**Quarterly Olmstead Community Integration Summary**

1. **Report For: 4rd** Quarter 2015
2. **Prepared By:** D.C.Office on Aging
3. **Date Submitted: January 15, 2015**

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| **Community Integration (Olmstead Plan)**  **Coordinator** | **Agency Leadership** |
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Please note in the chart below, “transitions related to MFP” refers to transitions completed by residents who meet the following eligibility requirements: the resident was in a nursing facility 90 or more days prior to discharge; is a Medicaid beneficiary; and meets the Elderly and Persons with Physical Disabilities (EPD) Waiver level of care.

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| **Number of PEOPLe to be Moved to Community Services**  **GOAL** | **Descrip-tion** | **CY1**  **(Jan-Mar) Progress** | **% of Annual Goal CY1** | **CY2**  **(Apr-Jun)**  **Prog.** | **% of Annual Goal CY2** | **CY3**  **(Jul-Sep)**  **Prog.** | **% of Annual Goal CY3** | **CY 4**  **(Oct- Dec)**  **Prog.** | **% of Annual Goal CY4** | **Total Progress** | **Total % of Annual Goal** |
| **210** | **Total Number Transitioned** | **42** | **20%** | **45** | **21%** | **38** | **18%** | **44** | **13%** | **169** | **80%** |
| **30** | # of individuals transitioned from nursing facility **(related to MFP)** | **5** | **17%** | **11** | **37%** | **6** | **20%** | **15** | **50%** | **37** | **123%** |
| **Number of PEOPLe to be Moved to Community Services**  **GOAL** | **Descrip-tion** | **CY1**  **(Jan-Mar) Progress** | **% of Annual Goal CY1** | **CY2**  **(Apr-Jun)**  **Prog.** | **% of Annual Goal CY2** | **CY3**  **(Jul-Sep)**  **Prog.** | **% of Annual Goal CY3** | **CY 4**  **(Oct- Dec)**  **Prog.** | **% of Annual Goal CY4** | **Total Progress** | **Total % of Annual Goal** |
| **30** | # of individuals transitioned from nursing facility (**Not related to MFP)**: | **3** | **10%** | **4** | **13%** | **3** | **10%** | **2** | **7%** | **12** | **40%** |
| **150** | # of individuals assisted by ADRC's Hospital Discharge program with transition from a hospital back into the community | **34** | **23%** | **30** | **20%** | **29** | **19%** | **27** | **18%** | **120** | **80%** |

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| **AGENCY GOAL TYPE** | **NARRATIVE** |
| **Quantitative Goal Progress** | **DCOA’s Community Transition**  During the months of January to March 2015 (Q1), the D.C. Office on Aging’s (DCOA), Aging and Disability Resource Center (ADRC) staff transitioned 42 people from institutional settings back into the community. Of those transitions, 34 were from a hospital, and 8 were from nursing facilities. As of the close of Q1, DCOA had reached 20% of its transition goal.  During the months of April to June 2015 (Q2), ADRC staff transitioned 45 people from institutional settings back into the community. Of those transitions, 30 were from a hospital, and 15 were from nursing facilities. As of the close of Q2, DCOA had reached 37% of its transition goal.  During the months of July to September 2015 (Q3), ADRC staff transitioned 38 people from institutional settings back into the community. Of those transitions, 29 were from a hospital, and 9 were from nursing facilities. As of the close of Q3, DCOA had reached 60% of its total transition goal.  During the months of October to December 2015 (Q4), ADRC staff transitioned 44 people from institutional settings back into the community. Of those transitions, 27 were from a hospital**,** and 17 were from nursing facilities. At the close of the Q4, DCOA had transitioned 169 total people, 49 from nursing facilities and 120 from hospitals, reaching, 80% of its overall transition goal.  Considered individually, the MFP program transitioned 37 residents back into the community, surpassing its goal by 7 people, and achieving 123% of the goal. Non-MFP nursing facility transitions were lower than expected, and reached 40% of the goal (12 transitions). This variance was largely due to a lower than expected referral rate of non-MFP community transition referrals.  The hospital discharge numbers were also lower than expected in 2015 due to a programmatic shift from direct service to consultant service on hospital discharges. DCOA offered direct assistance with hospital discharges to 10 clients and hospital discharge consultation to 17 clients (personally, or through their hospital discharge planner, family member, or caregiver). This programmatic change is addressed in more detail below.  ADRC’s Community Transition team includes 15 Transition Care professionals, responsible for prescreening customers for program eligibility; informing individuals about the Elderly and Persons with Physical Disabilities (EPD) Waiver; assisting them with enrollment if needed; and conducting options counseling with individuals to create a person-centered action plan that maps out the services and provides guidance of community resources to ensure a successful transition.  The ADRC received 93 referrals this quarter, and conducted 26 intake screenings for individuals seeking nursing home transition services. The intake screenings are lower than the referrals received because the ADRC frequently receives inappropriate referrals for the program for people who are not eligible (e.g. they have not been in a nursing facility for 90 or more days). ADRC staff will still work with residents, caregivers, and nursing facility discharge planners to assist with connecting resident with home and community based services, even if they are not eligible for the Community Transition program.  **Outreach**  To assist current nursing facility residents and their families in understanding the option of home care instead of institutional care, DCOA’s ADRC has an outreach specialist dedicated to conducting outreach events and facilitating meetings with individuals and/or families interested in transitioning from institutional settings back into the community. The purpose of these meetings and events is to increase the visibility and awareness of community transition services in order to aid program enrollment and increase transitions.  The community transition outreach specialist conducted 63 outreach sessions this quarter at Long-Term Care Facilities, including:12 Resident Council Meetings, and 51 one-on-one informational sessions with nursing home residents. The outreach specialist met with a total of 351 people, and handed out 153 info packets related to Community Transitions and home and community based services. |
| **Qualitative Goal Progress** | **Interagency Partnership, Collaboration, and Cross-Training**  **Department of Health Care Finance**  DCOA’s ADRC has improved access to community-based long-term supports for DC residents through a memorandum of understanding (MOU) with the Department of Health Care Finance (DHCF), initiated in 2013, to provide a comprehensive interdisciplinary program that organizes, simplifies, and provides access to community-based resources through referral to all public long-term care and support programs. The current MOU was initially signed on September 29, 2014, and amended on January 30, 2015, to include expanded pre-enrollment responsibilities and increased staff for the ADRC.  One of the challenges to community transition has traditionally been a long wait for enrollment into the EPD Waiver. Starting in October 2014, DCOA and DHCF began working together weekly on updating the EPD Waiver Enrollment process flow to begin identifying how to improve customer service and reduce wait times for EPD Waiver applicants. The above improvement-oriented activities resulted in the creation of a new Medicaid Enrollment Team, based at DCOA and funded by DHCF. To staff the new team, DCOA hired seven new staff members who started in May 2015, including:  5 Medicaid Enrollment Specialists, 1 Medicaid Lead, and 1 Community Social Work Supervisor, to take over pre-eligibility enrollment activities formerly tasked to the Elderly and Persons with Disabilities (EPD) Case Management Agencies, also DHCF providers.  DCOA continued to work with DHCF to finalize the enrollment procedure for Adult Day Health Program (ADHP) services this quarter, including people on home and community based waivers (EPD and IDD). The ADRC was tasked by DHCF with completing Person Centered Plans for 101 District residents prior to the end of 2015, to ensure that these Medicaid beneficiaries were able to continue attending their Medicaid-Funded ADHP in 2016. Each of the residents was contacted by ADRC staff, in-person visits were completed, and required documentation was submitted to the DHCF by close of business on 12/31/15. Thirteen of the referred residents decided they were no longer interested in attending ADHP. Since the summer of 2015, ADRC has been working closely with the DHCF to create an efficient ADHP enrollment process so DC residents receiving State Plan Medicaid who request, and are eligible for ADHP services, are able to enroll in a timely manner. Continuing into 2016, ADRC will work with DHCF on providing accurate information about this program and enrollment process to ADHP providers, ADRC staff, DCOA’s Senior Service Network, members of the public, and other key stakeholders.  The ADRC Medicaid Lead, Special Projects Coordinator, Associate Director and Deputy Associate Director, continued to hold weekly inter-agency meetings with DHCF to discuss complex EPD enrollment cases, improve systematic flaws, correspond with other providers to work out communication and process barriers, and plan community trainings for stakeholders.  **Veterans Services**  DCOA’s ADRC continues to collaborate and partner with the Veterans Administration (VA) Medical Center and VA Resource Center to assist D.C. veterans who are over 65 years old and/or have physical disabilities, in accessing person-centered, home and community-based services and supports. The ADRC team assists VA residents to connect to Friendship Place, a Veterans First Program; and Volunteers of America to seek housing placement, as well as other home and community-based services and supports.  Additional DCOA partnerships that ADRC transition staff work closely with to ensure safe and successful transitions include: Washington Hospital Center Mental Health, Psychiatric Institute of Washington, Adult Protective Services, and several of DCOA’s grantees, Lead Agencies in each of DC’s 8 Wards: Terrific Inc. (Wards 1, 2, 4), Seabury (Wards 5 and 6), Iona Senior Services (Ward 3), East of the River Family Strengthening Collaborative (Ward 7), and Family Matters of Greater Washington (Ward 8). Other key community organizations that frequently assist the transition process include: the Medical House Calls Program, Home Care Partners, Living at Home Consultation, LLC., Legal Counsel for the Elderly, D.C. LTC Ombudsman Program, and the Health Care Ombudsman and Bill of Rights program.  DCOA has coordinated 6 trainings with trainers/community partners this quarter to help improve staff’s cultural competence, disability awareness, and professional skills:   1. 10/14, **Medicaid spend-down, estate recovery, and patient pay-ability,**  presented by DHCF at the DC Citywide Case Management Meeting at DCOA 2. 10/23, **Elderly and Persons with Disability Waiver** Training presented by DCOA at Terrific, Inc., Ward 4 3. 11/4,  **Elderly and Persons with Disability Waiver** Training presented by DCOA and DHCF; and **Seniors Matter Mental Health Program**, presented by Family Matters at the Citywide Case Management Meeting at DCOA. 4. 12/1, **ADRC and Long Term Care Administration Meet/Greet and Training**, at DHCF, participants from both DCOA and DHCF 5. 12/2, **Medicaid Funded Adult Day Health Enrollment** - Discussion and Training with all ADRC Social Workers at DCOA 6. 12/9 **1098 B Training- Tax form for Medicaid Beneficiaries**, presented by DHCF at DCOA   **Co-Locating ADRC Social Workers at DCOA Lead Agencies**  Purpose: Improve service delivery and access to older adults and people with disabilities by co-locating community social workers at lead agencies. Expand scope, collaboration, and communication of DCOA’s ADRC by transitioning staff to a flexible community-based model.  Key tasks of community social workers:   * Assist with nursing home transitions. * Assist with hospital discharges both through direct social work service provision and consultation. * Assist people aged 18-59 in accessing home and community-based services and supports. * Conduct enrollment visits including developing Person-Centered plans for Adult Day Health Program enrollees. * Conduct home visits as needed to assess client needs. * Work collaboratively with Medicaid Enrollment Specialists on EPD Waiver enrollment. * Work collaboratively with lead agency staff on complex, multigenerational cases. * Establish and maintain office hours at the lead agency. * Together with assigned DCOA/ADRC Clinical Social Work Supervisor, act as a DCOA liaison to the assigned lead agency.   To facilitate the move of several ADRC social workers into the community, ADRC Managers conducted a conference call in April with Lead agency directors, and conducted site visits for all eight wards throughout the summer of 2015. During both the conference call and site visits, ADRC Managers and DCOA grant monitors reviewed the responsibilities of ADRC staff and lead agencies to collaborate on details necessary to transition ADRC social workers to each lead agency.  ADRC managers developed a system of case assignment to ensure community transitions are prioritized and handled in a timely manner both by MFP staff located at DCOA’s headquarters, and Community Social Workers with expertise in Nursing Home Transition and Hospital Discharge. Additionally, the case assignment process will ensure a manageable case mix of nursing home transition, hospital discharge, and community social work cases (people aged 18-59 years old with a disability) that is as geographically-based as possible.  This quarter, ADRC Managers updated the standard operating procedures for community transitions, and coordinated necessary trainings to begin preparing Community Social Workers to work with all proposed programs and populations for maximum flexibility and accessibility to DC residents.  **Person-Centered Planning and the No Wrong Door Initiative**  Person-Centered planning is central to DCOA’s ADRC efforts to transition people from institutional settings back into the community. ADRC staff have been trained to provide person-centered options counseling when assisting DC residents in understanding their long-term care options. To improve our practice and collaborate on person-centered practices, DCOA is currently partnering with other DC health and human service agencies (DDS, DBH, DHCF, Department of Health [DOH], DHS, and the Office of Veterans Affairs [OVA]), in developing and implementing a No Wrong Door (NWD) system of access to Long Term Care Services and Support for all population and all payers.  A NWD system, at its core, revolves around person-centered practice, and streamlined access to public community-based programs. To this end, the ADRC Associate Director is co-leading an inter-agency workgroup on examining and streamlining the District-wide definition of person-centered planning/thinking, and ensuring each DC agency is operating under a common set of core principles and practices. The resulting work will be included in the three-year plan that is required by a No Wrong Door federal Grant. DDS is the lead DC agency partner on this grant, and they co-facilitate the person-centered workgroup.  As part of its work on the person-centered work group, DCOA conducted three focus groups in August and September, 2015, to help gain insight on our intake/referrals process from the perspective of older adults and people with disabilities who have contacted DCOA for services/supports. ADRC staff also asked focus group attendees for feedback on ADRC’s outreach materials to ensure that the language and design was accessible and inviting to both older adults and people with disabilities.  Next steps for the person-centered workgroup will include creating District-wide trainings and a person-centered approach that take agencies’ current practices into consideration, and applies person-centered principles across agencies to help bring District-wide staff competencies into alignment.  **Programmatic Shift for the Hospital Discharge Program**  Prior to October 2015, DCOA’s Hospital Discharge program staff worked closely with social workers in each hospital’s discharge department to help ensure safe discharges in which home and community based services were in place either upon discharge, or soon thereafter. However, it became apparent that the hospitals had begun relying on ADRC to provide support to hospital patients that discharge departments are legally responsible for.  After a meeting with the director of DC’s Department of Health, outreach to the Hospital Association, and one-on-one conversations with administrators and/or social work supervisors at each of the partner hospitals, it was decided that DCOA’s role should transition to more of a home and community based services consultant for clients, families, and hospital discharge planners, rather than case management for the most complex cases in DC.  DCOA’s involvement in the Hospital Discharge program highlighted a service gap in DC that could not be filled by two ADRC social workers, but rather, must be addressed by renewed commitment by hospitals and coordination of multiple agencies.  DC updated its Olmstead Plan for 2016 and No Wrong Door federal grant objectives to include inter-agency collaboration on the most complex hospital and nursing facility cases, ensuring that hospitals and nursing facilities take primary responsibility for discharge planning, with some consulting assistance from ADRC on available home and community based services and supports.  DC has committed through the Olmstead and No Wrong Door initiatives to convene a workgroup of DC health and human services agencies (including DCOA), and hospital and nursing facility staff, to create a home and community based services manual primarily for training hospital and nursing facility staff on the many services and supports available in the community, eligibility requirements, and how best to access them. DCOA expects to participate extensively in the development of this manual.  DCOA’s number of hospital discharge transitions were lower than expected due to the process of shifting responsibilities from direct social work and case management, to an advising role. This quarter DCOA assisted with 27 hospital discharge cases including the provision of direct social work assistance to 10 clients, and hospital discharge consultation to 17 clients.  **Improving Outreach Materials**  With the aim of improving the accuracy and content of ADRC outreach materials, DCOA hired a consultant, Campbell and Company, to update ADRC outreach materials (ADRC logo, flyers, tri-fold, and website). DCOA staff also developed a basic DCOA training to ensure that all DCOA staff, external partners, community residents, and other key stakeholders receive current, clear, and consistent information about DCOA.  To achieve this, ADRC led bi-weekly strategic marketing meetings which helped create a work plan for Campbell and Company.  The consultant:   1. Developed a new logo for ADRC and revised the marketing template and style guide for ADRC publications and website with the new logo. 2. Updated messaging and content development for ADRC publications and website through the DCOA one-pager, ADRC tri-fold, and five programmatic fact sheets. 3. Translated the ADRC one-pager in to 5 languages (Amharic, Chinese, French, Korean and Spanish) to help make ADRC services and supports accessible to a wider range of DC residents.   To help reach a wider range of DC residents, ADRC printed the Long Term Care Guide created under the Options Counseling Grant in 2014, in the following five most widely spoken non-English languages in DC: Amharic, Chinese, French, Korean and Spanish. The translated versions are also available on DCOA’s website: <http://dcoa.dc.gov/node/1015322>. |