**Quarterly Olmstead Community Integration Summary**

1. **Report For: 1st** Quarter 2016
2. **Prepared By: DCOA**
3. **Date Submitted: May 1, 2016**

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| **Community Integration (Olmstead Plan)**  **Coordinator** | **Agency Leadership** |
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| **Number of PEOPLe to be Moved to Community Services**  **GOAL** | **Descrip-tion** | **CY1**  **(Jan-Mar) Progress** | **% of Annual Goal CY1** | **CY2**  **(Apr-Jun)**  **Prog.** | **% of Annual Goal CY2** | **CY3**  **(Jul-Sep)**  **Prog.** | **% of Annual Goal CY3** | **CY 4**  **(Oct- Dec)**  **Prog.** | **% of Annual Goal CY4** | **Total Progress** | **Total % of Annual Goal** |
| **45** | **Total transitions from institutional LTC settings (following at least 90 days in a NF)** | **15** | **33.3%** | **\_\_\_** | **%** | **\_\_\_** | **%** | **\_\_** | **%** | **\_\_\_** | **%** |
| 35 | Transitions completed through MFP Demonstration | 12 | 34.3% |  |  |  |  |  |  |  |  |
| 10 | Transitions completed with people who are not eligible for MFP | 3 | 30% |  |  |  |  |  |  |  |  |
| **200** | **Consultations to support transition planning** | **63** | **31.5%** |  |  |  |  |  |  |  |  |
| 100 | Consults to assist with hospital discharges | 7 | 7% |  |  |  |  |  |  |  |  |
| 100 | Consults to assist with transitions from nursing homes into community  (NF stays under 90 days) | 56 | 56% |  |  |  |  |  |  |  |  |

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| **Quantitative Goal Progress**  **Qualitative Goal Progress** | **Narrative here explains number above and also details barriers faced or programmatic shifts within the agency or DC gov that affect numerical transitions either positively or negatively.**  **Transitions from institutional settings**  DCOA’s Community Transition Team has an annual goal of assisting at least 35 people who are eligible for the Money Follows the Person (MFP) demonstration in transitioning from a nursing facility back into a community-based setting. Eligibility requirements include the person:   * currently resides in a Qualified Institution (hospital or a nursing facility) and has resided for a period of not less than 90 days, * will be eligible for the EPD Waiver upon discharge, including Level of Care, financial eligibility (300% of Federal Poverty Level or can spend down to this level), and age (18+ years old with a disability) * is receiving federal Medicaid benefits for inpatient services furnished by a Qualified Institution for at least one day before the transition to Medicaid Home and Community Based Services.   DCOA’s Community Transitions Team also assists people requesting assistance with transitions who have been in a nursing facility at least 90 days, but are not eligible for the EPD Waiver either due to level of care, and/or financial eligibility. DCOA has a goal of assisting at least 10 people with transitioning into the community regardless of whether they qualify for the EPD Waiver. Non-EPD Waiver beneficiaries are also considered “non-MFP transitions” for this report.  During the months of January to March 2016 (Quarter 1), DCOA assisted 15 people with community transitions. Twelve (12) people were eligible for MFP, and 3 were considered non-MFP, as described above. At the close of Quarter 1, DCOA had reached 33.3% of its community transition goal.  **Consultations to support transitions planning**  DCOA’s Community Transition, Social Work, and Information and Referral/Assistance teams further assist with community transitions by providing consultation (discussion of long term care options, information, and assistance) on both nursing home transitions and hospital discharges. DCOA has an annual goal of offering transition consultation assistance to at least 200 inquirers, including DC residents, caregivers, family members, professionals, and other stakeholders.  During the months of January to March 2016 (Quarter 1), DCOA provided 56 consultations to or regarding people in nursing facilities, with stays under 90 days (did not meet eligibility requirements for DCOA Community Transitions); and 7 consultations to or regarding people experiencing any length of hospital stay, seeking assistance with hospital discharge.  DCOA received fewer inquiries about hospital discharge than anticipated, potentially due to a meeting with hospital social workers, administrators, DC Department of Health and the DC Hospital Association in March 2016, to explain DCOA’s shift from offering a hospital discharge program in which two DCOA social workers took on caseloads of very complex hospital discharge clients, to consultant-only assistance with discharges. This shift was a result of federal funding ending for DCOA’s Hospital Discharge program. In 2016, DCOA will work collaboratively on a discharge manual with hospitals, nursing facilities and other DC agencies to ensure we are using the most streamlined process for discharges; stakeholders are educated on the home and community based services available; and the work group is identifying and seeking solutions for any service gaps at the District level (see below for more information).  As of the close of Quarter 1, DCOA reached 31.5% of its transition consultation goal.  **Narrative here provides descriptions of agency programs, initiatives, and services designed to foster community integration. Agencies should organize narrative under the following headings with the 9 priorities of the 2016 Plan in mind.**  The following responses include priority areas on which DCOA is one of the primary agencies responsible:  **Quality of Institutional and Community-Based Providers**  **Assess and reduce duplication of services offered by Medicaid and DCOA.**  This quarter, DCOA began work on streamlining Case Management for older adults and people with disabilities by analyzing the similarities and differences among the three main types of case management used by our key populations:   * DCOA-funded case management provided by our grantees in the Senior Service Network to older adults (ages 60 and over); * DCOA-funded case management provided by ADRC social workers to DC residents with disabilities (ages 18-59 years); and * Medicaid-funded EPD Waiver case management provided to both older adults and people with disabilities who meet the level of care and financial eligibility for the EPD Waiver.   DCOA initiated a conversation about streamlining the different types of case management with DHCF’s Medicaid Director, Long Term Care Administration Director, EPD Waiver Director, and other DHCF staff members to develop ideas on how best to provide streamlined case management services without duplicating effort and funds. One of the key areas of focus for both agencies over the past six months, is assisting DCOA’s lead agencies in building on their current responsibility of Older American’s Act/DCOA-funded case management, to include case management of EPD Waiver beneficiaries.  This would require that each lead agency (DCOA grantees) become a Medicaid case management provider, which would significantly increase the number of high quality EPD case management agencies in the District; and help streamline DC residents’ transition from DCOA-funded case management for older adults with a lower level of care, to Medicaid-funded EPD Waiver case management for older adults with a higher level of care. This would allow DC residents to stay with the same case management agency after enrollment in the EPD Waiver if they choose, instead of switching to a new agency and case manager.  DCOA also initiated conversations with four states that have successfully streamlined Older American’s Act and Medicaid-funded case management: Alabama, Massachusetts, Ohio, and Oklahoma. The focus of each discussion included implementing a data base that captured both funding sources and allowed multiple agencies to interact; sharing information on service plans; inter-agency collaboration; the history and implementation processes for each state; and general tips on how to make it work. DCOA expects to use this information to help update our internal and external case management processes, to enhance the No Wrong Door intake and data sharing discussion, and to continue work with DHCF and DDS on developing a new database.  **Create a customer satisfaction survey to cover the five components of quality described above.**  DCOA shared its current customer satisfaction survey with the director of the Office of Disability Rights this quarter. Next quarter DCOA expects to work collaboratively with the Olmstead workgroup to review each agency’s customer satisfaction survey, ascertain similarities and differences, and craft a new survey that covers the Olmstead report’s five key components of quality.  **Housing:**  **Implement environmental accessibility program to fund expedited housing adaptations up to $10,000 per person**  In fiscal year 2016, DCOA partnered with the Department of Housing and Community Development to create Safe at Home, a program that promotes aging in place for older adults (60 years and older) and people with disabilities (between 18 and 59 years old) by offering home accessibility grants to reduce the risk of falls and reduce barriers that limit mobility. Each eligible household receives a falls assessment, in-home evaluation by an occupational therapist, and may receive a grant of up to $10,000, paid directly to the contractor and/or occupational therapist, to cover recommended equipment and labor costs.  Safe at Home began operating on January 4, 2016. During the first three months of the program’s operation, Safe at Home received 607 referrals to the program. Of those, 242 people completed the intake process over the phone. To complete enrollment, individuals must submit supporting documentation. Ninety-eight people completed enrollment. Of those enrolled, 50 people have completed an in-home assessment with an Occupational Therapist in the reporting period. Construction has been completed in 18 projects and are waiting a final occupational therapist review. By the end of March 2016, a total of 11 projects were completed and reviewed by an occupational therapist. The average number days between the date of the initial occupational therapist assessment visit and the occupational therapist final review of completed project is approximately 18 days.  **Determine methodology to evaluate housing needs for individuals who have been referred to the ADRC because they want to live in the community.**  ADRC is currently evaluating how best to track the referrals requesting housing assistance.  **Wellness and Quality of Life**  **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**  DCOA has commissioned a needs assessment and feasibility study for wellness activities in all 8 wards for fiscal year 2016. DCOA is also working with DPR on expanding wellness activities at DPR recreational centers.  **Assess and align the capacity of transportation providers to support the transportation needs of people with disabilities**  DCOA has led the Transportation Collective, which is comprised of the DDOT, WMATA, DCTC, DHCF, and DCOA. The Transportation Collective gathered information on each type of transportation program for seniors and people with disabilities. Collectively, the District will allocate $63 million for transportation for seniors and people with disabilities in fiscal year 2017. The District will continue to evaluate how to improve information and access, while making sure the District is paying only once for transportation services.  **Intake, Enrollment, and Discharge**  **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**  In January 2016 DCOA initiated a meeting with the Director of the DC Department of Health, and in March 2016, DCOA initiated a meeting with hospital social workers, administrators, DC Department of Health, and the DC Hospital Association to explain DCOA’s shift from offering a hospital discharge program to discharge consultation. Previously funded by a federal grant, DCOA had two DCOA social workers with caseloads of very complex hospital discharge cases. However, when the federal grant ended, DCOA shifted to assisting hospital discharge social workers with accessing home and community based services for their clients; knowing what local supports are available; and assisting with referrals to lead agency or DCOA social workers after a discharge was complete as part of their discharge plan.  Also discussed at the meeting was whether participants would be interested in attending future meetings on developing a manual on home and community-based services and supports specifically for hospital and nursing facility social workers. The idea received a very positive response and participants agreed that this process would help streamline their work and highlight service gaps in DC. Therefore, it is important to have representation from all of DC’s health and human service agencies: DCOA, DHCF, DDS, DBH, DHS, DOH, and OVA.  Next steps for DCOA include introducing the idea to the Olmstead workgroup, No Wrong Door Leadership Council, and Interagency Council on Homelessness, then convening a kick-off meeting including representatives from DC health and human service agencies, hospitals, and nursing facilities. |