



Integration for All:

Rhode Island Olmstead Plan 2025– 2030

WORKING DRAFT
Version 1.0 | February 2025



[Community Preamble: In Progress]

Table of Contents

Plan Dedication and Acknowledgements	5
Dedication	5
Acknowledgements	5
Accessibility	5
Executive Summary	6
Navigating Rhode Island’s Olmstead Plan	6
The Importance of Olmstead Planning in Rhode Island	6
<i>Integration for All</i> at a Glance	7
Get Involved with Rhode Island’s Olmstead Efforts	8
Background	9
What was the Olmstead Ruling?	9
How Do States Comply with This Ruling?	10
What Makes a Strong Olmstead Plan?	10
Who is Covered by Olmstead?	11
Rhode Island Olmstead Planning	12
Rhode Island Executive Order on Olmstead	12
Guiding Priorities and Planning Principles	13
Planning for the Needs of All Disability Types	14
Engaging People with Lived Experience	15
Addressing Unnecessary Restrictions	15
Ensuring Meaningful and Safe Community Integration	16
Using Existing Models as a Guide	16
Building on What Works	17
Plan Writing Process	20
Phase 1: Building Capacity	21
Phase 2: Engaging the Community	24
Phase 3: Identifying Relevant Data, Assets, and Resources	28
Phase 4: Writing the Plan and Getting Public Comment	28
Phase 5: Refining the Plan Over Time	29
Phase 6: Evaluating and Reporting on the Plan	30
Current State of Disabilities in Rhode Island	32
Disability Data at a Glance	32
Learnings from Community Engagement	35
Existing State and Community Asset Inventory	38
Resource Investments: Past and Present	42
Consent Decree Progress	45

Implementation Plan	46
Olmstead Vision for Rhode Island	46
Goals, Outcomes, and Associated Recommendations	47
Moving Forward to Make the Olmstead Plan a Reality	57
Moving Forward	57
For More Information About This Plan	58

Appendix List*

- 1. Volume 1: Key References**
 - 1.1. Acronyms List
 - 1.2. Key Meeting Dates/Summaries
 - 1.3. Complete List of Stakeholders and Partners
 - 1.4. Public Comment Presentation
 - 1.5. Accessible Meetings Guide

- 2. Volume 2: Detailed Findings**
 - 2.1. Community Listening Sessions Feedback Report
 - 2.2. Full Map of Implementation Plan
 - 2.3. Full Asset Inventory (and Past Investments from OMB)
 - 2.4. Full Data Inventory by Agency and Community Partners
 - 2.5. Olmstead Alignment With Healthcare System Planning Recommendations
 - 2.6. Olmstead Vignettes

- 3. Volume 3: Detailed Methods**
 - 3.1. Community Listening Sessions Process
 - 3.2. Key Informant Interviews
 - 3.3. Community Survey
 - 3.4. Lived Experience Application for OAG
 - 3.5. Planning Workgroup Guide

- 4. Volume 4: Additional Resources**
 - 4.1. Executive Order
 - 4.2. Community Engagement and Planning Forum Agenda
 - 4.3. TAC Olmstead Presentation
 - 4.4. Other State Plans Review
 - 4.5. BHDDH Consent Decree Overview

**NOTE: The appendices will be available with Version 2.0 of the plan as public comment is received.*

Plan Dedication and Acknowledgements

Dedication

The Executive Office of Health and Human Services (EOHHS) dedicates the *Integration for All: Rhode Island Olmstead Plan* to those with lived experience whose expertise, feedback, and courage guided this plan. Thank you to those who served on the Olmstead Advisory Group (OAG), attended the Olmstead Community Forum, participated in workgroups, completed online surveys, and/or participated in interviews and Community Listening Sessions.

Acknowledgements

Developing this plan required authentic partnerships. These partnerships were crucial to ensuring a whole-of-government approach to this work and inspired and instilled a whole-of-community focus to planning. A whole-of-government approach is when agencies across state and local government come together and work with each other on a project. EOHHS would like to give special thanks to:

- The Olmstead Sub-Committee of the Governor’s Council on Behavioral Health for the vital work that pre-dated this effort
- The OAG and planning workgroups for their insights
- Community partners for hosting informative, fast-paced Community Listening Sessions
- The Governor’s Commission on Disabilities, Rhode Island Commission for Deaf and Hard of Hearing, and Real Access Motivates Progress for helping us ensure meetings are accessible to all
- State agency colleagues who dedicated their time and expertise to this process
- Champions across the executive and legislative branches

Accessibility

This plan was written using plain language whenever possible and designed following 508 compliance standards. When *Olmstead* challenges and solutions were written using legal or otherwise complicated terms, the planning team attempted to define them and provide examples. In partnership with the community, the planning team will continue to work to make future versions of the plan as accessible and understandable as possible.

During the planning process, the team also worked to increase accessibility. All OAG meetings were public and held in person. The Virks Building at EOHHS was chosen because of the accessible layout of the building, restrooms, and parking. Tables were arranged to allow for easy access and navigation for individuals with mobility equipment, interpretation services, and supporters or caregivers. Microphones were used and amplifiers were provided to those with hearing accessibility needs. Quiet spaces were provided for those who needed them.

American Sign Language (ASL) interpretation was provided for all OAG meetings and for planning workgroups as requested. Printed materials and color-appropriate audio-visual presentations were provided to attendees. Closed-captioning reminders were provided to those participating in workgroups on Zoom or Microsoft Teams. When possible, meetings were held later in the day to allow for the opportunity for participation with the least disruption to daily routines.

Executive Summary

The *Olmstead* Supreme Court decision (*Olmstead v. L.C.*, 1999) affirms that states must provide support to people with disabilities to live in their communities—not in institutions like nursing homes and psychiatric hospitals—if they choose. The *Integration for All: Rhode Island Olmstead Plan* outlines how the State will work to ensure that people with disabilities can live independently and receive needed services and support in their communities. The plan focuses on breaking down barriers, improving access to services, and promoting choice and dignity for individuals with disabilities, in line with the Americans with Disabilities Act (ADA). The *Olmstead* decision and state Olmstead Plans apply to all persons with a disability under the ADA. In Rhode Island, this applies to one in three adults with a disability, and more than one in five children with special healthcare needs.

Navigating Rhode Island’s Olmstead Plan

This Olmstead plan is the State’s first. It spans from 2025 to 2030, and outlines the State’s planning process from start to finish.

- The **Background** section explains the Olmstead Supreme Court ruling and what states must do to comply.
- The **Rhode Island Olmstead Planning** section summarizes the groundwork, guiding principles, and community engagement efforts that led to the plan’s creation, along with key considerations and models that influenced the planning team’s approach.
- The **Plan Writing Process** section details the four phases the team followed to ensure meaningful community engagement.
- The **Current State** section summarizes the results of this community engagement, provides data on unequal outcomes for people with disabilities, and maps out Rhode Island’s strengths and resources for supporting community integration.
- The **Implementation Plan** section outlines the vision, goals, recommendations, and intended outcomes for people with disabilities and their supports.
- The **Moving Forward** section explains what is needed from the State and key partners to ensure successful implementation of the plan, as well as continued progress and benefits for people with disabilities moving forward.

The Importance of Olmstead Planning in Rhode Island

Developing this plan strongly aligns with Rhode Island’s broader [Rhode Island 2030 Strategy](#). Both initiatives prioritize community integration, equity, and access to essential resources, ensuring that people of all abilities can live independently and fully participate in society. This plan supports RI 2030’s key priorities focused on:

- inclusive communities and affordable housing
- equitable healthcare services
- workforce development and economic growth
- reliable transportation and infrastructure
- support for children and families

Integration for All at a Glance

In August 2024, Rhode Island Governor Dan McKee signed [Executive Order 24-11](#) to strengthen collaboration across government and community partners to improve services and opportunities for people with disabilities. EOHHS sought federal approval for Olmstead planning through one-time Medicaid funds for home- and community-based services (HCBS e-FMAP funds). With this approval, the legislature directed that \$250,000 of these funds be invested in one-time Olmstead planning efforts as part of the state budget. Additionally, EOHHS invested an additional \$582,000 of one-time funding to further support this effort. These funds ended on February 28, 2025.

The Executive Order also required collaboration with government agencies and the creation of an OAG to guide and track progress from the perspective of community partners and individuals with lived experience. Based upon this collaboration, the following vision for this plan was formed:

Rhode Island is committed to being a state where people of all abilities—and their families and caregivers—are fully included in their chosen community and supported by the resources needed to live a fulfilling life. Rhode Island will be a place where dignity and respect are felt by all, regardless of ability. In Rhode Island, structures will be transformed, and information will be readily available, so that people with disabilities can make meaningful choices, participate in every aspect of life, and freely pursue their goals and aspirations without judgment, stigma, and/or discrimination.

Rhode Island Olmstead Plan Highlights

Some of the accomplishments and findings documented in this plan are highlighted below.

- Between August 2024 and February 2025, **44** community members representing the OAG met monthly to guide the development of the Olmstead Plan, while representatives from **26** different government agencies provided additional support and input.
- **Over 500** people with disabilities or who support those with disabilities provided input through key informant interviews, surveys, and Community Listening Sessions. The feedback came from a diverse group, including parents and caregivers, youth, and individuals with multiple disabilities. The responses were provided in various languages, such as English, Spanish, and ASL. Additionally, the input reflected a broad range of communities, including Black, Indigenous, and People of Color (BIPOC), formerly incarcerated, unhoused, and veterans from across the state.
- Feedback for this plan included **over 105** returned community surveys, **42** key informant interviews, input from **eight** individuals with lived experience appointed to the OAG, and **430** members of the disability community reached by 12 community organizations who held Community Listening Sessions. From this feedback, the following themes emerged:
 - **Social factors significantly affect individuals with disabilities**, including housing accessibility and affordability, employment and financial barriers, and transportation accessibility issues.
 - **Community capacity for individuals with disabilities is critical**, including ensuring community services, community involvement and inclusion, and transitions and discharges into community living.
 - **Systemic and quality issues exist for individuals with disabilities**, including stigma and discrimination, workforce and related healthcare gaps, and educational opportunity needs.

- **Structural changes are needed for individuals with disabilities**, including reducing siloed systems, moving past using the criminal justice system as a default care option, and improved data systems for decision-making.
- Four public workgroups met five times each, ranging from **26 to 49** participants per meeting. These meetings generated a total of six goals, 12 strategies, and **73** community-prioritized recommendations for this plan.
- Additionally, over **120** existing assets and many data sources were identified and, where relevant, mapped to the key outcomes for this plan. This plan also documents past investments, proposed investments, and progress made toward consent decrees in Rhode Island.
- **Three** public comment workshops were held; two were with community partners and individuals with lived experience and one was with the OAG. There was also an ongoing public comment submission form that remains live on the EOHHS website.
- **At least 13** plan presentations are being scheduled with the existing coordinating bodies to share the findings of this plan, including the Governor’s Council on Behavioral Health, Governor’s Overdose Task Force, and the EOHHS Independent Advisory Council.

This community-led plan is intended to serve as a guide for executive and legislative branch decision-making on policy changes and investment strategies. While there is always more work to be done, this plan provides Rhode Island with a blueprint for making the State’s Olmstead vision a reality. Annual progress reports and public dashboard updates will track investments and progress being made towards the plan’s goals and outcomes, as required by the Executive Order.

Get Involved with Rhode Island's Olmstead Efforts

EOHHS plans to continue involving the community every step of the way.

There are many ways to stay involved with Olmstead Plan implementation efforts. Community members can join regular meetings of the OAG, where the team will discuss progress, challenges, and updates to this plan. Each year, the State will review and update the group's membership to ensure it has expertise in emerging areas of need. EOHHS also hopes to hold Community Listening Sessions at least once per year, giving everyone interested a chance to share their experiences and suggestions. Your feedback will help us adjust the approach and better serve the community. Additionally, with community involvement through various planning workgroups, the State intends to issue a new version of the plan every five years, ensuring it continues to meet evolving needs.

You can engage now in the following ways:

1. [Sign up for EOHHS's *Integration for All* newsletter.](#)
2. **Check out the [Olmstead planning website](#).**
3. **Come to an Olmstead Advisory Group meeting. [See the schedule here](#).**

Background

What was the *Olmstead* Ruling?

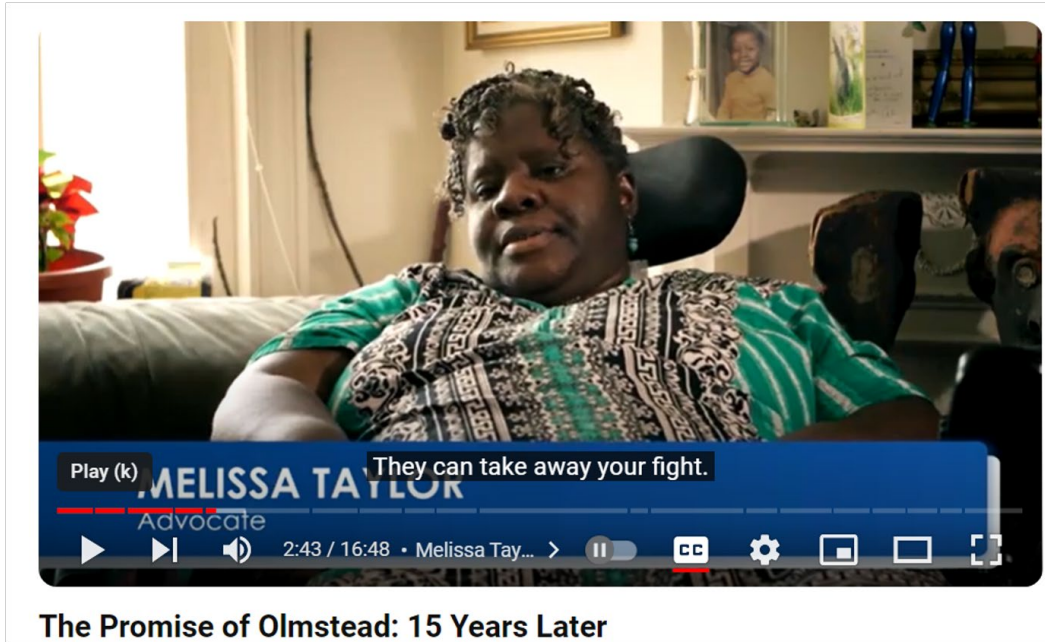
The *Olmstead v. L.C.* Supreme Court case of 1999 began when two women with disabilities, Lois Curtis and Elaine Wilson, were placed in a psychiatric institution even though doctors agreed they could live in the community with proper support. The women sued the state of Georgia, arguing that keeping them in an institution unnecessarily violated their rights under the ADA. The Supreme Court ruled in their favor, stating that people with disabilities have the right to live in community settings rather than in institutions when appropriate support is available.

Because of this ruling, all states are now required under the ADA to provide support for individuals with disabilities to live, work, receive services, and participate in activities in the least restrictive setting, as preferred by the individuals. The *Olmstead* ruling says that states must support individuals with integration into their community when:

- A doctor or specialist agrees that living in the community is the right choice
- The person does not oppose the community-based services
- The state can provide the support needed without taking away resources from others with disabilities

In the ruling, the Supreme Court also described why community integration is so important. Failing to do so reinforces hurtful stereotypes that people with disabilities cannot or do not deserve to participate in community life, the majority Justices wrote. It also limits an individual's ability to spend time with family, socialize, work, be financially independent, get the education of their choice, among other activities.¹

¹ [Olmstead v. L.C.](#), 527 U.S. 581 (1999)



[The Promise of Olmstead: 15 Years Later \(Link to Video\)](#)

How Do States Comply with This Ruling?

The Supreme Court set a standard to make sure each state complies with the *Olmstead* ruling and the ADA. A state meets the standard if it “demonstrates that it has a comprehensive, effectively working plan”,² meaning it has a clear, active plan to help people with disabilities live in the least restrictive and most preferred setting possible. This plan is often called an “Olmstead Plan”. The state may have a waiting list for services, but it must not keep people waiting too long for them. Also, states cannot keep individuals in facilities longer than needed just to keep beds filled.³

Why Are Olmstead Plans Needed?

An Olmstead Plan is a community asset that documents ways that a state is working to avoid isolating individuals with disabilities. This is needed because isolation and confinement affect everyday aspects of life such as family relationships, social contacts, work options, education, finances, and recreation. Rhode Island’s Olmstead Plan helps to document what is being done to support individuals.

It also aligns with each of the five EOHHS strategic priorities:

1. Focus on social, economic, and environmental factors that cause health problems, and make sure everyone has the chance to be healthy.
2. Make healthcare services work together to provide quality and fair care for everyone.
3. Improve mental healthcare, provide help to treat addiction, and reduce bias and stigma.
4. Create a diverse healthcare workforce to meet everyone’s needs.
5. Improve health technology and systems to provide better care and value.

² [Olmstead v. L.C.](#), 527 U.S. 581 (1999)

³ [Olmstead v. L.C.](#), 527 U.S. 581 (1999)

What Makes a Strong Olmstead Plan?

Without a clear and effective Olmstead Plan, a state may not be meeting its legal duty to support people with disabilities in their communities. Without a strong plan, a state may risk lawsuits for not following the ADA and could be required to act through legal processes. For a state to legally show it is complying with the Olmstead ruling, it must commit to increasing community-based options and dedicating funding to meet its commitments.

A strong Olmstead Plan should:

- Show how well the State provides support for people with disabilities to live in the community
- Provide a clear plan to improve the support and opportunities available for people with disabilities
- Include specific deadlines and goals so the State can manage and monitor progress over time
- Have resources dedicated to making progress, even if it means changing plans for existing funds
- Identify which groups of people may be in facilities (nursing homes, prisons, and psychiatric hospitals) unnecessarily, and explain how they can be moved into the community
- Show that people are actually leaving institutions as soon as possible and getting the support they need to live independently

Who is Covered by Olmstead?

The ADA defines an individual as having a disability if they have a “physical or mental impairment that substantially limits one or more [specified] major life activities,” if they have a “record of such an impairment”, or are “regarded as having such an impairment.”⁴ In other words, someone is considered to have a disability if they have or had a physical or mental condition that makes everyday activities difficult. If someone believes you have a disability, you are also covered by *Olmstead*.

Olmstead and state Olmstead Plans apply to more than individuals who are currently institutionalized or isolated. They also apply to individuals who are *at risk of* being placed in institutions unnecessarily or isolated.

⁴ [U.S. Department of Justice](#), *Americans with Disabilities Act (ADA) Definition of Disability (1990)*

Rhode Island Olmstead Planning

"Disability only becomes a tragedy when society fails to provide the things we need to lead our lives—job opportunities or barrier-free buildings." - Judy Heumann, disability rights advocate

Rhode Island began Olmstead planning in 2020 when the Governor's Council on Behavioral Health formed an Olmstead Sub-Committee. This committee identified the need for better community support for people with disabilities and recommended that the State invest in Olmstead planning. EOHHS sought federal approval for Olmstead planning through one-time Medicaid funds for home- and community-based services. Soon after receiving approval, the legislature directed in the state budget that \$250,000 of these funds be invested in Olmstead planning. Additionally, EOHHS invested an additional \$582,000 of one-time funding to host accessible meetings, translate materials, comply with 508 standards, pay community members for their expertise, and develop anti-stigma public messaging. These funds ended on February 28, 2025.

Rhode Island Executive Order on Olmstead

In August of 2024, Governor Dan McKee signed [Executive Order 24-11](#) to strengthen collaboration across government and community partners to improve services and opportunities for people with disabilities.

The Executive Order tasked EOHHS with facilitating the Olmstead planning process by:

- Developing a draft Olmstead Plan by February 2025, with a final version to follow public comment
- Reviewing and updating the plan every five years to keep it relevant
- Monitoring progress and formally reporting updates to state leaders annually
- Collaborating with government agencies and the creation of an OAG to guide and track progress from the perspective of community partners and individuals with lived experience

Between August 2024 and February 2025, the 44 community members representing the OAG met monthly to guide the development of the Olmstead Plan, while representatives from 26 different government agencies provided additional support and input, as described later in this plan.

The community significantly shaped this plan. Over 500 people with disabilities or who support those with disabilities provided input through key informant interviews, surveys, and Community Listening Sessions. The feedback came from a diverse group, including parents and caregivers, youth, and individuals with multiple disabilities. The responses were provided in multiple languages, including English, Spanish, and ASL. Additionally, the input reflected a broad range of communities, including BIPOC, formerly incarcerated, unhoused, and veterans, from across the state.

Based on the areas of need identified through this input and using the planning framework (described in detail below) that was informed and approved by the OAG, four workgroups were formed. These workgroups were made up of individuals with lived experience, community partners, and state agency staff. Input from these groups inspired and provided meaningful contributions to the creation of the recommendations listed in the [Implementation Plan](#) section. This input focused on four key areas:

- Housing
- Access to community services
- Preventing abuse, neglect, stigma, and discrimination
- Discharge and transition planning

Guiding Priorities and Planning Principles

The OAG adopted the following principles to guide the planning process and ensure that people of all abilities—along with their families and caregivers—can live fulfilling lives:

- 1. Fostering Inclusion and Community Integration**
Everyone should have the opportunity to live, work, and participate in their community in a way that is welcoming, accessible, and supportive. We promote understanding, acceptance, and equal opportunities for all.
- 2. Honoring Personal Choice and Support**
People should have the ability to make decisions about their own care and receive services that reflect their goals, needs, and preferences. We support transitions from restrictive settings to community living whenever possible and preferred.
- 3. Preventing Unnecessary Restrictions**
We work to identify and address the factors that lead to being unnecessarily placed in a facility before it happens by expanding community-based options, improving policies, and strengthening support systems.
- 4. Listening to Lived Experiences**
We recognize and respect the diverse backgrounds, identities, and experiences of people with disabilities, including differences in disability type, race, ethnicity, geography, gender identity, sexual orientation, and language.
- 5. Serving the Whole Disability Community**
Our efforts include individuals with any type of disability, including physical disabilities, mental health conditions, substance use disorders (SUDs), and intellectual or developmental disabilities.
- 6. Supporting People Across Their Lifespan**
From pre-birth, through childhood and adulthood, to end-of-life care, we consider the needs of individuals at every stage of life.
- 7. Addressing Community Barriers**
We work to remove systemic obstacles that impact health and quality of life for people with disabilities, ensuring universal access to services and opportunities.
- 8. Building on Strengths**
We learn from what has worked today or in the past and use those successes to create lasting improvements.
- 9. Balancing Short- and Long-Term Goals**
We focus on both immediate solutions and long-term changes to create a more inclusive future.
- 10. Aligning with Ongoing Efforts**
We coordinate with other state, local, and community initiatives to enhance our impact and ensure consistency across efforts.
- 11. Encouraging Collaboration**
We bring together government agencies, businesses, and community organizations to work toward shared goals, maximize resources, and avoid duplication.
- 12. Recognizing the Role of Healthcare**
Clinical systems play an important role in ensuring fair and effective support for people with disabilities. We work to integrate healthcare and community-based services for better outcomes.



Planning for the Needs of All Disability Types

This plan reflects the idea that **not all disabilities are the same**. Disabilities can affect communication, movement, thinking, mental health, and more. They can be present from birth or develop later due to injury, illness, stress, or trauma. Multiple disabilities also can occur at the same time.

Common types of disabilities that were included in planning efforts include:

- **Visual disabilities**, which can affect a person’s ability to see clearly, recognize colors, judge distances, or access visual information like books, images, or videos
- **Mobility disabilities**, which can make it difficult to use hands, feet, arms, or legs, affecting movement and daily activities
- **Hearing disabilities**, which can include partial or complete hearing loss, making it harder to understand spoken words or access audio-based information
- **Neurological disabilities**, which can affect how the brain processes sensory information, movement, or thinking skills
- **Cognitive disabilities**, which can impact memory, attention span, learning, problem-solving, or judgment

- **Medical disabilities**, which can cause pain, fatigue, limited movement, or difficulty focusing due to chronic illnesses or health conditions
- **Mental health disabilities**, which can affect emotions, memory, concentration, and a person’s ability to handle stress or regulate feelings

Recognizing these differences, the team worked to create a plan that meets the unique needs of all individuals with disabilities and ensures that every person receives the right support at the right time. The process to develop this plan focused on the following disability types:



Note: Behavioral health means both mental health and substance use.

Engaging People with Lived Experience

Meaningful engagement with people with disabilities and their caregivers ensures that services meet real needs and promote fair opportunities for all. The planning team sought input from the disability community by:

- **Releasing a community survey** in English, Spanish, and Portuguese to gather input on what is or is not working in Rhode Island, receiving more than 100 submissions
- **Conducting over 40 interviews** with individuals who have lived experience and those who support them
- **Opening applications for individuals with lived experience** to join the OAG, and appointing eight members from these applicants
- **Providing 12 community-based organizations with \$10,000 each in funding** to host 25 listening sessions and to offer stipends to over 430 participants
- **Making workgroups open to the public**, allowing individuals with lived experience to contribute directly in addition to attending the OAG

The [Learnings from Community Engagement](#) section provide more details on these activities and their key findings.

Addressing Unnecessary Restrictions

People with disabilities should have the support they need to live in their communities, but unnecessary placement in facilities still happens. Under the *Olmstead* ruling, states must provide resources to help people integrate into and stay in their communities. Preventing restrictive placements requires identifying the root causes and addressing those causes early.

Key strategies include:

- **Early intervention** (identifying and addressing the factors that lead to placement in facilities before placement becomes necessary)
- **Supporting quality transitions** (ensuring institutions focus on preparing individuals for community living whenever possible and desired)
- **Building strong community support** (creating services and opportunities that help people reintegrate into the community without experiencing barriers, isolation, or shame)

Ensuring Meaningful and Safe Community Integration

The Rhode Island Olmstead Planning Team explored several ways to construct this plan. Initially, the team focused on deinstitutionalization, which is the process of moving people from long-term institutions like nursing homes and psychiatric hospitals to community-based care. With feedback from the OAG, however, the emphasis shifted toward **meaningful community integration** to make sure that the plan:

1. **Is not too medical-focused.** Prioritizing institutions treats disability as a medical condition rather than a matter of rights and independence.
2. **Does not place blame on individuals.** These efforts need to focus on changing society to support individuals with disabilities instead of changing individuals with disabilities to better fit into the current society.
3. **Does not just relocate, but rather supports individuals.** True inclusion means providing resources and support for full participation in community life and the community setting, not just relocation.

Using Existing Models as a Guide

To support meaningful community integration, this plan incorporates relevant aspects from the following planning models:

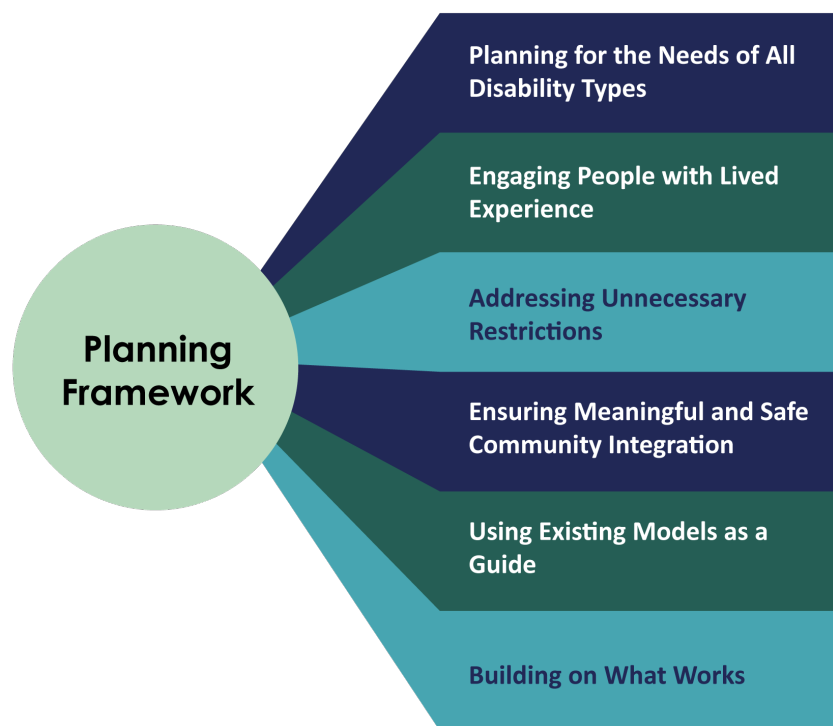
- **[Pathways to Population Health Equity Model](#):** This model addresses the social, economic, and environmental factors that contribute to inequality and ensures that people with disabilities have the resources they need for long-term success.
- **[Adverse Childhood Experiences \(ACEs\) Framework](#):** This model highlights the importance of early intervention and support, recognizing that early trauma impacts disability and long-term health.
- **[Social Ecological Model](#):** This approach considers multiple levels of influence—individual, social, community, and policy—to create environments that support independence and inclusion.
- **[Health Impact Pyramid Model](#):** By prioritizing broad, systemic changes (such as better housing and transportation), this model ensures long-term health and well-being for people with disabilities.

By integrating these models, Rhode Island’s Olmstead Plan takes a comprehensive approach to removing barriers and fostering a society where individuals with disabilities can fully participate and thrive.

Building on What Works

Rhode Island’s Olmstead planning process focused on improving community integration for people with disabilities by recognizing, coordinating, and strengthening programs that are already making a difference. Instead of starting from scratch, the planning team aimed to **identify what works and build on it** by:

- **Listening to the Community:** Gathering input through surveys and listening sessions to understand which programs are most effective
- **Learning from Experts:** Interviewing key professionals to identify successful initiatives and engaging with national experts for technical assistance
- **Collaborating with Partners:** Working with the OAG and state agencies to expand existing programs rather than duplicate efforts
- **Keeping Disability at the Center:** Aligning but separating [Health Care Systems Planning \(HCSP\)](#) and Olmstead planning to maintain a non-medicalized approach while still ensuring coordination
- **Aligning with Other Efforts:** Reviewing state planning initiatives in healthcare system change, behavioral health, suicide prevention, traumatic brain injury, Alzheimer’s, maternal and child health, health equity, and housing to ensure consistency



Aligning Olmstead Planning with Rhode Island 2030 Strategy

While developing the Olmstead Plan, it was clear that these efforts strongly align with Rhode Island's broader [Rhode Island 2030 Strategy](#)—a plan focused on building a more inclusive, resilient, and thriving state. Both initiatives prioritize **community integration, equity, and access to essential resources**.

This plan supports RI 2030's key priorities, including:

- **Inclusive Communities and Affordable Housing:** Ensuring accessible, affordable housing so people can live independently in their communities
- **Equitable Healthcare Services:** Expanding access to affordable, preventive care while addressing social and health disparities
- **Workforce Development and Economic Growth:** Creating job opportunities, training programs, and economic policies that support all Rhode Islanders
- **Reliable Transportation and Infrastructure:** Building an integrated, accessible transportation system that connects people to jobs, healthcare, and community life
- **Support for Children and Families:** Strengthening early education, K-12 schools, and family services

Together, these plans work toward a future in which all Rhode Islanders—regardless of ability—have the **resources, opportunities, and support** to live fulfilling lives.

Plan Writing Process

The plan writing process was completed in four overlapping phases:

- In **Phase 1: Building Capacity**, EOHHS formed a team, hired staff, researched past plans, and brought in experts to help develop the Olmstead Plan with input from the community and state agencies.
- In **Phase 2: Engaging the Community**, the team performed outreach and conducted interviews, surveys, forums, and listening sessions, reaching over 500 people with disabilities and their supporters to gather input for the Olmstead Plan.
- In **Phase 3: Identifying Relevant Data, Assets, and Resources**, the team gathered data and identified current programs from the OAG and interagency partners to help shape the plan and track progress.
- In **Phase 4: Plan Development and Public Comment**, community input and discussions with the OAG shaped the development of recommendations by workgroups in four key areas. These recommendations were reviewed, prioritized, and organized into a draft plan.

The following phases will come after the initial publication of this plan:

- In **Phase 5: Plan Refinement**, the plan continues to be refined and updated based on feedback and monitoring during implementation.
- In **Phase 6: Plan Evaluation and Reporting**, the OAG and community are informed on progress developing data measures, progress implementing recommendations, and reports provided to state leadership.



Phase 1: Building Capacity

- **The Olmstead Sub-Committee recommends a state planning process, and EOHHS receives one-time dedicated funding.** In February 2020, the Governor’s Council on Behavioral Health created a special group, the Olmstead Sub-Committee, to focus on improving services for people with disabilities. EOHHS also sought federal approval for Olmstead planning through one-time Medicaid funds for home- and community-based services. With this approval, the legislature directed that \$250,000 of these funds be invested in one-time Olmstead planning efforts as part of the state’s budget through February 28, 2025.
- **EOHHS dedicates leadership capacity and hires a full-time Olmstead Coordinator and a contracted Community Engagement Specialist.** In 2023, EOHHS identified three staff with lived experience and planning expertise to lead this work.
- **The EOHHS team researches Olmstead and best practices.** Between October 2023 and January 2024, the new State Olmstead Team reviewed possible planning models and met with key partners involved in this work. EOHHS applied with the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) to obtain technical assistance support from SAMHSA. The team also reviewed six Olmstead Plans from other states whose values most aligned with EOHHS: Oregon, Minnesota, Georgia, Connecticut, Massachusetts, and Pennsylvania. Review focused on common themes, key categories, and sub-themes to help guide Rhode Island’s planning process.

Key categories that stood out across these state plans included:

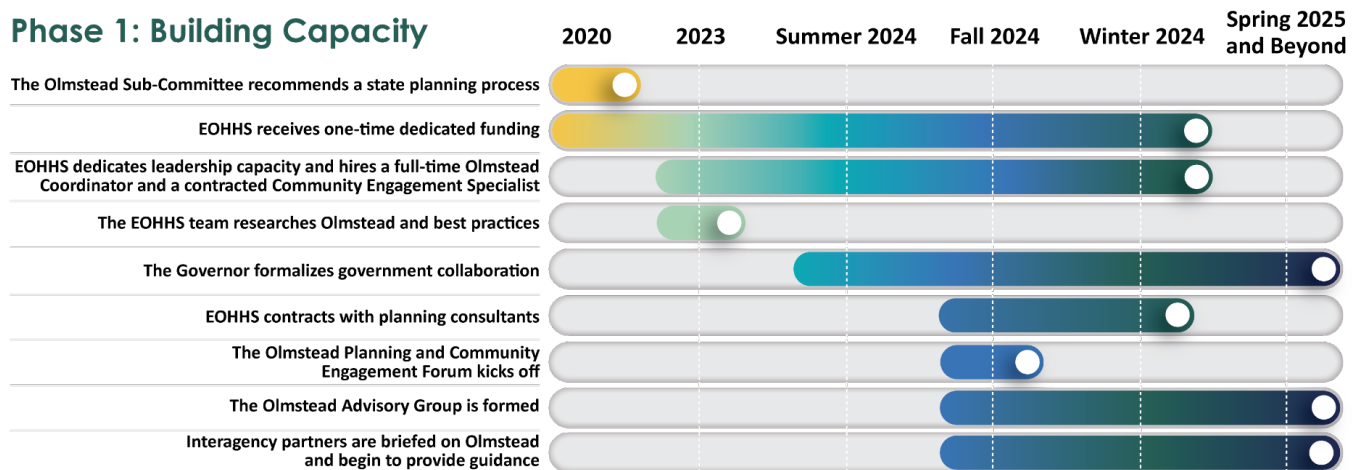
- Social factors that affect health
- Quality of health and human service programs
- Core management principles for service systems
- Community support and capacity

The sub-themes that emerged included:

- Assistive technology
 - Crisis services
 - Employment
 - Funding and financial support
 - Housing
 - Wait times and transition periods
 - Transportation
 - Workforce issues
 - Community connections
 - Education
 - Person-centered planning
 - Acute care
 - Accountability for following the plan
 - Preventing abuse and neglect
- **The Governor formalizes government collaboration.** As part of the Executive Order, state agencies were asked to engage with EOHHS to support a whole-of-government approach to the planning process where state agencies come together to work on this plan.

- **EOHHS contracts with planning consultants.** The EOHHS team brought on nonprofit public health and planning consultants from JSI Research & Training Institute, Inc. (JSI) to organize planning meetings, support community engagement, analyze data, identify best practices, and develop the plan with EOHHS.
- **The Olmstead Planning and Community Engagement Forum kicks off.** EOHHS held its first community-wide open and accessible event to hear from the community and experts, including the Technical Assistance Collaborative’s presentation on Olmstead requirements.
- **The Olmstead Advisory Group is formed.** Per the Executive Order, EOHHS establishes the OAG and makes appointments. More information is available on the [Rhode Island Secretary of State website](#).
- **Interagency partners are briefed on Olmstead and begin to provide guidance.** Most interagency partners were onboarded to the Olmstead Planning process from August to October of 2024, while new agencies continue to join in efforts as recommendations emerged that required additional coordination and subject matter expertise. Nineteen state agencies were represented in the Olmstead planning process. Interagency representatives are responsible for:
 - Listening to the OAG and participating in interagency discussions
 - Reviewing items identified by the OAG and participating in workgroups
 - Identifying gaps or areas of alignment with existing state work
 - Mapping the current state of data collection around Olmstead priorities
 - Mapping state assets, programs, and initiatives that currently support Olmstead populations

Phase 1: Building Capacity



Formation of the Olmstead Advisory Group

OAG members were onboarded between August and October of 2024. The group is made up of 43 members. Thirty-five of the 43 members represent organizations that focus on Olmstead populations and are reflective of identified community priorities, and eight community members have lived experience and expertise.

The team posted applications to join the OAG as an individual with lived experience to the State Olmstead website in English, Spanish, and Portuguese. Stakeholders and organizations also amplified the application in their communities. Ten individuals applied. Of those, nine were eligible for an interview, eight were interviewed, and all eight were appointed to the group.

In total, individuals appointed to the OAG represent a diversity of:

- Cultural perspectives and lived experiences
- Disability types or special healthcare needs
- Youth, adult, and older adult organizations
- Social determinants of health organizations
- Community supports and services
- Providers, clinicians, and facility types
- Advocacy organizations
- Policy, data, and capacity-building experts

Member organizations were formally appointed by the Secretary of EOHHS. Members are part of non-governmental organizations; healthcare; existing commissions aligned with Olmstead; councils and coalitions on disabilities; [Health Equity Zones](#); academic institutions; managed care organizations; disability rights organizations; and more (see full list in Appendix*).

Phase 2: Engaging the Community

Once established, the planning team carried out deep and continuous community engagement to inform the Olmstead Plan. From October 2023 to January 2025, the team conducted open-ended key informant interviews, developed and released an Olmstead Survey, hosted a Community Engagement Forum, and supported 12 nonprofits to fund 25 Community Listening Sessions. In total, these engagements reached over 500 Rhode Islanders with disabilities and the individuals who support them. To do this successfully, the OAG created the following group agreements to ensure inclusion and safety:

- **Value Every Voice:** Recognize that every member's perspective is important and deserves to be heard. Encourage members to share their unique insights and experiences to enrich discussions. Foster an environment where differing opinions are valued.
- **Embrace Diverse Perspectives:** Honor the personal nature and uniqueness of all disabilities.
- **Communicate Respectfully:** Actively listen and speak respectfully, allowing everyone the opportunity to share without interruption.
- **Use Person-first Language:** Emphasize the person first (e.g., "person with a disability" rather than "disabled person") while respecting individual preferences.
- **Stay Focused on the Agenda:** Keep discussions relevant to the agenda items to use limited time effectively.

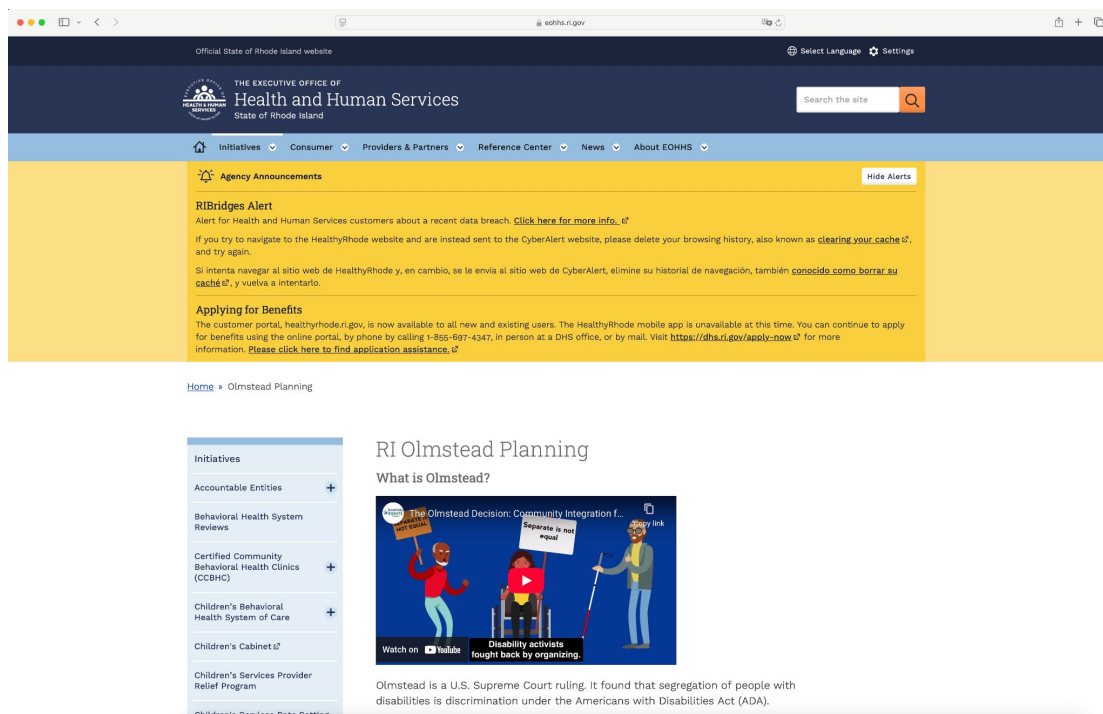
WORKING DRAFT FOR COMMUNITY REVIEW

- **Mindful of Accessibility:** Ensure that all materials, discussions, and spaces are accessible to everyone, and address any specific needs openly. Reiterate questions and answers so all can participate inclusively.
- **Be Solution-Oriented:** Encourage a mindset that focuses on finding solutions rather than dwelling on problems.
- **Regular Review:** Periodically review and adjust the ground rules as needed to enhance effectiveness.



Olmstead Website and Newsletter Communications

Both the EOHHS Olmstead Planning [website](#) and *Integration for All* [e-newsletter](#) are communications tools to promote transparency and ongoing engagement with the community. They were developed in early 2024 to keep the public informed and engaged throughout the planning process. The website serves as a platform for people to learn about Olmstead, subscribe to newsletter updates, and learn about ways to participate in community engagement opportunities. The newsletter reinforces information from the website, helps keep people updated on opportunities to participate, highlights key partners' efforts, and offers insights into the planning process.



Key Informant Interviews

During the first several months of the planning process, the planning team held key informant interviews. These interviews were initially designed with a structured interview format, asking specific questions. However, during the first few conversations, it became clear that the questions were limiting and did not necessarily align with what participants felt was most important to share. To make sure the most important issues were heard, the format was updated to an open-ended interview approach that allowed for more meaningful and relevant discussions. This process resulted in a compilation of stories about individuals with disabilities in Rhode Island that highlight key challenges and unique perspectives on community integration. Discussions were held both online and in person to accommodate different preferences and needs. In total, 42 key informants were interviewed.

Olmstead Survey

Using the themes identified from reviewing other plans, along with learnings from research and the interviews, the Olmstead Planning Team created a survey to further gather public input on what is and what is not working in Rhode Island for individuals with disabilities. The goal of the survey was to identify strengths in Rhode Island's services and highlight areas for improvement.

After creating a draft, the planning team partnered with experts, including individuals with lived experience, to make the survey more easily understood and accessible. The survey was then translated into Portuguese and Spanish and tested by native speakers. The survey was also tested with key informant interviewees, before being shared with the public through the Olmstead website, the *Integration for All* Newsletter, other state and local newsletters and LISTSERVs, and the OAG.

Between April and October 2024, 105 people engaged with the survey, though not all answered every question. The completion rate was 88%. The most represented age groups were 26-64 (25%) and 18-25 (19%). Eighty-five percent identified as non-Hispanic White, and 30% identified as having a disability.

Community Planning and Engagement Forum

Preliminary findings from the Olmstead Survey and stories from the key informant interviews were shared at the Olmstead Planning and Engagement Forum in September 2024. Forum participants were asked to validate information that the planning team had heard in these processes by indicating whether they shared in the experiences identified in the surveys and interviews. They were also asked to identify other areas that should be discussed as it related to those stories. More than 80 participants, including people with lived experience, subject-matter experts, and community service providers, took part in this kick-off event.

Community Listening Sessions

Olmstead Community Listening Sessions were an important way for the State to gather public input and ensure that a wide range of voices contributed to the Olmstead Plan. These sessions aimed to:

1. Give the public a chance to contribute ideas and feedback.
2. Ensure people with lived experience had a voice in the process.
3. Focus on real challenges and needs to improve services.
4. Include perspectives from groups that are often left out of policy decisions.

To find organizations to host these sessions, the planning team created an application process. An interest form (see Appendix*) was shared in English, Spanish, and Portuguese on September 27, 2024. A formal call for applications followed on October 31, 2024, closing on November 14, 2024. Organizations that had submitted interest forms received applications directly, and the opportunity application (see Appendix*) was also promoted through the Olmstead website, e-newsletter, and outreach efforts. By early December, a panel of five reviewers evaluated 14 applications. In the end, 12 organizations were selected and awarded \$10,000 each to support their session and gather participant feedback.

In January of 2025, the 12 selected organizations hosted a total of 25 listening sessions—some in-person, some virtual, and some hybrid—focusing on individuals covered under the ADA. The sessions prioritized underrepresented groups and different types of disabilities. The average attendance per session was 17. The following priority populations were represented by the 430 individuals who participated:

- Unhoused individuals
- Residents in high-density communities
- Mothers, children, and older adults
- Individuals who have been formerly incarcerated
- BIPOC and other minority groups
- People with behavioral health and SUD challenges

Total Number of Sessions	Total Number of Individuals Engaged	Meeting Type	Participants (Per Meeting)	Disability Types Represented
25	430	In person: 13 Hybrid: 5 Virtual: 7	Range: 6 to 50 Average: 17	<ul style="list-style-type: none"> ● Mobility ● Deaf/hard of hearing ● Blind/visually impaired ● Mental health ● SUD ● Neurodivergent ● Chronic conditions ● Traumatic brain injury ● Intellectual/developmental



Phase 3: Identifying Relevant Data, Assets, and Resources

During and after the community engagement phase, the planning team asked the OAG and state partners to share data they collect and programs they support for people with disabilities. These data points, programs, and initiatives were later used to identify areas of opportunity to support the recommendations generated for the Olmstead Plan and existing metrics that could be used to track progress on them. Additionally, organizations were asked about what assets exist within the state government and the community to inform the Current State section of this plan. Lastly, this list of assets was provided to the State’s Office of Management and Budget to begin to quantify the previous and current level of investments being made towards this plan (see Appendix*).

Phase 4: Writing the Plan and Getting Public Comment

Once Rhode Island’s planning framework (described previously in this plan) was solidified, community engagement and OAG input led to the creation of four workgroups focused on key areas:

- Accessing Community Services
- Discharge Planning and Transition
- Preventing and Addressing Abuse, Neglect, and Discrimination
- Affordable and Accessible Housing

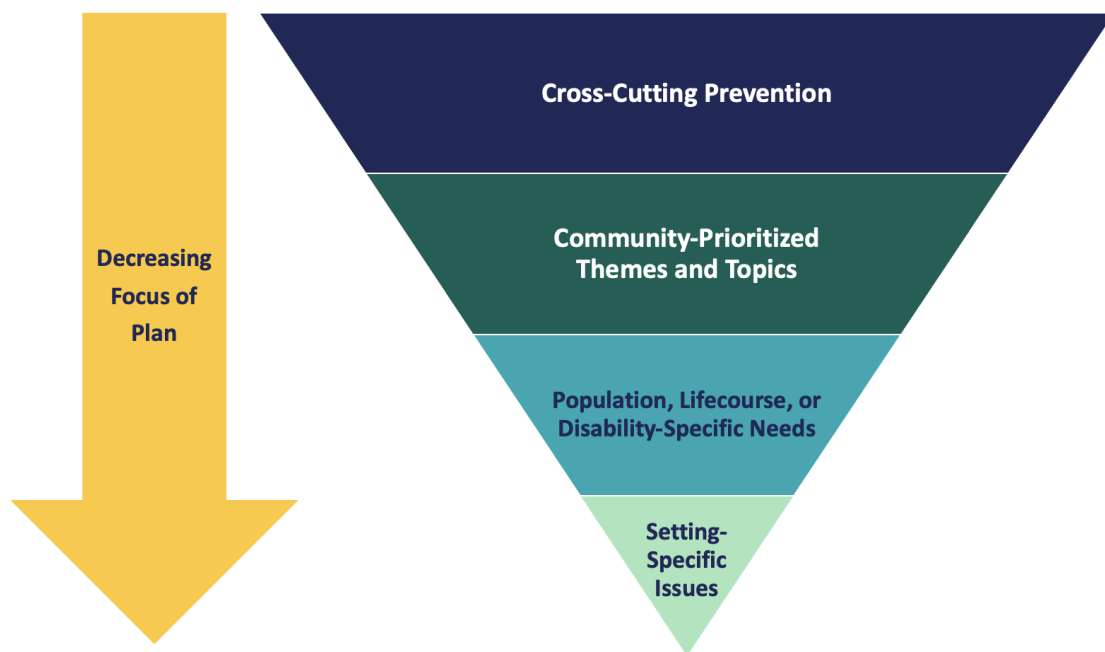
These workgroups were open to the public, including state employees, community-based organizations, and individuals with lived experiences and their caregivers or support systems. Workgroups ranged from 26 to 49 participants each. Each workgroup met five times to develop recommendations to help individuals with disabilities fully participate in their communities (further details in Appendix*).

The planning team organized these recommendations under a shared vision and set of goals, which were reviewed, edited, and approved by the OAG. Every part of the plan—including the vision, goals,

strategies, outcome measures, and recommendations—was reviewed by both interagency partner members and the OAG, who provided feedback for further refinement.

The OAG then prioritized the recommendations using an agreed-upon process that ranked recommendations based on six weighted criteria: Alignment, Impact, Equity, Feasibility, Sequencing, and Cost/Resource Burden. All recommendations were first aligned to outcome measures and then prioritized into Short-Term, Mid-Term, and Long-Term categories based on results of the OAG prioritization process. Where possible, recommendations were linked to existing initiatives and aligned with metrics provided by the OAG and interagency partners.

By February 15, 2025, the initial draft of the *Integration for All: Rhode Island Olmstead Plan* was circulated to the OAG for review and input. The plan was also summarized into a plain language slide deck. Two community partners used the slide deck to share the plan overview with members who attended listening sessions and to collect feedback from individuals with lived experience. The plan was also made available on the EOHHS Olmstead webpage with a standardized feedback form for interagency partner and community feedback. A two-week period of public comment was publicized in the *Integration for All* Newsletter and at the February OAG Meeting.



Phase 5: Refining the Plan Over Time

After the public comment period ended, feedback from the OAG, interagency partners, and community members was reviewed and changes were made to reflect areas in which feedback aligned in a specific direction or around a specific suggestion. The plan was then further graphically designed to continue to meet 508 compliance for maximum accessibility. This version of the plan was presented to the Governor’s Office, sent to the legislature, posted on the EOHHS website, and submitted to the OAG and two Community Listening Session hosts to gather feedback.

Moving forward, if continued resources for Olmstead planning are provided to EOHHS, the plan will be updated regularly with community input. Public comment on version one of the plan can be provided at any time through the feedback submission form on the [EOHHS website](#). This feedback form is checked monthly and brought to the OAG, as applicable. The Substance Abuse and Mental Health Services Administration (SAMHSA) aims to review and provide guidance on the plan to ensure compliance with Olmstead and indicate gaps or modifications necessary for individuals with mental health challenges and SUDs as part of free technical assistance offered to Rhode Island.

Continued Meeting and Planning

The OAG is set to continue to meet regularly to review additional updates to the plan, discuss opportunities to apply for funding, assist with monitoring of the plan, and review any timely trends or emerging priorities. Appointees have been asked to complete a two-year term into 2027, but annual review of membership may be conducted to ensure the appropriate expertise sits on the OAG as additional priorities emerge. In addition, state agencies will be provided the opportunity to bring their programs to the OAG for feedback on how processes could be improved to make the program more accessible to individuals with disabilities. Additional planning workgroups may be formed to continue work on the next set of priority topic areas as implementation of some recommendations is completed. If resources are available, EOHHS will host additional Community Listening Sessions with partners on Olmstead annually.

Phase 6: Evaluating and Reporting on the Plan

To monitor and evaluate progress towards the plan, several recommendations have been proposed (see Implementation Plan section below). As the plan is implemented, the OAG will continue to receive updates and will receive copies of the annual report due to the Governor and legislature at the beginning of each new fiscal year per the Executive Order.

Olmstead Data Council

EOHHS plans to convene an Olmstead Data Council to develop outcome measures (or proxy measures), review proposed data dashboards, and provide guidance on output measures associated with various recommendations. The Olmstead Data Council, if created, may assist state partners in streamlining standardized approaches to disability data collection and reporting.

Current State of Disabilities in Rhode Island

"I would love to live a carefree life. A life that I can easily take care of myself. That I can easily do whatever or go wherever I like.... I feel discouraged. I am a strong person.... I feel there should be a kind of help for people with disabilities because we are also humans and we have feelings, too. We just can't really do it ourselves." - Community Listening Session Participant

Disability Data at a Glance

As illustrated below, people with disabilities often face barriers to housing, education, employment, and healthcare, leading to worse outcomes compared to those without disabilities. The Olmstead Plan aims to address these challenges and create a more equitable and inclusive system.

Adults

Living with a disability in Rhode Island is a common experience. Nearly one in three adults has a disability⁵, and more than one in five children has special healthcare needs⁶. Disability status is not the same across the board. The likelihood of having a disability varies across races, ethnicities, gender identity, and sexual orientation. Adults 18 years of age and older are more likely to be disabled if they identify as multiracial or other, non-Hispanic (45.4%), or Hispanic (41.4%), as compared to individuals who identify as White, non-Hispanic (26.5%), Black non-Hispanic (26.5%), and Asian Non-Hispanic (16.9%)⁷. Additionally, a higher percentage of LGBTQIA+ adults (41%) identify as a person with a disability compared to Straight and/or Cisgender adults (26.8%)⁸.

Children

Children with special healthcare needs in Rhode Island are more likely to come from certain racial and ethnic backgrounds. For multiracial children, there's a notable difference: while only 8% of Rhode Island children overall identify as multiracial, 24% of children with special healthcare needs are multiracial. Differences also appear in other groups. Hispanic children make up 27% of Rhode Island's child population, but represent 38% of children with special healthcare needs. Only 1% of Rhode Island children identify as "other race," but this group represents 21% of children with special healthcare needs. Native American/Alaska Native children make up less than 1% of the state's children, but account for 2% of those with special healthcare needs. White children, who make up 53% of Rhode Island's child population, represent 47% of children with special healthcare needs. Some groups show proportional representation: Black, non-Hispanic children make up 6% both of the general child population and of children with special healthcare needs⁹.

Economic and Employment Outcomes

The financial strain for people with disabilities is particularly severe. For example, people with disabilities in Rhode Island are more than twice as likely to live in poverty compared to those without

⁵ [Rhode Island Department of Health](#), Behavioral Risk Factor Surveillance System (2023)

⁶ [RI Department of Health](#), Children with Special Healthcare Needs Rhode Island Research Brief (2024)

⁷ [Centers for Disease Control and Prevention](#), Disability and Health Data System, Rhode Island (2022)

⁸ [Rhode Island Department of Health](#), Behavioral Risk Factor Surveillance System (2023)

⁹ [RI Department of Health](#), Children with Special Healthcare Needs Rhode Island Research Brief (2024)

disabilities—about 25% versus 10% for working-age adults¹⁰. Housing costs make up a larger share of their expenses, too; nearly 30% of Rhode Islanders with disabilities spend a third or more of their income on housing, while only 19% of residents without disabilities face such high housing costs¹¹. In addition, finding and keeping a job is more challenging. Nationally individuals with disabilities are more than twice as likely to be out of work¹².

Educational Outcomes

Education presents another set of hurdles. While students with disabilities make up 17% of Rhode Island's school population, they account for a disproportionate 33% of suspensions¹³. The impacts continue into adulthood; people with disabilities are twice as likely to leave high school without graduating compared to their non-disabled peers (21% versus 10%)¹⁴.

Healthcare Outcomes

Healthcare access and outcomes show similar disparities. One in four people with disabilities had to go without needed medical care in the past year because they were unable to afford it¹⁵. They are also more likely to develop chronic conditions like heart disease and diabetes¹⁶. Women with disabilities face particular challenges in preventive care, being 22% less likely to get breast cancer screenings and 37% less likely to get cervical cancer screenings than women without disabilities.

Trauma and Justice

Rhode Islanders also tend to experience a cycle of childhood trauma that leads to other behavioral health and disability outcomes. Nearly two-thirds of Rhode Island adults have experienced at least one adverse childhood experience (ACE), and 16% have experienced four or more. This has a significant impact on mental health: while only 9% of people with no ACEs experience depression, this rises to 24% for those with one to three ACEs, and jumps to 45% for those with four or more ACEs¹⁷. “An ACE score ≥ 4 [is also] associated with increased odds for binge drinking, heavy drinking, smoking, risky HIV behavior, diabetes, myocardial infarction, coronary heart disease, stroke, depression, disability caused by health, and use of special equipment because of disability.”¹⁸

¹⁰ [Center for Disability Research](#), Annual Disability Statistics Collection, Disability Compendium, Section 6: Poverty (2024)

¹¹ [Center for Disability Research](#), Annual Disability Statistics Collection, Disability Compendium, Section 7: Home Environments (2024)

¹² [Center for Disability Research](#), Annual Disability Statistics Collection, Disability Compendium, Section 3: Employment (2024)

¹³ [Rhode Island KIDS COUNT](#), Factbook, Suspensions (2024)

¹⁴ Varadaraj, V., et al. (2021). National prevalence of disability and disability types among adults in the US, 2019. *JAMA Network Open*, 4(10), e2130358. [pmc.ncbi.nlm.nih.gov/articles/PMC8531993/](https://pubmed.ncbi.nlm.nih.gov/articles/PMC8531993/)

¹⁵ Varadaraj, V., et al. (2021). National prevalence of disability and disability types among adults in the US, 2019. *JAMA Network Open*, 4(10), e2130358. [pmc.ncbi.nlm.nih.gov/articles/PMC8531993/](https://pubmed.ncbi.nlm.nih.gov/articles/PMC8531993/)

¹⁶ [Centers for Disease Control and Prevention](#), Disability and Health Data System, Rhode Island (2022)

¹⁷ [Rhode Island Department of Health](#), Behavioral Risk Factor Surveillance System Spotlight: Adverse Childhood Experiences (2020)

¹⁸ Campbell, J. A., Walker, R. J., & Egede, L. E. "Associations Between Adverse Childhood Experiences, High-Risk Behaviors, and Morbidity in Adulthood." *Am J Prev Med*, vol. 50, no. 3, 2016, pp. 344-352. pubmed.ncbi.nlm.nih.gov/26474668/

ACEs also increase the risk of incarceration, an extremely restrictive form of facility-based care, in adulthood. Data is not available for the number of individuals with disabilities in Rhode Island prisons, but nationally it is a concerning trend. According to the Prison Policy Initiative, 40% of individuals in state prisons have a disability. This includes 10% with hearing impairments compared to the national percentage of 4%, 12% with vision impairments compared to 2% in the general population, 24% with a cognitive disability compared to 5% in the US at large, and 12% with an ambulatory disability compared to the US population at 7%.¹⁹ Nationally, in the justice system, people with disabilities are four times more likely to end up in jail compared to those without disabilities. SUDs, which affect about 8% of the general population who are 12 years old or older, are present in nearly half (47%) of state prison populations.²⁰

Institutional Care

Whether institutionalization is necessary or unnecessary needs to be determined on an individual basis, but there are indicators of potentially unnecessary institutionalization at the systems level which need to be monitored in Rhode Island:

- **Use of Medicaid long term support services for institutional care versus home and community-based services and both:** In 2021, only 9% of Medicaid Enrollees were using strictly home- and community-based services²¹ but 89% were using institutional long-term support services only.²² This may be an indication that there are not enough community-based providers.
- **Hospital length of stay for mental health:** When looking at all hospital data (excluding Eleanor Slater) the average length of stay for "mental diseases and disorder" is 10.97 days, while the average length of stay at Bradley Hospital for "mental disease and disorders" is 29.56 days.²³ At Eleanor Slater Hospital, with a significant range, the average length of stay is 16 years. This may also indicate a lack of less-restrictive settings necessary for transition.²⁴
- **High rates of mental health needs in Rhode Island prisons:** According to the Department of Corrections, "At any given time, approximately 5-10% of our population is designated as severely and persistently mentally ill, and as of January 9, 2023, 44% of our population was receiving psychiatric services and 31% of our population was receiving mental health counseling. Seventy (70) to 80% of incarcerated individuals have substance use histories consistent with national data of disease prevalence in correctional institutions. Inmates with co-occurring mental health and SUDs in combination with their overall compromised physical health status, are especially challenging."²⁵
- **Overall rate of institutionalization:** Compared to surrounding states, Rhode Island has the highest percentage of institutionalized individuals (see table below). According to 2020 Census estimates, 1.16% of Rhode Island's population is living in an institutional facility.

¹⁹ [Prison Policy Institute](#), Chronic Punishment: The Unmet Health Needs of People in State Prisons (2022)

²⁰ [Prison Policy Institute](#), Addicted to punishment: Jails and Prisons Punish Drug Use Far More Than They Treat It (2024)

²¹ [KFF](#), Medicaid Enrollees Using HCBS (2021)

²² [KFF](#), Medicaid Enrollees Using LTSS (2021)

²³ [RI Department of Health](#), RI Hospital Discharge Data Reporting (2025)

²⁴ [Eleanor Slater Hospital Needs Assessment](#) (2023)

²⁵ [RI Department of Corrections](#), Behavioral Health Services

Rhode Island ★	Connecticut	Maine	Massachusetts	New Hampshire	New Jersey	New York	Vermont
1.16%	1.06%	1.11%	0.93%	1.04%	0.91%	0.93%	0.78%

Note: These percentages were calculated by dividing the total number of people in institutional facilities by the total population in each state, as reported in the 2020 Census data.

This Olmstead Plan aims to address these challenges by providing recommendations for creating communities that work for everyone, regardless of disability status.

Learnings from Community Engagement

The data tell a stark story about life with disabilities in Rhode Island, but statistics alone cannot capture the full picture of what it means to navigate Rhode Island with a disability. Behind each percentage point are real Rhode Islanders—neighbors, friends, and family members—each with their own unique experiences, challenges, and insights.

To truly understand both the obstacles and opportunities that exist in Rhode Island, it was essential for the planning team to go beyond the data and listen to these voices directly. Through conversations with over 500 Rhode Islanders with disabilities and the individuals supporting them, the team not only gained deeper insight into why these disparities exist, but also discovered bright spots—programs and approaches that are working well and could be expanded.

Below are quotations and notes summarizing the common themes from conversations with participants.

Theme #1: Social Factors Significantly Affecting Individuals with Disabilities

Housing Accessibility and Affordability

“Accessible housing needs to be integrated into the community. And that people with disabilities are living in buildings with people without disabilities, too. I feel like where I live is in the middle of nowhere and I get depressed sometimes. That gets to the issue of transportation. It’s just hard.” - Community Listening Session Participant

- Affordable, accessible housing is a major gap, which makes it difficult for people with disabilities to live independently.
- Credit scores, felony convictions, and lack of housing availability create additional barriers.
- Having stable housing is key for employment, healthcare access, and overall well-being.

Employment and Financial Barriers

“Employment is so hard. I feel unqualified on so many things. I don’t even get to put my foot in the door because I am judged for my blindness. I am seen as a safety risk or a liability risk. I do have marketable skills, and I am confident, but I don’t even get to prove myself. Financial security is so important. If I don’t have any money, I can’t participate in the community.” - Community Listening Session Participant

- Employers need better training on disability rights and workplace accommodations.
- Many people are unable to afford basic needs because they don’t make enough money or lose benefits if they start working.

Transportation Accessibility Issues

"[The Ride program] is a great thing for many people and provides a lot of resources that are not there in many cases, and we do not live in an ideal world where everything is going to be perfect. But I do find people are arriving an hour or even an hour and a half early to their place of employment. And I know there are last minute challenges or cancellations. But this is a consistent problem and there are people sitting in their place of employment for hours unable to clock in. There is misinformation depending on which representative from Ride you are talking to. They can be rude or unsupportive... It would be great to have some kind of progress or improvement." Community Listening Session Participant

- Public transportation for people with disabilities, such as Ride (the RI Paratransit Program) and Non-emergency Medical Transportation, is sometimes unreliable—rides are often late, canceled, or don't show up, and bus stops can be inaccessible.
- Accessible vehicles are too expensive, which creates a need for mobility-related financial assistance programs.

Theme #2: Community Capacity for Individuals with Disabilities Is Critical

Gaps in Community Services and Supports

"Incredibly frustrating that the resources aren't available for people who need and want it." - Key Informant Interview

- There aren't enough mental health services, job support programs, and social services to keep people in the community.
- Lack of reliable transportation makes it harder for people to get to jobs, appointments, and services.
- There aren't enough trained workers to provide the care and support people need.

Community Involvement and Inclusion

"Fully inclusive approaches to education, employment, and transportation. These services are more than just the primary function, they are social opportunities." - Community Listening Session Participant

- People with disabilities need more opportunities to connect socially and be part of their communities.
- Faith-based and peer-support groups could help provide a stronger support network.

Transition and Discharge Challenges

"My brother was hospitalized multiple times in a psychiatric hospital, and it was just a revolving door.... When you are discharged you have a referral to go to social services. It is not a real appointment. It is just something to put on the form. When someone has a major mental illness and you send them out with a paper, it is not enough. It sets them up to fail, which is demoralizing." - Community Listening Session Participant

- When people leave hospitals, nursing homes, or prisons, they don't get enough support to transition back into the community.
- There aren't enough programs for people with severe disabilities who need ongoing supports and essential day services.
- Young people with disabilities have a tough time moving into adulthood because there aren't enough programs to help them prepare for jobs and independent living.

Theme #3: Systemic and Quality Issues for Individuals with Disabilities

Stigma, Discrimination, and Intersectional Barriers

"I'd like people to understand that inclusion isn't just about physical access; it's about changing attitudes and making everyone feel valued and respected." - Community Listening Session Participant

- People with invisible disabilities experience high levels of stigma and social isolation.
- There needs to be more public awareness to reduce stigma and make society more inclusive.
- People with disabilities face discrimination based on factors like gender, race, and sexual orientation, with additional barriers such as language, cultural differences, and lack of resources for BIPOC individuals.

Workforce and Related Healthcare Problems

"Yes, a lot of the challenges aren't being taken seriously. We have been to several neurologists. When we explain the problem, just because you can't see it even when I have videos, no one listens. I would like my husband to have answers so he can get to where he's going. What can we do to improve his quality of life? I am asking for help but there is no one on the other end." - Community Listening Session Participant

- Many healthcare providers lack specialized training in disability care, which limits access to proper care.
- Home care aides and personal support workers need additional training and oversight to improve service quality.
- Providers are less able to take on patients with disabilities due to concerns about Medicaid reimbursement rates.
- The shortage of ASL interpreters limits access to essential services.

Educational Opportunity Needs

"They limit learning opportunities for people with disabilities. They should give them the opportunity to learn. My daughter has an IDD and she is always willing to try and learn. It might take 100 times versus two, but she will learn it!" - Key Informant Interview

- People with disabilities need more opportunities to be challenged in their education.
- Schools punish students for behaviors related to their disabilities, setting them up for failure.

Theme #4: Structural Changes Are Needed for Individuals with Disabilities

Siloed Systems

"Lots of programs to apply to but you have to go to different places and it can be confusing to know what you applied for and if you have gone to the right place. Having a centralized place to apply would help." - Community Listening Session Participant

- Services for people with disabilities operate in silos, leading to inefficiencies and gaps in care.
- There is no overarching statewide structure to ensure services are coordinated.
- People with both mental health challenges and SUDs fall through the cracks.

Criminal Justice as Default Care System

"Police need ongoing training, consistency, [and] accountability so services are not staff-specific, and you luck out if you get a good trained officer, and if not, people are treated like criminals." - Community Listening Session Participant

- Many people with mental health issues end up in jails or homeless shelters instead of getting the help they need.
- People are often arrested for crimes like trespassing or disorderly conduct because they don't have the right support.
- Prisons and jails are not designed to care for people with serious mental illnesses.

Need for Data-Driven Decision-Making

"We count things in Rhode Island, but we aren't counting the right things." - Key Informant Interview

- The State doesn't collect the right data to understand what people need or track how well services are working.
- Without good data, it's hard to make sure money and resources go where they're needed most.

Existing State and Community Asset Inventory

The planning team also heard about many positive efforts happening in Rhode Island. People with disabilities and their supports told the team about programs and community assets that are really helping. This highlights that the State can grow what's already working well in Rhode Island to make life better for everyone.

Rhode Island already has services available that facilitate community integration and inclusion. An important aspect of this planning process has been identifying existing assets that can be sustained or built upon. The list of these assets was collected through the existing community engagement efforts and submitted by the OAG and interagency partners. Over 125 community programs and initiatives were shared. Some of them are described below; the complete list is available in the appendices.

Transportation Resources

The community said that transportation for people with disabilities is unreliable, with late or canceled rides and inaccessible bus stops, and that accessible vehicles are too expensive, creating a need for financial assistance. Some work is being done to address this in Rhode Island such as the services listed below. These services provide transportation options such as rideshare, public transit, and paratransit services for adults with developmental disabilities and seniors to access services, community activities, and jobs, including:

- Community resource guides, such as the [Aging and Disability Resource Center](#) guide and the [United Way RI Resource Directory](#), the Rhode Island Department of Education (RIDE) Anywhere Program, which is a pilot program that increases transportation flexibility for individuals with disabilities
- Accessible public transportation improvements as a result of advocacy for expanded wheelchair-accessible options and mobility training

Housing and Independent Living Options

The community said that finding affordable, accessible housing is a major challenge for people with disabilities, with poor credit scores, criminal records, and limited availability making it even harder—yet stable housing is essential for jobs, healthcare, and well-being. Some work is being done to address this in Rhode Island. For example, these services offer housing support for individuals with disabilities, those experiencing homelessness, and individuals in recovery, providing rental assistance, supportive housing, and home modifications for stable, independent living. They include transitional housing, shared living arrangements (SLA), and direct services such as medical care, therapy, and community integration to promote stability and independence for individuals with complex needs. Examples include:

- BHDDH SLA, a home-like setting with assistance for daily activities
- Section 8 housing assistance, which provides financial support for affordable, accessible housing
- Personal Assistance Services and Supports, which helps families and children with disabilities to maintain independence
- Respite services for caregivers, which provides support for family members providing care
- Access Independence II, which provides grants and loans of up to \$50,000 to families and caregivers of people with developmental disabilities to modify their homes to support their needs and continue living with their families

Employment and Financial Assistance Supports

The community said that employers need better training on disability rights and accommodations, and that many people struggle to afford basic needs because they either don't earn enough or risk losing benefits if they work. Rhode Island has some employment services for individuals with disabilities, but many focus on supporting the individual and not the employer. These services assist individuals with disabilities by offering job training, career development, workplace accessibility, and ongoing support to improve employment opportunities. They include tax incentives for employers, wage reimbursement programs, job coaching, and customized employment services to help individuals succeed in the workforce. Examples include:

- RI Vocational Rehabilitation, which provides employment training and job placement for individuals with disabilities
- Sherlock Center, for disability resources and education
- Organizations such as The Arc, which focus on advocacy and employment support
- Financial assistance programs, such as SSI, SSDI, and other benefits aimed at increasing economic stability
- Community workforce partnerships such as Real Jobs RI, a workforce development program of the Department of Labor and Training, funds a number of integrated occupational training programs for individuals with disabilities. Such programming is initiated and developed by the provider, in collaboration with one or more employer partners.

Healthcare Access

The community said that many healthcare providers lack training in disability care, home care aides need better training and oversight, Medicaid reimbursement rates, and fifteen-minute appointments make it harder for providers to serve patients with disabilities, and the shortage of sign language interpreters limits access to care. Rhode Island has some programs to address this, including those that enhance access to healthcare, mental health treatment, and emergency preparedness for individuals with disabilities, chronic conditions, or special needs. They provide medical coverage, community-based supports, professional training, and disease-specific resources to improve health outcomes and independent living. Examples include:

- Rhode Island Department of Health (RIDOH) Title V Community Contacts such as RIPIN Family Voices Family-to-Family Health Information Center, and the Care Transformation Collaborative for care coordination and healthcare transition
- RIDOH MomsPRN and PediPRN, which are programs that increase access to mental health treatment by building frontline healthcare professional competency
- Katie Beckett, a Medicaid eligibility pathway enabling children to be cared for at home instead of an institution
- Ryan White HIV/AIDS Program, which provides medical care and support services for individuals living with HIV/AIDS
- RIDOH Health Equity Institute, which provides trainings on the National Standards for Culturally and Linguistically Appropriate Services
- The Department of Children, Youth, and Families (DCYF) Home Based Service Array, for which DCYF-contracted providers provide a broad range of intensive in-home services and supports to address the behavioral health and developmental disability-related needs of children and their families

Community-Based Support and Accessibility

The community said that people with disabilities need more chances to connect and be involved; faith-based and peer-support groups could help build a stronger support network. It also shared that there aren't enough social supports to help people stay in their communities, and that unreliable transportation and a shortage of trained workers make it even harder to get the care and services they need to be included. In Rhode Island, there are some programs dedicated to community inclusion helping to enhance access to resources, promote independence, offer respite care, support foster families, and implement person-centered approaches to long-term care, prevention, and recovery. Examples include:

- Nonprofit organizations such as Tides Family Services, Progreso Latino, Rhode Island Parent Information Network (RIPIN), Ocean State Center for Independent Living, and many more
- Peer support networks and socialization programs to reduce isolation and promote inclusion
- The RIDOH Community Health Worker Program
- Rhode Island Department of Environmental Management Fish and Wildlife Wheelchair accessible fishing areas
- BHDDH Rhode Island Community Living And Supports, which provide direct supportive services include nursing, psychological, social services, dietary, respite care, medical services, transportation, community integration, assistance with activities for daily living and participation in self advocacy groups

Education and Transition Services

The community said that people with disabilities need more challenging educational opportunities. They also said that schools sometimes punish students for disability-related behaviors, making it harder for them to succeed. Rhode Island has some educational services and supports for individuals with disabilities to support educational success. Examples include:

- EOHHS Early Intervention to address developmental delays or disabilities in infants and toddlers through personalized support and therapies
- RIPIN special education resources for parents navigating the school system
- School-to-adulthood transition services, which provides coordinated support from multiple state agencies including BHDDH, RIDE, Office of Rehabilitation Services, and DCYF to help youth prepare for independent living, employment, and access to adult services
- Restorative Justice Practices for community partners to work with their local school system to promote restorative justice instead of punishment

Behavioral Health and Recovery Investments

The community said that many people with mental health issues end up in jails or shelters instead of getting proper care, often arrested for minor offenses, even though prisons aren't equipped to support their needs. Rhode Island is working to address this by preventing mental illness from escalating to a crisis level, supporting recovery opportunities for individuals with SUDs, and crisis intervention programs for veterans, people in custody, children and families, and those experiencing homelessness or behavioral health crises. With aims of improving access to treatment, promoting recovery, and preventing hospitalization or incarceration, the services include suicide prevention, medication-assisted treatment, peer recovery support, in-home and residential care, hospital diversion, and reentry planning. Examples include:

- Community-based organizations such as the Center for Justice; Ministers Alliance; RI Coalition for the Homeless; Crossroads; House of Hope; and Amos House
- Mental Health Clubhouses, such as the Warwick Hillsgrove Clubhouse
- BHDDH Recovery Community Centers, which provides a supportive space with resources for skill-building and peer support in early recovery
- DCYF Hospital Liaison, which supports discharge planning by coordinating weekly with Bradley and Hasbro psychiatric units and ARTS programs
- RIDOC Substance Use Treatment and Discharge Planning, where adults are assessed for SUDs and receive treatment, including medication assisted treatment, and reentry planning
- Certified Community Behavioral Health Centers (CCBHC) to enhance access to comprehensive behavioral health services
- Children's Mobile Response and Stabilization, which provides immediate crisis support and stabilization services for children and their families in their homes or communities

Adverse Childhood Experiences and Toxic Stress Prevention Efforts

The community acknowledged that all children, regardless of ability, deserve to grow up in communities that keep them healthy and safe. Adverse community conditions including lack of food access, unsafe and unhealthy housing, exposure to violence and unnecessary disciplinary action at a young age can drive poor mental health and make future isolation and unnecessary placement in facilities more likely. Rhode Island is working to address ACEs and other drivers of future institutionalization by building healthy communities and increasing awareness of violence and injury prevention. Examples include:

- Health Equity Zones (HEZ), which is a community-level infrastructure program to help individuals thrive by removing place-based barriers to health
- RIDOH Violence and Injury Prevention Program, which works to reduce injuries and violence in Rhode Island by promoting safety, supporting prevention programs, and addressing issues like domestic violence, falls, and firearm safety through education and community partnerships

Resource Investments: Past and Present

While the State and community-based organizations have made strides towards implementing the initiatives below (and others) to address Olmstead, adopting an Olmstead Plan will guide additional efforts to ensure people with disabilities can live and work in inclusive communities.

Historical Investments Towards Olmstead

Historically, Rhode Island has worked to reduce unnecessary placement in facilities by:

- Building community-based mental health services through CCBHCs and opening the Butler Short-Stay Unit to improve access to early initiation of behavioral health treatment.
- Reducing long stays at acute care hospitals or Skilled Nursing Facilities by investing in medical respite and mobile wound care.
- Investing in children’s Mobile Response and Stabilization Services (i.e., mobile crisis response) to help children and youth experiencing behavioral health crises to get care in the community instead of in hospitals.
- Strengthening community-level infrastructure to increase affordable housing options, design accessible streets, and enhance real-time social service feedback loops through HEZ—including a recent Community Integration Specialist pilot.
- Implementing Medicaid rate increases, as well as the Developmental Disabilities Consent Decree based on community need.

Preliminary Olmstead Investments Summary Since Fiscal Year (FY) 2022

In reviewing agency budgets, in partnership with the Office of Management and Budget (OMB), a total of 128 programs from 12 agencies were identified as aligned with Olmstead assets and recommendations. Preliminary estimates of spending in FY22 on these efforts totaled \$3,623,375,401. Moving ahead to FY25, spending authorized for these same programs increased to \$4,668,036,836. In total, Rhode Island has invested and proposed a total of \$16,646,866,082 from FY22–FY26.

New and Proposed Investments in Olmstead

Potential Investments from Governor’s Proposed FY26 Budget

The Governor’s revised FY25 and proposed FY26 budgets further increase spending across Olmstead assets by an additional \$492,769,256. Specifically, the Governor’s FY26 proposed budget reflects an increase of \$468,132,121 from the enacted FY25 budget in the following areas, some of which are due to caseload estimates:

- Housing (Recovery Housing and Community Development Block Grant)
- Corrections (Education and Programming, Behavioral Health Programs, Substance Use Treatment and Discharge Planning)
- Public Health (Title V Community Contracts)

- Healthy Aging (At-Home Cost Share Program)
- Children, Youth, and Families (Statewide Needs Assessment, Family Care Community Partnerships, Substance Use Prevention, Per Mentor Program for Foster Parents)
- Behavioral Health (Residential, Community-based Supports, Employment, Transportation, Group Home Expenses, Rhode Island Public Transit Authority (RIPTA) Supports)
- Health and Human Services (Home and Community-Based Services, Early Intervention, Certified Community Behavioral Health Clinics, Ryan White HIV/AIDS Program, and Medicaid Program Health Coverage)

Additionally, the Governor's FY26 proposed budget includes a new increase in funding for senior centers through the Office of Healthy Aging. Changes to the funding formula would allocate \$8.19 per senior to the program, above the existing rate of \$7.20. The total proposed investment would be \$1.6 million, with \$200,000 being new funds.

Potential Olmstead-Aligned Investments from Opioid Settlements

EOHHS plans to make continued investments into Olmstead through opioid settlement funding allocations approved by the Opioid Settlement Advisory Committee. This includes but is not limited to: Homelessness Prevention Initiatives for Justice-Involved and Opioid Use Disorder/SUD populations; Medications for Opioid Use Disorder programming; Rhode Island Foundation basic needs grants; oral health improvements for individuals in recovery; and other related activities.

New Medicaid Accountable Entity Investments in Behavioral Health

With recognition of the close alignment between the Accountable Entity (AE) Behavioral Health Investment goals and the goals of Olmstead, Medicaid has decided to invest \$1.5 million of Health Systems Transformation Project funds, in addition to any remaining AE Incentive funds from program years 2026 and 2027, into supporting the implementation of the Olmstead Plan. With this funding, AEs will be tasked with working with HEZ and Managed Care Organizations to create and implement action plans for one or more Olmstead Plan recommendations that relate to behavioral health. These funds will be aligned with recommendations in this plan, as applicable.

Investments Note

Any investments related to the EOHHS Medicaid program will require federal authority and state funding allocations. In addition, all funding related to opioid settlements is contingent upon allocations made by the Opioid Settlement Advisory Committee.

Community-Identified Assets with At-Risk Investments

Of the assets available to the disability community, some are sustainably funded, while others are at risk or underfunded to meet the need. While the current landscape makes it difficult to know the long-term viability of many programs, there are some known programs that are at risk, identified by state agencies (See Appendix*) and by the community. Some examples of promising programs identified by OAG members and interagency partners that may be at-risk in the near future are:

- **Affordable Connectivity Program:**
The Federal Communication Commission is currently extended through May 2025 but in danger of losing funding after that. Provides many low-income households with affordable internet connectivity.

- **Staple Community Resources:**
These include the Aging & Disability Resource Center at United Way of Rhode Island, the Autism Project, RIPIN, RAMP, Hillsgrove Mental Health, and the Resource Facilitation Program at the Brain Injury Association of Rhode Island. This last program is the only one of its kind in Rhode Island and is instrumental in assisting individuals with traumatic and acquired brain injuries to identify resources, provide referrals, support, and advocacy, and empower individuals to navigate the system, fostering independence, self-determination, and improved social and emotional functions. The funding for this vital program ended in September 2024.
- **Step-Down and Supportive Services Programs:**
These include step-downs programs like Craft and Rite House, and medical despite programs at Hallworth House, Woonsocket Health and Rehab, and Elwyn. Supportive service programs such as Pay for Success that could be expanded upon pilot completion in 2027.
- **Accessible Transportation Pilot:**
RIPTA transportation pilot program that expands paratransit services beyond the three-quarters of a mile zone. RIPTA has continued the funding until the allocated funds run out, but the State needs to look at longer-term sources of funding.
- **Place-Based Investments:**
Rhode Island’s HEZ initiative is an innovative strategy for improving the lives of Rhode Islanders in 14 communities across the state. HEZ has demonstrated that social vulnerability has reduced by 21% in HEZ communities, compared to non-HEZ communities that have only seen 0.4% improvement. Further, people living in HEZ communities are twice as likely to have public insurance as those in non-HEZ communities. Recent findings show that the average per-person public insurance costs are significantly lower in HEZ communities than non-HEZ communities, resulting in increasing public insurance savings over time. In addition, HEZ recently conducted a place-based Community Integration Specialists pilot that is aligned with Olmstead’s vision of home and community-based services. Despite the success of this model, Rhode Island’s HEZs are not sustainably funded and rely heavily on grants that may be under additional scrutiny given federal changes.

Data Opportunities

While the State collects some data effectively, one key lesson learned is that collecting better data and investing in data infrastructure are essential to meeting current and future needs. At the same time, the State should not let a lack of comprehensive data slow progress. For instance, it is not necessary to wait until there is formal tracking of the availability of affordable and accessible housing units to move forward as production takes significant time and there will be evidence of sufficient progress when there is more available housing and group homes than demand.

Data assets that currently exist and support Olmstead work include:

- EOHHS Data Ecosystem
- RIDOH Center for Health Data and Analysis
- KIDS COUNT Factbook
- Prevent Overdose RI and related dashboards

Consent Decree Progress

Some of the current assets available to the community resulted from consent decrees, which are legal agreements that a government and an organization make to resolve an issue, and which a court oversees to ensure follow through. The state has worked under three consent decrees and has recently

agreed to a fourth. These consent decrees include the [2025 Consent Decree](#), [2022 Katie Beckett Settlement Agreement](#), and the [2013 and 2014 Consent Decrees](#).

The 2013 and 2014 Consent Decrees between the United States Department of Justice (DOJ) and Rhode Island BHDDH were agreements aimed at addressing violations of the ADA. The two decrees required the State to improve services for youth in transition, the “youth exit” population (i.e., individuals who left secondary school between 2013 and 2016 and were eligible for adult services), the sheltered workshop population, and the segregated day services population. Some examples of progress made through these Consent Decrees include the elimination of subminimum wages and sheltered workshops, systemic investments and policy advancements, and cultural and programmatic shifts toward “Employment First” (i.e., ensuring people with disabilities have meaningful access to work). See the [2023 Addendum to the Rhode Island BHDDH Consent Decree](#) and the BHDDH Consent Decree Addendum Summary in the Appendix* for the complete list of progress made to date.

In the 2022 Katie Beckett Settlement Agreement, the parents of a child with disabilities filed a complaint claiming that the State failed to provide their son with the full home-based services he was approved for under Medicaid’s Katie Beckett program, leaving him with only half the authorized care and at risk of unnecessary segregation. The agreement was made between RI EOHHS, the State Medicaid Director, and government agencies that provide services for the Katie Beckett program. As a result of the agreement, the State provided a personalized service plan to ensure Medicaid services to the Complainant’s son, improve provider access and oversight, and enhance care coordination through Cedar Family Centers.

On December 14th 2024, a fourth [consent decree](#) was signed. The State of Rhode Island, through DCYF, entered into a Consent Decree following a review by the U.S. Department of Health and Human Services (HHS) and the U.S. Attorney’s Office. The review identified concerns regarding the unnecessary segregation of children with behavioral health disabilities in acute psychiatric care, in violation of the ADA and the Rehabilitation Act. As part of the agreement, Rhode Island is committed to implementing a plan to transition these children to more integrated, community-based services. This initiative aims to reduce avoidable hospitalizations and improve outcomes for children and families by ensuring that children receive care in the least restrictive, most appropriate settings.

Implementation Plan

Olmstead Vision for Rhode Island

Rhode Island is committed to being a state where people of all abilities—and their families and caregivers—are fully included in their chosen community and supported by the resources needed to live a fulfilling life.

Rhode Island will be a place where dignity and respect are felt by all, regardless of ability. In Rhode Island, structures will be transformed, and information will be readily available, so that people with disabilities can make meaningful choices, participate in every aspect of life, and freely pursue their goals and aspirations without judgment, stigma, nor discrimination.

Key Strategies for Achieving the Vision

To meet the Olmstead vision for Rhode Island, 12 key strategies were identified from community feedback, including from the OAG membership. These strategies also aligned with improvement strategies in other state Olmstead Plans and in recent Rhode Island Consent Decrees.

Enhancement Strategies

- Facilitate effective discharge and transition planning—including for youth
- Improve availability of outreach, education, and support initiatives
- Expand community-based services and develop intensive in-home services
- Enhance existing service planning and care coordination

Integration Strategies

- Assure quality socio-economic conditions for community living
- Support community provider capacity and development for integrated service delivery
- Expand career development planning and training, supported employment services, and placements
- Foster integrated day services and placements in the community

Overarching Strategies

- Promote stakeholder outreach and public participation
- Coordinate state agency actions and foster collaboration
- Strengthen disability data collection, monitoring, quality assurance, performance systems, and evaluation
- Invest in transformational change and secure sustainable funding

Goals, Outcomes, and Associated Recommendations

Six goals were identified from the planning workgroups and vetted with the OAG and interagency partners to anchor the recommendations resulting from community input. These goals are aimed at helping people with disabilities become more integrated into their communities. Each goal is tied to specific outcomes that are likely to change over time when progress towards the goal is made. To reach these goals, a set of tiered recommendations have been established, representing the specific actions for the State to consider. The recommendations are sorted by Short-Term, Mid-Term, and Long-Term recommendations based upon OAG review and prioritization.

Note for first draft review:

For the final draft, each recommendation will be sorted into the tiered prioritization as follows:

- Tier 1: Short-Term Actions (High Priority)
- Tier 2: Mid-Term Actions (Mid Priority)
- Tier 3: Long-Term Actions (Low Priority)

See the *example* final formatting below.

Tier 1: Short-Term Actions

#	Recommendation	Priority Score
1	Support programs and policies that help prevent harmful (also known as adverse) childhood experiences. <ul style="list-style-type: none"> ● <i>Potential State Partners: RIDOH, RIDE, DCYF, OCA</i> ● <i>Potential Community Partners: TBD</i> 	15

Goal 1: Focus on fixing the root causes of segregation and the factors that lead to individuals and families being or feeling isolated in society.

Why

Many placements in facilities don't need to happen, but because of community conditions, people are being put in facilities for a long time anyway. This can change with an understanding of what factors cause unnecessary placement in facilities before it happens and working to change them.

Anticipated Outcome(s)

- Reduced number of preventable situations that may result in institutionalization
In other words, there would be fewer situations where people become institutionalized due to preventable causes.

Recommendations

Tier 1: Short-Term Actions (High Priority)

#	Recommendation	Priority Score
1	Continue to require Crisis Intervention Training for police officers as part of the RI State Police and RI Municipal Police training academies and for Correctional Officers to better support people with disabilities.	18
2	Expand law enforcement models (such as the Police Officers Commission on Standards) to include individuals with lived experience and expertise in disability and to work together to propose policy, practice, and training changes for first responders as a way to reduce the criminalization of individuals with disabilities when their actions are driven by their disabilities.	17

Tier 2: Mid-Term Actions (Medium Priority)

#	Recommendation	Priority Score
3	Support programs and policies that help prevent harmful childhood experiences.	16
4	Promote health for all by making healthy food, safe and accessible public spaces, and safe, healthy housing (including working utilities) more available to everyone.	16
5	Work with OAG and interagency partners to cross-promote family visiting programs to increase early detection of disabilities.	15

Tier 3: Long-Term Actions (Low Priority)

#	Recommendation	Priority Score
6	Focus on preventing substance use in children.	14
7	Advocate for restorative justice practices in public schools.	14
8	Sustain and expand existing statewide efforts to prevent violence and injuries in communities.	14

Goal 2: Increase opportunities for people to live independently and be part of their communities, with a special focus on improving housing, transportation, and continuous access to utilities.

Why

Everyone deserves the chance to live on their own terms and be active in their community, no matter their abilities. Lack of affordable and accessible housing and barriers to accessing transportation make this challenging for people with disabilities. Improving access to housing and transportation to meet the needs of individuals with disabilities can ensure people can live where they want, get around easily, and have the basic services they need to thrive. These improvements can help people with disabilities live independently, participate in everyday activities of their choice, and connect with others, ultimately leading to a better, more fulfilling life. In addition, having access to continuous electricity, heat, and water is essential for many with life-sustaining equipment or special healthcare needs.

Anticipated Outcomes

- Increased access to affordable and accessible housing solutions and reduced homelessness among individuals with disabilities
In other words, there is more affordable and accessible housing, and fewer people with disabilities experience homelessness.
- Reduced number of individuals with disabilities who identify transportation as a barrier to participating in the activities that they need and desire
In other words, fewer people with disabilities say transportation stops them from participating in the activities they want or need.

Recommendations

Tier 1: Short-Term Actions (High Priority)

#	Recommendation	Priority Score
1	Create a centralized list of affordable, accessible housing options that tracks waitlists and future needs, including all public housing authorities.	19
2	Work to expand allowable destination types (like recovery meetings or service animal appointments) for non-emergency medical and other transportation services and discuss program monitoring needs with community partners.	18
3	Maintain and enhance the Transportation in Your Community webpage as a single list of transportation options for people with disabilities to include private options, town programs, state programs, and pilots with links for each.	18

Tier 2: Mid-Term Actions (Medium Priority)

#	Recommendation	Priority Score
4	Expand access to public transit for people with disabilities by continuing RIde Anywhere Pilot program and removing ¾ mile location restrictions.	17
5	Determine resource needs and a mechanism for a state-funded rental subsidy to supplement limited federal vouchers for individuals with disabilities and implement a pilot.	17
6	Support initiatives to make new housing easier for people with disabilities to access (such as support for Type C "visitable" housing units being the minimum requirement when building housing units in Rhode Island).	17

Tier 3: Long-Term Actions (Low Priority)

#	Recommendation	Priority Score
7	Build more affordable, low-barrier, and accessible housing units.	16
8	Reduce stigma and discrimination in rideshare and public transportation programs by promoting and incentivizing training for drivers on working with people with disabilities.	16
9	Provide better financial support for non-medical transportation, like rideshare reimbursements when regular services are unavailable.	16
10	Offer financial help for families with disabled children to buy accessible vehicles—perhaps exploring the State program for paying for accessible home modifications as a model.	14

Goal 3: Make care networks stronger, especially for mental health services, and improve coordination between different systems to make sure people get the support they need without gaps or confusion.

Why

Having the right services at the right time—without interruption—can keep us healthy and safe. With this goal the Olmstead Planning Team is working to make sure individuals with disabilities have easy access to the mental, physical, and social health services that they need when they need them without having to be isolated from their community.

Anticipated Outcomes

- Increased access to and utilization of home and community-based services
In other words, more people with disabilities can use home and community-based services.
- Increased placement into community-based settings or alternative living situations that are the least restrictive compared to facility- or institutional-based care
In other words, more people move into community living or other home-like settings instead of staying in hospitals or institutions.

Recommendations

Tier 1: Short-Term Actions (High Priority)

#	Recommendation	Priority Score
1	Evaluate Certified Community Behavioral Health Clinics’ (CCBHCs) performance and provide quality improvement support to better meet the needs of individuals with disabilities across the lifespan.	19
2	Increase collaboration between state health and human services agencies and disabilities commissions to strengthen the State’s ability to monitor and address complaints about accessibility and communication standards in healthcare facilities.	19
3	Work with state agencies and health insurance companies to reduce barriers to obtaining and maintaining mobility devices and other durable medical equipment that promote community integration.	18
4	Expand integrated community programs and spaces to better serve underrepresented groups, like those with brain injuries or behavioral health needs, memory care needs, intellectual and developmental disabilities, working adults, new diagnoses, and late-life diagnosis. Example: Mental Health Club Houses.	18
5	Support and provide resources for peer recovery specialists, peer support paraprofessionals, and community health workers working with all types of disabilities.	18
6	Improve 508 compliance and plain language in advertising and community and state staff training, and central resource inventories to increase individual access to disability resources.	18
7	Cross-train entry point staff on all available services and navigating support.	18

8	Support new or revised payments for behavioral health providers as determined through rate reviews to ensure more people get help where and when they need it.	18
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Tier 2: Mid-Term Actions (Medium Priority)

#	Recommendation	Priority Score
9	Continue to pilot in-home intensive clinical therapy for children.	17
10	Assess the number of medical provider offices that are physically accessible and the number of providers trained and comfortable with welcoming people with all disabilities.	17
11	Recruit, support, and retain more therapeutic foster parents by developing targeted and in-person recruitment strategies, strengthening peer support, improving training, collaborating with state and local agencies to share resources available to foster parents, and enhancing financial and logistical assistance.	17
12	Increase low-barrier access to working medical equipment by expanding access to refurbished medical devices and training more repair technicians.	17
13	Support and expand the children’s mobile crisis and stabilization program throughout the state.	17

Tier 3: Long-Term Actions (Low Priority)

#	Recommendation	Priority Score
14	Increase temporary, transitional, and accessible housing options for people leaving incarceration, including enhanced group homes for medical or accessibility needs.	16
15	Determine and pilot what additional nursing home supports—such as training, staffing, and risk mitigation—are needed and can be implemented to be able to safely care for patients with traumatic brain injuries and behavioral health diagnoses.	16
16	Build and make available permanent supportive housing for individuals and families who need this level of support regardless of their homelessness status.	16
17	Increase the State’s ability to monitor if there are enough mental healthcare workers for children and adults by developing and distributing a survey (e.g., Massachusetts Health Care Workforce Survey).	16
18	Develop pathways for priority placement into permanent supportive housing for people who are about to be discharged into homelessness.	16
19	Develop, with community input, standardized data and career ladders for the Community Health Worker, Peer Recovery Specialist, Outreach Worker, and Case Manager workforce through unique identifier collection, occupational licensing, and/or employer reporting of workforce data at the individual or aggregate level.	14

20	Develop model policies, practices, and systems for clinical providers to transition health records and care to avoid disruptions.	14
21	Improve cancer screening, treatment, and outcomes of individuals with disabilities by continuing to convene regular meetings between state cancer programs, cancer providers, and other agencies and experts to design and implement pilots, training, and policy changes.	14
22	Explore application of Fair Housing Act (FHA) to nursing homes for individuals with disabilities and incarceration histories.	14

Goal 4: Create fair opportunities and inclusive environments for people in places like work, school, and recreation.

Why

Everyone deserves the opportunity to work, learn, and play. With this goal, the Olmstead Planning Team is working to create a state where individuals with disabilities have many more opportunities to work, learn, and play based on their choice of where and how they want to do so. These opportunities increase independence, quality of life, and economic self-sufficiency.

Anticipated Outcomes

- Increased percentages of individuals with disabilities hired and retained in employment sectors of their choice
In other words, more people with disabilities are hired and stay employed in different job sectors.
- Increased equity in educational outcomes for individuals with disabilities
In other words, people with disabilities do better in school and have fairer educational outcomes.
- Increased accessible environments for recreation and leisure
In other words, there are more places for people with disabilities to enjoy recreation that are accessible.

Recommendations

Tier 1: Short-Term Actions (High Priority)

#	Recommendation	Priority Score
1	Expand career exploration programs for young people with disabilities and provide more pre-employment services within human services agencies.	18
2	Support all Rhode Island schools so that transition planning for students with disabilities starts by age 14.	18
3	Convene interagency education, human services, and workforce partners to identify and apply for funds to increase resources for adult education programs for individuals with disabilities.	18

Tier 2: Mid-Term Actions (Medium Priority)

#	Recommendation	Priority Score
4	Reduce bias and discrimination among employers by providing training and tools to follow ADA rules and support employees with disabilities—perhaps similar to the Recovery Friendly Workplaces initiative.	17
5	Coordinate discussions between human resources, buildings and grounds, and agencies working with individuals with disabilities to designate the State and other private sector employers as champions of disability-friendly workplaces that accommodate individual needs and improve hiring and subcontracting practices to make sure there is diversity and disability representation.	17
6	Work with state education partners to create a career pathway for ASL interpreters.	17
7	Increase students, teachers, and school awareness of and access to existing transition support partners and resources.	17
8	Increase accountability across all schools for improvements to academic achievement and growth of students with disabilities in the least restrictive environment to make sure all students with disabilities are supported in making academic progress while learning alongside their peers as much as possible.	17

Tier 3: Long-Term Actions (Low Priority)

#	Recommendation	Priority Score
9	Highlight and cross-promote good examples of accessible spaces to encourage private sector businesses like restaurants and retail stores to increase accessibility.	16
10	Promote existing employment support services by hosting joint meetings between the State Workforce Board and Governor’s Commission on Disabilities, and Boston Job Accommodations Network to identify future areas of collaboration.	16
11	Include social and emotional learning in school lessons and activities to help students cope with challenges and build confidence, as well as administrator and education training on trauma.	16
12	Support the development of universal pre-K to make sure children with disabilities can integrate with their peers.	16

Goal 5: Build stronger communities by supporting reentry, recovery, and engagement to make sure people feel connected and involved.

Why

Trying to reintegrate into the community after being isolated can be challenging. With this goal the Olmstead Planning Team is working to make this integration easier by building more opportunities for individuals with disabilities to be involved in civic and community life. This includes building social networks and connectedness and honoring individual choice about when, where, and how integration happens.

Anticipated Outcomes

- Reduced institutional recidivism rates of individuals with disabilities
In other words, fewer people with disabilities return to institutions after leaving.
- Increased civic engagement and reduced social isolation of individuals with disabilities
In other words, people with disabilities are more involved in their communities and feel less isolated.
- Increased life expectancy and life satisfaction for individuals with disabilities
In other words, people with disabilities live longer and experience a better quality of life.

Recommendations

Tier 1: Short-Term Actions (High Priority)

#	Recommendation	Priority Score
1	Develop alternatives or exceptions to in-person attendance requirements (i.e., Virtual Access and Telecommunications Ban) for virtual meetings and public events that maximizes Rhode Island community input while preventing disruption caused by cyber incidents.	19

Tier 2: Mid-Term Actions (Medium Priority)

#	Recommendation	Priority Score
2	Create more opportunities for and awareness of accessible options for people with disabilities (including those in recovery) to participate in social and civic activities.	18
3	Improve discharge planning and transition for people leaving jail or prison to include connections to transitional and supportive housing options, after-hours transportation, basic needs and documentation, and access to existing financial support sooner.	18

Tier 3: Long-Term Actions (Low Priority)

#	Recommendation	Priority Score
4	Evaluate options to remove penalties for people with disabilities earning more money by exploring state and other funding options to offset federal benefit reductions.	17
5	Explore the feasibility of flexible funding that allows people with disabilities more choices in community activities.	17
6	Develop standard language for disability services and accommodations that could be included in state contracts to encourage funded partner organizations to provide inclusive services.	17
7	Evaluate options to remove penalties for people with disabilities earning more money by exploring state and other funding options to offset federal benefit reductions.	17

Goal 6: Ensure good management, responsible use of resources, improved data collection and progress tracking, and continued planning to fully complete goals and agreements.

Why

By collecting the right data, tracking progress, and adjusting plans when needed, the Olmstead Planning Team can ensure Olmstead goals are being met and the team is following through on commitments. This includes having the resources in place to continue community engagement and planning processes.

Anticipated Outcome(s)

- Reduce systems fragmentation across the life course to support individuals with disabilities *In other words, services and support are more connected and easier to access for people with disabilities throughout their lives.*

Recommendations

Tier 1: Short-Term Actions (High Priority)

#	Recommendation	Priority Score
1	Promote and track opportunities for individuals with lived experience of disability to serve in leadership capacities, such as state, local, and private commissions and boards.	20
2	Increase opportunities for people with disabilities and their supporters to give feedback and ideas to state programs –perhaps through presentations at the OAG.	20
3	Continue the OAG, resource community engagement sessions, and develop an Olmstead Data Council to review progress and improve data reporting.	19
4	Provide resources for dedicated roles to oversee Olmstead planning and implementation as well as coordinate disability equity efforts.	19

5	Evaluate the Olmstead Plan implementation process annually.	19
6	Facilitate state collaborative agency meetings or expand the OAG functions to enable sharing and review of current services and resources.	19
7	Continue public outreach and stigma reduction campaigns to raise awareness about Olmstead.	19

Tier 2: Mid-Term Actions (Medium Priority)

#	Recommendation	Priority Score
8	Ensure resources provided for Olmstead are inclusive of efforts needed to comply with consent decrees.	18
9	Develop processes to identify and secure opportunities for ongoing funding for Olmstead Plan implementation.	18

Tier 3: Long-Term Actions (Low Priority)

#	Recommendation	Priority Score
10	Standardize how disability status is collected across state programs and agencies and create a community-reviewed, public dashboard to track Olmstead Plan progress towards outcomes and goals.	17
11	Build staffing and data capacity to monitor and plan long-term Olmstead goals.	17
12	Sustain and enhance program inventory activities across government on Olmstead-focused initiatives and discuss future funding needs.	17
13	Improve data collection systems to better support decision-making and track services for people with disabilities—including things like real-time data maps, public and accessible transit, affordable and accessible housing, Ride services, community resources, food vendors, and disability-friendly employers.	17

Moving Forward to Make the Olmstead Plan a Reality

"What frustrates me most is when organizations say they can't afford to make things accessible. But they never seem to account for the cost of excluding disabled people from education, employment, and public life. That's the real expense we should be talking about."- Haben Girma, deafblind lawyer and advocate

Moving Forward

This community-led plan is intended to serve as a guide for executive and legislative branch decision-making on policy changes and investment strategies. The state acknowledges the changing federal landscape and environment and will continue to work with the community and interagency partners as policy changes that may impact this plan occur. The EOHHS will work with partners to update the plan based on public comment and OAG feedback and plans to provide the revised Version 2.0 to the Governor's Office and the community in March 2025.

While there is always more work to be done, this plan provides Rhode Island with a blueprint for making the State's Olmstead vision a reality. Annual progress reports and public dashboard updates will track investments and progress being made towards the plan's goals and outcomes as required by the Executive Order.

Sharing Rhode Island's Olmstead Plan

This plan has been shared with the OAG, Governor's Office, Senate President, House Speaker, and participating interagency partners. To continue the momentum spurred by the Governor's Executive Order, a simple presentation of core elements of the plan will be used to continue to provide public presentations on this plan as requested by community members. In addition, the plan itself and an overview will be presented to the existing, named coordinating bodies from the Executive Order:

- Commission for Health Advocacy and Equity
- Commission for the Deaf and Hard of Hearing
- Governor's Commission on Aging
- EOHHS Independent Advisory Council
- Governor's Overdose Task Force
- Governor's Council on Behavioral Health
- Long-Term Care Coordinating Council
- Medicaid Consumer Advisory Council
- Rhode Island Continuum of Care
- Rhode Island Developmental Disabilities Council
- Rhode Island Reentry Alliance
- Youth Advisory Council
- Mental Health Association of Rhode Island

The plan is made available on the EOHHS Olmstead webpage with a standardized feedback form for interagency partner and community feedback on an ongoing basis.

Refining and Monitoring the Plan Over Time

Should continued resources for Olmstead planning be provided to EOHHS beyond June 2025, the plan will continue to be updated regularly and shared back with the community, including additional Community Listening Sessions throughout implementation.

The OAG is set to continue to meet regularly to review additional updates to the plan, discuss opportunities to apply for funding, assist with monitoring of the plan, and review any timely trends or emerging priorities.

An evaluation of processes related to this plan is being planned for Spring 2025 to obtain opportunities to improve efforts and document to what extent processes led to a culture of collaboration around Olmstead.

Additional planning workgroups may be formed to continue work on the next set of priority topic areas as implementation of some recommendations is completed. Topics that emerged through community engagement and other state review include:

- Crisis services and home-based nursing care
- Person-centered planning and assistive technologies
- Outreach, navigation, and faith-based supports
- Family and caregiver empowerment
- Sustainable financing and quality assurances

EOHHS plans to convene an Olmstead Data Council to develop outcome measures (or proxy measures), review proposed data dashboards, and provide guidance on output measures associated with various recommendations. To track progress, the State will set up clear ways to measure how well investments are meeting each goal. This means creating targets that can be reached and measured. Each year, a report that shows what was accomplished and where improvements continue will be issued.

Lastly, through technical assistance obtained by BHDDH and EOHHS, SAMHSA is aiming to review and provide guidance on the plan to ensure compliance with Olmstead and indicate gaps or modifications necessary for individuals with mental health challenges and SUDs.

For More Information About This Plan

Visit the EOHHS Olmstead Webpage or Contact:

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