A PILOT SELF-ASSESSMENT TOOL FOR STATE MENTAL HEALTH AGENCIES:

AN EFFORT TO PROMOTE COMMUNITY INTEGRATION OF PERSONS WITH SMI AND SED PLACED IN INSTITUTIONAL TREATMENT SETTINGS

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Version 3.2

Introduction

The Supreme Court decision in *Olmstead versus LC*, which provided a landmark interpretation of Title II of the Americans with Disabilities Act (ADA), determined that persons with disabilities are entitled to receive services and live in the most integrated settings appropriate for their care. Although there is no standard, universally-accepted definition, the Bazelon Center for Mental Health Law defines community integration as the individual's ability "to live in his own home, spend time with family and friends, find meaningful work, and enjoy the many small pleasures of being part of a community" (Bazelon, Community Integration, 2010). The Department of Justice has stated, "the preamble discussion of the 'integration regulation' explains that 'the most integrated setting' is one that 'enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible...'" (DOJ, 2011). SAMHSA is funding an effort to assist States with Olmstead implementation and activities to promote social and community inclusion for adults with serious mental illnesses (SMI) and children with serious emotional disturbances (SED).

Background on Development of State Community-Integration Self-Assessment Tool

In 2011, the Advocates for Human Potential (AHP) was contracted by SAMHSA to work towards the development of a self-assessment tool for state mental health agencies (SMHAs). The intent is to assist States in developing a comprehensive picture of how the state is doing regarding building and maintaining a mental health system that promotes community integration for adults with serious mental illnesses (SMI) and children with serious emotional disturbances (SED). The task order requires AHP, and its subcontractor—the NASMHPD Research Institute (NRI), to work with policy and technical experts in identifying potential indicators of community integration, as well as to review and recommend national and state data sources that can inform these indicators. AHP and NRI will then work with five (5) SMHAs to pilot test a community integration self-assessment tool during the summer of 2012.

To help inform the process, staff at NRI conducted a literature review of community integration to help shape the pilot design. The review provided guidance in developing an operational definition of community integration, identifying potential populations and defining treatment settings.

Working with the Technical Expert Panel (TEP), the AHP/NRI team prepared the recommended set of State self-assessment indicators described in this document. The indicators and suggested data sources were developed through an intensive process of weekly conference calls among AHP/NRI staff and members of the TEP to discuss the scope, focus, national and state data sources, and types of indicators that should be considered in the pilot. The discussions with the TEP began with the directions and focus identified by the Policy Expert Panel which met via conference call in February 2012.

Input from the Policy Expert Panel

On February 3, 2012, the AHP/NRI team convened a conference call of the project's Policy Expert Panel to receive guidance on the scope and focus of the pilot self-assessment tool for SMHAs. The Policy Expert Panel is comprised of representatives from SAMHSA/CMHS, other HHS Agencies, state representatives, and advocacy and research organizations. During their conference call, the Policy Expert Panel discussed their experiences with how community integration is being defined in its relation to promoting the goals of Olmstead. The experiences of the Policy Expert Panel identified a broad range of community integration focus, encompassing all persons currently receiving care in institutions, persons with mental illnesses living in the community but are "at-risk" of institutionalization, and persons living in the community who are not currently receiving any mental health services.

Traditionally, the Department of Justice (DOJ) and the Department of Health and Human Services' Office of Civil Rights have focused on how integrated individuals are into their communities – where they live, spend their day, and receive services. The Policy Expert Panel noted that DOJ experts define the target population

for community integration to include a broad range of individuals with serious mental illnesses who are institutionalized or at risk of institutionalization, as well as those who receive services in the private sector and other state agencies. Based on the State experiences working with DOJ on Olmstead cases, the panelists recommended that the focus of the pilot must extend beyond those living in state hospitals, and that broader population groups be considered. Potential populations include the following: children, persons served by other state agencies beyond the SMHA (e.g., Medicaid, child welfare, juvenile justice, etc.), persons in jails, and persons who have only received services in the private sector. However, in consideration of the time and resource constraints for this project, the Policy Expert Panel suggested a tiered approach to conduct the pilot that could broaden the target population over time to include focusing on what people do during the day.

Input from the Technical Expert Panel (TEP)

The Technical Expert Panel first met on Friday, February 17, two weeks after the Policy Expert Panel's meeting. During their first call, the panelists discussed ways to organize and structure the various recommendations from the Policy Expert Panel. The TEP held weekly conference calls to develop and refine recommendations regarding the scope of the pilot, types of institutional settings to address, potential community integration indicators and potential data sources.

The content of the tool, set of indicators, and expectations from pilot states that are presented in this document and discussed in succeeding paragraphs embody the recommendations of the TEP for this year's pilot.

Scope of the Pilot

Due to time limitation, the TEP recommends to limit the focus on persons who are receiving mental health services in an institutional setting (leaving persons who are 'at risk' of institutionalization for future work). This recommendation is supported by the following assessments of the TEP:

- Persons living in institutional settings are a population group that can be most easily defined and counted. States have much more information about persons currently residing in institutional settings than on persons in the community or persons not receiving any services.
- Identifying consumers currently living in the community who are "at-risk" of institutionalization is a much more difficult measure to operationalize and does not seem to be consistently measured across states or systems within states.

Identification of Applicable Settings

The TEP discussed various institutional settings that should be included in the pilot by considering the focus of Olmstead litigation and settlements, as well as settings identified by the Policy Expert Panel and findings from the community integration literature review.

Potential settings for 2012 include:

- State psychiatric hospitals
- Nursing homes
- Residential treatment facilities
- Emergency rooms
- Adult care homes
- Jails and prisons (to the extent information is available)
- Others institutional settings unique to specific state

Identification of the Set of Community Integration Indicators

The TEP discussed types of indicators currently being used by states in Olmstead settlements, consent decrees, and state mental health Olmstead Plans. NRI staff conducted a review of various State Olmstead plans and settlements to identify potential indicators.

In addition to working with the Policy Expert Panel and the TEP, AHP/NRI staff discussed the development of the self-assessment tool for SMHA with Elizabeth Priaulx of the National Disability Rights Network (NDRN). Ms. Priaulx set up a conference call with NDRN attorneys working on Olmstead-ADA cases to gather their input for this pilot. A brief report on the call with recommendations regarding indicators and processes for assuring community integration was provided.

NRI presented a long, combined list of about 90 indicators identified from the State Olmstead Plans, Settlement Agreements, NDRN recommendations, and the literature review for review by the TEP. Individual TEP member reviewed each of these indicators and submitted to NRI their independent selection of indicators. NRI tallied the individual choices and presented a short list of indicators (i.e., indicators selected by at least four out of six TEP members were included) to the TEP for a final group review and discussion. A total of about 30 indicators received final recommendation from the TEP for consideration in the pilot. This set of indicators is presented as Part II of the draft self-assessment tool.

In an effort to complete the pilot in a timely manner, and recognizing that this is an initial effort, the TEP limited the number of indicators. It should be noted that these indicators have been developed by policy, not legal, experts and are not intended to define the scope of a state's legal obligation under civil rights laws. They are instead part of a technical assistance effort designed to help states assess their mental health service systems and develop strategies to promote the policy of community integration.

The review of Olmstead Plans, Olmstead Settlements, and literature review all pointed to the need for inclusion of a number of community mental health services and supports, including housing services, when planning for the community integration of persons receiving care in institutions. Thus, even with a recommended focus on persons living in institutions, the recommended pilot Self-Assessment Tool for SMHAs includes several indicators of community capacity to support the consumer moving to and residing in the community.

The Pilot Self-Assessment Tool for SMHAs: Recommended Framework

The tool is comprised of two parts: (1) contextual information and (2) benchmark indicators. Although SMHAs will be relied upon to conduct the pilot self-assessment, the scope is not limited to the SMHA served population. Many community integration indicators that have been identified would require the inclusion of individuals served by Medicaid and other State agencies.

Part I gathers qualitative information that will provide context to the set of indicators that will be piloted. This information will help guide the expert consultants and the State staff in analyzing the trends and values of the indicators as they relate to the overall State system of mental health service delivery and State *Olmstead* activities.

Part II is a set of indicators classified according to dimensions of community integration. Serving as the basic framework for the pilot, this set of indicators will be used as a starting point of discussion with pilot States. Depending on the outcome of this discussion, the overall pilot design process will be finalized --- including the final selection of pilot indicators, agreement on the indicator specifications, identification of applicable institutional settings, and the assessment process.

During the pilot stage, technical expert consultants will work with State staff to access, analyze, and interpret the data that will be collected using the self-assessment tool. Although information from the self-assessment tool will not be submitted to SAMHSA or its contractors, participating States will be asked to submit a report (more details will be spelled out in the pilot protocol) that documents their experiences in the pilot, utility of the self-assessment tool, adequacy or inadequacy of the piloted indicators, and recommendations on how the process and the tool can be further refined.

Part I. Contextual Information

1. ***Role of SMHA in Olmstead implementation.*** Does your State have a current *Olmstead* Plan that addresses mental health? If yes, does that plan cut across multiple agencies, or is it targeted specifically toward the SMHA? What was the SMHA's role in development of the plan? What is the process for evaluating progress in implementing the plan (e.g., do you set targets)? **Please attach your plan (or provide a link to its location on the Web), and be sure to include the last revision date.**
2. ***State Olmstead Investigations.*** Is your state currently, or anticipating coming under an Olmstead investigation? If so, what is the focus of the investigation? What is the service population targeted?
3. ***Identifying and evaluating consumers in institutional settings***. How do you evaluate the status of consumers in institutional settings - please specify which settings are covered (i.e., Is there a mechanism that periodically assesses consumer's readiness for discharge? Do you identify consumers who are ready to leave and receive services in a community setting? Is there a process that facilitates timely discharge? Do you keep a waiting list of consumers ready for discharge, and if so, do you evaluate the waiting list?)
4. ***Interagency collaboration to promote community integration.*** How does the SMHA collaborate with other State agencies in promoting community integration (provide 2 to 3 examples)? For example, how is your SMHA working with State housing agencies to increase available community living settings?
5. ***Use of Medicaid to fund services that promote community integration.*** Does your state have a Medicaid HCBS Waiver or Option that is used for mental health services? If yes, please describe. If not, is your state pursuing 1915(i) Option or 1915(c) waivers? Is your state using "Money Follows the Person" or other special Medicaid funding to support community mental health services?

6. ***Follow-up activities to sustain community transition/integration.*** Do you monitor consumers who transitioned from an institutional setting to the community? Do you have specific indicators to determine how well consumers transition from an institutional setting into the community? What specific indicators are used? If so, how often is the measurement activity conducted?
7. ***Diversion programs and related activities to keep consumers in integrated settings and prevent unnecessary institutionalization.*** Does your SMHA engage in any activities, or implement any programs to divert consumers to appropriate mental health services? If yes, please briefly describe these programs, the partnerships necessary to make them work, and how they are sustained.
8. ***Budget development to finance community integration.*** How does your SMHA incorporate community integration to facilitate transition and diversion in its budget development process? What data are gathered and used? How does your SMHA calculate the cost savings that can be achieved and what expenditures are needed?
9. ***Affordable housing.*** Does the cost of living/renting an apartment reduce the number and availability of housing vouchers available to persons with mental illness in your state?
10. ***Use of peer services.*** Does your state rely on peers to assist consumers with transitions into the community? If yes, please describe. What other types of peer support services are offered in your state?

Part II. Indicators of Community Integration

The identified set of indicators applies to persons with SMI and SED receiving services and care from any institutional settings who may potentially experience unjustified segregation. The following institutional settings included in the pilot are defined as follows:

State Psychiatric Hospitals provide services to consumers with high levels of need, including those who are a threat to themselves or others. These facilities provide acute care services, long-term treatment, and forensic services to mental health consumers. For the purpose of this pilot, long-term forensic patients (including sexually violent predators) are excluded from the pilot to the extent that they can be identified. Long-term, forensic patients include defendants in legal cases who were acquitted **not guilty for reason of mental insanity** (NGRI); defendants convicted as **guilty, but mentally ill**; persons **transferred from prison to the State hospital** for mental health treatment and persons who have been determined **Incompetent to Stand Trial**. Additionally, States that have **Sexual Offender or Sexual Predator** laws that allow for a civil or criminal commitment to psychiatric facilities of convicted sex offenders deemed to need treatment should exclude these patients from the census for this pilot. The care and treatment of forensic patients, particularly the NGRI, is usually long term and their release is subject to more stringent conditions (usually approved by criminal justice courts) compared to patients under civil commitment. If a State's forensic population includes persons admitted for **pretrial competency evaluations** and these pre-trial evaluations are considered long-term, these should also be excluded from this pilot study.

Nursing Homes provide services to persons with significant medical conditions, who have been assessed as needing nursing level of care, but who are not acutely ill enough to require treatment in a hospital. The majority of nursing home residents tend to be older adults, but children and younger adults with disabilities are also served by nursing homes. Studies estimate that nearly 50 percent of those receiving care in a nursing home have a mental illness (Mental Health and Aging, 2012). Nursing homes provide on-site access to staff 24 hours per day.

Adult Care Homes and Other Congregate Living Settings: Each State has different nomenclature for adult care homes. For the purpose of this pilot, adult care homes are defined as any congregate

residential settings targeted toward people with low income, where more than half of the residents have psychiatric disabilities. This setting includes group homes for persons with mental illness funded by State or county funds.

Residential Treatment Centers are often used to provide services to children; however, these facilities sometimes provide services to adults and older adults. All licensed residential treatment facilities are included in this pilot.

Jails and Prisons: Many persons with mental illnesses end up in jails or prisons due to a lack of alternative (diversionary) community services and other supports.

On succeeding pages, the set of indicators being considered for the pilot is grouped according to five dimensions of community integration taken from the perspective of a timely and appropriate transitioning of consumers from a segregated setting (institution) to a community setting. The five dimensions are: financing/resources, movement to community and recidivism, community capacity, housing, and well-being. Under each dimension, several indicators are presented. Several of these indicators are highlighted in red indicating that they have been identified as core indicators. All of the core indicators received unanimous support from all six members of the TEP; signifying the importance of these indicators.

Expectations from Pilot States:

SMHAs are expected to perform the following activities related to the piloting of the self-assessment tool:

1. Complete the contextual information outlined in Part 1 of the tool. Specific guidelines for completion of this requirement will be provided in the pilot protocol, which is a separate document.

2. From the set of indicators presented in Part 2, the pilot SMHAs are expected to aggregate, compile and analyze data as may be required to report the indicators. The TEP, in consultation with the pilot SMHAs, will identify the final set of indicators and corresponding applicable institutional settings that participating SMHAs will report at the end of the pilot period. Observing the given timeframe, pilot SMHAs, as they may so desire, will be encouraged to extend the scope by identifying additional indicators and/or institutional settings.

3. To the extent possible, pilot SMHAs will be requested to analyze at least three years' worth of data to allow for trending. When appropriate, the indicators should be applied to both children and adults. There should be a separate analysis of the indicators for each population. Please note that although no data will be submitted to SAMHSA or to the contractors, the pilot SMHA, with assistance and guidance provided by the technical expert consultants, should be able to interpret the utility of these indicators in their overall effort of advancing community integration. The pilot protocol will include a recommended reporting template for State use.

4. Depending on the selected indicators and corresponding institutional settings, the pilot SMHA may need to reach out to other State agencies or institutions to collect data. This may involve identifying and accessing other available data sources. Along this line, a pilot SMHA with separate mental health systems for children and adults may need to coordinate their effort in order to have a single State reporting. Similarly, SMHAs that do not have direct access to the State hospital database may need to establish a process to facilitate data collection.

5. Track State experience in data collection, reporting, analysis, and interpretation. Submit a report to SAMHSA on their experience with the pilot as it relates to the usefulness of the self-

assessment tool in providing guidance to State planning, programming, and allocating resources; effectiveness of the tool in identifying areas where the State shows strength in its capacity and areas where resources, training and technical assistance are needed; barriers and challenges in conducting the pilot and advancing the State community integration efforts; and recommendations to improve the self-assessment tool and process.

Benefits to SMHAs for participating in the pilot:

- Gain a better understanding of the strengths and weaknesses of the State mental health system
- Be able to focus *Olmstead* and MHBG Plans on identified community integration needs
- Help SAMHSA and the mental health field develop a self-assessment tool for use by other States and other systems.

References:

Bazelon. (2010). *Community integration.* The Judge David L. Bazelon Center for Mental Health Law. Washington, D.C. Accessed 28 Jan 2012 via http://www.bazelon.org.

Department of Justice. (2011). *Statement of the Department of Justice on enforcement of the integration mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.* Accessed 28 Jan 2012 via http://www.ada.gov/olmstead.

Mental Health and Aging (2012). *Mental Health Services in Nursing Homes.* Accessed 3 April 2012 via http://www.mhaging.org/find-nh.html.

National Institutes of Health. (2012). *Nursing Homes.* Accessed 2 April 2012 via http://www.nlm.nih.gov/medlineplus/nursinghomes.html.

Recommended Set of Indicators for Advancing Community Integration

(Refer to notes at the end of this table)

Domain	Indicator	Indicator Specifications		Applicable Settings	Applicable Population	Data Sources	Additional Considerations
		Numerator	Denominator				
Financing/ Resources	Increase in funding for community-based programs	**1.** State MH expenditures on community-based programs	Total State mental health expenditures *(If possible, states should include SMHA, Medicaid, and any other funding sources the SMHA can identify. See Comment under Additional Considerations)*	SMHA/State System	SMHA served population, children and adults Should be reported at a minimum as Children & Adults (using state definitions) Pilot States recommended Reporting using URS age groups: (1) Children (age 0-17) and (2) Young adults 18-20 and (3) Adults 21 and over	Revenues & Expenditures Medicaid claims NDS for nursing homes SMHA MIS	Expenditure data may be collected as: • aggregate • by institution • by population (adults/children) • by service type Comment: If available, additional funding streams may be considered, but should be separated and identified as such.
		2. State expenditures on psychiatric hospital/inpatient care	Total State mental health expenditures *(If possible, states should include SMHA, Medicaid, and any other funding sources the SMHA can identify)*	SMHA/State System By institution (e.g. State Hospital, Nursing homes, RTCs)			
		3. Number of HCBS slots available	State SMI/SED population	SMHA/State System	Adults w/SMI Children w/SED	Medicaid SMHA MIS	Alternate denominator: Medicaid-eligible population or Number of persons with SMI/SED transitioning to the community
Movement to community and recidivism	Decrease in length of time waiting to be discharged	**4.** Number of persons with SMI/SED awaiting discharge by type of institution for more than three months	Institutional census # of persons discharged	By institution (see list of institutional settings)	Adults w/SMI Children w/SED	Institutional databases SMHA MIS Comment: At least one pilot state indicated they have a standardized assessment that identifies patients ready to be discharged. States that have such a measure should use it. If the state doesn't have such an assessment, they should skip this measure.	Alternate denominator: # of persons with SMI/SED deemed eligible and ready to transition; Or average daily census, by institution Other time factor may be considered, e.g. awaiting discharge for 30 days or more than 1 year, etc.

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(Refer to notes at the end of this table)

Domain	Indicator	Indicator Specifications		Applicable Settings	Applicable Population	Data Sources	Additional Considerations
		Numerator	Denominator				
	Decrease in Length of Stay	**5.** Number of Patients in the Institution w/ Length of Stay > One Year (at end of year) **6.** Number/% of Persons w/ LOS > 1 year discharged during year	1, Total Number of Persons in Institution 2. Number of Persons Served w/ LOS greater than one Year	By institution	Adults w/SMI Children w/SED	Institutional databases SMHA MIS	
	Decrease in readmission rate	**7.** Number of persons with SMI/SED readmitted to any (or same) type of institution within six months	Institutional census # of persons discharged	By institution (see list of institutional settings)	Adults w/SMI Children w/SED	Institutional databases SMHA MIS	Other time factor may be considered, e.g. readmission within 30 days Comment: At a minimum, states should look at readmissions to any state psychiatric hospital in their state. However, if states are able to measure readmission to any institutional setting (including jails, prisons, nursing homes, adult care homes, residential treatment centers, etc.) that would be a better measure. States should report which levels of institutional settings they are able to measure readmissions across.
	Decrease in utilization rate of institutional settings	**8.** Number of persons with SMI/SED admitted to institutional care	State SMI/SED population	By institution (see list of institutional settings)	Adults w/SMI Children w/SED	Institutional databases SMHA MIS	Use State definition for SMI/SED
		9. Average daily census (calculated by sum of total patient days during the year/365)	365 (for average daily census)	By institution (see list of institutional settings)	Adults w/SMI Children w/SED	Institutional databases	Alternate denominator: total bed capacity (for an alternate indicator – Percentage of capacity)
		10. Number of licensed psychiatric beds available	State SMI/SED population	By institution (see list of institutional settings)	Adults w/SMI Children w/SED	Institutional databases	Comment: Can be operationalized depending on each state's situation. For example, number of licensed beds available on the Last Day of the Year (each year), or whatever is easiest for states to report.

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(Refer to notes at the end of this table)

Domain	Indicator	Indicator Specifications: Numerator	Indicator Specifications: Denominator	Applicable Settings	Applicable Population	Data Sources	Additional Considerations
		11. Number of persons w/ SMI/SED declining transfer into the community	Number of persons awaiting discharge from an institution (see list of applicable settings)	By institution (see list of institutional settings)	Adults w/SMI Children w/SED	Institutional databases	Comment: This is a measure that some states track as part of their Olmstead settlements. If your state has this information, please report it. If your state does not allow patients to decline discharge, please indicate this in the contextual section.
		12. Number of persons w/SMI admitted to nursing homes identified through PASRR Assessments	Nursing Home Census	Nursing homes	Adults w/SMI	CMS Minimum Data Set	
	Increase in percentage of persons with SMI receiving housing support services	**13.** Number of persons w/SMI receiving permanent supported housing	State SMI population Potential alt. denominator: Clients receiving Housing Services/ Supports	SMHA/State System	Adults w/SMI	State Housing Agency SMHA MIS	Number waiting for supported housing services
		14. Number of persons w/SMI receiving Supervised Housing	State SMI population	SMHA/State System	Adults w/SMI	State Housing Agency SMHA MIS	
		15. Number of persons w/SMI receiving Other Housing Services	State SMI population	SMHA/State System	Adults w/SMI	State Housing Agency SMHA MIS	
		16. Number of housing vouchers and slots available by type for persons w/mental illness	State SMI population	SMHA/State System	Adults w/SMI	State Housing Agency SMHA MIS HUD	
	Increase in housing subsidy per capita	**17.** # persons with SMI receiving housing subsidies	State SMI population	SMHA/State System	Adults w/SMI	State Housing Agency SMHA MIS	Housing Subsidies are not included in the vouchers/slots reported above. These are often supplements provided to consumers to help them make rental payments.

Recommended Set of Indicators for Advancing Community Integration

(Refer to notes at the end of this table)

Domain	Indicator	Indicator Specifications Numerator	Indicator Specifications Denominator	Applicable Settings	Applicable Population	Data Sources	Additional Considerations
	Decrease in length of time on housing waiting lists	**18.** Number of persons with SMI on a housing waiting list	State SMI population	SMHA/State System	Adults w/SMI	SMHA/Provider housing MIS	How many consumers are on a waiting list by the length of time People are waiting: 3 months or less 3 to 6 months 6 months to 12 months 2 years (or more)
		19. Average wait time of for housing (months)		SMHA/State System	Adults w/SMI	SMHA/Provider housing MIS	
Community Capacity	Increase in utilization rate of community-based services	**20.** Number of persons w/SMI/SED receiving targeted case management services	State SMI/SED population	SMHA/State System	Adults w/SMI Children w/SED	SMHA MIS	
		21. Number of persons with SMI receiving Assertive Community Treatment (ACT)	State SMI/SED population	SMHA/State System	Adults w/SMI	SMHA MIS	Alternate numerator: # of persons with SMI receiving ACT who have a history of institutionalization (this demonstrates how it helps with diverting people from institutions)
		22. Number of persons with SMI enrolled in supported employment	State SMI population	SMHA/State System	Adults w/ SMI	SMHA MIS	
		23a. Number of persons with SMI employed **23b.** Number of persons served by SMHA who were employed.	State SMI population	SMHA/State System	Adults w/SMI	SMHA MIS	
		24. Number of children with SED receiving wraparound services	Number of Medicaid-eligible children	SMHA/State System	Children w/SED	Medicaid SMHA MIS	Recommended combining all community services that are an alternative to institutionalization. Alternate numerators: Number of children with SED receiving any evidence-based practices – or – # of children with SED receiving TFC, MST, FFT, etc.

Recommended Set of Indicators for Advancing Community Integration

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Domain	Indicator	Indicator Specifications		Applicable Settings	Applicable Population	Data Sources	Additional Considerations
		Numerator	Denominator				
		25. Number of crisis residential beds available for inpatient diversion	State SMI /SED population	SMHA/State System	Adults w/SMI Children w/SED	SMHA MIS	Depends on state operational definition
		26. Number of children receiving in-home services	State SED population	SMHA/State System	Children w/SED	SMHA MIS	Look at procedure code modifiers for place of service.
		27. Number of SED persons receiving family-support services	State SED population	SMHA/State System	Children w/SED	SMHA MIS	
		28. SMI emergency room admissions to general hospital	State SMI population	SMHA/State System	Adults w/ SMI	SMHA MIS	
Well-Being	Increase in the percentage of persons expressing social inclusion or connectedness	**29.** Number (%) of consumers reporting positive Social Connectedness (MHSIP Survey module)	State SMI population responding to consumer survey	SMHA/State System	Adults w/ SMI	SMHA MIS	
	Increase in percentage of consumers involved with peer run (self-help) services	**30.** Number of persons involved in peer support programs (including clubhouse programs)	State SMI population	SMHA/State System	Adults w/SMI	SMHA MIS	