**Quarterly Olmstead Community Integration Summary**

1. **Report For: 3rd** Quarter 2015
2. **Prepared By:** D.C.Office on Aging
3. **Date Submitted: October 19, 2015**

|  |  |
| --- | --- |
| **Community Integration (Olmstead Plan)**  **Coordinator** | **Agency Leadership** |
| Sara T. Clark | Brenda Donald |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Number of Persons to be Moved to Community Services**  **GOAL** | **Description** | **CY1**  **(Jan-Mar) Progress** | **Percentage of Annual Goal CY1** | **CY2**  **(Apr-Jun)**  **Progress** | **Percentage of Annual Goal CY2** | **CY3**  **(Jul-Sept)**  **Progress** | **Percentage of Annual Goal CY3** | **Total Progress** | **Total Percentage of Annual Goal** |
| **210** | **Total Number Transitioned** | **42** | **20%** | **45** | **21%** | **38** | **18%** | **125** | **60%** |
| 30 | # of individuals assisted by ADRC with transition from nursing facility (**Related to MFP**: Nursing facility 90+ days prior to discharge; Medicaid beneficiaries; Meet EPD level of care) | **5** | **17%** | **11** | **37%** | **6** | **20%** | **22** | **73%** |
| 30 | # of individuals assisted by ADRC with transition from nursing facility (**Not related to MFP**: Nursing facility 90+ days prior to discharge; Medicaid beneficiaries) | **3** | **10%** | **4** | **13%** | **3** | **10%** | **10** | **33%** |
| 150 | # of individuals assisted by ADRC's Hospital Discharge program with **transition from hospital** back into the community | **34** | **23%** | **30** | **20%** | **29** | **19%** | **93** | **62%** |

|  |  |
| --- | --- |
| **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 42people 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 41% 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 transition goal.  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 83 referrals this quarter, and conducted 36 intake screenings for individuals seeking nursing home transition services.  **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 enrollment and increase transitions.  The community transition outreach specialist conducted 61 outreach sessions this quarter at Long-Term Care Facilities, including:31 Resident Council Meetings, 3 Family Council Meeting, and 27 Individual (one-on-one) informational sessions with nursing home residents |
| **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 D.C. 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 “one-stop shop” access 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 30th, 2015, to include expanded pre-enrollment responsibilities and increased staff for the ADRC.  One of the challenges to community transition has traditionally be a long wait for enrollment into the EPD Waiver. In October 2014, DCOA and DHCF began working together weekly on updating the EPD Waiver Enrollment process flow to begin identifying and figuring out 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’s ADRC hired seven (7) 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.  ADRC staff are also responsible for developing Person-Centered Plans for Medicaid-funded Adult Day Health. DCOA is working with DHCF to finalize the enrollment procedure for ADHP services, and has begun conducting Person-Centered interviews with ADHP attendees who would like to be enrolled under Medicaid State Plan.  In July DCOA’s Medicaid Enrollment Specialist began the pre-eligibility enrollment activities for clients to enroll into the Elderly and Persons with Disability Waiver. In August DCOA’s ADRC social workers began to complete Person Centered Plans for individuals enrolling into Adult Day Health. 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, and plan community trainings for stakeholders.  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), 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 conducted 7 trainings this quarter to help improve staff’s cultural competence, disability awareness, and professional skills:   1. 7/07 Behavior Symptom Management Training 2. 7/20 Internal Messaging and Professionalism 3. 7/29 Money Smart Training 4. 8/12 LGBTQ Training 5. 8/17 Person- Centered Planning 6. 08/30-09/05 National Association of States United for Aging and Disabilities Conference 7. 09/30 Risk Mitigation Preparation   **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. * Assist people ages 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 four site visits in June (Wards 1, 4, 5, and 7). 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 are developing 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 ages 18-59 years old with a disability) that is as geographically-based as possible.  This quarter, ADRC Managers completed four more site visits to lead agencies, completed 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 D.C. residents in understanding their long-term care options. To improve our practice and collaborate on person-centered practices, DCOA is currently partnering with other D.C. 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 D.C. 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 D.C. 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 this quarter 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.  Next steps for the 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. Progress will be reported in future Olmstead reports. |