistic. State agencies are only responsible for work plans within their service scope. Each agency is responsible for ensuring that activities comply with state and federal laws and regulations and relevant court orders.¹⁵⁸

The Olmstead Compliance Coordinator is primarily responsible for overseeing the implementation and compliance activities conducted by the state agencies and will use the work plans throughout the year to review the progress of the work and facilitate any necessary adjustments.¹⁵⁹

Accountability and Evaluation

Implement an evaluation process that includes an annual review and official report detailing the progress of the goals and strategies outlined in the South Carolina Olmstead Plan. The Olmstead Compliance Coordinator would develop an evaluation framework to assess the implementation activities of each state agency and the opportunities individuals have for community engagement.¹⁶⁰ A Quality of Life Survey will be used to examine:

- How well people with disabilities are integrated into and engaged with their community.
- How much autonomy people with disabilities have in daily decision making.
- Whether people with disabilities are working and living in the most integrated setting of their choice.
- How effective assistive technology is for people with disabilities who use it.¹⁶¹

The Olmstead Implementation Council is responsible for conducting the Quality of Life Survey.

Evaluations of the progress of the state agency on implementing the strategies along with the Quality of Life Survey results would be summarized in an annual report detailing the progress of the goals in the South Carolina Olmstead Plan. This annual report would be made available to the public.¹⁶²

The review process will also include evaluating the goals of the Olmstead Plan to determine if the goals require amending based on the feedback of the Olmstead Implementation Council and the feedback from the Quality of Life Survey. Any proposed amendments will be posted for review by the public, and the Olmstead Compliance Coordinator will conduct a public comment period. Following the comment period, the Olmstead Implementation Coordinator will consider any necessary changes to the proposed amendments before adoption.¹⁶³

Awareness of the South Carolina Olmstead Plan

The South Carolina Department of Administration should:

- Build statewide awareness of the South Carolina Olmstead Plan through various communication platforms.
- Develop a standardized and regularly updated resource with information on available service options.
- Provide outreach to those with disabilities and their caregivers and/or families to discuss available options to enable more informed decision-making.

The Olmstead Compliance Coordinator has primary responsibility for overseeing and managing communication about the South Carolina Olmstead Plan. The coordinator will establish guidelines for communication materials and facilitate the development of a website.

Conclusion

Twenty-three years ago, South Carolina began efforts to support people with disabilities living in the most integrated settings. Although the 2001 South Carolina Home and Community Based Services Task Force report offered an in-depth analysis of the status of community-based services in South Carolina, the report never transitioned into an Olmstead Plan for South Carolina. South Carolinians with disabilities still face many of the same barriers to community integration today. Now is the time for South Carolina to affirm its commitment to inclusion and community integration for its residents with disabilities by developing, implementing and maintaining the South Carolina Olmstead Plan.



Appendix A: Glossary of Frequently Used Terms

Community Residential Care Facilities (CRCF): Facilities that house two or more individuals 18 years old or older for more than 24 consecutive hours. Residents are offered room and board and coordinated personal care. CRCFs are licensed by the South Carolina Department of Health and Environmental Control.¹⁶⁴

Community First Choice (CFC): The Community First Choice (CFC) State Plan Option 1915(k): Included in the Affordable Care Act (ACA), the Community First Choice Option offers a six-percentage point increase in federal matching funds (FMAP) to states, which provides individuals meeting an institutional level of care the opportunity to receive necessary personal attendant services (PAS) and supports in a home and community-based setting.^{165, 166}

Community Integrated Residential (CIRS): A housing model that offers a transition from a 24-hour supervised housing option to a semi-independent option. Individuals select their support providers, housemates and housing.¹⁶⁷

Community Training Home I (CTH 1): Referred to as “Foster Care,” this housing model is where individuals live in the home of a support provider and are provided with personalized care, supervision and individualized training. A maximum of two individuals can live in this setting.¹⁶⁸

Community Training Home II (CTH 2): A housing model that offers residence to a maximum of four people. Individuals are supervised by staff and care, skills training and supervision are provided individually.¹⁶⁹

Developmental Disabilities: A group of conditions due to an impairment in physical, learning, language or behavior areas that begin during the developmental period and last throughout an individual’s lifetime. Developmental disability is a broad category of lifelong disabilities that can be intellectual, physical or both. Examples include, autism, behavior disorders, brain injury, cerebral palsy, Down syndrome, spina bifida and others.^{170, 171}

Home and Community-Based Services: Services provided in the home and community that generally are considered either health services or human services. Health services meet medical needs and include home health care (skilled nursing care, therapies, pharmacy and dietary management), medical equipment, case management, personal care, caregiver and client training, health promotion and disease prevention, and hospice care). Human services support daily living and include senior centers, adult daycares, home-delivered meal programs, personal care (dressing, bathing, toileting, eating, position and transferring), transportation services for medical appointments, respite care and other services. Home and Community-Based Services are funded through state waivers.¹⁷²

Intellectual Disability: A term used when there are limits to an individual’s ability to learn at an expected level and function in daily life. There are significant limitations in intellectual functioning (learning, reasoning, problem-solving, etc.) and adaptive behavior (conceptual skills, social skills and practical skills that are learned and performed every day) that originate before the age of 22. Intellectual disability is one of several conditions that are considered developmental disabilities.^{173, 174}

Mental Illness: Health conditions that involve changes in emotion, thinking, behavior or a combination of all three. Serious mental illness is a mental, behavioral or emotional disorder that results in functional impairment and interferes or limits major life activities. Serious mental illness does not include developmental or substance use disorders. However, a mental illness can coexist with a developmental or substance use disorder. Examples include major depressive disorder, schizophrenia and bipolar disorder. Serious Emotion Disturbance describes a mental, behavioral, or emotional disorder that results in functional impairment and interferes with or limits a child's role or functioning in family, school or community activities.^{175, 176, 177}

Money Follows the Person (MFP): Established by the Deficit Reduction Act of 2005, Money Follows the Person (MFP) focuses on promoting and funding home and community-based services (HCBS) at the State level as a replacement for institutional care. MFP provides supplemental services to assist an individual with transition from an institution.¹⁷⁸

Managed Care Organization (MCO): A health care plan provider provides health care benefits to individuals enrolled in South Carolina Healthy Connections Medicaid Program. Healthy Connections provides benefits through five MCOs: Absolute Total Care, BlueChoice Health Plan of South Carolina, First Choice by Select Health of South Carolina, Molina Health Care and Humana Health Care.^{179, 180}

Psychiatric Residential Treatment Facilities (PRTF): In-patient psychiatric treatment facilities. In South Carolina most of these facilities are for individuals under 21 years old.¹⁸¹

Supported Living Model I (SLP 1): A housing model for individuals requiring occasional support. Staff is available 24 hours a day by phone. This model is generally offered in an apartment or house setting.¹⁸²

Supported Living Model-II (SLP 2): A housing model for individuals that need intermittent supervision and support services. Residents in these models can handle most daily activities but may need periodic advice, support and supervision. Staff is available 24 hours a day, either onsite or within proximity. This model is generally offered in an apartment setting.¹⁸³

Supplemental Security Income (SSI): A federal income supplement program for older adults and individuals with disabilities that provides monetary payments to meet basic needs for food, clothing and shelter.¹⁸⁴

Social Security Disability Insurance (SSDI): A federal disability benefit program that pays benefits if you worked long enough, recently enough and paid Social Security taxes on your earnings.¹⁸⁵

Traumatic Brain Injury (TBI): An injury that affects how the brain works caused by a bump, blow, jolt to the head or a penetrating injury to the head such as from a gunshot.¹⁸⁶

Waiver: Waivers are provisions from the federal government to waive certain Medicaid requirements allowing states to target groups and tailor services to serve those with the greatest need, at risk of institutionalization or who would otherwise not be eligible, giving income and resources, unless receiving care in an institution.¹⁸⁷

Appendix B: Olmstead Status in the United States: A Survey of Olmstead Plans^g

State	Date First Published	Title
Alabama	2012	Gateway to Community Living, State of Alabama Long Term Care Rebalancing Initiatives https://medicaid.alabama.gov/documents/6.0_LTC_Waivers/6.1_HCBS_Waivers/6.1_Olmstead_Plan_4-8-12.pdf
Arizona	2001	Arizona Olmstead Plan https://www.azahcccs.gov/AHCCCS/Downloads/Initiatives/ArizonaOlmsteadStrategicPlanFinal.pdf
Alaska	2018	Alaska Transition Plan for Home and Community-Based Services Settings http://dhss.alaska.gov/dsds/Documents/transitionPlanHCBS/AK-STP-FINALApproved-Plan-08222018.pdf
California	2003	California Olmstead Plan https://chhs-data-prod.s3.us-west-2.amazonaws.com/uploads/2019/06/California-Olmstead-Plan.pdf
Colorado	2014	Colorado Community Living Plan https://www.colorado.gov/pacific/sites/default/files/2018%20Community%20Living%20Update%20Report.pdf
Connecticut	2002	Balancing the System: Working Toward Real Choice for Long-term Services and Supports in Connecticut https://portal.ct.gov/-/media/OPM/HHS/LTC_Planning_Committee/LTC-Plan---2019-Appendices_FINALR.pdf?la=en
Delaware	2007	A Path Forward https://web.archive.org/web/20120506204321/http://www.udel.edu/cds/ccba/pdfs/commission/A_Path_Forward.pdf
Georgia	2002	State of Georgia Olmstead Strategic Plan https://dch.georgia.gov/olmstead-plan
Hawaii	2001	Developmental Disabilities Division Strategic Plan https://health.hawaii.gov/ddd/files/2015/01/DDD-Strategic-Plan-FY2015-2017.pdf
Illinois	2001	Developmental Disabilities State Plan https://www.dhs.state.il.us/OneNetLibrary/27897/documents/DD%20Reports/StrategicPlan2011to2017.pdf
Indiana	2016	Five Year State Plan https://www.in.gov/gpcpd/files/State_Plan_2017-2021_Goals_and_Objectives_Final_Public.pdf
Iowa	2001	Life in the Community for Everyone https://dhs.iowa.gov/sites/default/files/MHDS-Olmstead-Framework-2018.pdf?112020200826
Kentucky	2002	https://www.chfs.ky.gov/agencies/os/Pages/olmstead.aspx
Maine	2003	Roadmap for Change https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/OlmsteadupdateFinal31414_000.pdf
Massachusetts	2018	2018 Massachusetts Olmstead Plan https://www.mass.gov/files/documents/2018/09/20/olmstead-final-plan-2018.pdf
Michigan	2017 ^h	Michigan's Statewide Transition Plan for Home and Community-Based Services https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder2/Folder45/Folder1/Folder145/Michigan_Revised_STP_03312017.pdf?rev=07c4494c73154b20ab2c700b7435addb
Minnesota	2015	Putting the Promise of Olmstead into Practice: Minnesota's Olmstead Plan https://mn.gov/olmstead/assets/2022-04-olmstead-plan_tcm1143-526399.pdf
Mississippi	2016	Mississippi Access to Care https://medicaid.ms.gov/wp-content/uploads/2018/02/MAC_Plan_Update110816.pdf
Nebraska	2019	A Vision for Community Integration: Nebraska's Olmstead Plan https://dhhs.ne.gov/Olmstead/Nebraska%20Olmstead%20Plan%20FINAL%20for%20Submission%20to%20Legislature.pdf

g. No Olmstead Plan was located for the following states: Alaska, Florida, Idaho, Kansas, Louisiana, Maryland, Missouri, Montana, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Washington and Wisconsin.

h. The first published date of Michigan's plan was not located however Version 4.0 of the plan is from 2018.

State	Date First Published	Title
Nevada	2016 ⁱ	Olmstead Plan Aging and Disability Services Division Strategic Plan https://adsd.nv.gov/uploadedFiles/adsdnvgov/content/Boards/COA/DHHS%20Olmstead%20Plan%20ADSD%20Strategic%20Plan%202016%20Final.pdf
New Hampshire	2015	New Hampshire State Plan on Aging https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/beas-nh-state-plan-on-aging.pdf
New Jersey	2007	New Jersey Department of Human Services Division of Developmental Disabilities Olmstead Plan https://www.state.nj.us/humanservices/ddd/documents/Documents%20for%20Web/Olmstead/JSOlmPlanFinal.pdf
New Mexico	2018	Strategic Plan for Supportive Housing in New Mexico https://newmexico.networkofcare.org/content/client/1446/NMStrategicHousingPlan2018-2023-Jan2018FINAL.pdf
New York	2013	Olmstead Implementation Plan https://www.ny.gov/sites/default/files/atoms/files/Olmstead_Final_Report_2013.pdf
North Carolina	2021	North Carolina's Olmstead Plan https://www.ncdhhs.gov/media/14142/download?attachment
North Dakota	2021 ^j	Putting Olmstead into Practice in North Dakota https://www.olmstead.nd.gov/sites/www/files/documents/ND%20Olmstead%20Plan%20revision%202022%20discussion%20draft%206.21.21.pdf
Ohio	2021	Ohio's Plan to Increase Independent Living Options for People with Developmental Disabilities https://dodd.ohio.gov/wps/wcm/connect/gov/99daea8e-252f-488f-ab36-f06f7d513722/Independent_Living_Options.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0J000Q09DDDDM3000-99daea8e-252f-488f-ab36-f06f7d513722-nX5CuOk#:~:text=This%20plan%20seeks%20to%20improve,communication%2C%20education%2C%20and%20technology.
Oklahoma	2006	Oklahoma Olmstead Strategic Plan https://digitalprairie.ok.gov/digital/collection/stgovpub/id/10128
Oregon	2016	Oregon Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness https://www.oregon.gov/oha/HSD/BHP/Oregon%20Performance%20Plan/Oregon-Performance-Plan.pdf
Pennsylvania	2011	Olmstead Plan for Pennsylvania's State Mental Health System https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Documents/Olmstead%20Plan/Olmstead%202016.pdf
Texas	2001	Texas Promoting Independence Plan https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/sb-36-revised-tx-promoting-ind-plan-dec-2018.pdf
Vermont	2006	Vermont Olmstead Plan https://web.archive.org/web/20101110205416/http://humanservices.vermont.gov/publications/olmstead-commission/vermont-olmstead-commission-comprehensive-plan
Virginia	2014	Virginia's Olmstead Strategic Plan https://www.olmsteadrights.org/self-help/tools/advocacy-materials/attachment.260832
West Virginia	2005	West Virginia Olmstead Plan: Building Inclusive Communities Keeping the Promise https://www.wvdhhr.org/oig/pdf/OLMSTEAD/West%20Virginia%20Olmstead%20Plan%20Full%20Length.pdf
Wyoming	2000	Wyoming and Olmstead https://health.wyo.gov/wp-content/uploads/2017/09/Wyoming-Department-of-Health_Olmstead-Primer-and-Plan_FINAL_Q1-SFY2018.pdf
District of Columbia	2017	One Community for All https://odr.dc.gov/book/olmstead/OneCommunity

i. Nevada published the Nevada Strategic Plan for People with Disabilities and Older Adults in 2003. The most recent Olmstead Plan is from 2016.

j. North Dakota has a Draft revision of Olmstead Plan, 2008 document on its Olmstead Commission website. No other reports on the website are dated before 2008.

Appendix C: Investigations and Challenges on State Compliance with the Olmstead Decision

Marlo M. v. Cansler – 09-CV-535 – (E.D. NC 2009)

https://www.ada.gov/olmstead/olmstead_cases_list2.htm#marlom

ARC of Virginia, Inc. v. Kaine – 09-CV-686 – (E.D. VA 2009)

https://www.ada.gov/olmstead/olmstead_cases_list2.htm#arc

Clinton L., et al. v. Cansler, et al. – 10-CV-00123 – (M.D. NC 2010)

https://www.ada.gov/olmstead/olmstead_cases_list2.htm#clinton

The United States of America v. The State of Georgia 2012

https://www.justice.gov/sites/default/files/crt/legacy/2012/01/19/US_v_Georgia_ADA_Cmplt_01-28-10.pdf

North Carolina U.S. Department of Justice Findings 2011 & U.S. v. North Carolina, No. 5:12-cv-557 (E.D.N.C. 2012)

https://www.ada.gov/olmstead/olmstead_cases_list2.htm#NC

U.S. v. Virginia - 3:12CV059 (E.D. VA 2012)

https://archive.ada.gov/olmstead/olmstead_cases_list2.htm

West Virginia Department of Health and Human Resources (2015)

https://archive.ada.gov/olmstead/olmstead_cases_list2.htm

Louisiana U.S. Department of Justice Findings 2016

<https://www.justice.gov/opa/file/920141/download>

Samantha R., et al. v. North Carolina 2022

<https://disabilityrightsnc.org/wp-content/uploads/2022/11/Sam-R-Order.pdf>

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