



Olmstead
DC-One Community for All
Calendar Year 2015 Annual Summary

For Calendar Year (CY) 2015, the District of Columbia Olmstead Plan and Addendum outlined the following goals:

1. The District committed to helping individuals, families, and nursing facilities understand the availability and accessibility of home- and community-based services and supports.
2. The District continued to provide a person-centered approach to assess and facilitate an individual's desire and ability to transition from the nursing facility to the community, leading to the successful transitions outlined in this report.
3. The District reviewed its current informational materials on long-term services and supports and produced new materials for 2016, including materials for nursing facilities to provide to residents on home- and community-based care options.
4. The District reviewed its current training processes through the Olmstead Working Group, and tasked the Working Group to come up with a Customer Satisfaction Survey to better evaluate these trainings and processes in 2016.
5. In 2015, the District evaluated the need for a prioritization process for the Elderly and Persons with Physical Disabilities (EPD) Waiver with interested stakeholders. In 2016, the District will adopt a waiting list policy for the EPD Waiver, which will be developed with interested stakeholders.
6. The District collected and reported 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).



DC OFFICE ON AGING (DCOA)

DCOA Quantitative Progress Summary

DCOA transitioned forty-nine (49) consumers into the community. This number includes discharges from nursing homes, hospitals, and long-term care facilities.

- ✚ The *Money Follows the Person* (MFP) program transitioned thirty-seven (37) residents back into the community, surpassing its goal by seven (7) people, and achieving one hundred twenty three percent (123%) of the goal. Non-MFP nursing facility transitions were lower than expected, and reached forty (40%) of the goal (twelve transitions). This variance was largely due to a lower than expected referral rate of non-MFP community transition referrals.
- ✚ The hospital discharge numbers were also lower than expected in 2015 due to a programmatic shift from direct service to consultant service on hospital discharges. DCOA offered direct assistance with hospital discharges to ten (10) clients and hospital discharge consultation to seventeen (17) clients (personally, or through their hospital discharge planner, family member, or caregiver). This programmatic change is addressed in more detail below.
- ✚ DCOA's efforts were in large part steered by the Aging and Disability Resource Center's (ARDC) Community Transition Team. This team includes fifteen (15) Transition Care professionals, responsible for prescreening customers for program eligibility; informing individuals about the Elderly and Persons with Physical Disabilities (EPD) Waiver; assisting them with enrollment if needed; and conducting options counseling with individuals to create a person-centered action plan that maps out the services and provides guidance on community resources to ensure a successful transition.

DCOA Qualitative Progress Summary

- ✚ DCOA has improved access to community-based long-term supports for DC residents through a memorandum of understanding (MOU) with the Department of Health Care Finance (DHCF).
- ✚ The MOU resulted in the creation of a new Medicaid Enrollment Team, created to improve customer service and decrease wait times for waiver enrollment, based at DCOA and funded by DHCF. To staff the new team, DCOA hired seven (7) new staff members who started in May 2015, including: five (5) Medicaid Enrollment Specialists, one (1) Medicaid Lead, and one (1) Community Social Work Supervisor, to take over pre-

eligibility enrollment activities formerly tasked to the Elderly and Persons with Disabilities (EPD) Case Management Agencies, also DHCF providers.

- ✚ DCOA continued to work with DHCF to finalize the enrollment procedure for Adult Day Health Program (ADHP) services, including people on home and community based waivers (EPD and IDD). The ADRC was tasked by DHCF with completing Person Centered Plans for one hundred one (101) District residents prior to the end of 2015, to ensure that these Medicaid beneficiaries were able to continue attending their Medicaid-Funded ADHP in 2016. Each of the residents was contacted by ADRC staff, in-person visits were completed, and required documentation was submitted to the DHCF by close of business on 12/31/15. Thirteen (13) of the referred residents decided they were no longer interested in attending ADHP. Since the summer of 2015, ADRC has been working closely with the DHCF to create an efficient ADHP enrollment process so DC residents receiving State Plan Medicaid who request, and are eligible for ADHP services, are able to enroll in a timely manner. Continuing into 2016, ADRC will work with DHCF on providing accurate information about this program and enrollment process to ADHP providers, ADRC staff, DCOA's Senior Service Network, members of the public, and other key stakeholders.
- ✚ DCOA continued to collaborate and partner with the Veterans Administration (VA) Medical Center and VA Resource Center to assist D.C. veterans who are over 65 years old and/or have physical disabilities, in accessing person-centered, home and community-based services and supports. The ADRC team assists VA residents to connect to Friendship Place, a Veterans First Program; and Volunteers of America to seek housing placement, as well as other home and community-based services and supports.
- ✚ Additional DCOA partnerships that ADRC transition staff work closely with to ensure safe and successful transitions include: Washington Hospital Center Mental Health, Psychiatric Institute of Washington, Adult Protective Services, and several of DCOA's grantees, Lead Agencies in each of DC's 8 Wards: Terrific Inc. (Wards 1, 2, 4), Seabury (Wards 5 and 6), Iona Senior Services (Ward 3), East of the River Family Strengthening Collaborative (Ward 7), and Family Matters of Greater Washington (Ward 8). Other key community organizations that frequently assist the transition process include: the Medical House Calls Program, Home Care Partners, Living at Home Consultation, LLC., Legal Counsel for the Elderly, D.C. LTC Ombudsman Program, and the Health Care Ombudsman and Bill of Rights program located at DHCF.
- ✚ DCOA trained Transition Coordinators on a flexible community-based model, including co-location with lead agencies in each of the 8 wards of the District. The ADRC social workers have continued conducting transition coordination activities at DCOA lead agencies to improve service delivery, proximity to clients, and community-based services access to older adults and people with disabilities.. This move has expanded DCOA's scope, collaboration with community partners, and communication among organizations, ultimately benefitting DC residents. .

- ✚ Person-Centered planning is central to DCOA's efforts to transition people from institutional settings back into the community. DCOA staff have been trained to provide person-centered options counseling when assisting DC residents in understanding their long-term care options. To improve our practice and collaborate on person-centered practices, DCOA is currently partnering with other DC health and human service agencies (DDS, DBH, DHCF, DOH, DHS, and the OVA), in developing and implementing a No Wrong Door (NWD) system of access to Long Term Care Services and Support for all population and all payers. Over 20 of DCOA's front line staff and managers will be trained in the District-wide Person-Centered Counseling training in FY16, funded by the No Wrong Door initiative.
- ✚ As part of its work on the person-centered work group, DCOA conducted three (3) focus groups in August and September, 2015, to help gain insight on our intake/referrals process from the perspective of older adults and people with disabilities who have contacted DCOA for services/supports. ADRC staff also asked focus group attendees for feedback on ADRC's outreach materials to ensure that the language and design was accessible and inviting to both older adults and people with disabilities.
- ✚ DC has committed through the Olmstead and *No Wrong Door* initiatives to convene a workgroup of DC health and human services agencies (including DCOA), and hospital and nursing facility staff, to create a home and community based services manual primarily for training hospital and nursing facility staff on the many services and supports available in the community, eligibility requirements, and how best to access them. DCOA expects to participate extensively in the development of this manual.
- ✚ With the aim of improving the accuracy and content of ADRC outreach materials, DCOA hired a consultant, Campbell and Company, to update ADRC outreach materials (ADRC logo, program flyers, and an ADRC tri-fold). DCOA staff also developed a basic DCOA training to ensure that all DCOA staff, external partners, community residents, and other key stakeholders receive current, clear, and consistent information about DCOA. To achieve this, ADRC led bi-weekly strategic marketing meetings which helped create a work plan for Campbell and Company.



DEPARTMENT OF DISABILITY SERVICES (DDS)

DDS Quantitative Progress Summary

DDS transitioned one (1) person from an Intermediate Care Facility to community-based residential supports and transitioned two hundred three (203) people who were receiving day services in solely congregate settings to receive day supports in the community.

DDS Qualitative Progress Summary

- ✚ DDS conducted twenty-four (24) outreach activities to inform people with intellectual and developmental disabilities (IDD), their families, advocates, providers, and other governmental agencies about community-based support options.
- ✚ DDS increased the number of qualified service providers by six (6) in an effort to decrease service gaps.
- ✚ DDS worked with Department of Healthcare Finance (DHCF) to submit waiver amendments to the Centers for Medicare and Medicaid Services on February 28, 2015 that created greater opportunities for community integration, including the development of small group day habilitation services and companion services, as well as changes to a number of service definitions to specifically include community exploration, inclusion and integration. The waiver amendments were approved on September 24, 2015.
- ✚ DDS developed assessment tools for guided discussions around employment exploration and most integrated day and vocational services. The implementing policy and procedure are effective as of June 1, 2015.
- ✚ DDS met with stakeholders to revise the day and vocational supports waiver regulations to make changes to infuse person-centered thinking principles and ensure opportunities for community integration and employment discovery. DDS worked with DHCF to publish regulations for day habilitation and individualized day supports in October 2015; employment readiness in December 2015; and supported employment in January 2016.
- ✚ DDS provided training for its own staff and day and vocational provider organizations on the development of customized employment Positive Personal Profiles and Job Search and Community Participation Plans. Trainings took place in March and April 2015. DDS also created an on-line Discovery Toolkit, available at: <http://dds.dc.gov/page/discovery-toolkit>.
- ✚ DDS provided training and technical support to facility-based day and employment readiness programs to improve the quality of those programs and to help those providers plan for future business models that support community integrated services. That training and technical assistance kicked off in March 2015 and continued through September 2015.



DEPARTMENT OF BEHAVIORAL HEALTH (DBH)

DBH Quantitative Progress Summary

DBH transitioned ninety nine (99) consumers into the community. This number includes individuals with a length of stay of 187 days or more were transitioned back to the community from Saint Elizabeths Hospital, as well as youth who were discharged/transferred from Psychiatric Resident Treatment Facility (PRTF) placements.

DBH Qualitative Progress Summary

- ✚ In its efforts to assist individuals who are transitioning from Saint Elizabeth's Hospital (SEH) to community living, DBH hired and trained eight (8) consumers of DBH services to work as Transition Specialists/Peer Specialists. These Transition Specialists utilize their training and lived experience to assist the individuals in care at SEH in making a smooth transition back to community living.
- ✚ DBH also had in-services for the summer class of the Peer Specialist Certification Training (PSCT). These individuals, once certified will provide peer support to other consumers of behavioral health services in their efforts to live successfully in the communities of their choice. The PSCT began on June 29, 2015 and eighteen (18) individuals, including family members of children and youth in the DBH system, were certified as Peer Specialists in September.
- ✚ To support community integration of individuals discharged from institutions, DBH collaborates with other District agencies to offer a session called *Family Talk*, which informs parents of PRTF treatment, discharge and community based services. These sessions are supported by numerous agencies (including DCPS, DYRS, OSSE, CFSA, and DHCF).
- ✚ As part of its outreach efforts to the community, DBH, in collaboration with the D.C. Office of Disability Rights (ODR), hosted the Annual Olmstead/Community Integration Conference. Since May is Mental Health Awareness Month, this Conference was held on May 28, 2015. DBH reached at least one hundred (100) consumers informing them of the myriad of community services/events available to enhance their quality of life and support successful community living. Also, in September, in recognition of National Recovery Month, DBH sponsored a community conference to support recovery. Approximately eight five (85) individuals attended this conference to share their stories of recovery and to support others who are struggling with their recovery efforts.
- ✚ DBH works with several community groups such as the Consumer Action Network (CAN), National Alliance on Mental Illness (NAMI-DC), and the Total Family Care

Coalition (TFCC), to provide information on services and supports available through the DBH network of care.



DEPARTMENT OF HEALTHCARE FINANCE (DHCF)

DHCF Quantitative Progress Summary

DHCF transitioned thirty two (32) consumers into the community. This number reflects transitions based on claims data from nursing facilities, rehabilitative facilities and hospitals and home and community-based Personal Care Aide (PCA) service providers. The figure includes all beneficiaries who started PCA services within 60 days of discharge from a nursing facility or hospital after a stay of at least 90 days. These individuals did not receive transition services from the DC Office on Aging.

DHCF Qualitative Progress Summary

- ✚ DHCF convened sixteen (16) meetings for its Intellectual and Developmental Disabilities (IDD) Waiver Program and Medicaid State Plan home and community-based services providers (i.e., Adult Day Health providers and home health agencies) in 2015. Meetings ranged from sessions for providers on policy and practice to trainings on person-centered planning.
- ✚ In keeping with the federal HCBS requirement for person-centered planning, DHCF provided seven (7) trainings to staff and providers who provide and support LTSS services. Trainings were focused on case managers, EPD waiver providers, adult day health providers, DHCF's long term care services and supports contractor Delmarva, the ADRC, and DHCF staff.
- ✚ DHCF finalized work with nursing facilities on the admission process and update of the Pre-Admission Screening and Resident Review (PASRR). DHCF has also worked with nursing facilities to streamline the discharge process to ensure that individuals who are being discharged from nursing facilities to the community have LTSS services in place on day one.
- ✚ DHCF increased funding to support the ADRC's role in providing application assistance and choice counseling to individuals seeking access to Medicaid funded HCBS services.
- ✚ DHCF conducted multiple training for ADRC staff on LTC eligibility and case processing.
- ✚ In collaboration with DCOA's ARDC, DHCF convened monthly meetings with the *Money Follows the Person* (MFP) stakeholder Advisory Commission. With feedback

from the stakeholders and key government partners, the MFP Sustainability Plan was submitted to CMS on April 30, 2015; and the plan was accepted by CMS on July 1, 2015. It includes funding for implementation of the Demonstration's transition coordination activities at the DCOA/ADRC through December 31, 2018, and the allocation of rebalancing funds to support nursing facility residents transitioning to Medicaid State Plan HCBS through December 31, 2020.

- ✚ DHCF provided guidance and support to DCOA/ADRC to implement the March 2, 2015 lottery for thirty (30) MFP Housing Choice Vouchers for nursing facility residents who want to transition to the community and need subsidized housing to do so. DHCF worked with the DCOA/ADRC and the DC Health Care Association to reach all nursing facilities and residents with information about the lottery and how to participate. On March 2, 2015, thirty (30) nursing facility residents were selected in the first round of the lottery; and thirty (30) alternates were also selected. DHCF acted as a liaison between DCOA/ADRC and the DC Housing Authority to coordinate training for Community Transition Team members and develop accompanying processes for eligibility packet review and resident notification.
- ✚ As of December 31st, nineteen (19) of the thirty (30) vouchers available in the lottery had been issued and used in the community. One (1) additional voucher was pending finalization of the voucher process with DCHA and the selected property. Fourteen (14) vouchers could not be used by lottery winners or selected alternates and a new lottery will be held in 2016 to award these vouchers to other residents.
- ✚ DHCF launched a new State Plan Adult Day Health Program to serve individuals who are age 55 and older who have chronic conditions. This program is designed to provide medical supports and therapeutic activities to older adults as an alternative to nursing home placement. DHCF and its contractor, Delmarva, have been working with individuals to conduct the LTC assessment required to enroll in the ADHP program, and DHCF and its sister agency, ADRC, have been working with eligible individuals to develop person-centered plans required for enrollment in the ADHP program. During this time, DHCF has also enrolled six new ADHP providers. As of December 31, 2015, 90 beneficiaries were enrolled in this new program.
- ✚ DHCF received federal approval of several amendments to the Elderly and Persons with Disabilities (EPD) Waiver. Significant changes designed to support transitions to the community include: a provision that allows DHCF to pay case managers for up to 120 days for transition services when an EPD waiver beneficiary is hospitalized or institutionalized; stronger programmatic standards for case managers and case management agencies; increased payment rates for case management services and a new payment methodology; the addition of adult day health services, physical therapy and occupational therapy as new services in the waiver; and a new eligibility process designed to streamline access to the waiver.
- ✚ DHCF has continued to expand the use of its standardized, conflict-free assessment tool and process. In 2015, in addition to PCA services, the tool was implemented for the new

ADHP program. The assessment tool will serve as an entry point to DHCF's entire LTC program, where the assessment will establish eligibility for a range of LTC services and supports and allow applicant to make informed choices among a range of options.

- ✚ DHCF made significant progress toward launch of Services My Way, the District's first Participant Directed Service (PDS) offering in the EPD waiver. Starting in August 2014, DHCF convened a workgroup on development of its PDS program. This involved onboarding a consultant with experience in over 25 other states of developing PDS programs, and coordinating a monthly meeting of PDS stakeholders who advised on the PDS program development. With support from the consultant and weekly meetings with the PDS workgroup, DHCF developed a request for proposals for the PDS vendor, a Fiscal Management Service (FMS)--Support Broker Entity (SBE). In addition, DHCF created a series of required forms connected to all levels of the program, a PDS operations manual, a participants' guide, and marketing materials. In spring 2015, DHCF hired a PDS Program Coordinator, and in January 2016 awarded the PDS vendor contract to DC Consumer Direct. The PDS workgroup continues to advise DHCF via monthly meetings, and the PDS Program Coordinator has begun various trainings of the community, DHCF staff, and stakeholders, on the PDS Program. DHCF anticipates enrolling the first beneficiaries into Services my way no later than March 31, 2016.

APPENDIX

The agency summaries below outline how each of the participating agencies, both separately and in collaboration, helped work toward the District's quantitative and qualitative goals. CY 2015 detailed reports and documentation may be found on the DC Office of Disability Rights' website at the following link:

<http://odr.dc.gov/page/olmstead-community-integration-plan-dc-one-community-all>.

DC – One Community for All

Calendar Year 2015 Quantitative Goals

Agency	CY 2015 Goal	CY 2015 Achieved	CY 2016 Goal
DCOA	30	37	45
DDS	5 (residential) 100 (day)	1 (residential) 203 (day)	0 (residential) 100 (day)
DBH	80	99	70
DHCF	20	32	30