

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. !

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.nasddd.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.ⁱⁱ 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.

ⁱ “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.

ⁱⁱ 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>