

# Appendix A:

## The 2016 Olmstead Plan

### I. 2016 Quantitative Transition Goals

The District continues to set quantitative goals that measure performance in integrating people with disabilities into the least restrictive environment possible, given each individual's needs and the available resources. Building on their 2015 Olmstead goals (see Appendix A), the four core service agencies (DCOA, DDS, DHCF and DBH) have set the following goals for 2016, with detail following the table:

Agency	2016 Goal	Detail
DCOA	45 transitions from institutional settings	<ul style="list-style-type: none"> <li>Following a stay of at least 90 days</li> <li>35 transitioned through the Money Follows the person (MFP) program.</li> <li>10 transitioned non-MFP.</li> </ul>
DCOA	200 consultations to support transition planning	<ul style="list-style-type: none"> <li>100 consultations in hospitals for people with any length of stay.</li> <li>100 consultations in nursing facilities for people with stays under 90 days.</li> </ul>
DDS	100 transitions from day supports	<ul style="list-style-type: none"> <li>Transition is from day supports in a congregate setting to a more integrated setting.</li> </ul>
DHCF	30 transitions from institutional settings	<ul style="list-style-type: none"> <li>Unduplicated count from the transition goals of other District agencies' Olmstead goals.</li> </ul>
DBH	70 transitions from Psychiatric Residential Treatment Facilities (PRTFs) or Saint Elizabeths Hospital (SEH)	<ul style="list-style-type: none"> <li>To home and community-based settings</li> <li>Following stays of 187 days or more from Saint Elizabeths Hospital</li> </ul>

#### DCOA:

DCOA's goals for 2016 have shifted more than those of other agencies due to structural changes in the way services are delivered. DCOA's 2015 goal of 210 transitions included 30 MFP, 30 non-MFP, and 150 transitions from hospitals. The funding for DCOA's hospital discharge program ended in 2015, so DCOA is now working with DC hospitals and sister agencies to assist hospitals in fulfilling their legal obligations to provide transition services to their customers. DCOA involvement with hospital transitions shifted to a consultation role. Consultations may include, but are not limited to, discussion about options for home and community-based services and how to access them; developing appropriate contacts; trouble-shooting discharge planning; and

providing general advice to social workers and family members in the discharge planning process.

Like hospitals, nursing facilities have a legal responsibility to provide discharge planning services to their residents. In order to focus resources on the most difficult cases, DCOA's nursing home transition team works with people who have resided in a nursing facility 90 or more days. DCOA also continues to provide consultation to nursing facilities, residents, and caregivers, for residents with nursing facility stays of less than 90 days.

DCOA relies on referrals from nursing homes, individuals, and caregivers, for transition care services requests and does not refuse consultations for hospital discharge planning or for nursing facility transitions. As a result, the goals are projections of the number of consultations DCOA expects in 2016 based on the number of referrals and requests DCOA received in 2015.

#### *DDS:*

In 2016 DDS is no longer tracking movement of people from Intermediate Care Facilities for People with Intellectual Disabilities (ICFs) into the waiver due to its success in reducing the number of people in ICFs and the size of those homes. DDS meets with each person living in an ICF at least on an annual basis to discuss support options. At that time, the person's needs are assessed and he/she, along with his/her support team, determines whether they are in the least restrictive setting to meet their needs.

DDS retains its goal of reducing the number of people receiving day supports in a congregate setting by 100. Success is demonstrated by: 1) increased numbers of people engaged in competitive integrated employment; 2) greater enrollment in Individualized Day Supports, Supported Employment, or Small Group Day Habilitation; and/or 3) increased participation in community-based Active Treatment for people living in ICFs.

#### *DHCF:*

DHCF's 2016 goal of transitioning 30 people from institutional settings is a deliberate increase from its 2015 goal of 20. The increase is based on the addition of the Adult Day Health Program (ADHP) in 2015 and the expected demand for ADHP by residents in institutional settings.

#### *DBH:*

DBH reduced its 2016 goal by 10 from 2015 because 1) the goal is specific to people who have a length of stay of 187 days (6 months) or more from Saint Elizabeths Hospital; and 2) fewer children are being placed in PRTFs because DBH has been successful in collaborating with other agencies to provide alternative wrap-around care, when possible, which diverts children and youth from residential care.

## **II. Strategic Priorities for 2016**

In addition to the quantitative transition goals, the Olmstead Working Group has identified nine

strategic areas in which the District must improve data collection and the provision of services and supports. While there is certainly overlap among these, for organizational purposes each is presented separately here. The nine areas (presented alphabetically) are:

- A Person-Centered Culture
- Community Engagement, Outreach and Training
- Employment
- Housing
- Intake, Enrollment and Discharge Processes
- Medicaid Waiver Management and Systems issues
- Quality of Institutional and Community-Based Services, Providers and Workforce
- Supporting Children and Youth
- Wellness and Quality of Life

In each strategic area, this plan lays out:

**The Backdrop.** The importance of the issue and some of the specific challenges in DC's current operations, both for institutions and for providers of home and community-based services.

**The Vision.** Where work in this area is headed and aspirations for the end result.

**The Data.** What is currently known and what is missing.

**Key Problems.** The barriers and challenges that make it difficult to achieve goals in this area.

**Action Steps and Lead Entities.** Needed actions and the agencies and entities that will take the lead on pursuing them, and be accountable for results.

## 1. A Person-Centered Culture

### *Why is this important?*

Person-centered thinking is a philosophy underlying service delivery that supports people in exerting positive control and self-direction in their own lives. Person-centered thinking is important for the promotion of health, wellness and safety, and for supporting people with disabilities to be valued and contributing members of the community.

While the use of person-centered thinking is important in all service contexts, its adoption by service providers working with people transitioning out of institutionalized settings is particularly crucial. It can increase the likelihood that service plans will be used and acted upon,

that updating service plans will occur “naturally,” needing less effort and time, and that the person’s ability to lead a fulfilling, independent life will be maximized.

### *What is the Vision?*

The vision is for a culture in our city that deeply respects each person’s right to make independent decisions about all facets of his or her life. We envision an LTSS system that fully embraces person-centered thinking – in the kinds of services and supports that are provided, the ways in which they are provided and the central role of people with disabilities in all aspects of decision-making about the programs and services they wish to utilize.

### *What are Some of the Challenges the District Faces?*

**The road to culture change is long.** While a few departments have had notable success in fully embedding person-centered thinking and practice into its culture and work, looking across the city government, awareness, capacity and competence in this area is uneven and can vary depending on agency or source of funding. There are no specified cross-system expectations or performance measures in this area for District agencies.

### *Action Steps, Lead Entities and Timeframes*

The District’s *No Wrong Door* initiative has articulated and is moving forward on a series of specific objectives for establishing a person-centered culture. These objectives center around improved accountability for the use of person-centered practice; widespread training in the methodology to increase capacity; and a reduction in duplicative intake and planning processes that tend to undermine person-centered approaches.

*No Wrong Door*’s cross-agency Leadership Council and project team will lead the work to accomplish the following objectives during the first year of the city’s implementation grant (fiscal year 2016):

1. Develop and implement clear expectations, competency criteria, standards, policies and protocols for all LTSS staff in the consistent use of person-centered approaches to service and planning, including using principles of supported decision-making<sup>i</sup> (regardless of whether individuals have guardians or other substitute healthcare decision-makers) (NWD/DDS by September 2016).
2. Add person-centered practice standards to District personnel job descriptions for staff in key LTSS agencies (NWD/DDS by September 2016).
3. Develop procedures and protocols for supporting family members and others in a person’s support network to ensure that plans accurately and continuously reflect the individual’s preferences and needs (NWD/DDS by September 2016).

### *Measuring Progress Going Forward*

Baseline data and planned metrics to evaluate improvements in the use of person-centered

approaches are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- #/% of core LTSS agencies that have implemented person-centered service protocols.
- #/% of performance measures (for agencies and providers) linked to person-centered practice and the use of supported decision-making.
- #/% of core LTSS agencies and staff that have completed training.
- #/% of HCBS provider staff who have completed training.

## 2. Community Engagement, Outreach and Training

### *Why is this important?*

A robust, transparent system of Long Term Service and Supports requires the active participation of people with disabilities, family members and caretakers, advocates and local service providers. The active engagement of broad stakeholders also demonstrates the District's commitment to supporting people to make their own choices and lead their lives as they choose. Finally, ensuring people with disabilities are involved and engaged will keep agencies and providers focused on the right outcomes, and ensure they are addressing the barriers that people are facing every day – many of which may not be obvious when the experience is not lived.

### *What is the Vision?*

We envision a wide variety of high-impact community engagement, outreach and training strategies to ensure people with disabilities have ongoing, meaningful involvement in planning for, and executing, their own service and support plans. We envision an engagement, outreach and training infrastructure and support system that is efficient, effective, and person-centered; and that government commitments in these areas are not only transparent to the community, but are met in the defined timeframes.

### *What are Some of the Challenges the District Faces?*

**Limited community engagement opportunities.** Much of the planning around community engagement work currently leaves key decision-makers (i.e. people with disabilities, service recipients, caregivers and families) out of the process altogether. In addition, participation in decision-making is often limited to formal work development and comment periods, which are not accessible to a broad range of stakeholders.

**Current outreach misses key targets.** Finding and engaging at-risk populations can be difficult, as is developing messages that resonate across all stakeholder groups. That said, current

outreach and information dissemination across agencies and settings is not coordinated, resulting in duplication and confusion among recipients of the material. Further, there are few opportunities for in-person exposure to the Long Term Services and Supports that are available – outreach efforts are almost exclusively through printed materials as well as electronic, TV, radio, and social media communication. The District does not currently measure the effectiveness of its outreach efforts.

**Planful training.** Community trainings tend to be general or conducted *ad hoc*, rather than following a plan that is based on a needs analysis, goal setting, and attendee feedback. There are no District-wide training goals or basic training expectations for all agency staff. Trainings are often conducted in places that are not convenient for attendees and they are rarely evaluated in a meaningful way.

### *Action Steps, Lead Entities and Timeframes*

Through the *No Wrong Door* initiative, DC has made strides in moving toward a unified approach to community engagement, outreach, and training. The NWD Stakeholder Engagement Workgroup developed a comprehensive contact list across all affected communities and convened the Outreach or Public Engagement staff at each NWD partner agency to brainstorm strategies for better work and inter-agency collaboration. The Workgroup also conducted several stakeholder engagement sessions and held preliminary focus groups with people with I/DD, physical disabilities, older adults, District-wide intake staff, and ADRC staff.

Building on this work:

1. Develop and promulgate policy and protocols to increase linguistically and culturally diverse stakeholder involvement in the development, implementation and ongoing evaluation of engagement and outreach activities (NWD/DDS by December, 2016).
2. Develop mandatory training for front line staff of District *No Wrong Door* partner agencies about the key plans and practice changes being developed through NWD. (NWD/DDS by December, 2016).
3. Develop a unified messaging and marketing “look” for outreach materials and replicate on all *No Wrong Door* partner agencies’ websites (NWD/DDS by December, 2016).
4. Launch and publicize an “Olmstead-comments-and-questions” email address that is permanently live. ODR will collect comments and present them to the Olmstead Working Group’s quarterly meetings for review (ODR by January 2016 and each subsequent quarter).

### *Measuring Progress Going Forward*

Baseline data and planned metrics to evaluate improvements in community engagement, outreach and training are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for

gathering these data.

- % of customers and # of caregivers reached through outreach and training.
- #/% reached who are not currently connected to services but may be at-risk.
- % of outreach meetings conducted in languages other than English.
- % of sessions receiving positive participant rating.
- # of active website information links, total and per agency; # of hits/month.

### 3. Employment

#### *Why is this important?*

Competitive and integrated employment – and the access to stable housing that it can bring – is a key pathway to the middle class. For people with disabilities employment also increases connections to the community, builds self-confidence and can lower rates of isolation and depression. Our city gains much from the perspectives and talents people with disabilities bring to the workforce, in addition to their positive impact on the economy in wages earned, taxes paid, and the purchase of goods and services.

#### *What is the Vision?*

All working-age people have access to – and are prepared for -- competitive and integrated employment that meets their individual interests, preferences and informed choices. Pursuing these opportunities is the first option explored in publicly-funded services and people with disabilities have the support they need to do so. The District of Columbia strives to be a model employer of people with disabilities.

#### *What are Some of the Challenges the District Faces?*

**Disproportionate unemployment for people with disabilities.** There is a significant gap in employment rates between DC residents with and without disabilities. According to the Census Bureau, 31% of DC residents with disabilities are employed, compared with 72% of people without disabilities. For working age District residents with cognitive disabilities (defined as having serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition) only 27% are employed.<sup>ii</sup> Only 13% of people with intellectual and developmental disabilities supported by DDA were competitively employed, slightly below the national rate of about 15%.<sup>iii</sup> Many young people with disabilities are not successfully transitioning from school to work.

**Support structures need strengthening.** Agencies and community providers working to support

employment for people with disabilities need targeted support to build capacity, ensure efforts utilize best practices in the field and are coordinated and aligned. While long-term employment supports are available through the HCBS IDD waiver, the EPD waiver does not offer such supports. Transportation, a critical work support, is also a barrier for many.

**Larger employment trends in the District.**<sup>iv</sup> The District's economy is thriving in many respects, with an overall unemployment rate of only 6.8% and demand for middle and high-skilled jobs improving steadily. However, there are also significant disparities in our city on several key economic indicators. For example, nearly 30% of DC households earn only about half of the city's median household income. Similarly, while unemployment city-wide is low and declining, in Wards 7 & 8 it remains in the double digits at 11.8 and 14.7% respectively. Further, unemployment amongst certain populations, such as African Americans and youth is high and significantly exceeds the national average.

The skills gap is an important factor in unemployment. Approximately 10% of DC residents have a high school diploma or less and 50% of these individuals are unemployed or under-employed. In a labor market where the demand for low skilled jobs is declining, the competition for low skilled jobs can be substantial.

### *Action Steps, Lead Entities and Timeframes*

As described in Section I, the District is an *Employment First* state with multiple initiatives and collaborations underway seeking to improve employment outcomes for youth and adults with disabilities. Building on this work:

1. Review and realign (if necessary) structures across the workforce development system to better support people with disabilities. (WIC by December 2016).
2. Increase the capacity of staff across the system, focusing on managers and supervisors in developmental disability and vocational rehabilitation programs through a train-the-trainer model and virtual community of practice to reinforce onsite training and provide virtual coaching to support best practices (DDS by December, 2016).

### *Measuring Progress Going Forward*

Baseline data and planned metrics to evaluate improvements in employment for people with disabilities are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- #/% of people referred from DDA to RSA who maintain employment and have their cases successfully closed.



- #/% of people referred from DBH to RSA who maintain employment and have their cases successfully closed.
- # of people jointly served by RSA, DDA, DBH, DOES, DCPS.
- #/% of working-age people with disabilities in competitive, integrated employment.
- # of new, customized employment opportunities created with District support.
- #/% of people with intellectual and developmental disabilities (IDD) supported by RSA to enroll in post-secondary educational programs to reach employment goals of their choice.

## 4. Housing

### *Why is this important?*

The need for accessible, affordable, and consistent housing is the very foundation for any individual to obtain a stable, secure quality of life. Without housing, life is always in flux and focusing on addressing other needs like employment, social activities, and self-care is made substantially more difficult.

### *What is the Vision?*

Quality permanent housing will be accessible, affordable, and available to all people with disabilities.

### *What are Some of the Challenges the District Faces?*

**An increasingly constricted housing market.** As a jurisdiction that is entirely urban, DC faces some unique challenges. Residential and retail development are booming, creating a highly competitive rental market not favorable for low-income people, especially for people who have been living in long term care facilities for years, have limited sources of income, and need to identify rental housing to return to the community.

**Lack of a housing continuum.** In the District, the most viable housing options for low-income people with long term care needs (especially those under age 55), hover at two ends of the spectrum: either in long term care facilities or in completely independent apartments or single family homes. There are currently only three Assisted Living Facilities operating under the District's EPD Waiver Program, with a total of 61 beds. "Affordable housing" may be targeted for people in the 50-80% Adjusted Median Income (AMI) level, meaning it is not affordable to people with incomes at or below 30% of the area AMI.

**Limited subsidies.** For many people with disabilities who need rental assistance, housing subsidies are not readily available. The DC Housing Authority stopped accepting new

applications for housing assistance in 2013 because there was no meaningful movement on its waiting list.

**Environmental accessibility.** In cases where people with disabilities have identified housing, but there are accessibility issues, it is often difficult to access needed home modification funds. In fact, some residents are unable to leave institutions due to lack of modifications such as grab bars or ramps. While the District does have programs that provide funds for such modifications, they are for limited populations (e.g., only for people on the EPD or ID/DD Waivers) and/or funds may be difficult to access because of program design.

**Homelessness.** Ending homelessness is one of the District's priority focus areas. In the homeless services program, the Department of Human Services assessed 40% of singles and 16% of adult heads of families entering shelters to have a disability in at least one of eight categories.<sup>v</sup> This Olmstead plan recognizes that people with disabilities living in long term care facilities who want to return to the community, and do not have a home, may be at risk of joining DC's homeless population.

### *Action Steps, Lead Entities and Timeframes*

1. Evaluate and improve access to the Handicapped Accessibility Improvement Program (HAIP), which provides assistance for housing adaptations costing \$10,000-\$30,000 (DHCD by December 2016).
2. Implement environmental accessibility program to fund expedited housing adaptations up to \$10,000 per person (DCOA and DHCD, by January 2016).
3. Determine methodology to evaluate housing needs for individuals who have been referred to the ADRC because they want to live in the community (DCOA by December 2016).

### *Measuring Progress Going Forward*

Baseline data and planned metrics to evaluate improvements in housing are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- #/% of people with disabilities whose discharge from an institutional setting is prevented only by lack of housing.
- #/% of people who, during discharge planning, are successfully helped to secure permanent, affordable, suitable housing.
- % of existing affordable DC housing stock (units) that is fully ADA compliant and accessible to this population.
- % of planned housing stock (units) that will be fully ADA compliant and accessible to this

population.

- #/% of people with disabilities who lack access to housing choices, whether limited by income and/or accessibility.

## 5. Intake, Enrollment and Discharge Processes

### *Why is this important?*

Consistent, coordinated and person-centered intake, enrollment and discharge processes increase people's decision-making power and reduce potential barriers to community integration. Further, streamlined processes reduce duplication and save resources that can be redirected elsewhere.

### *What is the Vision?*

The District seeks intake, enrollment and discharge processes that are easy to access, efficient, coordinated, transparent and reflect throughout a person-centered approach. The vision is that discharge planning begins on the day of a person's admission into a facility and that all needed discharge services and support start on the day a person leaves institutional care. In addition, all people with disabilities and their family members and supporters who encounter the LTSS system understand these processes and can utilize them seamlessly.

### *What are Some of the Challenges the District Faces?*

**Limited Data and Information Sharing.** One of the principal barriers to seamless intake, enrollment and discharge processing is the inability of multiple involved agencies and partners to easily share information and data. This delays processing and necessitates duplication of work. At best, this is frustrating for consumers, but it can also have a negative impact on their choices, well-being and successful integration into the community.

**Staff capacity.** Staff from multiple agencies involved in multiple processes often do not have the full-system knowledge they need to effectively help people navigate through to a successful outcome. In addition, although most DC human services agencies have trained staff on person-centered thinking and planning, the full culture shift needed to infuse all of these processes with this approach has not yet been achieved.

**Public understanding and awareness.** Given the complexity of these processes, and a lack of a unified communication effort, it is not surprising that much of the public that would be eligible for LTSS has a limited or inaccurate understanding of what is available and how to access it.

### *Action Steps, Lead Entities and Timeframes*

One of the primary objectives of the *No Wrong Door* initiative is the development of agency process and work flows that improve coordination and integration of functions while reducing

or eliminating duplication of efforts in intake, screening, eligibility determinations, application processes, case management and other areas. Building on this work, the District will:

1. Develop a “person-centered profile” for use in District LTSS agencies with common information that can be collected by referral sources or state systems and shared to avoid duplication of effort (NWD/DDS by December, 2016).
2. Develop guidance and training for case managers and service coordinators to ensure that the plans they create at intake and enrollment reflect a person’s preferences and needs, and plans are adjusted as necessary (NWD/DDS by December, 2016).
3. Develop a discharge manual to be used by both institutional and community-based professionals in collaboration with the Interagency Council on Homelessness (ICH) and make recommendations to improve the process, if needed (DCOA, DHCF, DBH, DOH, DDS, ICH by December, 2016).

### *Measuring Progress Going Forward*

Baseline data and planned metrics to evaluate improvements in intake, enrollment and discharge processes are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

% of relevant DC agency staff and providers receiving training on HCBS services and discharge procedures.

Average EPD and IDD Waiver enrollment times.

# of public events/participants on LTSS system access and Medicaid Waiver protocols and processes.

## **6. Medicaid Waiver Management and Systems issues**

### *Why is this important?*

Home and community-based services (HCBS) offered through Medicaid Waiver programs are the backbone of the support system that people with disabilities need to remain in the community. The development and implementation of these Medicaid Waiver services must be cost effective and sustainable, yet also sufficient to meet the needs of a wide range of people. The effective management of the Medicaid Waivers improves access to the programs and increases visibility, satisfaction and, for participating individuals, quality of life. Simpler applications and systems can ensure a person with a disability understands the system and can make decisions on his or her own behalf.

### *What is the Vision?*

The District's Medicaid Waiver HCBS services meet people's varied needs so they can avoid institutional services altogether, or minimize a necessary stay and transition back into the community without delay and receiving services on the day of discharge. People with disabilities are fully integrated in the community and able to live as independently as they can.

### *What are Some of the Challenges the District Faces?*

**Needed service Improvements.** Medicaid Waiver services would be significantly improved through the increased use of technology to supplant some paid supports and implementation of self-directed services to increase choice and control on the part of people receiving services. People with disabilities in the District also need a broader range of services and supports, with an emphasis on employment.

**Process Consistency.** Medicaid Waiver service enrollment processes can be inconsistently followed and not maximally aligned across agencies and providers. As a result, people may exit institutional care without services being fully in place. A lack of coordinated communication protocols for stakeholders and the public at large exacerbates process concerns.

**Trained Workforce.** Service providers must have full knowledge about community resources and services as well as discharge planning and service enrollment processes. They must understand and be able to apply the principles of person-centeredness.

**Unserved Populations.** In the District, people with developmental disabilities and brain injury can have difficulty accessing services through the DDA or EPD Waiver program, even though they may be at significant risk for institutionalization. People diagnosed with DD, but not ID, as well as people with brain trauma/injury resulting in significant cognitive impairments after age 18 are not eligible for DDA services. If they are not physically disabled, they are not eligible for services under the EPD program either.

**Costs.** Medicaid Waiver costs continue to grow approximately 5% per year.

### *Action Steps, Lead Entities and Timeframes*

Both DHCF and DDS have identified a need to procure a new case management system that can also perform critical quality management functions, and interface with existing eligibility and payment systems for the Medicaid program. Such a system should improve the efficiency in the operations of the Medicaid Waiver programs, quality assurance and subsequent satisfaction with service delivery.

Under No Wrong Door, District agencies will be collaborating to improve stakeholder engagement, outreach, marketing and communication regarding all LTSS services.

Building on this work:

1. Research a new Medicaid Waiver program for people with IDD who live in family homes, including services targeted to help families continue their support (DDS, DHCF by December, 2016).

2. Research track-dependent residential supports in the IDD Waiver and for DOH/HRLA regulations (DDS, DOH by December, 2016).
3. Develop training on how to access Medicaid Waiver services and troubleshooting for agency and provider staff involved in the EPD Waiver process (DHCF, ADRC, DOH).
4. Develop and implement a Participant Directed Program, allowing people receiving EPD Waiver services to have responsibility for managing and directing all aspects of service delivery, including who provides the services and how the services are provided (DHCF by December 2016).

### *Measuring Progress Going Forward*

Baseline data and planned metrics to evaluate improvements to Medicaid Waiver management and systems are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- % decrease in average length of IDD and EPD Waiver application processes.
- % of cases for which intake processes are followed 100% of the time.
- #/% of people who have DD, but not ID, as well as people who are not elderly, do not have physical disabilities, or have brain trauma that occurred after the age of 18.

## **7. Quality of Institutional and Community-Based Services, Providers and Workforce**

### *Why is this important?*

People with disabilities rely on critical services and supports, as well as on the people who are employed to help them carry out basic personal care needs and activities of daily living. From receiving health care treatments, to accomplishing everyday tasks at home, to obtaining and maintaining employment, people who are dependent on someone else for support in critical areas are especially vulnerable to the quality of those services.

Quality, consumer-directed care and supports will lead to greater health and well-being; poor quality service can lead to depression, lack of self-confidence and reduced functioning. Quality services help ensure that people with disabilities will have a higher likelihood of achieving their dreams and being integrated in the community.

### *What is the Vision?*

The goal of the District's LTSS service delivery system is to provide high quality care and services that are consistent with people's needs and preferences and promote independence and quality of life in the most integrated settings. Quality means:

- *Reliability*: will the person arrive on time?
- *Competence*: Is the person properly trained in the specific support needs? Is the person properly supervised?
- *Safety*: has the agency complied with required background checks? Is equipment properly maintained?
- *Respect*: Does the agency embrace and ensure the dignity and rights of people are respected and protected?
- *Choice*: are there a sufficient number of provider agencies available to provide needed supports when they are needed?

These are just a few of the questions that must be answered in the affirmative for people who rely on a service system.

### *What are Some of the Challenges the District Faces?*

**Workforce turnover and availability.** In both institutions and among HCBS providers, maintaining high quality, high performing staff is a challenge, as is filling vacancies. With five major hospitals located in DC, there is significant competition for qualified providers to deliver clinical services including nursing, physical, occupational and speech therapy and mental health services. Licensing and regulatory requirements, while intended to ensure quality, can sometimes slow the recruitment of new providers of these services.

**Service Gaps, Duplication and Underutilization.** The District's current system is not fully aligned. There are gaps in services for some populations, duplication of other services, or services that are underutilized, and varying performance standards depending on the source of funding. For example, Medicaid does not fund case management outside of the two Medicaid Waivers, leaving some individuals without this critical support. At the same time, some individuals may be receiving case management from two or more agencies as not all case management is funded through Medicaid.

**Meeting Quality Standards.** Virtually all LTSS providers must comply with a panoply of Federal and District regulations that set standards for provider qualifications and quality of care. However, a robust regulatory environment does not, by itself, guarantee that services are high quality, consumer-focused and designed around the needs of the individual. Disparate, complicated standards and certification and licensing requirements across District agencies contribute to the problem.

**Services for Individuals with Limited English Proficiency.** The District must increase its capacity to provide multi-lingual LTSS as increasing numbers of people with limited English proficiency age and require more services.

### *Action Steps, Lead Entities and Timeframes*

1. Assess and reduce duplication of services offered by Medicaid and DCOA (DHCF and DCOA by September, 2016).
2. Review and strengthen regulatory options to more effectively deal with quality issues when they arise (DHCF, DDS, DBH, DOH by December, 2016).
3. Review all providers' Language Access plans to ensure residents with limited English proficiency have access to linguistically and culturally appropriate services (DHCF and DDS by December, 2016).
4. Create a customer satisfaction survey to cover the five components of quality described above (Olmstead Working Group by December, 2016).

### *Measuring Progress Going Forward*

Baseline data and planned metrics to evaluate improvements in the quality of providers are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- #/% of ICF/IDDs that pass certification and licensing reviews with only standard level deficiencies or better.
- #/% of adult day health recertifications completed within designated timeframes.
- % of people who receive the services for which they have been assessed/referred.
- % of mandatory, annual HBCS training requirements that providers meet.
- #/% of people receiving supports from DDA spending fewer days/week in facility-based day programs.

## **8. Supporting Children and Youth**

### *Why is this important?*

Ensuring that children and youth with disabilities are fully and equally integrated into the life of our city sends the clear message that the District values them. Encouraging and challenging all children and youth with disabilities to succeed academically will position them for success in the workforce and in life. Individuals with high school diplomas are less likely to be institutionalized or dependent on public benefits down the road. Further, seamless coordination between secondary school systems and adult service delivery systems can ensure a smooth transition for



students with disabilities from child to adult supports, thus lowering the risk of institutionalization and the need for emergency or crisis services.

### *What is the Vision?*

Children and youth with disabilities, and their families, will be supported so they can achieve self-determination, interdependence, productivity, integration, and inclusion in all facets of community life, including competitive, integrated employment.

### *What are Some of the Challenges the District Faces?*

**Information-sharing.** There is limited data and information sharing across agencies working with transitioning youth and there remains low public awareness of the need for students to be trained on workforce competencies, and have a paid work experience prior to exit from high school.

**Service gaps.** Employers have limited capacity to work with students with disabilities who have complex needs, and limited job coaching is available to support on the job training for most students. Further, the city does not offer comprehensive peer-to-peer support for families to help them identify and connect with needed formal and informal supports for their children and youth with disabilities. And, families have further identified a need for better coordinated services and supports across the lifespan, particularly during the transitions from infant and toddler services to school, from school to employment and, as needed, to adult services.

**Limited end goals.** Guardianship is often seen as the only option for parents of children with disabilities rather than self-determination and supported decision-making.

### *Action Steps, Lead Entities And Timeframes*

1. Develop an inter-agency plan to ensure that students with disabilities who graduate with a certificate (rather than a diploma), have at least one community-based, integrated paid work experience prior to school exit (DDS/RSA, DC public and charter schools, and DOES by December, 2016).
2. Increase the timely submission and completion of applications for adult DDA services for children with IDD who are in out of state residential facilities (DDA, CFSR by December, 2016).
3. Develop NWD Person-Centered Practices curriculum and train 2 NWD staff to deliver the training to public LTSS agencies, community partners (NWD/DDS by December, 2016).

### *Measuring Progress Going Forward*

Baseline data and planned metrics to evaluate improvements in supporting children and youth

are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- #/% of youth receiving employment services in an integrated environment.
- #/% of students with disabilities who graduate with a certificate (rather than a diploma), who have at least one community-based, integrated paid work experience prior to school exit.
- # and ages of children and youth with intellectual disabilities currently in nursing facilities.
- #/% of youth in out of state residential facilities for whom submission and completion of applications for adult DDA services is completed at least 2 years before they age out.

## 9. Wellness and Quality of Life

### *Why is this important?*

Full community integration for people with disabilities is inextricably linked to good health, wellness and a host of other “intangibles” that contribute to the feeling that one has a high quality of life. While it may be difficult to define “high quality of life” precisely – and certainly the definition varies by individual – there are some core pillars, including: accessible, effective health care; abundant opportunities for recreation (indoor and outdoor); healthy and nutritious meals; and convenient and easy transportation to work, play and personal appointments. These are among the staples of a high quality life that all residents of the District should equally enjoy.

### *What is the Vision?*

People with disabilities will have opportunities to fully engage in their communities and connect with others in ways that are meaningful and aligned with their personal choices and desires. People with disabilities will have access to a wide range of integrated services to ensure their health, well-being and quality of life.

### *What are Some of the Challenges the District Faces?*

**Health and Wellness Disparities.** Across the country, and no less true in the District, people with disabilities are more likely to experience difficulties or delays in getting the health care they need; to not have had recommended annual check-ups and tests; to be overweight or obese, have lower rates of participation in fitness activities, and to use tobacco. People with disabilities are also more likely to have high blood pressure, experience psychological distress, and receive less social and emotional support.<sup>vi</sup>

**Community Integration and Engagement.** In the District, 34% of adults with ID who participated in the National Core Indicators survey reported that they had no friends other than family or paid staff; this is higher than the national the rate of 24%.<sup>vii</sup>

**Limits in Transportation.** While the District offers a wide array of transportation options, the programs are not aligned with each other. For example, WMATA's MetroAccess program has specific requirements, which are also used by Transport DC, operated by the Taxi Commission, but DCOA's transportation program operated by its grantee Seabury, does not use the same guidelines. This is also true of the transportation services offered by Medicaid for medical appointments. Knowledge about the nuances of available programming is not consistent across agencies and as a result, some services are oversubscribed, while others are underutilized. In order to fully leverage the District's transportation services for people with disabilities, the District must align and focus each entity's transportation offerings.

### *Action Steps, Lead Entities and Timeframes*

1. More broadly implement a medical home primary care model successfully piloted with adults with IDD in community based residential settings (DDS, DHCF by December, 2016).
2. Increase inclusive daytime programming offerings and provide technical assistance and training to improve staff capacity at Adult Day Health providers, Senior Wellness Centers, Senior Centers, public libraries and DPR recreation centers (DPR, DCPL, DCOA, DDS by December 2016).
3. Assess and align the capacity of transportation providers to support the transportation needs of people with disabilities (DDS with DDOT, DCOA, WMATA, MTM by December, 2016).

### *Measuring Progress Going Forward*

Baseline data and planned metrics to evaluate improvements in the wellness and quality of life are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

#/% of medical professionals using the medical home primary care model.

#/% of inclusive daytime program offerings.

#/% of people with disabilities using various transportation mechanisms.

# Glossary of Acronyms

ADA: Americans with Disabilities Act  
AFCH: Adult Foster Care Home  
ALFs: Assisted living Facilities  
APS: Adult Protective Services in DHS  
ARDC: Aging and Disability Resource Center in DCOA  
CFSA: Child and Family Services Agency  
CMS: Center on Medicaid Services (federal agency)  
CRFs: Community Residential Facilities  
CSAs: Core Services Agencies (DBH subcontract)  
DBH: Department of Behavioral Health  
DCSRC: DC State Rehabilitation Council  
DCHA: DC Housing Authority  
DCOA: D.C. Office on Aging  
DCPL: DC Public Libraries  
DCPS: District of Columbia Public Schools  
DCRA: DC Regulatory Authority  
DD: Developmental Disabilities  
DDC: DC Developmental Disabilities Council  
DDOT: DC Department of Transportation  
DDS: Department on Disability Services in DDS  
DHCD: Department of Housing and Community Development  
DHCF: Department of Health Care Finance  
DHS: Department of Human Services  
DMHHS: Deputy Mayor for Health and Human Services  
DOC: Department of Corrections  
DOES: Department of Employment Services  
DOH: Department of Health  
DPR: Department of Parks and Recreation  
DYRS: Department of Youth Rehabilitation Services  
EPD: Elderly and Persons with Disabilities  
HAIP: Handicapped Accessibility Improvement Program in DHCD  
HCBS: Home and Community Based Services  
HRLA: Health Regulation and Licensing Administration in DOH  
ICF/IDDs: Intermediate Care Facilities for individuals with Intellectual Disabilities  
ICFs: Intermediate Care Facilities  
ID: Intellectual Disabilities  
  
ID/DD: Individuals with Developmental and Intellectual Disabilities  
ILOB: Independent Living Older Blind Program  
ILS: Independent Living Services  
LOC: Level of Care  
LOS: Length of Stay  
LTSS: Long Term Services and Supports  
MFP: Money Follows the Person Rebalancing Demonstration Grant

MH/BH: Mental Health/Behavioral Health  
MHCRFs: Mental Health Community Residence Facilities  
MTM: DC Non-Emergency Transportation  
NCI: National Core Indicators  
NWD: No Wrong Door  
ODR: Office on Disability Rights  
OSSE: Office of the State Superintendent for Education  
PCP: Person-Centered Practice  
PRTFs: Psychiatric Residential Treatment Facilities  
RSA: Rehabilitation Services Administration in DDS  
SILC: DC Statewide Independent Living Council  
SIM: State Innovation Model  
SNAP: Supplemental Nutrition Assistance in DHS Program  
TANF: Temporary Assistance for Needy Families in DHS  
VR: Vocational Rehabilitation  
WMATA: Washington Metropolitan Area Transit Authority

## **Appendix B**

### **The 2015 Olmstead Plan**

**DC—One Community For All**  
**An Olmstead Community Integration Plan**  
**Prepared by the DC Office of Disability Rights**

#### **Introduction and Background**

On June 22, 1999, the United States Supreme Court ruled in *Olmstead v. L.C.*, 527 U.S. 581, that the unjustified segregation or isolation of people with disabilities in institutions may constitute discrimination based on disability in violation of the Americans with Disabilities Act (ADA). Accordingly, the Court held that the ADA requires that States provide community-based treatment for persons with disabilities “when the State’s treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the States and the needs of others with . . . disabilities.” 527 U.S. at 607.

In light of this decision, the District instituted a comprehensive working plan to serve qualified individuals with disabilities in accordance with the Supreme Court’s holding in *Olmstead*. This plan establishes certain goals of the District to ensure that community-based treatment is provided to persons with disabilities, when such treatment is appropriate. However, this plan does not create independent legal obligations on the part of the District.

Mayor Vincent Gray and a wide range of District stakeholders including persons with disabilities directed and supported the Office of Disability Rights to develop the

Olmstead Community Integration Plan in accordance with policies and procedures outlined in D.C. Act 16-595 the Disability Rights Protection Act of 2006. The District values its residents with disabilities as contributing members of society and understands the cost-effective benefits of supporting them with integrated, community-based services. The DC Olmstead Community Integration Plan, One Community for All is a policy document that details the rights of each person with a disability to self-determination in the District of Columbia.

***One Community for All*** endeavors to meet the needs and preferences of the individual while allowing him or her to choose where s/he wants to live in the community with the appropriate supports and services consistent with the Olmstead decision and the resources available to the District to serve such individuals, taking into account the needs of others. The Plan is a living document, providing specific goals, action steps, and tools, while allowing for better flexibility and improved services for individuals with disabilities.

Nine (9) District agencies participating in this initiative are responsible for implementing the Plan. These District agencies include: Office of the State Superintendent for Education (OSSE), Office on Aging (DCOA), Department of Youth Rehabilitation Services (DYRS), Department of Disability Services (DDS), Department of Human Services (DHS), Department of Behavioral Health (DBH), Child and Family Services Agency (CFSA), DC Public Schools (DCPS) and the Department of Health Care Finance (DHCF). These agencies are collaborating in the hope that the District of Columbia will become a national model for providing community services and supports to persons with disabilities.

### **The Fiscal Year (FY) 2015 Plan**

For Fiscal Year 2015 (FY '15), the District's Plan will focus on the programs, services, and outcomes of the following agencies:

- DC Office on Aging (DCOA);
- Department of Behavioral Health (DBH);
- Department on Disability Services (DDS); and
- Department of Healthcare Finance (DHCF).

The above-named agencies provide direct service to a quantifiable population of District residents individually and with other District agencies and community partners. This year's Plan seeks to highlight collaboration among these agencies, as well as the Plan's remaining five (5) participating agencies, to illustrate the wrap-around, holistic approach to support provided by the District to individuals with disabilities who are transitioning into the community of their choice.

This year's Plan is designed to specifically address how these agencies carry out the Primary Service Agency Priorities set forth in the original iteration of DC—One Community for All published in April 2012. .<sup>viii</sup>

The FY '15 Plan contains benchmarks for each of the above agencies. Each agency will report quarterly on the number of individuals with disabilities it has assisted in transition. Moreover, each agency will report on any qualitative measures it has taken to promote and support successful integration into community life for people with disabilities. These types of measures will include, but are not limited to the following:

- Outreach and training;
- Internal and external agency publications;
- Development of transition-relevant new community partnerships;
- Fostering of existing transition-relevant community partnerships; and
- Opportunities for input from persons with disabilities being served.

Last, the FY '15 Olmstead Plan will explore avenues to address the most prevalent barrier to successful, lasting transition for the disability community—accessible, affordable housing. To facilitate this effort, the DC Housing Authority (DCHA) and DC Housing and Community Development (DHCD) will participate or provide comment on all District-wide housing issues related to DC's Olmstead Plan.

### **FY '15 Olmstead Planning Questions and Outline**

Please address the following with respect to the particular population of individuals your agency serves.

#### **Setting Priorities**

1. When does your agency consider an individual to be “institutionalized” under the auspices of the Olmstead mandate?
  - ☐ 91 days or more
  - ☐ 181 days or more
  - ☐ 365 days or more
  - ☐ Other:\_\_\_\_\_
2. What policies/procedures does your Agency utilize for identifying individuals ready and invested for transition into the community?
3. How do you communicate with your target population and their families/caregivers/advocates/providers about community-based options?
4. What procedures or policies do you have in place to allow people with disabilities to assess the quality of the supports they receive?
5. What measures has your agency taken to address the needs of the following:
  - a. Children who receive residential services from District agencies but live outside the District of Columbia.
  - b. Adults who receive residential services from District agencies but reside outside the District of Columbia.
  - c. Individuals who are long-term homeless and seeking permanent housing.
  - d. Individuals who are soon to be released from jail/juvenile detention facilities.

- e. Individuals who are receiving services but still have significant unmet needs which put them **at risk** of placement in non-community-based settings.
- f. Individuals who do not receive services but are known to have unmet needs that put them at risk for placement in non-community-based settings.
- g. Individuals not receiving formalized services but live with a family member unable to support them effectively.

### **Interagency Collaboration**

- 6. Explain specifically how your agency works with other participating agencies, District residents, and community stakeholders. Please identify the agency/agencies (Government and Community-based) and consider the following:
  - a. Recommend community services and supports that allow an individual to select services and supports designed for their specific needs.
  - b. Develop effective and timely transition plans for individuals who are placed in non-community-based settings.
  - c. Conduct outreach on your services or other participating agencies' services specifically geared toward your service population.

### **Addressing Barriers**

- 7. How does your agency address any or all of the following **barriers** to successful provision of community-based supports for individuals with disabilities? **Note:** address only those populations applicable to your agency's mission and vision.
  - a. Lack of comprehensive information on the supports and services available.
  - b. Impacts of transitioning to life in the community: discrimination, fear, and stigma.
  - c. Unavailability of support services to assist with daily life for individuals with severe disabilities, such as education, transportation, and employment.
  - d. Insufficient numbers of compensated, trained employees to work with the population of people with disabilities.
  - e. Post-discharge into community-based living with subsequent assessment that transition is not meeting the needs of the individual.

### **DC Office on Aging (DCOA) FY 2015 Olmstead Planning Questions and Outline Setting Priorities**

- 1. When does your agency consider an individual to be “institutionalized” under the auspices of the Olmstead mandate?**

The nursing home transition and hospital discharge teams define “institutionalized” as 91 days or more.



**2. What policies/procedures does your Agency utilize for identifying individuals ready and invested for transition into the community?**

The Agency receives referrals from individuals seeking services, family caregivers, healthcare professionals, or nursing home social workers. When an individual expresses interest in transitional assistance, a referral is sent to Information and Assistance. The referral is assigned to a transition care specialist.

In addition, there is a screening done by the Transition Care Specialist for potential Money Follows the Person and Aging and Disability Resource Center Nursing Home Transition clients. The screening tool determines if the client is eligible for either nursing home transition through Money Follows the Person (MFP) (client must be a Medicaid beneficiary, be assessed at a nursing home level of care, and have viable housing or a housing voucher) or Aging Disability Resource Center (ADRC) (client does not meet the MFP eligibility requirements, but has expressed interest in leaving a nursing facility).

- If the client is eligible for MFP, he/she will be assigned an MFP Transition Care Coordinator.
- If the client is not eligible for MFP, but expresses interest in transitioning out of a nursing facility, he/she will be assigned a Transition Care Specialist on the Nursing Home Transition team.

**3. How do you communicate with your target population and their families/caregivers/advocates/providers about community-based options?**

DCOA has a community outreach team that conducts outreach at various sites including Senior Wellness Centers, churches, and community events. The target population is also reached via DC Office on Aging website.

The hospital discharge team communicates directly with our targeted population and their support system via hospital visits, home visits, telephone, and/or email. This team also conducts hospital discharge planning presentations at local hospitals.

**4. What procedures or policies do you have in place to allow people with disabilities to assess the quality of the supports they receive?**

The procedures and policies for persons with disabilities, ages 18-59, is the same as persons 60 and older. Once we have received a case, reviewed options, and linked the individual with necessary resources, we provide case management services for 90 days. After 90 days, a customer satisfaction survey is completed.

**5. What measures has your agency taken to address the needs of the following:**

- a. **Children who receive residential services from District agencies but live outside the District of Columbia.**

DC Office on Aging does not provide services to children who receive residential services from local DC agencies.

**b. Adults who receive residential services from District agencies but reside outside the District of Columbia.**

The Nursing Home Transition Team and the Hospital Discharge Team assists adults who have been in a hospital or nursing facility outside the District of Columbia if they have been in the hospitals and nursing facility for 90 days or more, receive community-based Medicaid, and desire to transition back into the District of Columbia. However, if a person does not have Medicaid, both of these teams would work with staff, providing Options Counseling to the individual to inform them of potential resources. Options Counseling provides person-centered counseling to individuals, family members and/or significant others with support in their long-term care decisions to determine appropriate choices. During this process, a written action plan for receiving community resources is developed based on an individual's needs, preferences, values, and circumstances. Follow-up is provided by option counselors to ensure service delivery and customer satisfaction.

**c. Individuals who have been homeless long-term, and are seeking permanent housing.**

Individuals who are experiencing long-term homelessness and seeking housing are referred to DCOA's Housing Coordinator who assists individuals in locating permanent and/or affordable and suitable housing. The housing coordinator works with DC Housing Authority, So Others Might Eat, Pathways to Housing, Green Door, and Housing Counseling Services to locate housing.

**d. Individuals who are soon-to-be released from jail/juvenile detention facilities.**

Individuals who are re-entering the community can contact DC Office on Aging Information and Assistance Department for a referral to the Employment and Training Coordinator. Individuals can also receive other services once identified and/or requested.

**e. Individuals who are receiving services but still have significant unmet needs, which put them at risk of placement in non-community-based settings.**

Individuals receiving services who have significant unmet needs and are at risk of being placed in a non-community based setting can contact the DC Office on Aging Information and Assistance Department for a referral to the appropriate Aging Disability Resource Center ward social worker.

**f. Individuals who do not receive services but are known to have unmet needs that put them at risk for placement in non-community-based settings.**

Individuals receiving services with significant unmet needs and are at risk in being placed in a non-community base setting can contact DC Office on Aging Information and Assistance Department for a referral to the appropriate Aging Disability Resource Center ward social worker.

**g. Individuals not receiving formalized services but who live with a family member unable to support them effectively.**

Individuals not receiving formalized services, but who live with a family member unable to support them effectively are referred to an Options Counselor who works both with the client and caregiver on Long Term Care options and in-home supports. The caregiver may also be referred to the Lifespan Respite Care program to receive caregiver support and services.

**Interagency Collaboration**

**6. Explain specifically how your agency works with other participating agencies, District residents, and community stakeholders. Please identify the agency/agencies (Government and Community-based) and consider the following:**

- a. Recommend community services and supports that allow an individual to select services and supports designed for their specific needs.**
- b. Develop effective and timely transition plans for individuals who are placed in non-community-based settings.**
- c. Conduct outreach on your services or other participating agencies' services specifically geared toward your service population.**

DCOA has expanded access to community-based long-term supports for individuals through a memorandum of understanding (MOU) with the Department of Health Care Finance (DHCF) to provide a comprehensive interdisciplinary program that organizes, simplifies, and provides a "one-stop shop" for access to all public long-term care and support programs. Also DCOA has a memorandum of agreement (MOA) with DHCF and Department of Behavioral Health (DBH) to conduct a preliminary intake of all individuals. In addition DCOA has informal partnerships with Washington Hospital Center Mental Health and House Call Programs, Psychiatric Institute of Washington, DC Long term care Ombudsman office, Adult Protective Services, and Senior Service Network. DCOA has an outreach specialist who facilitates meetings with individuals, and/or families interested in transitioning.

An ADRC Transition Care Specialist prescreens consumers for eligibility, informs individuals about the Elderly and Persons with Disabilities (EPD) Waiver, and provides transition assistance through options counseling individuals, creates a person centered action plan that maps out the services, and provides guidance on community resources to ensure a successful transition back into the community.

**Addressing Barriers**

**7. How does your agency address any or all of the following barriers to successful provision of community-based supports for individuals with**

disabilities? **Note:** address only those populations applicable to your agency's mission and vision.

**a. Lack of comprehensive information on the supports and services available**

**b. Impacts of transitioning to life in the community: discrimination, fear, and stigma.**

**c. Unavailability of support services to assist with daily life for individuals with severe disabilities, such as education, transportation, and employment.**

i. **Challenges** include locating affordable and suitable housing for homeless hospital patients who are medically stable for discharge, as well as obtaining services for non-Medicaid hospital patients in need of long-term in-home support care. Also, there is a challenge in locating affordable transportation services for the disabled population ages 18-59.

ii. **Solution:** The Hospital Discharge Planning Team and Nursing Home Transition Team continues to work closely with our Housing Coordinator to identify affordable housing options for our participants, as well as work with identified agencies to assist participants with obtaining necessary personal care aide services (in-home support) as quickly as possible. Participants with disabilities ages 18-59 needing transportation are referred to Metro Access.

**d. Insufficient numbers of compensated, trained employees to work with the population of people with disabilities.**

i. DCOA is working on improving partnership with the disability community and disability-focused organizations, and knowledge of disability services through training on the following topics:

Introduction to independent living and services; disability cultural competence; and person-first perspective; Services and resources for people with disabilities.

**e. Post-discharge into community-based living with subsequent assessment that transition is not meeting the needs of the individual.**

iii. **Challenge:** Due to the length of the Elderly & Persons with Physical Disabilities Waiver Program's application process, some participants do not receive adequate hours of in-home supportive services post-discharge.

iv. **Solution:** The Hospital Discharge and Nursing Home Transition Teams provide assistance and linkages to the participant and/or

his/her family with in-home supportive resources and options counseling.

## **Department of Behavioral Health (DBH) FY 2015 Olmstead Planning Questions and Outline**

### **Setting Priorities**

#### **1. When does your agency consider an individual to be “institutionalized” under the auspices of the Olmstead mandate?**

The Department of Behavioral Health defines “institutionalized” as 181 days or more.

#### **2. What policies/procedures does your Agency utilize for identifying individuals ready and invested for transition into the community?**

The Department of Behavioral Health has a number of policies to support a successful transition to the community. These policies include:

For youth in Psychiatric Residential Treatment Facilities (PRTFs), DBH Policy 200.7 requires a Continued Stay referral. The Continued Stay referral is a clinical packet submitted by the responsible District agency which describes the opinion of the treatment team (to include the youth with his/her parent(s)/guardian(s)) regarding whether or not the youth would benefit from continued treatment within the PRTF or discharge into the community. This policy supports the work of the DBH staff assigned to work with the youth while they are in a PRTF. The staff participates in monthly treatment team meetings for youth in the PRTF.

DBH Policy 525.4 details the practice guidelines for community integration of consumers in institutional settings. This policy provides guidance to community mental health providers who are required to participate in the discharge planning process for consumers who are in institutional settings.

DBH Policy 511.3A TL-174 describes the procedures by which consumers are screened for placement in a nursing facility (NF) using the Preadmission Screening and Resident Review (PASRR), the review of level of care and appropriateness of a NF for those already in a NF, and the discharge and transition process when NF is no longer indicated in the consumer’s level of care.

DBH Policy 200.2B TL-178 establishes specific guidelines to ensure the continuity of care for adult consumers who seek or receive urgent or emergency mental health treatment and supports and/or transfer, as well as adults who are discharged to different levels of care within the mental health system.

#### **3. How do you communicate with your target population and their families/caregivers/advocates/providers about community-based options?**

The Department operates a 24 hour/7 days a week Access Helpline which links individuals to community based services. The line receives over 60,000 calls per year and is able to link and/or inform callers about the range of community-based services available to them.

In addition, the Department has the following activities:

In FY09, the former Department of Mental health (DMH) through its Office of Consumer and Family Affairs developed a program to utilize individuals who self-identify as mental health clients to assist long term inpatients at Saint Elizabeths Hospital (SEH) transition into the community. The program involves peers in providing 1:1 support and intervention, teaching skills needed to live in the community and being active team members of the evidence-based Critical Time Intervention that assists consumers in their transitions to the community.

Among the other supports, services, and resources offered by peers is working with consumers who have been admitted to psychiatric hospitals including community hospitals, e.g. Psychiatric Institute of Washington, Providence, United Medical Center, and SEH. Some of the key activities of these initiatives are as follows:

- Working with the hospital, community providers, and families to facilitate a smooth transition to the community.
- Providing the highly regarded Wellness Recovery Action Plan (WRAP) services for consumers hospitalized at SEH. WRAP helps individuals who are hospitalized manage their own recovery and health.
- SEH uses trained peer specialists to facilitate recovery groups. SEH uses peer specialists on medication review panels.

For youth at PRTFs, DBH works with the youth and his/her parent(s)/guardian(s)/family within the PRTFs monthly treatment team meetings.

**4. What procedures or policies do you have in place to allow people with disabilities to assess the quality of the supports they receive?**

The Peer Transition Specialist Program is designed to assist consumers who have been long term institutionalized at SEH consider and explore community living and ultimately assist these consumers in leaving the institutional setting for community-based living.

DBH also has a codified grievance procedure available for individuals to use when they feel they have received inadequate or inappropriate treatment or care.

In addition, DBH funds a Peer-run organization, the Consumer Action Network. This organization is responsible for, among other things, conducting regular consumer surveys at the sites in Washington, D.C. where individuals receive care.

DBH clinical monitors continue to monitor Transition Age Youth (youth ages 18-25) discharged from PRTF into placements outside the District of Columbia when these youths continue to receive District services.

**5. What measures has your agency taken to address the needs of the following:**

**a. Children who receive residential services from District agencies but live outside the District of Columbia.**

DBH clinical monitors continue to monitor youth discharged from PRTF into placements outside of the District of Columbia when these youth continue to receive District services.

Children/youth who live outside of the District of Columbia but who receive District services such as youth in the care and custody of Child and Family Services Administration (CFSA) are eligible for services offered through DBH.

**b. Adults who receive residential services from District agencies but reside outside the District of Columbia.**

If adults are being served by another District agency, they are eligible for all DBH services. For example, when consumers are transitioning to a nursing home and have been known to DBH, that provider may stay involved with that individual.

**c. Individuals who are long-term homeless and seeking permanent housing.**

Individuals who are long-term homeless and seeking permanent housing are a priority for a DBH housing voucher.

**d. Individuals who are soon to be released from jail/juvenile detention facilities.**

DBH has a structure in place to coordinate service with the Department of Youth and Rehabilitation Services (DYRS).

**e. Individuals who are receiving services, but still have significant unmet needs which put them at risk of placement in non-community-based settings.**

DBH's Division of Integrated Care has responsibility for ensuring individuals discharged from psychiatric hospitalization are linked to a community provider within seven (7) to thirty (30) days.

DBH has implemented high utilizer meetings for both children and adults to ensure that community services are available to high risk individuals, as well as ensuring that services are well coordinated.

**f. Individuals not receiving formalized services but who live with a family member unable to support them effectively.**

DBH offers crisis services available to any District resident. These include mobile crisis services for adults and youth. These teams of mental health

professionals and specialists are available to respond to an individual who is not currently involved with the treatment system. Since police officers are first responders to families that may have an individual experiencing a psychiatric crisis in many situations, DBH has worked with the Metropolitan Police Department (MPD) to develop the Crisis Intervention Officer (CIO) program. Since 2009 DBH and MPD have trained over 600 MPD officers.

In addition, the Department operates two mental health clinics that provide same day or urgent care service to any District resident.

### **Interagency Collaboration**

**6. Explain specifically how your agency works with other participating agencies, District residents, and community stakeholders. Please identify the agency/agencies (Government and Community-based) and consider the following:**

The DBH Child Division works with the Child and Family Services Agency (CFSA), Department of Youth Rehabilitation Services (DYRS), District of Columbia Public Schools (DCPS), Department of Disability Services (DDS), Health Services for Children with Special Needs (HSCSN), the Office of the State Superintendent of Education (OSSE), and the District of Columbia Superior Court (DCSC).

DBH Adult Services has collaborative relationships with Department of Human Services (DHS), Department of Housing and Community Development (DHCD), Department of Housing Authority (DCHA), Metropolitan Police Department (MPD), Department of Disabilities Administration (DDA), Office on Aging, and the Department of Health Care Finance (DHCF).

**a. Recommend community services and supports that allow an individual to select services and supports designed for their specific needs.**

DBH's policies are based on choice and selection of providers according to each individual's desire and need.

**b. Develop effective and timely transition plans for individuals who are placed in non-community-based settings.**

DBH policies require the community providers to be active participants in working with individuals who are in PRTFs, SEH, and nursing facilities.

**c. Conduct outreach on your services or other participating agencies' services specifically geared toward your service population.**

DBH's policies require its provider network to provide outreach to individuals who are living in an institutional setting.



In addition, DBH has worked with other agencies to offer a session called Family Talk which is intended to inform parents of PRTF treatment, discharge, and community-based services. This session has been supported by numerous agencies (including DCPS, DYRS, OSSE, CFSA, DHCF, DCSC, and Health Services for Children with Special Needs (HSCN)).

### **Addressing Barriers**

- 7. How does your agency address any or all of the following barriers to successful provision of community-based supports for individuals with disabilities? Note: address only those populations applicable to your agency's mission and vision.**

- a. Lack of comprehensive information on the supports and services available.**

DBH keeps its webpage up-to-date to inform the community on its supports and services. In addition, we work with community groups such as Consumer Action Network National Alliance on Mental Illness-DC (NAMI), family groups, and peer operated services to provide information on services and supports available through DBH's network.

- b. Scarcity of accessible, affordable, integrated housing.**

DBH is committed to the availability of accessible, affordable, integrated housing. The agency provides over 800 housing subsidies a year to DBH consumers which are consumer-based, i.e. the consumer can use it for any appropriate housing they choose. Additionally the agency works aggressively to develop accessible, affordable, integrated housing. It has had a partnership with DHCD for the past five years and made more than \$26 million available for the development of new or renovated housing units for the exclusive use of our consumers. More than 181 units have been built and are occupied and an additional 155 units are under development. This is an on-going initiative, and the agency requests additional funding for continued development in its annual budgets.

- c. Unavailability of support services to assist with daily life for individuals with severe disabilities, such as education, transportation, and employment.**

Through a program called Supported Employment, DBH helps people with mental illness find and keep full or part-time jobs in the community. The jobs pay minimum wage or higher and are based on individual interests and abilities.

- d. Insufficient numbers of compensated, trained employees to work with the population of people with disabilities.**

The Department of Behavioral Health operates the most comprehensive behavioral health training program in the District, called the DBH Training Institute. The Training Institute produces over 150 training events annually. Topics relate to identified system needs determined by agency goals, compliance/audit data, and other sources including needs identified by mental health clients.

**e. Post-discharge into community-based living with subsequent assessment that transition is not meeting the needs of the individual.**

DBH has structure in place to provide support and assistance to providers who are working closely with individuals leaving institutional settings.

**Department on Disability Services (DDS) FY '15 Olmstead Planning Outline  
Setting Priorities**

**1. When does your agency consider an individual to be “institutionalized” under the auspices of the Olmstead mandate?**

The Department on Disability Services (“DDS”), Developmental Disabilities Administration (“DDA”) uses 91 days or more for the purposes of the Money Follows the Person (“MFP”) program. However, through policy and procedure, discussed below, every nursing facility referral for a person who receives supports from DDS/ DDA is reviewed by the DDS Human Rights Advisory Committee (“HRAC”), and the agency begins to engage in transition planning for the person to return back to the community immediately, starting from the day of admission.

**2. What policies/procedures does your Agency utilize for identifying individuals ready and invested for transition into the community?**

It is DDS’s policy to ensure that all people who receive support from the DDA service system have access to and receive quality supports, services, and health care in the most integrated, least restrictive community-based setting appropriate to their needs. This is reflected in a range of policies and procedures including: Human Rights policy and Human Rights Advisory Committee (the Committee) procedure; Individual Support Plan (“ISP”) policy and procedure; Most Integrated Community Based Setting policy; Out of State Placement policy; and the Nursing Facility Placement policy (all available on-line at <http://dds.dc.gov/page/policies-and-procedures-dda>.)

As an example, the DDS Nursing Facility Placement policy defines acceptable uses for nursing facilities for people with intellectual disabilities who receive supports from DDA as follows:

- The person has a need for a time-limited stay following hospitalization and his or her rehabilitation requires the availability of skilled nursing staff on a twenty-four (24) hour basis. The referral and placement must be directly related to a hospitalization discharge recommendation; or
- The person has a need for medical supports that minimize deterioration in abilities and maximize quality of life and cannot be provided in the

individual's current level of care, nor can it be met in a more intensive community-based alternative, such as an Intermediate Care Facility for Individuals with Intellectual Disabilities ("ICF/IID"); and facility and community-based interventions are currently unavailable to address the person's medical support needs.

Additionally, the HRAC reviews each proposed nursing facility placement to determine whether it is the least restrictive and most appropriate setting to meet the person's needs. The Committee also establishes the schedule and recommendations for on-going review.

All placement decisions are determined based upon the person's assessed needs and preferences. Developmental Disabilities Administration (DDA) begins transition planning as soon as the person is admitted to a facility to ensure that he or she can return to an integrated, community-based setting, preferably his or her home, as soon as possible, given the person's health condition and need for ongoing medical treatment and therapies. At times, a person may be able to return to a more integrated community setting, but may not be able to return to his or her home because he or she needs an increased level of care, or, if given the length of stay in the nursing facility, the person's placement in a particular residential facility is no longer available. Federal Medicaid rules prohibit payment to the person's residential provider for any days when the person is in a nursing facility. To ensure that people are able to return to their homes, when appropriate, the Medicaid Home and Community-Based Services Waiver for Individuals with Intellectual and Developmental Disabilities ("HCBS IDD Waiver") rates do include a vacancy factor so that providers are able to hold a person's place in the home for short-term stays at a hospital, nursing facility, or other institution.

Finally, it is DDA's practice to use Person-Centered Thinking ("PCT") for all service and support planning. Michael Smull, one of the national experts on PCT, with whom DDS is working closely, describes PCT skills as follows: "At their core all of these skills are about how we can help people who traditionally have led isolated lives, lead ordinary, self-directed lives, within their own communities. The skills are about supporting people as ordinary citizens while recognizing (and accounting for) their unusual support needs." <http://www.nasddds.org/pdf/importanceofpersoncenteredthinking5a.pdf>.

DDA is engaged in implementing PCT throughout not only the agency, but the entire IDD support and service delivery system. DDA currently has five (5) certified PCT trainers on staff, and is training two (2) additional staff members; with additional trainers planned in FY 2015. These trainers offer ongoing PCT training for DDA staff and provider agencies, both on site at DDS and at provider agencies to facilitate attendance. Once the new trainers are certified, they will assist with providing PCT training to providers, families, and people served by DDA.

**3. How do you communicate with your target population and their families/caregivers/advocates/providers about community-based options?**

DDS communicates with the people we serve and other stakeholders in a variety of ways; including hosting community forums, attending community events, e-mails, the DDS website, and use of social media. We have a stakeholder outreach list that includes more than 700 people, many of whom are grass-top leaders who will help spread the word. As an example, in the spring, we hosted a series of forums to educate the community and receive feedback on proposed changes to the HCBS IDD waiver. We held a community forum at the Gateway Pavillion in Anacostia, accessible to where many of the families of the people we support live. We also presented at Project ACTION!, D.C.'s advocacy group for people with intellectual disabilities and the DC Coalition of Providers of Developmental Disabilities Services among other places. As a result, we received extensive comments on the proposed waiver amendments and made changes, accordingly, to reflect community input.

For people who receive supports from DDA, PCT tools and skills are now an integral part of the ISP pre-planning process. The tools identify the interests, preferences, preferred environments, support requirements, and provide important information for the development of ISP goals and programmatic activities that are meaningful to the person and lead to support delivery in the most integrated, least restrictive setting appropriate to the person's needs. DDA also offers home and community-based services to persons who reside in ICF/IID settings during annual planning meetings and at any other time a person or their support team expresses an interest in home and community-based services.

**4. What procedures or policies do you have in place to allow people with disabilities to assess the quality of the supports they receive?**

DDA has automated all of its performance metrics, and the data we collect is used to provide relevant information to assist consumers in choosing service providers. The system may also be used to evaluate our staff, providers, and performance on a monthly basis for corrective action and quality improvement initiatives. Additionally, DDA posts the results of our Provider Certification Review process on our website, as well as provider reports cards, and listings of providers who are currently under sanctions. For District licensed facilities, the Department of Health, Health Regulation and Licensing Administration also posts results of its surveys and investigations on its website. In FY 2014, DDA re-joined the National Core Indicators (NCI) project. NCI is a voluntary effort by public developmental disabilities agencies to measure and track their own performance. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety. Results are drawn through interviews with people who receive services, and through responses from mailed surveys to families and guardians. The results are prepared by the Human Research Institute (HSRI) and the District

will be able to compare its performance against forty (40) other participating states.

RSA provides people or, as appropriate, their representatives with information and support services to assist the person in exercising informed choice. Informed choice begins when the person first contacts RSA to apply for Vocational Rehabilitation (“VR”) services and continues throughout the rehabilitation process. An applicant or a person eligible to receive VR services has the right to exercise informed choice in decisions related to the provision of VR services including: the provision of assessment services, choices among the methods used to procure VR services, the selection of the employment outcome, the specific services needed to achieve the employment outcome, and the entities that will provide the services to help them achieve their employment outcome.

To ensure that the availability and scope of informed choice is consistent, in accordance with 34 C.F.R. § 361.52 (c) (1), the information provided includes:

- Costs, accessibility, and duration of potential services;
- Consumer satisfaction with those services to the extent that information relating to consumer satisfaction is available;
- Qualifications of potential service providers;
- Degree to which services are provided in integrated settings; and
- Outcomes achieved by people working with services providers, to the extent that such information is available.

In FY 2013, DDS RSA added to the Office of Quality Assurance and Compliance two (2) new employees whose primary focus is to monitor the quality and effectiveness of Supported Employment and Job Placement services provided by RSA’s Community Rehabilitation Programs (“CRPs”). A robust monitoring tool was developed to better qualify each CRP’s performance. Based on the data submitted to RSA by the CRPs, the Agency develops a Provider Profile showing each provider’s performance for the covered time period. Data presented includes:

- Number of referrals per service area;
- Number of referred persons returned to the Agency;
- Number of people placed in employment;
- Number of employed people successfully employed for 90 days through DDS RSA;
- Average number of days between referral and employment;
- Average number of hours worked per week;
- Average hourly pay;

Currently, this information is provided to the VR supervisors and counselors for sharing with people receiving VR services. The agency is developing a CRP module through which this information will be available electronically.

**5. What measures has your agency taken to address the needs of the following:**

**a. Children who receive residential services from District agencies but live outside the District of Columbia.**

DDA works closely with the Child and Family Services Agency (“CFSA”), the Office of the State Superintendent of Education (“OSSE”), the District of Columbia Public Schools (“DCPS”), the Department of Youth Rehabilitation Services (“DYRS”) and Health Services for Children with Special Needs (“HSCSN”). Our mission is to identify children who have been placed in out of state residential facilities at least two to three years prior to aging out of such services so that DDA can ensure timely submission and completion of applications for eligibility determinations for adult services. If eligible for adult services, DDA works with the sister agencies, families, guardians, and youth to prepare transitions back to the District for community-integrated supports as indicated based on person-centered planning. DDS is guided by statute, policy, and best practices; it ensures that transitioning youth receive services in Medicaid funded community-integrated services. See D.C. Official Code § 7-761.05(9).

RSA has worked with staff from DCPS, CFSA, and DBH to identify DC youth, receiving secondary education outside of the District, to give them the opportunity to apply to RSA. RSA also provided training to all DBH supervisory staff on the VR process to facilitate effective referral of cases when a youth is transition back to the District from an out-of-state facility. A presentation to provide an overview of the RSA process is planned for DBH staff. RSA has also invited representatives from DBH to provide input and feedback on the development of the RSA Youth in Transition Toolkit, which describes the RSA process and expectations for when a youth applies for RSA services.

**b. Adults who receive residential services from District agencies but reside outside the District of Columbia.**

Since 2007, DDA has returned 263 District residents to District based community-integrated services from out-of-state residential placements. Currently, eleven (11) people remain out-of-state in Medicaid funded home and community-based settings as the DDA worked to honor their preference to remain with long-standing friends and service providers. Four (4) people continue to be served in locally funded settings as a result of agreements with guardians to permit their family members to remain where they have lived, in some cases, for over thirty years. Three (3) people receive specialized, locally funded treatment services out-of-state that are currently unavailable in the District.

**c. Individuals who are long-term homeless and seeking permanent housing.**

For people who are homeless and seeking permanent housing, one of the most important issues is lack of steady and adequate income. RSA's focus is to help them obtain employment, but the reality is that the rehabilitation process can be long, and the need for housing/shelter is acute. Housing stability is a challenge for many of the people RSA serves because they have limited or no income. Currently, 1,874 RSA clients receive SSI or SSDI, while many of the other people served are already relying on family or friends for support.

RSA Counselors provide information at intake about housing and homeless services, which includes information about available programs; and if necessary, help connect people by making the call and providing transportation to get to the shelter.

RSA also supports many of the related issues that homeless people confront, including access to health care, deficits/gaps in education/literacy, and transportation issues. RSA provides assistance with these services, e.g., health services that are necessary to accomplish a vocational goal can be funded with VR funds. Transportation is provided as an adjunct service with any other service provided. RSA also works with OSSE and adult literacy programs to coordinate services.

For people who are homeless and applying to DDA for supports, DDA uses local funds to provide emergency respite for short-term housing until eligibility can be determined. Once determined, DDA uses person-centered planning to identify community-based residential and other supports that will meet the person's assessed needs. If the person is found ineligible, DDA will connect him or her with appropriate community resources. Occasionally, a person who already receives supports from DDA may become homeless due to illness, hospitalization, or death of his or her primary support person in the home, or because there is an allegation of abuse or neglect by the person's caregiver. In those instances, DDS also uses local or Medicaid funds to provide emergency respite and then uses person-centered planning for long term supports.

**d. Individuals who are soon to be released from jail/juvenile detention facilities.**

DDA supports people eligible for services who are pending release with a full range of housing and supportive services based on person-centered planning.

**e. Individuals who are receiving services, but still have significant unmet needs which put them at risk of placement in non-community-based settings.**

DDA currently does not experience challenges with meeting unmet needs that could place a person at risk of placement in non-community settings except as noted above. In cases where specialized services are not available, it

seeks to recruit specialized providers from across the country to develop services in the District to avoid out-of-state placements.

**f. Individuals who do not receive services but are known to have unmet needs that put them at risk for placement in non-community-based settings.**

DDS recently applied for a grant for “Transforming State Long Term Services and Supports (“LTSS”) Access Program and Functions into a No Wrong Door System for All Populations and All Payers. The proposal development process brought together over 20 partners who are committed to working together to create more streamlined and person-centered approaches for people with disabilities and others in need of LTSS. The proposal will also make it easier for people of all ages, disabilities and income levels to learn about and access the services and supports they need. If awarded, this grant will help facilitate access to community-based services and person-centered planning for people with unmet needs who are at risk for placement in non-community based services.

**g. Individuals not receiving formalized services but who live with a family member unable to support them effectively.**

In May 2013, DDA, in partnership with the Developmental Disabilities Council (“DD Council”), was awarded the “National Community of Practice: Supporting Families Throughout the Lifespan” grant. This grant is funded by the Administration on Intellectual and Developmental Disabilities (“AIDD”) and is managed by a partnership between the National Association of State Directors of Developmental Disabilities Services (“NASDDDS”), University of Missouri Kansas City Institute for Human Development (“UMKC-IHD”), Human Services Research Institute (“HSRI”), and the National Association of Councils on Developmental Disabilities (“NACDD”).

The National Community of Practice: Supporting Families Throughout the Lifespan grant provides funding and technical support to develop systems of support for families throughout the lifespan of their family member with an intellectual or developmental disability. “The overall goal of supporting families, with all of their complexity, strengths, and unique abilities is so they can best support, nurture, love, and facilitate opportunities for the achievement of self-determination, interdependence, productivity, integration, and inclusion in all facets of community life for their family members”—Building a National Agenda for Supports to Families with Member with I/DD, 2011.

Through this five (5) year grant, DDA, in collaboration with the DD Council, Project ACTION!, the Quality Trust for Individuals with Disabilities, and the Georgetown Center for Excellence in Developmental Disabilities, has convened a team of family members, people with IDD, and other government and community partners, to develop and implement an action plan that ultimately will shape policies and programs that support families. Through our work with the State Team, we have strengthened two-way communications



with people with developmental disabilities and their families throughout the lifespan and have begun to identify and address gaps. As an example, a consistent message from families has been about the need for peer-support across disabilities and across the lifespan. The DC Core Team has been working closely with Health Services for Children with Special Needs and the National Parent to Parent to plan the launch of a DC Parent to Parent chapter. We have also identified many parent leaders in the community who participate in the Community of Practice and will share information back and forth within the community. We have seen increased participation by family members at community meetings.

### **Interagency Collaboration**

- 6. Explain specifically how your agency works with other participating agencies, District residents, and community stakeholders. Please identify the agency/agencies (Government and Community-based) and consider the following:**
  - a. Recommend community services and supports that allow an individual to select services and supports designed for their specific needs.**

DDA has extensive and established policies, procedures, and practices that ensure people who apply for services are connected to government and community services. For persons who apply but are found ineligible for services, the DDA intake service coordinator provides information and referral resources based on the information and assessment materials gathered in the eligibility determination process to the person and their allies. These resources include, but are not limited to:

- Department of Human Services, Economic Security Administration (“DHS/ESA”) for Medicaid, Temporary Aid to Needy Families (“TANF”), Supplemental Nutrition Assistance Program (“SNAP”) and other social service benefits;
- RSA
- Office on Aging, Aging and Disabilities Resource Center (“DCOA/ADRC”);
- Department of Behavioral Health (DBH);
- Department of Health Care Finance (“DHCF”) for the Elderly and Person with Physical Disabilities (“EPD”) waiver;
- Housing Authority (“DCHA”);
- Mayors Liaison Services Center ;
- Center for Independent Living (“DCCIL”);
- University Legal Services;
- The Quality Trust for Individuals with Disabilities;
- Mary's Center;
- Consumer Action Network;

- Health Services for Children with Special Needs (“HSCSN”);
- Rachel’s Women’s Center;
- Bread for the City;
- Lifeline Partnership; and
- Columbia Heights/Shaw Family Support Collaborative: Parenting Program.

For persons found eligible, DDA completes numerous assessments and subsequently person-centered planning with the person and their support team. Based on identified needs, the person is provided with an extensive list of formal, informal, government and community services and supports that can meet each need. For paid services, DDA has strict policies and procedures that govern choice of providers from an approved list of qualified providers under the Medicaid programs.

**b. Develop effective and timely transition plans for individuals who are placed in non-community-based settings.**

DDA participates in the MFP program and offers home and community-based services to persons who reside in ICF/IID settings during annual planning meetings and at any other time a person or their allies request home and community-based services. DDA works collaboratively with OSSE, DCPS, CFSA, and DBH to identify people with intellectual disabilities who are placed in non-community-based settings and are or may be seeking transition to community-based services and supports. Once identified, DDA works with the person and sister agencies to complete eligibility determinations, assessments, person-centered planning, and a transition plan to community services.

DDA is also notified of all nursing home placements within the District for persons who are suspected to have an intellectual or developmental disability through the Preadmission Screening and Resident Review (“PASRR”) process. Upon such notice, DDA conducts a PASRR evaluation and (a) determines if such placement is appropriate, (b) determines if supportive services are required to assist the person to assess the community or receive habilitative supports while in the nursing home, and/or (c) prepares to work on transitioning the person from the nursing home to community supports, if not already known to DDA. Lastly, DDA receives referrals from the ADRC and utilizes its intake service coordination team to assist eligible persons for DDA services to transition from nursing homes to community services.

**c. Conduct outreach on your services or other participating agencies’ services specifically geared toward your service population.**

DDA regularly conducts outreach on services and supports available for people with intellectual disabilities. Outreach venues include, but are not limited to:

- RSA
- HSCSN, including at the June Fair and Family and Community Health Expo
- DC City Wide Transition Fair
- Mayors Disability Awareness Expo
- Public and charter school fairs
- OSSE events such as the Transition Professional Development Series and the OSSE CIRCLES Transition meeting
- DC Superior Court, Pretrial Services, Drug Court
- Seeking Equality Empowerment and Community (“SEEC”)/ Smithsonian Project SEARCH
- Public Defender Service Re-entry Summit

RSA conducts outreach through a number of means:

- RSA has established Memoranda of Agreement with a number of District agencies and community based non-profit social services and health providers. Through these agreements, RSA currently accepts referrals, conducts intakes, and sees clients at a variety of sites across the District. These include:
  - 4 DOES sites
  - 3 Unity Clinics
  - Project Empowerment
  - N Street Village, Inc.
  - Mayor’s Liaison Office DC Superior Court
  - Ethiopian Community Center
  - Office of Asian Affairs
  - Salvation Army (Harbor Lights Treatment Program)
  - Aging and Disability Services
  - GW Acute Rehabilitation
  - Washington Literacy Center
  - Independent Living Services (Urban League)
  - Columbia Lighthouse for the Blind
  - Providence Hospital
  - S.O.M.E. Veterans
  - Langston Lane Apartments
  - Community of Hope
  - S.O.M.E
  - Harvest House
  - New Endeavor’s for Women
  - Central Union Mission.
- VR counselors from RSA’s transition unit visit all District Public High Schools, all Public Charter Schools, the Model Secondary School (Gallaudet University) and all non-public schools that serve

transition-aged District youth. The counselors conduct intakes and provide information about services to students, their families, and school staff.

- RSA developed a number of materials to improve outreach. A printed application for services is widely available in the community. The application is also available on the agency's website. In addition, as indicated above, the agency worked with SchoolTalk, Inc., OSSE, DCPS, DBH, and The Arc to develop a Transition Tool Kit for youth and their families. Lastly, the administration developed an orientation video regarding VR services that is shown at intake and is available on the agency's website.

The outreach efforts over the past year have been successful. RSA has seen continued growth in the number of new referrals. There was an increase from 2,380 referrals in FY 2012 to 3,141 in FY 2013. This increase continued in FY 2014.

### **Addressing Barriers**

- 7. How does your agency address any or all of the following barriers to successful provision of community-based supports for individuals with disabilities? Note: address only those populations applicable to your agency's mission and vision.**

- a. Lack of comprehensive information on the supports and services available.**

As part of the 2014-2016 State Plan for Independent Living, the DCCIL plans to create a How-to Information Guide for distribution to the community that will promote understanding of local housing requirements for persons with significant disabilities. The State Independent Living Council ("DCSILC") will advise the RSA and DCCIL in these efforts through community outreach and advocacy, with the end goal of ensuring that the guide bridges the knowledge gaps consumers have on the array of Independent Living services and supports available to them. The DCSILC will also advocate and provide testimony in reference to improved housing opportunities for people with disabilities before the Mayor and DC Council.

- b. Impacts of transitioning to life in the community: discrimination, fear, and stigma.**

DDS works closely with its service provider community to ensure community and neighborhood relations are developed and maintained to help mitigate stigma and negative perceptions among community members, especially as it pertains to NIMBY issues. DDS also presents at

community meetings, ANC meetings, and hiring events, for example, to advance education about the rights and contributions of people with disabilities. DDS supports fully community-integrated services and through those efforts has significantly increased the opportunities of persons with disabilities to receive services in settings where people without disabilities live, work, and play, thus advancing the overall awareness and enrichment of our community at-large. DDS is now working on other media campaigns that will continue to educate our community to embrace and value all members of our city.

**c. Unavailability of support services to assist with daily life for individuals with severe disabilities, such as education, transportation, and employment.**

The most significant deficit in the District's services and support for people with disabilities is for persons with developmental disabilities and brain injury who are not eligible for services from DDA or the EPD waiver program. These are constituents in the program operated by DHCF. Despite its name, DDA is only authorized to serve people with intellectual disabilities, narrowly defined as persons with an IQ of 70 or below and deficits in at least two areas of adaptive functioning such as communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work, established prior to the age of 18 years of age.<sup>ix</sup> Due to the nature of developmental disabilities and brain injuries, these persons require supports and may be at significant risk for institutionalization but are not eligible for any services in the District.

The District remains one of two jurisdictions in the nation to only provide services to people with ID and not DD. DDS has supported expanding its statute to serve people with DD within available appropriations and previously met opposition by the advocacy community as it may lead to waiting lists for services where none existed in the past. Despite this, it is imperative that the District again seek to expand its eligibility under DDA to serve this population to avoid unnecessary institutionalization of persons with DD.

A second under-served population is persons who experience brain trauma and the injury results in significant cognitive impairments. Again, those persons are not eligible for services from DDA if the injury occurred after age 18. Additionally, if they are not physically disabled, they are not eligible for services under the EPD program. The number of persons who experience brain injury is growing via service related injuries, vehicle accidents, and gun violence. As a result, this is another population that often must rely on nursing facilities for support.

Another significant barrier to community living is the absence of the Medicaid Buy-in Program for Working People with Disabilities ("MBI-WPD") in the District. The MBI-WPD is a program that allows individuals with disabilities to work and get or keep Medicaid. Many persons with

significant disabilities are unable to obtain employer-funded private health insurance that provides coverage comparable to Medicaid. The fear of losing Medicaid and/or Medicare is one of the greatest barriers keeping individuals with disabilities from maximizing their employment, earnings potential, and independence. For many Social Security Disability Insurance (“SSDI”) and Supplemental Security Income (“SSI”) beneficiaries, the risk of losing health care through work activity can be a greater work disincentive than the risk of losing cash benefits through work activity.

For people who receive supports from DDA, the DDS HRAC has identified ventilator-use as a systemic barrier to community based living, albeit one that affects a small number of people DDA supports. The HRAC made a recommendation to the DDS Deputy Director for DDA to research barriers and propose solutions. DDS has begun discussions on this issue with DHCF and the Department of Health (“DOH”).

Finally, the RSA Vocational Rehabilitation (“VR”) program is able to provide time limited supports to help people with significant disabilities move to employment. When people need extended supports to maintain employment, RSA attempts to develop a plan including natural supports through its VR program. Long term employment supports are currently available for people with intellectual disabilities through the Home and Community Based Services waiver for People with Intellectual and Developmental Disabilities (“HCBS IDD”) waiver. However, long term supports are more difficult to identify for people with physical or other disabilities, and the EPD waiver currently lacks long-term employment supports in its benefit package. Ticket to Work does provide some job retention support, but for a person who needs ongoing supported employment, this level of support is not adequate.

**d. Insufficient numbers of compensated, trained employees to work with the population of people with disabilities.**

Currently, DDS is not experiencing significant problems with the ability to retain trained employees to work with the population of people with disabilities. Our current vacancy rate in key service positions working with individuals with intellectual disabilities (service coordination) is approximately 7%, which is a reasonable and expected rate allowing for normal turnover. The current vacancy rate for VR specialists is 13% and this is a bit higher than ideal, but during the recent year it has been very low and the 13% is not a long term rate. DDS keeps the vacancy rates low through active, targeted recruiting.

The ability of the disability service providers to recruit and retain trained individuals is a bit more of a concern particularly in regards to clinical staffing. DDS has taken steps to assist the providers in their staffing by retaining professional services to develop a series of advertisements to recruit clinical professionals into the disability field in the District of Columbia. At this time, we are waiting for service provider input prior to

launching the advertising campaign. Additionally, working collaboratively with DHCF, DDS is submitting an amendment to the HCBS IDD waiver that would raise the rates for a number of clinical services in an effort to increase provider capacity in this critical area.

**e. Post-discharge into community-based living with subsequent assessment that transition is not meeting the needs of the individual.**

DDA provides ongoing service coordination for people with intellectual disabilities who transition into community-based services through the HCBS IDD waiver. Through our policy and procedure, there are required post-transition visits by a service coordinator to ensure the transition has gone smoothly. The service coordinator will assess how the person is doing in both their new residential and day/vocational setting and add additional supports or make changes in supports as needed, based upon the person's assessed needs and preferences. DDA has also retained a nurse via its quality assurance project contract with the Georgetown University Center for Excellence in Developmental Disabilities ("UCEDD") whose sole function is to monitor the course of care a person receives while hospitalized or in a nursing home. The nurse then conducts follow-up with the community home setting post-discharge to ensure that all health-related discharge orders are being followed.

As part of the State Plan for Independent Living, the DCSILC has taken on the charge of advocating for city-wide implementation and education to support and campaign to improve transition planning for people who are on track for discharge from institutional or other restrictive settings. The DCSILC will monitor such planning to ensure that person-centered thinking is the focus of all such planning. The DCSILC will also advise RSA, other District government, and community agencies to achieve an Independent Living services and supports system that ensures planning for independence across the lifespan.

Additionally, the DCCIL provides advocacy and peer support services to people with disabilities.

**Department of Healthcare Finance (DHCF) FY '15 Olmstead Planning Outline Setting Priorities**

**1. When does your agency consider an individual to be "institutionalized" under the auspices of the Olmstead mandate?**

Department of Healthcare Finance (DHCF) defines "institutionalized as 91 days or more.

**2. What policies/procedures does your Agency utilize for identifying individuals ready and invested for transition into the community?**

DHCF works in partnership with the DC Office on Aging/Aging & Disability Resource Center (DCOA/ADRC) and DDS/DDA Department on Disability Services/Developmental Disabilities Administration (DDS/DDA) to identify individuals ready for and invested in transition. This is consistent with the agency's Centers for Medicare and Medicaid Services approved Money Follows the Person (MFP) Rebalancing Demonstration Operational Protocol and Memoranda of Understanding between DHCF and DCOA/ADRC on MFP outreach to nursing facilities and operating as the intake and referral entity for the Elderly and Physical Disabilities (EPD) Home and Community-Based Services Waiver.

**3. How do you communicate with your target population and their families/caregivers/advocates/providers about community-based options?**

Through its MFP Rebalancing Demonstration, DHCF conducts outreach to all District nursing facilities on a monthly basis in collaboration with the DCOA/ADRC. A monthly stakeholder meeting is convened by MFP as well. During FY 2015, the responsibility for convening the stakeholder meeting will be transitioned to DCOA/ADRC, the agency assuming the responsibility for MFP operations for DC residents transitioning from nursing facilities. The Demonstration also offers individualized consultation in service planning meetings about community-based options for residents of Intermediate Care Facilities for people with Intellectual and Developmental Disabilities (ICFs/IDD) at the request of residents and/or DDA service coordinators.

DHCF hosts monthly provider meetings for its EPD Waiver and Medicaid State Plan providers of home and community-based services.

DHCF's web site also features participant handbooks that include home and community-based options for its Medicaid Fee-for-Service beneficiaries and Elderly and Physical Disabilities Waiver Program participants.

**4. What procedures or policies do you have in place to allow people with disabilities to assess the quality of the supports they receive?**

The MFP Rebalancing Demonstration, through its operating agencies, DCOA/ADRC and DDS/DDA, administers a Quality of Life survey immediately before transition from a long term care facility and at 11 and 24 months after discharge from the long term care facility to home and community-based services.

DHCF solicits feedback from people with disabilities during planning and design for home and community-based services. This process provides people with disabilities the opportunity to comment on the quality of services.

**5. What measures has your agency taken to address the needs of the following:**



- a. Children who receive residential services from District agencies but who live outside the District of Columbia.**
- b. Adults who receive residential services from District agencies but who reside outside the District of Columbia.**

Through its MFP Rebalancing Demonstration, DHCF supports transition coordination for Medicaid beneficiaries who are placed in out-of-state nursing facilities and ICFs/IDDs. These referrals come directly or through the Demonstration's operating agencies (DCOA/ADRC, DDS/DDA).

- c. Individuals who are long-term homeless and seeking permanent housing.**

Through its MFP Rebalancing Demonstration, when housing financing is available (either through Housing Choice Voucher or other housing subsidies through the DC Housing Authority), DHCF supports transition coordination for Medicaid beneficiaries who are long-term homeless and currently residing in a nursing facility, and remain there in large part because they do not have a home to return to.

- d. Individuals who are soon to be released from jail/juvenile detention facilities.**
- e. Individuals who are receiving services, but who still have significant unmet needs which put them at risk of placement in non-community-based settings.**
- f. Individuals who do not receive services but are known to have unmet needs that put them at risk for placement in non-community-based settings.**
- g. Individuals not receiving formalized services but who live with a family member unable to support them effectively.**

Through its MFP Rebalancing Demonstration, DHCF supports individualized consultation for these families when referred by DDS/DDA.

### **Interagency Collaboration**

- 6. Explain specifically how your agency works with other participating agencies, District residents, and community stakeholders. Please identify the agency/agencies (Government and Community-based) and consider the following:**
  - a. Recommend community services and supports that allow an individual to select services and supports designed for their specific needs.**

See responses above regarding the MFP Rebalancing Demonstration. In addition, when it is identified that a participant has a serious and persistent mental illness, the compilation of documentation required for DBH services is initiated by MFP Transition Coordinators (TCs), and review and approval, if appropriate, is facilitated by the TCs.

DHCF has a Memorandum of Agreement with DCOA/ADRC and DBH that outlines roles and responsibilities specifically for the purpose of transitioning nursing facility residents.

**b. Develop effective and timely transition plans for individuals who are placed in non-community-based settings.**

See responses above for the MFP Rebalancing Demonstration. DHCF has a Memorandum of Agreement with DCOA/ADRC and DBH that outlines roles and responsibilities specifically for the purpose of transitioning nursing facility residents.

**c. Conduct outreach on your services or other participating agencies' services specifically geared toward your service population.**

DCOA/ADRC, Department of Behavioral Health (DBH), DDS/DDA  
See responses above for the MFP Rebalancing Demonstration. DHCF has a Memorandum of Agreement with DCOA/ADRC and DBH that outlines roles and responsibilities specifically for the purpose of transitioning nursing facility residents.

**Addressing Barriers**

**7. How does your agency address any or all of the following barriers to successful provision of community-based supports for individuals with disabilities? Note: address only those populations applicable to your agency's mission and vision.**

**a. Lack of comprehensive information on the supports and services available.**

DCHF has developed accessible, easy-to-read handbooks on Medicaid home and community-based services as noted above, and they are posted on DHCF's Web site.

Monthly face-to-face outreach and meetings as noted above.

**b. Impacts of transitioning to life in the community: discrimination, fear, and stigma.**

Through the MFP Rebalancing Demonstration, in partnership with the DCOA/ADRC, DHCF delivers intensive case management services during the first year after discharge from a nursing facility.

DHCF anticipates that the operationalization of the Peer Counseling MFP Demonstration service through DC Medicaid in FY15 should also help to mitigate these impacts.

**c. Unavailability of support services to assist with daily life for individuals with severe disabilities, such as education, transportation, and employment.**

MFP Project Team members continue to actively participate in several systems change initiatives aimed at increasing community integration for people with disabilities. Among these are the Association of People Supporting EmploymentFirst (APSE) board and membership meetings, the EmploymentFirst Leadership meeting, and the EmploymentFirst Community of Practice meeting.

**d. Insufficient numbers of compensated, trained employees to work with the population of people with disabilities.**

Through its MFP Rebalancing Demonstration, DHCF is discussing partnership with DDS/DDA on person-centered thinking training for day program provider staff that focuses on community integration for FY 2015.

DHCF rate setting, and mandatory training requirements for long term care home and community-based service providers addresses this factor on a large scale.

**e. Post-discharge into community-based living with subsequent assessment that transition is not meeting the needs of the individual.**

Through the MFP Rebalancing Demonstration, in partnership with the DCOA/ADRC, the delivery of intensive case management services during the first year after discharge from a nursing facility. These case managers often identify and work to resolve care coordination issues when the transition is not meeting the needs of the individual.

## **Addendum to DC—One Community For All: 2015 Community Integration Plan**

### **Purpose**

This Addendum to the District's current Olmstead Plan, DC –One Community for All: 2015 Community Integration Plan (the Addendum) clarifies the time frame of the current Olmstead Plan and provides an explanation of the District's goals and commitments to assist individuals with disabilities with the transition process from nursing facilities to less restrictive settings when treatment in a less restrictive setting is appropriate given the available private and public home- and community-based supports for the individual, the individual does not oppose a less restrictive setting, and the needed assistance and home- and community-based services can be reasonably accommodated, taking into account the District's available resources and the needs of others with disabilities.

This Addendum also confirms the District's commitment to a substantial revision of the Olmstead Plan, which will be drafted, with the consultation of community stakeholders, during the remainder of 2015. The District will convene an Olmstead Working Group, comprised of government and community stakeholders, to advise on the drafting of the 2016 Olmstead Plan. The District will also provide a draft of the 2016 Olmstead Plan to the community to review, with an opportunity to provide suggestions and comments in community meetings prior to the publication of the 2016 Olmstead Plan.

### **Time Frame for 2015 Plan**

As part of its effort to increase transparency, the District moved from fiscal year (October-September) reporting to calendar year (January-December) reporting at the end of 2014.

The switch from fiscal year to calendar year reporting resulted in one quarter, October – December 2014, as a stand-alone report, not included in any yearly report. Moving forward, the District will continue to report on a quarterly basis, but the year-end compilations will be calculated on a calendar year basis to minimize confusion about the reporting cycle.

Because of this reporting change, the District has deleted references to the fiscal year in the Olmstead Plan. No other changes have been made; all of the agency quantitative and qualitative goals remain the same for 2015.

### **Nursing Facility Transition Process**

The District is committed to a streamlined person-centered approach of nursing facility transitions for individuals when treatment in a less restrictive setting is appropriate given available home- and community-based supports, the affected individual does not oppose a less restrictive setting, and the needed assistance and home- and community-based services can be reasonably accommodated.

## **Outreach and Training**

Goal: Ensure individuals, families, and nursing facilities understand the availability of home- and community-based services and supports and how to access them.

### District Commitments:

- The District provides oversight of nursing facilities to ensure compliance with federal and local requirements. Nursing facilities are required to conduct initial quarterly and annual assessments of all nursing facility residents using the standard MDS 3.0 (produced on the federal level by Centers for Medicare & Medicaid Services and used by all jurisdictions), which include asking residents their preference for home- and community-based settings. If an individual expresses a desire to speak with someone about living in a less restrictive setting, the nursing facility is required by federal standards to make a referral to the District for appropriate follow-up.
- The District contracts with a Quality Improvement Organization (QIO). Among other responsibilities, the QIO must perform an on-site review of every nursing facility resident on an annual basis (and two reviews within the first year of nursing facility admission). For individuals who do not meet the Level of Care required for Medicaid paid nursing facility stays (nursing facility LOC), the QIO provides information on home- and community-based services.
- The District conducts regular outreach at every nursing facility in the District of Columbia and selected facilities in the neighboring jurisdictions with significant populations of District residents receiving DC Medicaid-funded nursing facility services. The District also provides outreach and trainings on various topic areas related to home- and community-based services to nursing facilities upon request outside the standard outreach calendar.
- The District will review its current informational materials on long-term services and supports and will produce new materials for 2016, if needed, including posters for nursing facilities to place in common areas and materials for nursing facilities to provide to residents on home- and community-based care options.
- The District will review its current training processes through the Olmstead Working Group, including trainings for nursing facilities and hospitals regarding available home- and community-based services and supports, and will include specific training goals in the 2016 Olmstead Plan.

## **Transition Services<sup>1</sup>**

Goal: Provide a person-centered approach to assess and facilitate an individual's desire and ability to transition from the nursing facility to the community.

### District Commitments:<sup>2</sup>

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<sup>1</sup> All District Commitments to Transition Services are dependent on the District's available resources and the needs of others with disabilities unless otherwise stated.

- Once the District receives a referral regarding an individual's interest in transitioning from the nursing facility, the District will contact the individual within three business days, absent extraordinary circumstances, to initiate the assessment process for transitioning to a less restrictive setting and schedule a time to administer the Community Preference Survey (see attachment 1). The Community Preference Survey solicits information on the individual's desire to live in the community, general health needs, and resources (including access to appropriate housing, income, and family support).
- Within three business days of completing the Community Preference Survey, the assigned District personnel compose an Initial Transition Services Checklist (the Checklist) for the individual, if the individual continues to express a preference for treatment in a less restrictive setting.

Items that can be included in the Checklist include applications for personal identification documents; applications for wheelchair-accessible transportation services; requests for benefit statements; applications for employment supports; and applications (or updating applications) for public housing through DC Housing Authority.

The individual is responsible for providing necessary information and paying any applicable fees for obtaining the required services. If the District has funds available to assist individuals with applicable fees for obtaining the required services, District personnel will assist individuals in obtaining those funds when individuals meet the eligibility criteria. The Checklist is updated as needed to reflect any changes in circumstances or information.

- Once individuals have identified appropriate housing and sufficient resources to support treatment in a less restrictive setting (with assistance from District personnel, if necessary), District personnel are responsible for assisting individuals with connecting to the appropriate home- and community-based services for which the individual qualifies based on the eligibility criteria for each individual program (see attachments 2-5 for information on specific programs).

In order to be eligible for continued transition services, treatment in a less restrictive setting must be appropriate for the individual given the home- and community-based supports for which the individual is eligible, as determined by the individual's support team, which includes the individual and people the individual invites (family and/or friends), and can include treatment professionals, including the person's doctor, social worker, nurse, and/or legal representative.

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<sup>2</sup> During fiscal year 2015 (beginning October 2014), the District engaged in a one-year planning process for a No Wrong Door (NWD) system to transform the delivery of long term services and supports through a planning grant from the federal government. NWD is an effort to develop streamlined, coordinated systems of access to long term care services and supports, across District agencies, with the assistance of stakeholder and advisory groups. The District currently is working on a three-year implementation work plan for a NWD system, which will span fiscal years 2016-2018, and focuses on coordinating the District's person-centered philosophy, stakeholder engagement, resource sharing, and coordinated IT systems across the District's human service agencies.

If an individual, family member, and/or legal representative for the individual disagrees with the support team's finding that treatment in a less restrictive setting is inappropriate, given the home- and community-based supports for which the individual is eligible, the individual, family member, and/or legal representative can contact the District's Long-Term Care Ombudsman (LTC Ombudsman) at 202-434-2190 for further assistance. The District provides funding for the LTC Ombudsman, but the LTC Ombudsman remains independent from the District and advocates for the rights of individuals receiving long-term care services in the District.

- If a less restrictive setting is appropriate for the individual, District personnel collaborate with the nursing facility social worker to assist individuals in identifying the individual's available resources and applying for public benefits including Medicaid as needed.

Depending on the individual's level of need and eligibility for services, the District will collaborate with the nursing facility social worker to assist the individual to obtain needed services such as Durable Medical Equipment, behavioral health services, day treatment services, home health services including skilled nursing care, occupational therapy and physical therapy, personal care aid services, support for employment, and other services and supports as needed and for which the individual is eligible.

- District personnel or case managers (if the individual is enrolled in the Elderly and Persons with Physical Disabilities Waiver (EPD Waiver)) participate in discharge meetings and ensure treatment in a less restrictive setting is safe for the individual.
- Once the transition to the community is complete, individuals may be eligible for ongoing case management. If the individual is receiving services under the EPD Waiver, case management is included as part of the EPD Waiver. If the individual is not on the EPD Waiver, the individual may still qualify for community case management at one of the eight District Lead Agencies. Lead Agencies are District grantees that provide case management services to people ages 60 and over. Community social workers from the District of Columbia's Aging and Disability Resource Center are co-located at each Lead Agency to assist with case management of individuals with disabilities ages 18-59. District personnel assigned to assisting the individual in the transition process assist in identifying ongoing case management assistance, if needed.

## **Capacity**

Goal: Maximize District resources to assist the greatest number of individuals possible in appropriate, sustainable treatment in the least restrictive setting in a streamlined, person-centered process.

### District Commitments:

- Medicaid waivers

For individuals who meet the nursing facility LOC, the District offers two home- and community-based waivers, which are special programs that provide long term care services to eligible individuals, allowing them to live in the community

with necessary services and supports.

The EPD Waiver offers a range of services (see attachment 2). The District can enroll up to 4,960 eligible individuals in the EPD Waiver in 2015. Based on current enrollment and past utilization, the District does not expect a need for a waiting list. If enrollment approaches the cap for the program in 2015, the District will evaluate the need for a prioritization process with interested stakeholders. In 2016, the District will adopt a waiting list policy for the EPD Waiver, which will be developed with interested stakeholders.

The Intellectual and/or Developmental Disabilities Waiver (ID/DD Waiver) provides residential, day/vocational, and other support services for people with intellectual disabilities who choose to live in their own homes or in other community-based settings (see attachment 3). The District can enroll up to 1,692 eligible individuals in the ID/DD Waiver in 2015. The District does not currently anticipate a waiting list, but if one were to be put in place, it would be in accordance with the HCBS IDD Waiver policy and procedure, available at: <http://dds.dc.gov/book/vi-administrative-dda/hcbs-idd-waiver-waiting-list>.

- Community Medicaid

Community Medicaid (also sometimes called State Plan) is an entitlement program that does not have a cap on enrollees. Individuals are required to meet certain income eligibility requirements. Community Medicaid offers fewer services and supports than the District's Medicaid waivers because individuals receiving Community Medicaid require a lower level of care (see attachment 4).

Community Medicaid services that provide long-term care supports and services to individuals in the community include: home health care, personal care assistance services, adult day health services, and an array of mental health services including Assertive Community Treatment (ACT) and mental health rehabilitative services.

- Money Follows the Person Demonstration Project (MFP)

MFP is a federal demonstration project with an allocation of 65 housing choice vouchers (vouchers), some of which are being used by participants in the community. All 65 vouchers will be in use by individuals who transitioned from nursing facilities to the community by the end of 2015. MFP includes all EPD Waiver services (EPD Waiver eligibility is a condition of MFP participation) and some additional services (see attachment 5).

## Reporting

Goal: Collect and report data to track the effectiveness of the District's system of ensuring individuals are in the least restrictive living environment where appropriate, the individual does not oppose a less restrictive setting, and the needed assistance and home- and community-based services can be reasonably accommodated, taking into account the District's available resources and the needs of others with disabilities.



### District Commitments:

- The District reports on qualitative and quantitative goals in the District's 2015 Olmstead Plan, DC—One Community for All: 2015 Community Integration Plan. The District publishes the agencies' reports on a quarterly basis. The reports are available here: <http://odr.dc.gov/page/olmstead-community-integration-quarterly-reports>. On or before February 2016, the District will publish the compilation of the 2015 quarterly reports into one annual report. The annual report will include whether or not the District achieved its goals, along with explanations for each goal.
- In the drafting process of the 2016 Olmstead Plan, the District will review the current reporting requirements through the 2015 Olmstead Plan and make adjustments as necessary on the reporting metrics. New reporting metrics may include the average length of time it takes individuals to apply and be approved for home- and community-based services, how many individuals inquire about home- and community-based services, and if individuals are unable to transition, what reasons prevent treatment in a less restrictive setting, even if individuals desire it.
- All agencies involved in the nursing facility transition process, whether providing direct services or oversight of contracted or licensed entities, report directly to the Deputy Mayor of Health and Human (DMHHS) services. If agencies are unable to meet the commitments in the Olmstead Plan, DMHHS works with the agencies to correct any deficiencies and make adjustments as needed.

### **Conclusion**

In 2015, the District has made significant system improvements to the nursing facility transition process based on feedback from District personnel and the community. The District is pursuing an ongoing dialogue with stakeholders to ensure that individuals are able to access all of the services and supports for which individuals are eligible in the least restrictive setting possible, subject to the District's available resources.

# **ATTACHMENT 1**

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
District of Columbia Office on Aging  
Aging and Disability Resource Center



## Introduction to Preference Interview Tool

### Note to Interviewers:

*DC is using this Preference Interview to confirm a resident's preference for leaving a health care facility to live in a community setting, and to identify services that might be needed to assist in the move ("transition"). District agencies and federal funding sponsor a variety of programs to make it possible for facility residents to choose where they receive health care and supportive services.*

*Any discussion on moving from a health care facility to community living is complex. Many residents are not aware of available services to assist them in the community. The survey has two goals: to identify residents who choose to move to the community and to ensure that residents who choose NOT to move are fully informed of their choices when they make their decision. All residents interviewed, including those who express an initial preference to stay in the health care facility, are asked the same questions. Specific questions about housing and services are not designed to screen out residents from further consideration for assistance with any relocation.*

*The Preference Interview is designed to educate residents and family members about available services and housing options whether they are or are not eligible for some services. Residents who are not eligible for some services but who request to live in the community will be referred to existing service providers consistent with their choice of health care and service setting and the goals of the US Supreme Court's Olmstead decision.*

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**  
**District of Columbia Office on Aging**  
**Aging and Disability Resource Center**



<b>Resident Name</b>		<b>Date</b>	
<b>Facility Name</b>		<b>Room #</b>	
<b>Facility Contact</b>		<b>Facility Contact #</b>	
<b>Interviewer Name</b>		<b>Resident Number#</b>	
<b>Interview Start Time</b>		<b>62 years old +?</b>	
<b>Date of Birth</b>			
<b>Health Conditions</b>			

**Authorization**

I hereby authorize the use and/or disclosure of my protected health information (my "Information") as described below. I understand that this authorization is voluntary. I also understand that this is a general authorization used for nursing facility transition purposes, and not for purposes of medical treatment within the nursing facility.

**Revocation**

I understand that I may revoke this authorization at any time by revoking my authorization in writing. Revocations must be sent to the Associate Director DCOA-ADRC (500 K Street, NE, Washington D.C. 20002). I understand that revoking this authorization will *not* affect any action that ADRC has taken in reliance on this authorization before ADRC received my written revocation.

**Individual Signature**

I acknowledge that I have had the full opportunity to read and consider the contents of this authorization. I understand that I am authorizing the use and/or disclosure of my Information to DCOA-ADRC. I understand that if the receiving person or organization listed above is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the individual's personal representative signs this authorization, complete the following:

Personal Representative's Name (Printed): \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

## INTERVIEWER GREETING

Hello, my name is \_\_\_\_\_, a Transition Care Specialist from the District of Columbia's Office on Aging / Volunteer with AARP's Long Term- Care Ombudsman Program.

*Did you know that there are programs and community agencies that may provide you care at home if you qualify for it? These programs include support with housing issues, medical, dental or prescription needs, home health services, meal delivery, and other supports that could help you move from this nursing facility and remain at home.*

*Currently, I am working on a special initiative to help people who live in nursing facilities to return to the community if they are able to.*

*If it is ok I would like to ask you some questions about where you might want to live and what services you might need if you don't live here. What you say is private and will not change the care you receive in this [nursing facility name]. Would you like to talk more about the possibility of moving to a home setting?*

**\_\_\_ If No, Stop Interview.** Thank you for letting me talk with you. If you would like to talk about living in your own home at another time, here is the name and phone number of someone you can call. Please call: Ms. Margaret Woods, DCOA Nursing Home Transition Program Coordinator at 202-535-1446.

**\_\_\_ If Yes, Continue with the script below:**

*If you would like to move out of the nursing facility and return back to the community, there are a few questions that I need to ask in order to better serve you. This interview will take about 25 minutes and the main reason for this interview is to provide you with information. If you want to move, more information will be given to you.*

**Is now a good time to ask you some questions?**

**(If YES)** *I have more questions to ask you. The questions might help you decide if moving to your own home is a good choice for you (or your relative).*

**(If NO) Stop Interview.** Thank you for letting me talk with you. If you would like to talk about living in your own home at another time, here is the name and telephone number of someone you may call. Please call: Ms. Margaret Woods, DCOA Nursing Home Transition Program Coordinator at 202-535-1446.

**BEGIN INTEVIEW:** *Is now a good time and can I ask you some questions?*

**\_\_\_ NO STOP INTERVIEW**

**\_\_\_ YES CONTINUE INTERVIEW**

## PREFERENCE INTERVIEW QUESTIONS

1. Do you (the resident) know how long you have been in this Nursing Facility?

☐

NO (GO TO Q3)

☐

Don't know – Not sure (GO TO Q3)

☐

YES (GO TO Q2)

2. Have you (the resident) been in this or other nursing facilities continuously for 90 or more days?

☐

NO (GO TO Q3)

☐

Don't know – Not sure (GO TO Q3)

☐

YES (GO TO Q3)

3. *There are options for living outside the nursing home. You (the resident) could live in your (their) own home or an apartment with help from in-home supportive services, personal care assistants, community meals, and special activities; or you (the resident) could live in an assisted living facility (if it takes DC Medicaid & SSI could go toward room & board), which provides meals, housekeeping, some light personal assistance, and special activities. Would you like to hear more about any of these options?*

NO (Go to Q4)

YES (Go to Q4)

Don't know-Not Sure (Go to Q4)

4. I am going to list some services that you (the resident) might be able to get. You (the resident) could get help with: (STATE the services listed below.)

Bathing

Preparing meals

Eating

Housekeeping

Toileting

Taking medications

Getting dressed

Managing money

Using the telephone

Getting out of bed/walking

5. Having heard that this assistance may be available, do you want to move out of this nursing facility back into the community in a home setting?

☐

NO (GO TO Q5A)

☐

Don't know (GO TO Q6)

Comments:

☐

YES (GO TO Q6)

5a. What are some of the reasons you (the resident) want to continue living in the nursing home? (LIST)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**(STOP INTERVIEW, Reply: Thank you for taking the time to answer these Questions.)**

6. Do you (the resident) already have a place to live and with whom? Do you know the address or have contact information for this person? **(If YES, please write down in notes)**

☐ YES (Go to Q6a-c) ☐ NO (Go to Q7)

6a Apartment or home alone

6b Apartment or home with family (How many? Parents ☐ Kids ☐ Other ☐

6c Apartment or home with Spouse or Friend(s)/roommate(s) ☐ How many?

**(Go to Q9)**

7. Where would you (the resident) want to live?

7a Apartment or home alone

7b Apartment or home with family (How many? Parents ☐ Kids ☐ Other ☐

7c Apartment or home with Spouse or Friend(s)/roommate(s) ☐ How many?

7d Assisted living facility (if they take DC Medicaid and your SSI could go toward room & board)

7e Group home with 3-4 other people

8. Would you be willing to live:

8a in a group home with 3-4 other people?

8b in an assisted living facility?

8c in an apartment building for seniors and people with disabilities? **(Refer to Public Housing IF YES to Q8c, AND 62 and over.)**

9. Do you have a way to pay for housing- either through income or another way?

NO (Go to Q10) YES (Go to Q9a) Don't know-Not Sure (Go to Q9b)

9 a How would you pay for housing?

9 b Who should we ask to find out about this?

Next Steps to arrange housing: \_\_\_\_\_

10. Will you need accommodations in your new home to make it accessible? E.g. no stairs, flashing lights (if the person is deaf), lower countertops, etc.

YES (Go to Q10a-c) NO (Go to Q11)

10a. What type of accommodations will you need? \_\_\_\_\_

*In arranging for transitions in the past, we have found that unpaid utility bills can pose problems in setting up living situations. These problems can be avoided by addressing the bills before the move.*

11. Do you have any unpaid or past due phone, gas, or electricity bills?  
NO YES (Go to Q11a)

11a. With what companies do you have an unpaid or past due phone, gas, or electricity bill (i.e., Pepco, Washington Gas, etc.) .

*In arranging housing, we have found that poor credit ratings and felony convictions can make finding housing more difficult. If we know about any issues up front we can take steps to address them with property managers.*

12. Do you have unpaid credit card bills or loan payments?  
NO YES

12a. Do you owe money to the DC Housing Authority? Y/N

13. Do you think that credit repair is something we should work on before your move?  
NO YES

13a. Have you ever been evicted? Y/N

b. If so, do you still owe money to any housing entity? Y/N

14. Do you have any felony convictions?  
NO YES



*Now I'm going to talk about home care services that might help you (the resident) live outside the nursing home.*

*Let's talk a little about paying for these services.*

15. Are you on Medicaid?

NO (Go to 15a) YES

15a. Think about where you would live when you leave the nursing facility. Who you would live with. Including everyone, how much money do you think the house would bring in a month? \_\_\_\_\_

16. What about Medicare?

☐ NO ☐ YES

17. Do you have Veteran's benefits?

N O Y E S

18. Do you have any other type of insurance, including long-term care insurance that could help pay for community-based living?

☐ NO YES (Go to 18a)

18a. What is this insurance? \_\_\_\_\_

*In the next set of questions, I am going to list the home care services that might help you (the resident) live outside the nursing home. Listen to them and tell me if you (the resident) need(s) the service.*

19. Help getting out of bed and into a chair? **(ADL 1 of 5: Overall Mobility)**

NO (Go to Q20) YES (Go to Q19a-d)

If yes, how much assistance:

19a Set-up only (side rails moved out of way, wheelchair placed nearby)

19b Supervision from nurse aide

19c Limited assistance – nurse aide does not bear resident weight during assistance, resident uses bed-rails or other devices such as a trapeze for support

19d Extensive/total assistance – nurse aide bears significant amount or all of resident weight

20. Help getting started to eat? For example, cutting up your food, or getting your silverware at meal times? **(ADL 2 of 5: Eating)**

☐ NO ☐ YES

21. Help eating? For example, someone to feed you?

N O Y E S

22. When eating, do you use:

22a Special utensils to eat?

22b Special cups to drink?

23. Help cooking or preparing meals? (**IADL 1 of 5: Meal Preparation**)

N O                      Y E S

24. Help turning or moving in bed? (**ADL 1 of 5: Overall Mobility**)

N O                      Y E S

25. Help using a catheter to use the toilet? (**ADL 3 of 5: Toilet Use**)

N O                      Y E S

26. Help getting to or using the toilet?

N O                      Y E S

26a. Wears adult briefs or pads

N O (Go to Q27)                      Y E S (See below)

If adult briefs are worn, how often are they worn?

☐

Always

☐

ONLY when going out of the facility

☐

O t h e r \_ \_ \_ \_ \_

27. About how many times during the day do you think you need help getting to the toilet OR changing adult brief/pad? \_\_\_\_\_ \*\*

\*\*If resident states they do not know, use the following prompts

27a Do you need help when you wake up?                      N O Y E S

27b Do you need help after breakfast?                      N O Y E S

27c Do you need help before lunch?                      N O Y E S

27d Do you need help after lunch?                      N O Y E S

27e Do you need help before dinner?                      N O Y E S

27f Do you need help after dinner?                      N O Y E S

27g Do you need help before bed?                      N O Y E S

Total number of YES responses approximates how many times the resident needs assistance to get to the toilet or have their pad changed.

28. Help with morning care like brushing your teeth, washing your face, brushing your hair, or putting on your deodorant? (**ADLs 4 & 5 of 5: Bathing & Dressing**)

N O (Go to Q29)    Y E S (Go to Q28a-d)

If yes, what type of assistance?

28a      Set-up only

28b      Supervision from nurse aide

28c      Limited assistance- nurse aide performs some but not all care tasks

28d      Extensive/total assistance – nurse aide performs all morning care tasks

29. Help with bathing or taking a shower? (**ADL 4 of 5: Bathing**)

N O (Go to Q29a-b)    Y E S (Go to Q29a-b)

29a. Showers

29b. Baths

30. Help walking inside? **(ADL1 of 5: Overall Mobility)**

N O                      Y E S

31. Help walking outside? **(ADL1 of 5: Overall Mobility)**

N O                      Y E S

32. What kind of help do you need?

Cane

Walker

Safety rails on walls

Wheelchair (Go to 32a-b)

32a If Wheelchair, do you need help getting around in your wheelchair inside?

N O                      Y E S

32b If Wheelchair, do you need help getting around in your wheelchair outside?

N O (Go to 33)                      Y E S (Go to 33)

**For questions 33 and 34:** Ask the resident if they: a) were able to bend down and reach their shoes before coming to the nursing facility. **Do not allow them to demonstrate how to bend and reach their toes;** and b) need assistance with buttons, zippers or tying laces, even if they state that they do not need help dressing.

33. Help getting dressed in the morning? **(ADL 5 of 5: Dressing)**

N O (Go to Q34)    Y E S (Go to Q33a)

33a. If YES, what do you need help with?

Shoes/socks

Shirt/dress

Pants

34. Help getting dressed at night? **(ADL 5 of 5: Dressing)**

N O (Go to Q35)    Y E S (Go to Q34a)

34a. If YES, what do you need help with?

Shoes/socks

Shirt/dress

Pants

35. Help using the telephone? **(IADL 2 of 5: Using Telephone)**

N O (Go to Q36)    Y E S (Go to Q35a)

35a. If YES, do you need:

Volume increased; can't hear

Large numbers; can't see to dial

Dialing assistance; can't dial

36. Help with medications? **(IADL 3 of 5: Medication Management)**

N O (Go to Q37)    Y E S (Go to Q36a-b)

36a. If YES, what do you need help with?

Reading labels

Opening medication bottles and/or blister packs

37. Help with housework? (**IADL 4 of 5: Housekeeping**)

NO (Go to Q38) YES (Go to Q37a)

37a. If YES, what do you need help with?

Laundry

Washing dishes

Cleaning house

38. Help managing your money or finances? (**IADL5 of 5: Money Management**)

NO (Go to Q39) YES (Go to Q38a)

38a. If YES, what do you need help with?

Paying your bills

Balancing your check book

Tracking your bank accounts

*I am going to ask you about two challenging issues: substance abuse and mental health. I am asking about both of these so that we can plan together to have the right supports in place throughout the transition process.*

39. Do you now or have you in the past had a substance abuse problem?

NO YES (Go to 39a)

39a. What treatment has been helpful? \_\_\_\_\_

40. Have you experienced any challenges with mental health?

NO YES (Go to 40a)

40a What kind of challenges? \_\_\_\_\_

40b What support will you need to stay healthy? \_\_\_\_\_

40c Are you taking any medications related to mental health? Y/N

If yes, which ones? \_\_\_\_\_  
(for each, list dosage and purpose)

**If someone requires:**

**-EXTENSIVE ASSISTANCE OR is TOTALLY DEPENDENT in at least 2 of 5 basic Activities of Daily Living (Q19-34) OR**

**-SUPERVISION or LIMITED ASSISTANCE in at least 2 of 5 basic Activities of Daily Living (Q19-34) AND ASSISTANCE of some kind in at least 3 of 5 Instrumental Activities of Daily Living (Q23, 35-38) they may be eligible for the EPD Waiver.**

**>GIVE THEM information packet on DCOA-ADRC and the DCOA/DC Health Care Finance State Plan information and Steps in the Waiver Admission Process Packet, including point of contact Nursing Home Transition Coordinator for Nursing Facility.**

**STOP INTERVIEW. CLOSE WITH THE FOLLOWING:**

*Thank you for taking the time to talk with me. We want to be sure you understand that answering these questions does NOT mean that you will be relocated out of the nursing home without your consent and discussion about what you want to do. We don't want to create false hope about moving. We do want to get information to you if you would prefer to live some place other than the nursing home.*

**OFFER TO FOLLOW UP TO PROVIDE INFORMATION OR REFERRAL ABOUT COMMUNITY SERVICE OR FOR ANY NEED THAT IS EXPRESSED IN THE INTERVIEW.**

- Resident's information will be entered into C-Stars Case Management System.
- Resident will be given a packet of materials concerning DCOA-ADRC and the DCOA/DC Health Care Finance State Plan Information and Steps in the Waiver Admission Process Packet. These materials will also identify the Point of Contact Transition Coordinator for the Resident's particular Nursing Home.
- Point of Contact Nursing Home Transition Coordinator will contact Nursing Home Social Worker within 48 hours in order to start to schedule Care Plan Meetings with Resident and other stakeholder.

**NOTES:**

***Interviewer, complete the following:***

42. How clear is the person in terms of what services are needed?

Not at all clear   Somewhat clear   Neither clear nor unclear   Somewhat clear  
Very clear

43. How motivated is the person to relocate?

Not at all motivated   Somewhat motivated   Neither motivated or unmotivated  
Somewhat motivated   Very motivated

**Interview End Time:**

# **Attachment 2**



## **THE ELDERLY AND PERSONS WITH PHYSICAL DISABILITIES WAIVER**

### **What is the Elderly and Persons with Physical Disabilities (EPD) Waiver Program?**

The **EPD Waiver** is a combination of home and community-based long term care services designed to help older adults and individuals with disabilities stay in their home, as an alternative to care in an institution.

### **What are the eligibility requirements for the EPD Waiver?**

- Be a resident of the District of Columbia;
- Be a U.S. citizen or qualified alien;
- Be eligible to receive DC Medicaid with an income of less than 300% of SSI; Less than \$2,199 a month or Be eligible for Spend Down
- Have no more than \$4000 in countable assets;
- Require assistance with activities of daily living;
- Be elderly (65 years of age or older);
- Be 18-64 years old and diagnosed with having a physical disability;
- Meet the “Level of Care” established for the EPD Waiver;
- Must choose home and community based services;

### **How can I be sure the EPD Waiver is right for me?**

The EPD Waiver is a choice program. Beneficiaries have the right to choose whether or not to participate in home and community-based services. The EPD Waiver may be a good fit for you if you feel services provided under the Waiver will meet your needs.





## **What services are available under the Waiver?**

- Case Management-assistance with obtaining services under the Waiver
- Personnel Care Aide Services (PCA)-assistance with activities of daily living i.e. grooming, dressing, eating, toileting etc.
- Personal Emergency Response Services (PERS)-an electronic services that allows people to call for assistance
- Respite Services-assistance with supervision and assistance if the primary caregiver is absent
- Assisted Living-licensed home participants can live in and have access to services they need to maintain independence
- Environmental Accessibility Adaptation Services (EAA)-assistance with physical adaptations to a person's home that are necessary to ensure safety, and welfare of an individual
- Homemaker Services-general household activities such as meal preparation, housekeeping and running errands
- Chore Services-a one-time non-medical household task such as washing floors, windows, walls, trash removal, and rearranging furniture in order to provide safe access to the home

## **What is the timeline for the EPD Waiver?**

- Once an EPD Waiver application is submitted to the Economic Security Administration (ESA), processing can take up to 60 days.

Aging & Disability Resource Center (ADRC)

500 K Street NE

Washington, DC 20002

Phone: (202) 724- 5626

Email: [EPDWaiver.dcoa@dc.gov](mailto:EPDWaiver.dcoa@dc.gov)

Fax: (202) 724-4979

TTY: (202) 724-8925

# **ATTACHMENT 3**

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## ***Next Steps...***



If you are seeking or  
interested in DDA  
services please contact

the DDA Intake and Eligibility Unit. This unit is  
responsible for receiving and processing applica-  
tions and determining eligibility for people apply-  
ing for services from DDA. You can complete the  
application on line, mail it in, bring the application  
to our office or you can schedule an appointment  
by calling 202.730.1745. An Intake and Eligibility  
Coordinator will assist you through this process.  
Contact us at :

### **Developmental Disabilities Administration**

#### **Office Hours**

Monday –Friday, 8:15am to 4:45pm

1125 15th Street, NW  
Washington DC 20005  
202.730.1700 (Phone)  
202.730.1843 (Fax)  
202.730.1516 (TTY)

<http://dds.dc.gov/DC/DDS>  
<http://www.facebook.com/DDS.DC>  
[http://www.twitter.com/DDS\\_DC](http://www.twitter.com/DDS_DC)"<>img

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District of Columbia  
Department on Disability  
Services  
Developmental Disabilities  
Administration



***SUPPORTING PERSONS WITH  
INTELLECTUAL AND OTHER  
DEVELOPMENTAL DISABILITIES  
IN THE DC COMMUNITY...***

# Developmental Disabilities Administration

The Developmental Disabilities Administration (DDA) is the agency in the District of Columbia



DDA has key functions to carry out on behalf of the individuals, families, providers in the community

responsible for the oversight and coordination of all services and supports

provided to qualified persons with intellectual and other developmental disabilities.

Once a person is determined eligible for DDA, they are able to apply for the Home and Community Based Services Waiver Program.

## Home and Community Based Services (HCBS) Waiver

The HCBS Waiver is a Medicaid program that allows the District to provide person-centered community based programs and supports designed to help adults live in the community and/or leave institutional settings. The District must assure to the Federal government that people enrolled in the program have person-centered plans, receive services outlined in the plan, free choice of service providers, safeguards in place to remain safe & healthy and ensure the program is fiscally sound. DDA operates the program under the administrative oversight of the Department of Health Care Finance, the District Medicaid agency.



## Eligibility

You may be eligible to participate in the HCBS waiver program only if all the following requirements are met:

- ☑ You are eligible to receive services from DDA.
- ☑ You are at least 18 years of age or older.
- ☑ You meet the required Level of Care.
- ☑ You are DC Medicaid eligible.
- ☑ You choose to participate in the HCBS waiver. (Participation in the HCBS waiver is entirely voluntary.)

## Waiver Services

The Medicaid Home and Community Based Services (HCBS) waiver program provides residential, day/vocational and other support services in the community for people with intellectual and other developmental disabilities living in the District of Columbia. The HCBS waiver program supports individuals who are eligible for Medicaid and who choose to live in their own homes or live in a community setting, rather than an institutional setting. Institutional settings are defined as a hospital, nursing home or intermediate care facility for persons with an intellectual/developmental disability (ICF-ID). For more information on the description of the services please visit our website at <http://dds.dc.gov/DC/DDS>

## Services Available through the HCBS Waiver Program are:

### Residential Supports:

Host Home  
In Home Supports  
Residential Habilitation



Respite  
Supported Living  
Supported Living w/  
Transportation ( **NEW! NOVEMBER 2012** )  
Shared Living ( **NEW! NOVEMBER 2012** )  
Personal Care

### Day Supports:

Day Habilitation  
Employment Readiness  
( **Revised November 2012** )  
Individualized Day Supports  
( **NEW! NOVEMBER 2012** )  
Small Group Supported Employment  
( **NEW! NOVEMBER 2012** )  
Supported Employment

### Assistive Supports:

Environmental Accessibility Adaption  
Personal Emergency Response Services (PERS)  
One Time Transitional  
Vehicle Modification

### Professional Services:

Art Therapies ( **Revised November 2012** )  
(Includes: Art Therapy; Dance Therapy; Drama Therapy and Music Therapy)  
Behavior Supports  
Dental ( **NEW! NOVEMBER 2012** )  
Family Training  
Occupational Therapy  
Physical Therapy  
Skilled Nursing ( **NEW! NOVEMBER 2012** )  
Speech, Hearing and Language  
Wellness Services ( **Revised November 2012** )  
(Includes: Bereavement Counseling, Fitness Training, Nutritional Counseling, Massage Therapy and Sexuality Education)



**DC Employment First**  
vision statement  
"DC expects that all people of working age will **work and earn the** prevailing wage, in the career path they choose."



At work, it's what people can do that matters.

# **Attachment 4**



## **Accessing Personal Care Aide (PCA) services through the District's State Plan:**

**Purpose:** To provide health-related services to individuals because they are unable to perform one or more activities of daily living such as bathing, dressing, toileting, ambulation, or feeding oneself as a result of a medical condition or cognitive impairment causing a substantial disability.

### **Eligibility**

- The beneficiary/applicant must be eligible for District of Columbia Medicaid.
- Be unable to independently perform one or more activities of daily living for which personal care services are needed.
- Be in receipt of a written Physician Order Form (POF) order for PCA services.

### **Steps to Accessing Personal Care Aide (PCA) Services**

#### **1. Physician Order Forms**

- A Physician's Order Form (POF) completed by a Medicaid enrolled physician is required to request PCA services. The blank POF is available through the Aging & Disabilities Resource Center (ADRC), or at the Department of Health Care Finance's (DHCF's) website: [www.dc-medicaid.com](http://www.dc-medicaid.com). Medicaid Physicians should have this form.
- The completed POF should be sent to Delmarva, DHCF's Long-Term Care Supports Contractor (LTCSC) via fax @: **(202) 698-2075**.
- Once the POF is received, the LTCSC will verify the beneficiary's Medicaid eligibility, and contact the beneficiary to schedule a face-to-face visit to complete a PCA Assessment within three (3) business days of receipt of a complete POF.
- The LTCSC will review the POF, and if it is incomplete, they will work directly with beneficiaries and/or their authorized representative and the provider to resolve.

#### **2. Home Visit/In-Person Assessment**

- A registered nurse (RN) from the LTCSC will conduct a home visit to complete the PCA assessment which may take up to two (2) hours.
- The assessment process will require the LTCSC RN to interview the beneficiary/applicant (and/or his or her authorized representative) to gather current/past medical history, to directly observe the beneficiary's functional limitations and home environment.
- Each beneficiary is afforded the opportunity to select a home health aide provider to render personal care aide services. The LTCSC RN will provide resource information (brochures, fact sheets, etc.) and a list of approved service providers.
- The result of the assessment will indicate whether the beneficiary met the criteria to receive PCA services and also the recommended hours. Under the District's State Plan Option a beneficiary is eligible to receive up to eight (8) hours per day, seven (7) days per week of PCA services.

#### **3. If the Applicant is Deemed Eligible**

- If the applicant/beneficiary is eligible for services, the LTCSC will contact the provider(s) selected by the beneficiary to confirm acceptance or denial within 24 hours of completing the PCA assessment.

- The LTCSC will communicate the results of the assessment in writing to the beneficiary and/or their authorized representative, the referring physician, and to DHCF.
- The LTCSC and DHCF will coordinate the issuance of prior authorizations for all approved PCA services within 24 hours of completing the assessment and confirmation of acceptance by the Home Health Agency (HHA) selected by the beneficiary. The prior authorization is submitted through OMNICAID or MMIS.
- All PCA services require authorization prior to service delivery and the service must be provided by a HHA appropriately licensed to deliver the service. Each authorization will indicate the amount, frequency, and duration of the service.

#### **4. Initiating PCA Services**

- Once the selected, the HHA receives a prior authorization for PCA service through OMNICAID or MMIS, they are required to complete an admission/intake process which includes a face-to-face meeting to complete an intake assessment and develop an individualized plan of care.
- The individualized plan of care (POC) is developed by a registered nurse and is approved and signed by the beneficiary's physician or an advanced practice registered nurse (APRN) within thirty (30) days of the start of care, provided that the physician or APRN has had a prior relationship with the beneficiary that includes a physical examination.
- A registered nurse will review and update the POC at least every sixty days or more frequently if needed to determine the need to continue services.

#### **5. If the Applicant is Deemed In- Eligible**

If the applicant is found to be in-eligible, the LTCSC will send the beneficiary and or the responsible party a denial letter detailing the appeal rights, within 24-hours of completing the PCA assessment..

#### **Acronyms**

- Department of Health Care Finance - (DHCF)
- Home Health Aide - (HHA)
- Plan of Care - (POC)
- Long-Term Care Supports Contractor - (LTCSC)
- Medicaid Management Information System - (MMIS)
- Personal Care Aide (PCA) Services
- Physicians Order Form - (POF)
- Prior Authorization - (PA)

#### **For more information please contact:**

**Department of Health Care Finance/  
Long Term Care Administration**  
Attn: James Brannum  
441 4<sup>th</sup> Street N.W., Suite 1000S  
Washington, D.C. 20001  
Telephone: (202) 442-5986

**Delmarva Foundation**  
**2029 K Street NW Suite 700**  
**500 K Street, NE, Washington, DC 20006**  
Telephone: (202) 496-6541  
Fax: (202) 698-2075-4979  
Email: [DCLongTermCare@dfmc.org](mailto:DCLongTermCare@dfmc.org)  
Website: <http://dhcf.dfmc.org>

# **ATTACHMENT 5**





*For participants*

## Money Follows the Person. New Choices. New Lives.

**Money Follows the Person (MFP) can help people who live in nursing homes or hospitals to move out and begin a new life in the home of their choice.** It is a demonstration project operated by the D.C. Department of Health Care Finance in partnership with DC's Office on Aging & Aging and Disability Resource Center.

*Who can participate in MFP?*

You can participate in MFP, if:

- ❖ You are eligible for the DC Medicaid Elderly and Physical Disability Home and Community-Based Services waiver
- ❖ You have lived in a nursing home or hospital for at least 90 days
- ❖ You had Medicaid pay for the services you received in the nursing home or hospital in the last month
- ❖ You want to have a choice about where and with whom you live, and
- ❖ You are randomly selected in the lottery for eligible nursing home residents.

*How would participating in MFP help me?*

You would get extra assistance with making choices about how you want to live your life, including:

- ❖ Finding and setting up a new home or modifying your existing home
- ❖ Choosing who you want to live with
- ❖ Choosing service providers
- ❖ Learning about and reconnecting with places to go in your community
- ❖ Improving your quality of life, and
- ❖ Getting the support you need to live more independently like a personal care assistant who will assist you with getting around and preparing meals.

*Who will help me make all these decisions?*

Family, friends, and people who have helped you in the past – like your nurses, doctors and other members of your care team.

*How will I get the help that I need to move and live in the community?*

You and your team will decide what assistance you will need to live in a home or apartment. Services you need at home will be paid for through the DC Medicaid Home and Community-Based Services Waiver and the MFP Demonstration Project. The Medicaid Waiver pays for the help that many people with disabilities need to live at home. MFP also works with the DC Housing Authority to help pay for your housing.

*What other assistance will I get by participating in MFP?*

MFP will provide benefits like the assistance of a Transition Coordinator and MFP Case Manager who will help you with your move, and getting used to your new living situation. MFP will also pay for essential furniture and basic household set-up items like sheets, towels, and kitchenware. After the first year, those benefits will stop, but you will continue to get all of the waiver services you need to live in the community.

**Based on the project's experience in DC, you can expect your move from the nursing home to take 6 months or more. That is the time it takes to line up a place to live, and the services you need to live safely and comfortably at home.**

**Once you are selected through the lottery to leave the nursing home through MFP, you will have important responsibilities to make your move successful.**

**Responsibilities include:**

- ❖ **Getting a community primary care physician**
- ❖ **Sticking to the plan you and your transition team come up with.**

For more information, contact:

**The DC Office on Aging/Aging and Disability Resource Center (ADRC) at 202-724-5626. 500 K Street NE, Washington, DC 20002.**

August 2013



## **Appendix C:**

# **Olmstead Working Group**

DC Center for Independent Living  
DC Coalition on Long Term Care  
DC Department of Behavioral Health  
DC Department of Health  
DC Department of Health Care Finance  
DC Department of Transportation  
DC Department on Disability Services  
DC Developmental Disabilities Council  
DC Housing Authority  
DC Long Term Care Ombudsman Program  
DC Office on Aging  
DC Office on Disability Rights  
DC Quality Trust  
DC Supporting Families Community of Practice  
DC University Center on Developmental Disabilities  
Executive Office of the Mayor  
United Spinal Association  
Washington Legal Clinic for the Homeless

# Appendix D:

## Government Agency Contact Information

For questions about the Olmstead Plan, please contact [olmstead@dc.gov](mailto:olmstead@dc.gov).

### Department of Behavioral Health (DBH)

Phone: (202) 673-7440

TTY: (202) 673-7500

Email: [dbh@dc.gov](mailto:dbh@dc.gov)

### Department of Health (DOH)

[\(202\) 442-5955](tel:(202)442-5955)

TTY: 711

Email: [doh@dc.gov](mailto:doh@dc.gov)

### Department of Health Care Finance (DHCF)

Phone: (202) 442-5988

TTY: 711

Email: [dhcf@dc.gov](mailto:dhcf@dc.gov)

### Department of Human Services (DHS)

Phone: (202) 671-4200

TTY: 711

Email: [dhs@dc.gov](mailto:dhs@dc.gov)

### D.C. Office on Aging (DCOA)

Phone: (202) 724-5622

TTY: (202) 724-8925

Alternate Number: (202) 724-5626

Email: [dcoa@dc.gov](mailto:dcoa@dc.gov)

### Department on Disability Services (DDS)

Phone: (202) 730-1700

TTY: (202) 730-1516

Email: [dds@dc.gov](mailto:dds@dc.gov)

### Office of Disability Rights (ODR)

Phone: (202) 724-5055

TTY: (202) 727-3363

Email: [odr@dc.gov](mailto:odr@dc.gov)

**Office of the State Superintendent for Education (OSSE).**

Phone: (202) 727-6436

TTY: 711

Email: [osse@dc.gov](mailto:osse@dc.gov)

# **APPENDIX E:**

## **Waiver Services for Individuals with Developmental and Intellectual Disabilities (ID/DD)**

### *DAY SERVICES*

#### **Employment Readiness**

Employment Readiness (also known as Prevocational supports) services are designed with the intent to assist persons to learn basic work-related skills necessary to acquire and retain competitive employment based on the person's vocational preferences and abilities. Services include teaching concepts such as following and interpreting instructions; interpersonal skills, including building and maintaining relationships; Communication skills for communicating with supervisors, co-workers, and customers; travel skills; respecting the rights of others and understanding personal rights and responsibilities; decision-making skills and strategies; support for self-determination and self-advocacy; and budgeting and money management. Developing work skills which include, at a minimum, teaching the person the appropriate workplace attire, attitude, and conduct; work ethics; attendance and punctuality; task completion; job safety; attending to personal needs, such as personal hygiene or medication management; and interviewing skills. Services are expected to specifically involve strategies that enhance a person's employability in integrated community settings. Competitive employment or supported employments are considered successful outcomes of Employment Readiness services.

#### **Day Habilitation Services**

Day habilitation services are aimed at developing activities and skills acquisition to support or further integrate community opportunities outside of a person's home and assist the person in developing a full life within the community. Day habilitation services are aimed at developing meaningful adult activities and skills acquisition to: support or further community integration, inclusion, and exploration, improve communication skills; improve or maintain physical, occupational and/or speech and language functional skills; foster independence, self-determination and self-advocacy and autonomy; support people to build and maintain relationships; facilitate the exploration of employment and/or integrated retirement opportunities; help a person achieve valued social roles; and to foster and encourage people on their pathway to community integration, employment and the development of a full life in the person's community. Day habilitation can be provided as a one-to-one service to persons with intense medical/ behavioral supports who require a behavioral support plan or require intensive staffing and supports. Day habilitation services may also be delivered in small group settings at a ratio of one-to-three for people with higher intensity support needs. Small group day habilitation settings must include integrated skills building in the community and support access to the greater community

#### **Individualized Day Supports**

Individualized day supports services provide crucial habilitation supports in the community to ensure that a person's community integration is increased and the particular skills necessary for independence and community involvement outside the home are developed and maintained in ways that enhance community integration outcomes. These services and activities operate totally in the community and are focused on opportunities to increase a person's abilities. All Individualized Day Supports activities must be structured learning based events. Individualized Day Supports can be provided to people who choose to participate in

structured activities in community settings; are transitioning into retirement activities; are interested in volunteerism and community services; or for those who previously participated in a day habilitation service setting and now wish to participate in a smaller and more individualized setting.

### **Supported Employment Services**

Supported employment facilitates competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred, and who, because of the nature and severity of their disability, need ongoing support services in order to perform their job. Supported employment provides assistance such as job coaching, travel training, and customized employment. Supported Employment services can be delivered individually, entrepreneurial or in a small group settings.

## ***RESIDENTIAL SERVICES***

### **Companion Services**

Companion services provide non-medical assistance and supervision to support a person's goals, desires, and needs as identified in the person's Individual Support Plan (ISP), and reflected in his or her Person-Centered Thinking and Discovery tools. Goals may be related to the person's safety, promotion of independence, community integration, and/or retirement. Companion services may be provided in a person's home or in the community.

### **Host Home Services**

Host Home providers enables people to live in the community in a family-type setting that will support them to achieve their goals, participate in community life and activities, maintain their health, and retain or improve skills that are important to them, which may include activities of daily living, money management, travel, recreation, cooking, shopping, use of community resources, community safety, and other adaptive skills they identify that are needed to live in the community.

### **In-Home Support Services**

In-Home Support Service is provided to persons living in their own home or living in their family member's home. In-Home Support services are blended services that provide habilitation, personal care and other support services to the person in their home. These services assist the person to reside successfully in their home as their primary place of residence.

### **Personal Care Services**

Personal Care services are the activities that assist the person with activities of daily living (ADL's) including bathing, transferring, dressing, grooming, and assistance during meals, and assistance with difficulties with incontinence. Personal Care Services through the Waiver is offered an extension through the DC State Medicaid Plan Personal Care services. DC State Medicaid Plan Personal Care services must be exhausted prior to Waiver Personal Care can be used. Personal Care services through the DC State Medicaid Plan and the wavier must be provided by a Home Health Agency.

### **Respite Care Services**

Respite care services are the provision of short-term, temporary relief to those who are caring for family members enrolled in the Waiver. Respite care will ensure that persons will continue to receive services and have access to community activities as described in their ISP/Plan of Care including transportation to and from the activities.

### **Residential Habilitation Services**

Residential Habilitation Service is provided by an agency in a licensed home serving four to six persons that is owned or leased and operated by the agency. Residential Habilitation is a blended service that provides habilitation, personal care, nursing, other residential supports, and transportation to the persons living in the home.

### **Supported Living Services**

Supported Living Service is provided by an agency in a home serving one to three persons. Supported Living is a blended service that covers habilitation, personal care, nursing, and other residential supports. Supported Living services can be provided either with or without transportation. A provider choosing to provide Supported Living services with transportation, must ensure the provision of transportation services are used to gain access to Waiver and other community services and activities for all persons living in the home.

## ***CLINICAL SUPPORTS***

### **Creative Art Therapies**

Creative Art Therapies are professional services which include Art Therapy, Music Therapy, Dance Therapy, or Drama Therapy and are provided by a licensed or certified professional in their respective field of expertise. Art Therapies are intended to help a person to express and understand emotions through artistic expression and the creative process. The service can be used for the treatment of a person's behavioral or physiological health needs, including but not limited to improving self-image; fine and gross motor skill development; increasing communication skill; reducing maladaptive behaviors; and enhancing emotional expression and/ or adjustment. This service can be delivered at the provider's place of business, in a day habilitation program, one's own or family home, or provider operated home. Creative Arts Therapies services are available both as a one-to-one service for a person, and in small-group settings, not to exceed 1:4.

### **Dental**

Dental services under this Waiver are identical to Dental services offered under DC Medicaid State Plan. Dental services for persons enrolled in the Waiver or Intermediary Care Facilities (ICF's) are reimbursed at an enhanced rate if the person requires additional support to successfully complete dental treatment. The Dentist must bill for the enhanced rate when providing services to those enrolled in the Waiver or ICF's. For persons enrolled in the Waiver between the ages of eighteen (18) and twenty-one (21), the DDS Service Coordinator shall ensure that Early and Periodic Screening, Diagnostic and Treatment benefits (EPSDT) are fully utilized and the Waiver service is not replacing or duplicating the service.

### **Behavior Support Services**

Behavioral Support services are preventive and consultative services that focus on long-term behavioral supports to improve and maintain a person's long-term health, attitude, and behavior rather than short-term responses to immediate crises. Behavioral Support services assist to improve the person's independence and inclusion in their community.

### **Family Training Services**

Family Training services provides coaching, consultation and other professional supports services offered to families or unpaid primary caregivers of persons enrolled in the Wavier. The training focuses on how to improve the caregivers support the person or gain a better understanding of the services outlined in the person's ISP/Plan of Care.



### **Skilled Nursing**

Skilled Nursing Services are medical and preventative care activities related to serious or persistent health issues that treat and manage a condition. These services include health assessments and treatment, health related trainings, and education for persons receiving Waiver services and their caregivers. Skilled Nursing Services through the Waiver is offered an extension through the DC State Medicaid Plan. DC State Medicaid Plan Skilled Nursing Services must be exhausted prior to Waiver Skilled Nursing Services can be used. Skilled Nursing Services through the DC State Medicaid Plan and the Waiver must be provided by a Home Health Agency

### **Speech, Hearing and Language Services**

Speech, Hearing and Language services are designed to evaluate and treat people with communicative, hearing, cognitive or swallowing disorders and assist them in achieving the highest level of functioning possible. These services should be provided in accordance with the person's ISP/Plan of Care. All Speech, Hearing and Language Therapy services should be monitored to determine which services are most appropriate to enhance the person's well-being and to meet the therapeutic goals

### **Occupational Therapy Services**

Occupational therapy services are designed for a person to gain independence and promote development of fine, gross, and sensory motor skills, that are needed to function and socialize in their home, work, and community. In the case of an injury or debilitating illness, services focus on rehabilitation, allowing people to return to their daily routines at their highest level of function. All Occupational Therapy services should be monitored to determine which services are most appropriate to enhance the person's well-being and to meet the therapeutic goals. This service is delivered by a licensed practitioner and is delivered in the person's home or day service setting. For persons enrolled in the Waiver between the ages of eighteen (18) and twenty-one (21), the DDS Service Coordinator shall ensure that Early and Periodic Screening, Diagnostic and Treatment benefits (EPSDT) are fully utilized and the Waiver service is not replacing or duplicating the service.

### **Physical Therapy Services**

Physical therapy services are designed to remediate impairments and disabilities that limit a person's physical ability. The services promotes functional mobility and physical abilities, improves quality of life and movement through examination, evaluation, diagnosis and physical intervention to maximize independence, prevent further disability, and maintain health. These services should be provided in accordance with the person's ISP/Plan of Care. All Physical Therapy services should be monitored to determine which services are most appropriate to enhance the person's well-being and to meet the therapeutic goals. This service is delivered by a licensed practitioner and is delivered in the person's home or day service setting. For persons enrolled in the Waiver between the ages of eighteen (18) and twenty-one (21), the DDS Service Coordinator shall ensure that Early and Periodic Screening, Diagnostic and Treatment benefits (EPSDT) are fully utilized and the Waiver service is not replacing or duplicating the service.

### **Wellness Services**

Wellness services are professional services which include Bereavement Counseling, Nutritional Counseling, Fitness Training, Massage Therapy, and Sexuality Education and are provided by a licensed or certified professional in their respective field of expertise. Fitness services can be delivered in small group settings at a ratio of one-to-two for people who want to exercise with a partner. These services assist in increasing persons' independence, participation, emotional wellbeing, and productivity in their home, work, and community. This service can be delivered at the provider's place of business, in a day habilitation program, one's own or family home, or provider operated home.

## *ASSISTIVE SUPPORTS*

### **Environmental Accessibility Adaptations (EAA)**

Environmental accessibility adaptations are adaptations to a home which are necessary to ensure the health, welfare and safety of the person, or which enables the person to function with greater independence in the home, and without which, the person would require institutionalization. Adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing. **Environmental Accessibility Adaptations** cannot increase the square footage of the person's home.

### **One-Time Transitional Services**

One-Time Transitional Services are non-recurring set-up expenses for people who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for their own living expenses. One-Time Transitional Services is limited up to \$5,000 (One-Time). Allowable expenses are those necessary to enable a person to establish a basic household and may include: (a) security deposits; (b) essential household furnishings; (c) set-up fees or deposits for utility or service access; (d) services necessary for the participant's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, arrange for and procure need resources.

### **Personal and Emergency Response Services (PERS)**

A Personal and Emergency Response service is an electronic device that provides access to emergency assistance through a two-way communication system. The system connects to a twenty-four (24) hour operated call center and the person's home. PERS services are available to those who live alone, or who are alone for significant part of the day and have no regular caregiver for extended periods of time, and who otherwise would require extensive routine supervision.

### **Vehicle Modification Services**

Vehicle Modifications services are physical adaptations or modifications to a vehicle, including the installation of a lift or other adaptations. Vehicle modifications can be made to vehicles owned by the person or the person's family, guardian, or other primary care giver that is not compensated through other Waiver support services. Vehicle Modifications are designed to help the person function with greater independence through the use of the adaptation.

# **Appendix F:**

## **Waiver Services for the Elderly and Persons with Physical Disabilities (EPD)**

- Adult Day Health
- Assisted Living
- Case Management
- Chore Aide
- Environmental Accessibilities Adaptations (EAA)
- Home Maker
- Individual-Directed Goods and Services
- Occupational Therapy
- Participant-Directed Community Services (PDCS)
- Personal Care Aide (PCA)
- Personal Emergency Response System (PERS)
- Physical Therapy
- Respite

# **Appendix G:**

## **ADRC Transition Planning Process**

### **1. Referral to Aging and Disability Resource Center (ADRC) for Community Transition Services**

Nursing facility social worker makes a referral to ADRC's Community Transition Program at request of resident and/or legally authorized representative. Upon receipt of the referral, ADRC assigns Transition Coordinator to follow-up with referring social worker to confirm that resident is eligible for transition services. If so, Transition Coordinator schedules appointment to meet with resident at the nursing facility for assessment.

### **2. Assessment/Preference Interview Tool**

Within three business days of establishing contact with the referring social worker, an assessment process is initiated using the Preference Screening Tool (see Attachment 1 in Appendix A), which solicits information about the individual's living preferences in the community, community resources and informal supports available to him/her, and general health needs. The Preference Screening Tool is administered on-site at the facility by the ADRC Transition Coordinator after he/she has reviewed the community transition process with the resident and/or legally authorized representative and a consent form authorizing transition services has been signed by the aforementioned parties.

### **2. Initial Transition Services Checklist & Identifying Transition Needs**

The ADRC Transition Coordinator utilizes an "Initial Transition Services Checklist" to guide the process of gathering all documentation required to advance the community transition process. The Checklist includes items such as: personal identification documents, financial and medical documentation, and applications for transportation services or public housing (see Attachment 1 to this document).

### **3. Decision-Making**

Decisions about the appropriateness of a less restrictive setting are ultimately made by the resident and his or her legally authorized representative. In lieu of a legally authorized representative, a resident may elicit the support and input of family, friends, and/or other chosen supporters who can assist them with making decisions based on recommendations provided by the facility's interdisciplinary treatment team, commonly referred to as the "IDT." The IDT typically consists of the facility's physician, social worker, nurse, dietitian, and physical or occupational therapist.

If a resident, and/or their legally authorized representative disagrees with the IDT's assessment that treatment in a less restrictive setting is inappropriate (given the home and community-based supports for which the individual is eligible), the District's Long-Term Care (LTC) Ombudsman is available to serve as an independent advocate for the resident's position.

### **4. Developing Discharge Plan/Putting Services and Supports in Place**

If a less restrictive setting is determined to be appropriate by the resident and/or legally authorized representative; and housing and sufficient resources to support transition have been identified, the ADRC Transition Coordinator works collaboratively with facility's social worker, and other DC agency partners (DHCF, ESA, DBH, DDS), to secure those resources. These might include: durable medical equipment, behavioral health services, day treatment services, home health services including skilled nursing care and personal care aide services, occupational therapy and physical therapy, and support for seeking

employment. The Transition Coordinator also coordinates with the resident's informal supports when applicable (i.e. faith-based groups, family members, social clubs, and neighbors, as identified by the resident as key supporters).

#### **5. Discharge and Transition to the Community**

When the resident and/or legally authorized representative and IDT have collectively determined that all necessary supports and services have been put in place, the nursing facility's social worker convenes discharge planning meetings to schedule the resident's date of discharge and to finalize plans to ensure treatment in a less restrictive setting is safe for the individual.

Once the resident has been successfully transitioned back to the community, there are a number of options for ongoing case management services through the District's EPD Waiver program, ADRC's Money Follows the Person Demonstration, and the DCOA's Senior Service Network.

# **ATTACHMENT 1**

## Transition Checklist

Date: \_\_/\_\_/\_\_/

Participant: \_\_\_\_\_

Nursing Home: \_\_\_\_\_

DOB: \_\_\_\_\_

Age: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Present (include name, title, phone # and email address in place of business cards):

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	Need	Pending	Have	Notes
Income				
SS Card				
Birth Certificate				
Photo ID:				
DMV				
DHS				
Military				
Income Statement				
Housing Application				
Housing				
MetroAccess				
Primary Care Doctor				
PT/OT				
Pharmacy				
Medicaid Card				
Medicare Card				
Medicare Part D Enrollment (must enroll online at medicare.gov or by calling 800-Medicare)				
Prescriptions				
Narcotics				
Waiver Waitlist				
Waiver Provider				
LOC				
DME:				
Standard Hospital Bed				
Bariatric Hospital				

Bed				
Hoyer Lift				
Trapeze Bar				
Gel Mattress Overlay				
Air Mattress				
Overbed Table (not covered by Medicaid)				
Motorized WC				
Manual WC				
Transport WC				
Geri-Chair				
Gait Belt				
Scooter (Medicare only)				
Shower Chair				
Commode				
Combination shower chair/commode				
Lift Chair (motorized recliner)				
Raised Toilet Seat				
Walker				
Rollator				
Grabber/Reacher				
Urinal/Bedpan				
Supplies:				
Diapers				
Wipes				
Gloves				
Chuxs				
Syringes				
Glucometer				
Catheters				
PASRR				
Psychiatric Evaluation				
Legal Guardian				
Payee (must have a mental illness)				
Psychiatric Day Treatment Program				
Substance Abuse Evaluation				
Substance Abuse Treatment Program				
Senior Wellness				



Program				
Job Training Program				
Furniture				
Household Items				
Food				
Rental Assistance:				
Application Fee				
First Month Rent				
Security Deposit				
Ramps/Lifts:				
Portable				
Modular				
Stair Lift				
Elevator Lift				
Eye Glasses				
Hearing Aid				
Prosthetic Limbs				
Community Map				
Contact List				
QOL				
Cell Phone				
Home Phone				
Bank Account				
PERS				
Moving Assistance				
Discharge Summary				
Discharge Meds				
Discharge Transportation				
Patient Relocation Form				

# Appendix H:

## District of Columbia *No Wrong Door* System

The District envisions a user-friendly No Wrong Door (NWD) system that is designed for all people with disabilities, older adults, and their families/caregivers to have easy access to a full range of integrated long-term services and supports (LTSS) that is culturally and linguistically appropriate and competent, and tailored and responsive to all cultures. The NWD system will assist all people with disabilities and older adults to live their lives in dignity, maintain their independence long as possible in their homes, and remain fully included members of their communities.

### Mission Statement

The District will create a network comprised of government and non-profit organizations that will engage in person and family/caregiver-centered planning and provide responsive and comprehensive information about and referrals for LTSS. The information received will enable people with disabilities, older adults, and their families/caregivers to make informed choices regarding the LTSS they prefer and need in order to live with dignity in their homes and be fully included in their communities.

### Outcomes

- Access to LTSS will be streamlined by developing and implementing a single application process that is easy to use, available in multiple languages, and linked to the full range of LTSS across agencies and programs available in the District.
- The application process will result in increased awareness about the LTSS options available in the District, and provide people with disabilities, older adults, and their families/caregivers with reliable information about LTSS from government agencies and/or non-profit organizations they trust.
- LTSS planning will be person and family/caregiver-centered, culturally and linguistically competent, and focused on identifying what is important to and for each person who needs LTSS and their families/caregivers. The goal of person and family-centered LTSS planning is to enable all people with disabilities and older adults to live in their homes with dignity and be fully included in their communities.
- All people with disabilities, older adults, and their families will have streamlined access to integrated LTSS that are a blend of family/informal supports, community, and paid services that support dignity, independence, and community inclusion.
- The District's No Wrong Door system will promote and embody the principles of person-centeredness, self-determination, cultural and linguistic competency, and accessibility.

### Goals

To accomplish the vision and mission, the District of Columbia's No Wrong Door system will:

- Offer one-on-one person- and family/caregiver-centered counseling that provides all people with disabilities and older adults access to LTSS based upon what is important to and for them

and their families/caregivers;

- Be responsive to the cultural preferences, needs, and the diverse languages spoken by people with disabilities, older adults, and their families/caregivers who reside in the District; and
- Offer excellent customer service.

### Objectives

The District of Columbia's No Wrong Door system will:

- Be easy to access, use, and understand;
- Be responsive to all ages and disability groups;
- Connect people to desired services and supports regardless of where they start seeking services;
- Respond to a person's stated and assessed preferences and needs through either the provision of direct services or linkages to other appropriate community-based, private and/or public services and supports;
- Use uniform methods to collect and/or summarize intake, assessment, and planning information that provides for streamlined application and eligibility processes for all public LTSS;
- Use consistent person-centered approaches;
- Coordinate comprehensive information, referral, and assistance to support informed choice;
- Support knowledgeable, well-trained, respectful, and culturally and linguistically competent staff.
- Support people to live with dignity in their homes, with the services they prefer and need to live as independently as possible and be fully included in all aspects of their communities;
- Be fiscally responsible and efficient and ensure all sources of services and support are offered and accessed to their fullest capacity; and,
- Link people with community-based LTSS through a coordinated and comprehensive network of public and private supports.

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<sup>i</sup> See endnote ii for a definition of supported decision making.

<sup>ii</sup> 2013 American Community Survey (ACS), U.S. Bureau of the Census.

<sup>iii</sup> John Butterworth *et al.*, StateData: The National Report on Employment Services and Outcomes (Institute for Community Inclusion (UCEDD) University of Massachusetts Boston 2014).

<sup>iv</sup> Data provided by the DC Department on Employment Services

<sup>v</sup> DHS assesses the following categories of disability: "Alcohol Abuse," "Drug Abuse," "Both Alcohol and Drug Abuse," "Chronic Health Condition," "Developmental," "HIV/AIDS," "Mental Health Problem," and "Physical."

<sup>vi</sup> Healthy People 2020, Disability and Health, available on-line at:

<http://healthypeople.gov/2020/TopicsObjectives2020/overview.aspx?topicid=9>

<sup>vii</sup> <http://www.nationalcoreindicators.org/states/DC/>.

<sup>viii</sup> "District of Columbia Primary Service Agency Priorities," DC—One Community for All pp. 8-9 (April 2012).

Available at:

[http://odr.dc.gov/sites/default/files/dc/sites/odr/publication/attachments/olmstead\\_community\\_integration\\_initiative.pdf](http://odr.dc.gov/sites/default/files/dc/sites/odr/publication/attachments/olmstead_community_integration_initiative.pdf).

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<sup>ix</sup> There are estimated to be 10,000 persons in the District who have developmental disabilities including; autism spectrum disorders, Spina Bifida, cerebral palsy, Down's Syndrome, Prader Willi Syndrome, borderline intellectual deficits, epilepsy, and other neurological disabilities. See Assessment and Analysis of the Service Needs of Washington, D.C. Residents with Intellectual and Developmental Disabilities, June 2011; available online at <http://ddc.dc.gov/sites/default/files/dc/sites/ddc/publication/attachments/FinalReportSupportNeedsDCResidents.pdf>

