**Quarterly Olmstead Community Integration Summary**

1. **Report For:** October - December 2014
2. **Prepared By:** DCOA
3. **Date Re-Submitted: January 20, 2015**

**Agency Analysis**

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| **Community Integration (Olmstead Plan)**  **Coordinator** | **Agency Leadership** |
| Sara Tribe | Dr. John Thompson |

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| **Number of Persons to be Moved to Community Services** | **Quarterly Progress** | **Percentage of Agency Goal Met** |
| 160 | 44 | 27.5% |

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| **AGENCY GOAL TYPE** | **NARRATIVE** |
| **Quantitative Goal Progress** | During the months of October to December 2015, DCOA transitioned 32 people from the hospital to home, and 12 people from nursing facilities to home.  DCOA has expanded access to community-based long-term supports for individuals in the community 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 “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 the 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 whofacilities meetings with individuals, and/or families interested in transitioning.  An ADRC Transition Care Specialist prescreens customers for eligibility, informs individuals about the Elderly and Persons with Disabilities (EPD) Waiver, and provides transition assistance through options counseling with individuals to create a person centered action plan that maps out the services and provides guidance of community resources to ensure a successful transition back into the community. |
| **Qualitative Goal Progress** | **Integration**  Over the past two years DCOA has developed and strengthened its Nursing Home Transition and Hospital Discharge teams by developing standard operating procedures, and increasing its presence in the community. Within the first quarter of FY15 DCOA further strengthened the community transition effort with the addition of five Money Follows the Person (MFP) staff who relocated from the Department of Health Care Finance (DHCF) to DCOA. The five new MFP staff members include one Program Coordinator, three Transition Coordinators, and one Management Assistant. The combined Nursing Home Transition and MFP teams have been renamed the “Community Transition Team”; their intake and referral procedure has been streamlined; and standard operating procedures are in the process of being updated. With full support from both DCOA and DHCF, the MFP team experienced a 40% increase in nursing facility discharges in CY15.  **Outreach**  DCOA’s community outreach specialist currently conducts weekly outreach events in long-term care facilities and community events to educate families and the public about transitional and supportive services able to District of Columbia residents.  To expand and improve outreach efforts, DCOA’s ADRC is working closely with DCOA’s External Affairs department to improve all ADRC outreach materials. Once completed, ADRC staff will conduct expanded outreach efforts to each nursing facility, hospital, lead agency, and other stakeholders to ensure that District-wide professionals and the public are aware of the scope and resources offered by the ADRC’s Community Transition Team.  **Interagency Collaboration & Cross-Training**  DCOA is working toward improving disability awareness among its staff by:   1. Scheduling two initial meetings on January 27 and January 29, with disability, Mental/Behavioral Health, and I/DD sister agencies/organizations: DDS, ODR, RSA, DBH, and the DC Center for Independent Living. 2. Working with these organizations to improve partnership, plan cross-trainings, gain input from stakeholders, and obtain suggestions for creating an ADRC Advisory Committee. 3. Building an active ADRC Advisory Committee which meets quarterly, has program-specific sub-committees/workgroups, and can provide ongoing stakeholder engagement and input into ADRC inclusion of both aging and disability awareness in its practices and programs.   **Person-Centered Planning and New Intake Procedure**  DCOA is working with the Department of Healthcare Finance (DHCF) and DHS/ESA to reengineer the intake and access system for the Elderly and Persons with Disability Waiver and other Long-term care services. The agencies have spent several months updating the LTC business practices to ensure a person-centered approach in which DCOA staff members assist DC residents in accessing both Medicaid and non-Medicaid services starting with the initial contact through DCOA’s Information and Referral/Assistance Unit. DCOA aims to improve the person-centered process of enrollment in Medicaid programs, while also helping residents to gain a better understanding of the full picture of DC resources offered.  **Long Term Care Resources**  DCOA promotes awareness of long-term supports by providing Information and Referral/Assistance, Options Counseling/ person-centered transition support, streamlined eligibility determination/assistance, eight ADRC sites co-located with District-wide lead agencies, and in collaboration with other DC human service agencies (DHCF, DDS, DBH, OVA, DHS) aims to be one of several No Wrong Door entry points for long-term services and supports in the District. To this end, DCOA has published a Long-term Guide and is currently working on translating it into several languages both for publication and for posting on DCOA’s website. The English version of the Long Term Care Guide has been distributed to key organizations across the District and at many outreach events. |