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## Executive Summary

In 1990, the Supreme Court held that the Americans with Disabilities Act (ADA) Title II required that state and local governments not discriminate against people with disabilities and/or exclude them from participating in, or receiving benefits from, government services, programs or activities. The ADA's "integration mandate" requires that these services, programs and activities be provided in the most integrated setting that is appropriate. A state's "Olmstead Plan" demonstrates compliance with the ADA's integration mandate

### *Olmstead Planning in the District of Columbia*

Since 2007, the District's Office of Disability Rights (ODR) has had the responsibility of developing and submitting the city's Olmstead Compliance Plan to the Mayor for approval. In August 2015, Mayor Muriel Bowser created an Olmstead Working Group charged with making recommendations for revisions to future iterations of the District's Olmstead Plan to support this effort, and to include a broad array of voices in the process, . In 2016, during its first full year of existence, the Olmstead Working Group focused its efforts on determining what data the District should track to allow for a comprehensive picture of what transition looks like for individuals leaving institutionalized care and attempting to access long-term services and supports in the District. The Group concentrated its efforts and discussion around data collection that would aid the District in its effort to create a seamless system across agencies that tracks a person's progress toward independence in a meaningful, understandable way.

### *Improving Long Term Services and Supports*

The District is engaged in a multi-year effort to design and implement a seamless process for accessing Long Term Services and Supports. The new system embraces the principles of No Wrong Door and will ensure that individuals receive accurate information regardless of where they enter the system. Efforts are underway to streamline and simplify the eligibility process. These efforts are supported by federal grants including a three year, No Wrong Door Implementation Grant awarded by the Administration on Community Living and CMS, as well as a major grant awarded to the Department of Health Care Finance to support the procurement of a new, multi-agency case management system. These system improvements will reduce fragmentation and the time it takes to connect to needed services.

The Olmstead Plan details remaining system challenges and lays-out specific action steps in nine strategic areas. That work will take place within the context of a number of on-going District-level

initiatives aimed at systems improvement. These include: Age-Friendly DC; DHCF’s system reform efforts; *Employment First* State Leadership Mentoring; National Core Indicators work; and DC’s No Wrong Door Initiative. In addition, a strong advocacy community lends its support and oversight, led by groups such as the DC Developmental Disabilities Council (DDC), Project ACTION!, the DC State Rehabilitation Council (DC SRC), and the DC Statewide Independent Living Council (SILC).

### **The 2017 Olmstead Plan**

Working with the information gathered in 2016, the Olmstead Working Group has created a multi-year Plan around the same nine (9) priority areas which were the focus of the 2016 Plan:

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

Each action step in each priority area has a measurable, trackable, and meaningful goal that will lead the District into 2020 with a cross-agency system that is more relatable, comprehensive, and based more on an individual’s preferences and concrete goals while in transition.

## **SECTION 1: Overview**

### **I. Olmstead Planning in the District of Columbia**

In 2006, the District of Columbia government passed the Disability Rights Protection Act, which

created the Office of Disability Rights (ODR). Among other things, ODR was given responsibility for developing and submitting an Olmstead Compliance Plan. ODR published the District's first Olmstead Plan in 2011, and the city has since made numerous revisions based on stakeholder feedback.

The Olmstead Working Group was developed with the advice and recommendations of ODR and other agencies serving people with disabilities. The group is comprised of representatives from District agencies as well as community stakeholders, including people with disabilities and advocates for people with disabilities. The list of participating entities can be found at Appendix D.

ODR is the agency in charge of developing the Olmstead Plan and the Deputy Mayor for Health and Human Services has provided substantial support and oversight in development of this 2017 iteration. ODR will continue to coordinate the reporting required under the Olmstead Plan and submit recommendations to the Mayor as appropriate.

## **II. Understanding DC's Service Structure for People with Disabilities**

People with disabilities can have a broad range of medical and personal care assistance needs, from support for daily living activities – like preparing meals, managing medication and housekeeping – to help accomplishing basic activities like eating, bathing, and dressing. They may require help training for and securing a job, or special accommodations to do the job as required. These various forms of assistance (known as “Long Term Services and Supports,” or LTSS) are most often provided informally through unpaid caregivers like family and friends. But they can also be provided by professionals who serve people in institutions, in a person's home, or in a community-based setting.

### *Who Provides These Services?*

The District's service system for people with disabilities is comprised of multiple government agencies, public and private institutions that provide residential care, as well as local organizations that receive District and federal funds to provide home- and community-based services. All of these components of the service system are described below. Contact information for each agency can be found at Appendix E.

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## Government Agencies

- **Department of Behavioral Health (DBH)**

DBH provides prevention, screening and assessment, intervention, and treatment and recovery services and supports for children, youth, and adults with mental health and/or substance use problems. Services include emergency psychiatric care, residential services and community-based outpatient care. DBH also operates Saint Elizabeths Hospital, which is the District's inpatient psychiatric facility.

- **Department of Health (DOH)**

The DOH Health and Intermediate Care Facility Divisions administer all District and federal laws and regulations governing the licensure, certification and regulation of all health care facilities in the District of Columbia.<sup>i</sup> In this role, Health Regulation and Licensing Administration (HRLA) staff inspect health care facilities and providers who participate in the Medicare and Medicaid programs, certified per District and federal laws, respond to consumer and self-reported facility incidents and/or complaints, and conduct investigations, if indicated. When necessary, HRLA takes enforcement actions to compel facilities, providers and suppliers to come into compliance with District and Federal law.

- **Department of Health Care Finance (DHCF)**

DHCF is the District's Medicaid agency and the primary payer for all long term services and supports the city provides. In fiscal year 2016, the District spent a total of \$796 million in Medicaid funds on these services; \$241 million (or 30%) were local dollars. These funds pay for care in institutional settings including nursing facilities and Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IDDs), as well as a variety of home and community-based services (HCBS), described below. Approximately 44% of total Medicaid funds spent on LTSS were spent on institutional care while 56% were spent on home and community-based services.

- **Department of Human Services (DHS)**

Across its extensive range of programming, DHS routinely serves people with disabilities. For example, in fiscal year 2014, approximately 17% of applicants were assessed as likely to have a mental disorder of some magnitude, and 4% to have a learning disability in income-based programs such as TANF, SNAP, and Medicaid. In the homeless services program, 40% of

singles and 16% of adult head of families entering shelters were assessed by DHS to have a disability in at least one of eight categories.<sup>ii</sup> In the Adult Protective Services program -- which investigates reports of abuse, neglect, exploitation and self-neglect, and provides temporary services and supports in some founded cases -- an estimated 45% of those served were assessed to have a disability.

- **D.C. Office on Aging (DCOA)**

DCOA manages the Aging and Disability Resource Center (ADRC) and funds the Senior Service Network, which together consist of more than 20 community-based organizations, operating 37 programs for District residents age 60 and older, people with disabilities (age 18-59), and their caregivers. In addition, ADRC provides information, coordinates service access, and provides direct social work services to help people move to the community and/or stay in the community for as long as possible. In fiscal year 2015, the ADRC served 11,290 people, 9.38% of whom were 18 to 59 years old, living with a disability. The remaining individuals served by ADRC are people age 60 and older who may also have a disability.

- **Department on Disability Services (DDS)**

DDS oversees and coordinates services for District residents with disabilities through a network of community-based, service providers. Within DDS, the Developmental Disabilities Administration (DDA) coordinates person-centered home and community services so each person can live and work in the neighborhood of his or her choosing. DDA promotes health, wellness and a high quality of life through service coordination and monitoring, clinical supports, and a robust quality management program. In fiscal year 2016, DDA served 2,363 people.

DDS's Rehabilitation Services Administration (RSA) provides comprehensive, person-centered employment services and supports for people with disabilities, pre-employment and transition services for youth with disabilities, independent living services and services for people with visual impairments. In fiscal year 2016 RSA served 7,309 people.

- **Office of Disability Rights (ODR)**

ODR assesses and evaluates all District agencies' compliance with the ADA and other disability rights laws, providing informal pre-complaint investigation and dispute resolution. ODR also provides expertise, training and technical assistance regarding ADA compliance and disability sensitivity and rights training to all DC agencies. ODR's current initiatives include efforts to increase access to District-owned and leased facilities, worksites and community

spaces; leading monthly disability-wellness seminars and managing the District’s Mentoring Program for students with disabilities.

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

The office of the State Superintendent of Education (OSSE) is the District’s state education agency. OSSE is responsible for ensuring that all education-related public agencies identify and evaluate children who may have a disability and provide an education that meets the children's individualized needs alongside peers without disabilities to the maximum extent appropriate. OSSE also has oversight of nonpublic special education schools -- the most restrictive educational placements for children with disabilities. In fiscal year 2015, 12,173 children with qualifying disabilities ages 3- 21 were served. In addition, OSSE oversaw IDEA Part C early intervention services for approximately 700 infants and toddlers. Finally, OSSE operated hundreds of buses that traveled 34,000 miles per day to transport more than 3,000 students with disabilities to their schools across the region.

- **Other Government Agencies**

Many other agencies in the District of Columbia serve and support people with disabilities. In doing so, they interface on a regular basis with the agencies listed above. These other government agencies include:

- The DC Housing Authority (DCHA) (Independent agency)
- The DC Public Libraries (DCPL)
- The DC Public Schools (DCPS)
- The Department of Child and Family Services (CFSA)
- The Department of Corrections (DOC)
- The Department of Housing and Community Development (DHCD)
- The Department of Employment Services (DOES)
- The Department of Parks and Recreation (DPR)
- The Department of Youth Rehabilitation Services (DYRS)
- DC Department of Transportation (DDOT)

### Institutional Care Providers

Over the last several decades, the District of Columbia has worked to reduce the number of institutional care settings for people with disabilities in favor of home and community-based alternatives. In 1991, the city closed the Forest Haven facility for children and adults with intellectual and developmental disabilities and, over the course of the past 25 years, the population of Saint Elizabeths Hospital has been reduced from several thousand to less than 300. Today, the

District operates or pays for services in only three types of institutional care settings: inpatient facilities, intermediate care facilities, and nursing facilities.

- **Inpatient Facilities**

Saint Elizabeths Hospital is the only inpatient psychiatric facility operated by the District of Columbia. This 292-bed facility provides in-patient psychiatric treatment to individuals with serious mental health diagnoses. In fiscal year 2016:

- Total bed capacity: 292
- Average daily census: 276
- Total new admissions: 407 admissions in total (38 per month)
- Total discharges to the community: 413 discharges in total (34 per month):
  - 1-20 days: 96 (23%)
  - 21-90 days: 160 (39%)
  - 90+ days: 157 (38%)
- Median length of stay (LOS) was 478 days and average LOS was 2376 days.

Through Medicaid, the District also pays for inpatient psychiatric care for youth in 20 facilities (known as psychiatric residential treatment facilities, or PRTFs), all of which are located outside of the District. In fiscal year 2016:

- Total Census: 131 District youth were in PRTF placements
- Total new admissions monthly: 6.1 admissions per month
- Total discharges/lateral placements: 60:
- Total discharges to the community: 4
  - 1-20 days: one youth
  - 21-90 days: one youth
  - 90+ days: 41 youth
- Average length of stay: 8.5 months

Finally, the District’s HSC Pediatric Center provides long-term chronic, acute or rehabilitative services for children with disabilities. In calendar year 2014:

- Total bed capacity: 130 licensed beds/118 operating beds
- Total census: 39
- Total new admissions: 173
- Total transitions to the community: 199
- Average cost per patient per day: \$2,485 (85% Medicaid)
- Average length of stay: 69 days



- **Intermediate Care Facilities (ICFs)**

ICFs for people with intellectual and developmental disabilities (ICF/IDD) provide comprehensive residential, day, clinical and medical services by a certified provider. The District does not operate any ICF/IDDs, but pays for intermediate care in 68 private facilities.

Between fiscal year 2007 and fiscal year 2015, the District intentionally reduced the total ICF/IDD capacity by 233 beds, and residents by 213 people -- a 40% reduction in the use of these institutional services. As of the close of fiscal year 2016:

- Total bed capacity: 400
- Total census: 354
- Total new admissions: 4
- Total transitions to the community: 3
- Average length of stay: People typically live in an ICF/IDD home for a number of years, but are offered a choice to move to waiver-funded supports at least annually during planning meetings.
- Average annual cost per person: \$177,886

- **Nursing Facilities**

Nursing facilities, regulated by the Department of Health, provide both short- and long-term care for individuals who require skilled nursing, supervision, and assistance with activities of daily living. The District does not directly operate any nursing facilities. Medicaid is the single largest payer for nursing facility services, along with Medicare and private pay. In fiscal year 2016 for Medicaid-paid services:

- Total number of DC-based facilities: 18<sup>iii</sup>
- Total bed capacity: 2, 770
- Total current census: 2,512 total users in Q4
- Total new admissions: 801
- Total transitions to the community:<sup>iv</sup>
  - 1-20 days: 1 individuals
  - 21-90 days: 1 individuals
  - More than 90 days: 35 individuals
- Average length of stay: 624 days
- Average cost per person per day: Medicaid paid \$232. 38/person per day for nursing

facility services<sup>1</sup>.

## Home and Community-Based Services

The District of Columbia offers a wide variety of home and community-based supports and services (HCBS) for people with disabilities. These range from comprehensive adult day health programs to vocational rehabilitation to wellness classes. Depending on the program or service, eligibility is based on a person’s age, income and/or the level of care they need.

- **Medicaid Waivers & Demonstration Projects**

The District operates three Medicaid programs that facilitate community living for people who would otherwise be eligible for institutional care based on their level of care need (in an ICF or nursing home). The long-term services and supports provided under these programs are funded with a combination of federal and local Medicaid dollars.

- *The ID/DD Waiver* offers 24 different services for individuals with developmental and intellectual disabilities offered by community providers certified by DDS. These include: day services such as supported employment and individualized day supports; residential services such as supported living and in home supports; clinical supports such as creative art therapies, wellness, and physical and occupational therapy; and assistive supports such as environmental accessibility adaptations, personal and emergency response services and vehicle modification. A complete listing of services can be found in Appendix D. For fiscal year 2015 (as of October 1, 2015):
  - Enrollees: 1,644
  - Cap: 1,692
  - Total budgeted: \$192,837,58
  - Total Spent: \$191,940,457
- *The Elderly and Persons with Disabilities (EPD) Waiver* supports individuals who are age 65 and older, or between 18 and 64 and have a physical disability. As of January 1, 2016, there are 13 services offered in the EPD waiver including: case management, personal care assistance, respite, environmental accessibility, occupational and physical therapy, assisted Living, and others<sup>2</sup>. A complete listing of EPD Waiver

<sup>1</sup> Figure represents the average FY16 daily payment to the nursing facility by DHCF calculated by DC Medicaid beneficiary, and based on each beneficiary’s actual length of stay in the nursing facility during the year.

<sup>2</sup> DHCF submitted an EPD Waiver amendment to CMS in September 2016. As of this publication, the amendment is pending approval. The amendment includes a new service, Community Transition Services, which covers up to

services can be found in Appendix E. For fiscal year 2016 (as of October 1, 2016):

- Enrollees: 2,769
  - Cap: 5,060
  - Total budgeted: \$73,647,354
  - Total spent: \$42,802,166
- *The Money Follows the Person (MFP)* grant demonstration supports individuals who are making the transition from institutional care to an HCBS setting. The intensive wrap-around services include funds to cover “set-up” costs incurred as part of the transition. Since 2008, MFP has provided transition coordination services that have helped over 250 Medicaid beneficiaries to return to the community. As federal funding for the demonstration across the country comes to an end, the District’s MFP project plans to support transitions from institutional care to an HCBS setting through December 31, 2017. It will continue to support HCBS for DC residents who transition under the demonstration through December 31, 2018. In preparation for the end of the MFP demonstration, the District drafted a plan to sustain transition activities supported by the project. That plan was approved by CMS in July 2016.

- **“State Plan” Support**

People with disabilities may also access community-based services and supports through the District’s Community Medicaid program (called the “State Plan”). Covered services include personal care assistance, hospice, adult day health, home health, occupational therapy, physical therapy, and skilled nursing services. The Developmental Disabilities Administration also provides service coordination for people receiving state plan services or local funding. State Plan services for mental health, substance use disorder, and Health Homes for people with mental health diagnoses are described separately below.

- Number of state plan enrollees receiving Long Term Services and Supports: 7,588 in fiscal year 20142016.

- **Assisted Living<sup>v</sup>**

Assisted living facilities (ALFs) provide community-based housing, health and personalized assistance according to individually developed service plans. These facilities vary greatly in

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\$5,000 for household set-up and allowable transition-related expenses for DC Medicaid beneficiaries who are transitioning from nursing facilities to EPD Waiver services in the community. In addition, the reimbursement rate for Assisted Living services under the EPD Waiver is increased.

the room configurations and amenities they offer. The District licenses 13 ALFs, three of which are used by Medicaid recipients via the EPD waiver. One of these, The Marigold, is a public housing assisted living facility operated by the city’s Housing Authority (DCHA) in partnership with a private contractor. In fiscal year 2016, across the three facilities:

- Total bed capacity: 46
- Total current census: 37 users in Q4
- Total new admissions: 8

The Department of Behavioral Health operates two types of assisted living facilities, called Mental Health Community Residence Facilities (MHCRFs).

- Supported Residences (SR) are for individuals who need less intensive support to live in the community. In fiscal year 2015:
  - Total bed capacity: 432
  - Total current census: 385
- Supported Rehabilitative Residences (SRR) provide twenty-four hour supervision for individuals with severe and persistent mental health diagnoses who need an intense level of support to live within the community. In fiscal year 2015:
  - Total bed capacity: 205
  - Total current census: 198

To support assisted living, the District also participates in the Optional State Supplemental Payment Program (OSSP) which supplements the income of low-income older adults and individuals with disabilities to help them pay for housing in licensed Adult Foster Care Homes (AFCHs). AFCHs include licensed Community Residential Facilities (CRFs), Assisted Living Facilities (ALFs) and Mental Health Community Residential Facilities (MHCRFs). The monthly OSSP payment (issued directly to the participant) ranges from \$620 to \$730 for an individual and from \$1,606 to \$1,825 for a couple. In fiscal year 2014, 7,807 people received OSSP support.

- **Employment and Wrap Around Services for People with Disabilities**

The Department on Disability Services uses a person-centered approach to provide extensive wrap around services to support eligible people with disabilities to live as independently as possible in the community. Services include:

- Counseling and guidance
- Payment for vocational and other training services, or college
- Assistive technology (e.g., I-pad touch, Zoom Text; Dragon Speak; hearing aids, etc.)
- Visual impairment services
- Transportation necessary to participate in training
- Clothing and equipment needed for work
- Transition services for youth still in school

In addition, the Independent Living Services (ILS) program partners with the DC Center for Independent Living and other private agencies to provide four core independent living services: advocacy; independent living skills training; information and referral; and peer support. The Independent Living Older Blind Program (ILOB) provides in-home and community-based services for this specialized population.

- **Housing Support**

Securing affordable, appropriate housing is often a significant challenge for people with disabilities whose incomes may be limited and their physical needs very specific. There are some housing resources targeted for this population, but the demand for affordable accessible housing in the District exceeds the supply..

The Department of Behavioral Health provides a range of housing options for individuals with mental health diagnoses including over 2,000 subsidized community-based housing units. In fiscal year 2015, DDA funded housing supports for approximately 960 people enrolled in the IDD waiver who required out of home residential supports. In addition, there are 65 funded Housing Choice Vouchers for people in the Money Follows the Person (MFP) demonstration described above. 51 are currently being used, and the remainder will be used by MFP participants in fiscal year 2017. Finally, there are seven Non-Elderly Persons with Disabilities (NEPD) vouchers that have been in use by MFP participants since fiscal year 2011.

The Department of Housing and Community Development (DHCD)'s Handicapped Accessibility Improvement Program (HAIP) supports critical home modifications and adaptations costing \$10,000-\$30,000. Home modifications up to \$10,000 are also covered expenses in the EPD and the IDD waivers.

In fiscal year 2016, DCOA and DHCD partnered to create Safe at Home, program offering grants of up to \$10,000 for accessibility adaptations. The program completed more than 200 projects in its first year.

- **Mental health and substance abuse services**

There are currently eleven Mental Health Rehabilitation Services: diagnostic and assessment; mediation somatic; counseling; community support; crisis/emergency; rehabilitation day services (mentioned above); intensive day treatment; community-based intervention for children and youth; assertive community treatment for adults; trauma-focused cognitive behavioral therapy for youth and child-parent psychotherapy – Family Violence, also for youth. These services are offered through community providers - Core Services Agencies (CSAs) or specialty providers - who are certified by DBH. At least 60% of the services are required to be provided in the community in natural settings, rather than at the clinic.

In addition to Medicaid–reimbursable treatment services, DBH offers numerous other supportive services for people with mental health diagnoses such as rental subsidies and Supported Employment. DBH also certifies Substance Use Disorder (SUD) treatment and recovery providers in the District who provide clinical care coordination; assessment/diagnostic and treatment planning; counseling; medication management and a variety of other services.

- **Wellness, Fitness and Nutrition**

The DCOA and Department of Parks and Recreation collectively provide a broad range of wellness and fitness programs, classes and activities that support people in maintaining healthy lives in their communities. In addition to wellness and day treatment programs, services include transportation, home delivered meals, congregate meals, and nutritional supplements.

- **Day Services**

DDS, DCOA, DHCF, DBH and a host of community-based providers collectively offer a variety of day services for adults with intellectual disabilities, elderly, people with physical disabilities, and people with mental health diagnoses. These services all work to support individuals live an integrated and independent life in the community. Program examples include:

- Individualized Day Supports (IDS) to foster independence, encourage community integration, and help people build relationships. IDS include vocational exploration and can supplement employment services.
- Adult Day Health Services offer non-residential medical supports and supervised therapeutic activities in an integrated community setting.
- Geriatric Day Care provides supervision, socialization, rehabilitation, training, therapy and supportive services for functionally-impaired seniors to help them remain in their homes.
- Rehabilitation Day Services is a structured clinical program to develop skills and foster social role integration through a range of social, psycho educational, behavioral and cognitive mental health interventions.

- **Transportation**

The District provides Medicaid-funded emergency and non-emergency transportation support to people who are eligible, as well as non-Medicaid transportation through several providers. The primary objective is to provide low-income, functionally impaired District residents with transportation to life-sustaining medical appointments so they can maintain maximum functioning and independence in the community.

In addition, the District Department of Transportation (DDOT) works with the Washington Metro Area Transit Authority (WMATA) and the D.C. Taxi Commission to provide broader transportation services to District residents living with a disability. “MetroAccess” is a shared-ride, door-to-door, paratransit service for people whose disability prevents them from using bus or rail. The “Transport DC” program (formerly CAPS-DC) provides alternative taxicab transportation for MetroAccess customers. The D.C. Office on Aging also funds a transportation program through Seabury Resources for the Aging, primarily for medical appointments, but also for DCOA social outings.

### *How Do People Access Long Term Services and Supports (LTSS)?*

The District’s goal is to make it as simple and seamless as possible for people with disabilities to access the variety of Long Term Services and Supports described above. If an individual is living at home or in the community, multiple agencies provide information and referrals to these services. For people temporarily in an institutional care setting, discharge and community transition processes can be set in motion.

## Information and Referral to Services within the Community

Information about Long Term Services and Supports (*e.g.*, what's offered, who's eligible, how to apply) is available through multiple District agencies. These agencies either support people in applying for services they offer, or provide referrals to other agencies.

District residents are also directed to the District's **Aging and Disability Resource Center (ADRC)**, which is the most comprehensive source of information for connecting residents to Long Term Services and Supports. The ADRC is operated by DCOA and has a presence in each ward of the District. The ADRC's Information and Referral/Assistance Unit, Community Transition Team, and Community Social Workers provide "options counseling," which is person-centered discussion to assist an individual understand their long term care options and empower them to make choices based on personal preference. These discussions frequently end with referrals to services and community supports, including:

- Community-based, private sector resources.
- DC government health and human service programs.
- A Medicaid Enrollment Specialist who can assist with pre-enrollment for the EPD Waiver.
- Community case managers or social workers, if the resident is eligible and in need of home- and community-based services and supports right away.

## Transitioning from an Institutional Setting

The District government has established processes by which people with disabilities are helped to transition from institutional care settings to a less restrictive environment.

- For people with intellectual and developmental disabilities, DDS coordinates transition planning and support. If a person has already been served by DDA, admission to a nursing home triggers enhanced monitoring to ensure the setting remains the least restrictive to meet the person's needs. People who reside in ICF/IDD settings are offered, on at least an annual basis, the opportunity to receive services under the IDD HCBS waiver as an alternative to ICF services during person-centered planning meetings.
- For people over the age of 60 or adults with physical disabilities, transition assistance is conducted by staff in the facility in conjunction with ADRC. The process uses a uniform preference screening tool and transition services checklists. Decisions about the appropriateness of a less restrictive setting are ultimately made by the resident and any legally authorized representative, social worker, medical professional, or other members of



the individual's care team. Once the individual has been successfully transitioned back to the community, ongoing case management services are available through the District's EPD Waiver, MFP, or DCOA's Senior Service Network. For a full description of the transition planning process used by the ADRC, see Appendix F.

- For youth with mental health issues being discharged from PRTFs, DBH has a very vigorous process to ensure youth are successfully integrated back into the community. DBH has staff assigned to every youth in a PRTF, visiting the youth in person and participating in all treatment team meetings. Prior to discharge, a Core Service Agency (CSA) is assigned if no relationship previously existed. Working with the youth and his or her family (if any), the PRTF staff, DBH monitor, CSA and any other involved District agencies develop a discharge plan that includes not only mental health services, but also housing, education and other support services as needed.
- For people discharged from Saint Elizabeths Hospital, transition planning starts from the day of admission. A Core Service Agency (CSA) is assigned if no relationship previously existed, and CSA staff participate in all aspects of discharge planning. Upon anticipation of discharge, but no earlier than 90 days prior, the individual can be referred to Rehabilitation Day Services, which occur in the community, to enable him or her to start the transition out of the hospital. The type of housing needed is identified, and the individual is supported to identify a residence to move to upon discharge. The discharge plan is developed with the individual so that services can begin immediately upon discharge.

### III. Working to Improve Long Term Services and Supports

The District is engaged in a multi-year effort to design and implement a seamless process for accessing Long Term Services and Supports. The new system embraces the principles of No Wrong Door and will ensure that individuals receive accurate information regardless of where they enter the system. Efforts are underway to streamline and simplify the eligibility process. These efforts are supported by federal grants including a three year, No Wrong Door Implementation Grant awarded by the Administration on Community Living and CMS, as well as a major grant awarded to the Department of Health Care Finance to support the procurement of a new, multi-agency case management system. These system improvements will reduce fragmentation and the time it takes to connect to needed services. Section 2 of this Plan details remaining challenges and lays-out specific action steps in nine strategic areas. That work will take place within the context of a number of District-level initiatives aimed at systems improvement. A strong advocacy community lends its support and oversight.

## On-Going District-Level Initiatives

There are a number of initiatives currently underway in the District working to assess, and make concrete improvements to, various aspects of the Long Term Services and Supports system. These initiatives include:

- **Age-Friendly DC**

In 2012, DC adopted World Health Organization (WHO) guidance to prepare for the growing number of residents aged 50 and older, by transforming built, natural, and social environments into great places to grow up and grow older. The WHO outlined a framework for creating age-friendly cities and communities through four phases: 1) assessment; 2) planning; 3) implementation; and 4) evaluation. The District is implementing 75 strategies led by 38 DC agencies to transform the District by 2017 into an easier city to live and visit. The Age-Friendly DC strategies are closely aligned with this Olmstead Plan and will help it move forward. Data in the 2017 Olmstead Plan will also help measure progress in transforming DC into an age-friendlier community. More information at: [www.agefriendly.dc.gov](http://www.agefriendly.dc.gov).

- **DHCF System Reform Efforts**

DHCF is undertaking major system reforms to improve the quality and delivery of Medicaid-funded Long Term Services and Supports. The work is focused in three areas: organizational change; program evolution and growth; and quality improvement. The numerous specific activities in this effort can be found in the nine priority areas detailed in Section 2 of this plan.

- **Employment First State Leadership Mentoring**

People with disabilities in the District experience disproportionate unemployment. In 2012, a Mayoral Proclamation made the District of Columbia the 20<sup>th</sup> “Employment First State,” a commitment to supporting people with disabilities in pursuing competitive employment in integrated settings and *as the first option explored in publicly-funded services*. To realize this vision, a cross-agency Employment First State Leadership Mentoring Program is helping develop initiatives to increase the capacity of provider and District staff in key agencies to more effectively advance Employment First strategies with a focus on transition age youth and customized employment. More information at: <http://dds.dc.gov/page/employment-first>.

- **The National Core Indicators (NCI)**

The National Core Indicators (NCI) initiative helps state agencies gather a standard set of

performance and outcome measures that can be used to track their own progress over time and compare results across the country. Until recently, NCI has focused on efforts by public developmental disabilities agencies on employment, rights, service planning, community inclusion, and other areas. NCI recently expanded its scope to support states in assessing their performance for older adults, individuals with physical disabilities, and caregivers. For the last two years, the District has participated in NCI and will begin to explore the use of the expanded scope in 2017 and 2018. DDA's current NCI reports can be reviewed on-line at: <http://www.nationalcoreindicators.org/states/DC/>.

- **No Wrong Door (NWD)**

In 2014, DC was one of 25 states to receive a year-long federal planning grant through the U.S. Administration for Community Living to develop a comprehensive, "No Wrong Door" (NWD) approach to the delivery of Long Term Services and Supports. In fiscal year 2015, DC was one of five states to receive a three year NWD implementation grant. DC's goal is a visible, trustworthy, easy-to-access system in which people encounter person- and family-centered systems and staff with core competencies that facilitate their connection to formal and informal LTSS, regardless of where they enter the system. The NWD Work Plan is referenced frequently in Section 2 of this report as it targets many of the same goals, outcomes, challenges, and strategies as the Olmstead plan. For a detailed description of the NWD mission, outcomes, goals and objectives, see Appendix H.

- **State Innovation Model (SIM)**

In a year-long, federally funded planning process, multiple agencies and stakeholders<sup>vi</sup> are coming together to develop DC's strategy for health system transformation. The work is focusing on care delivery; payment models; community linkages; Health Information Exchange; and quality measurement as well as design of the District's second Medicaid Health Home State Plan benefit. This benefit will achieve whole-person, person-centered integrated care services coordination for people with two or more physical chronic health conditions. Many people with disabilities, due to co-morbid physical chronic conditions, will be eligible for this Health Home benefit.

- **Vision Zero**

By the year 2024, DC has a goal of zero fatalities and serious injuries to travelers of our transportation system, through more effective use of data, education, enforcement, and engineering. Vision Zero is a part of Mayor Bowser's response to the US Department of Transportation's Mayor's Challenge for Safer People and Safer Streets, which aims to improve pedestrian and bicycle transportation safety by showcasing effective local actions,

empowering local leaders to take action, and promoting partnerships to advance pedestrian and bicycle safety. Multiple agencies, including Office of Disability Rights and DC Department of Health, are involved in this initiative.

### The Advocacy Community

The District of Columbia has a robust community of advocates and stakeholder organizations actively involved in working to improve services and supports for people with disabilities. Examples include:

- **The DC Developmental Disabilities Council (DDC)**

The DDC is an independent, federally-funded, Mayorally-appointed body. The DDC works to strengthen the voice of people with developmental disabilities and their families in DC in support of greater independence, inclusion, empowerment and the pursuit of life as they choose. The DDC strives through its advocacy to create change that eliminates discrimination and removes barriers to full inclusion.

- **Project ACTION!**

Project ACTION! is a coalition of self-advocates and self-advocacy groups that shares personal experiences of living with developmental disabilities and trains and encourages peers to speak out on issues important to them. The group's motto is "Nothing About Us without Us." Many members have joined boards, committees, work groups, and commissions that make decisions that affect their lives.

- **Supporting Families Community of Practice**

For the past four years, the District has been working to create an active, broad-based "Supporting Families Community of Practice" (the DC SFCoP) to support people with Intellectual and Developmental Disabilities Across the Lifespan. The group's State Team meetings often engage 50 or more people, most of whom are people with disabilities and their families. The DC SFCoP has developed processes for strengthening the voices of families and self-advocates, trained trainers, and helped pass legislation to create a Family Support Council and to provide stipends for family and self-advocates for expenses related to participating in stakeholder engagement activities.

- **The DC State Rehabilitation Council (DC SRC).**

The DC SRC advises on the needs of District residents with disabilities who receive, or are

seeking, vocational services from DDS's Rehabilitation Services Administration. DC SRC partners with RSA on increasing meaningful employment outcomes, developing the agency's annual goals and priorities, crafting agency policies, and tracking performance. Members of the DC SRC are appointed by the Mayor, and include consumers of RSA services, advocates, and other stakeholders.

- **The DC Statewide Independent Living Council (SILC)**

The DC SILC promotes independent living services for DC residents with disabilities. Members are appointed by the Mayor and include advocates, individuals with disabilities, and other stakeholders in independent living (IL) services. The goals for the DC SILC are to expand IL services District-wide; ensure that residents with disabilities are aware of IL services; increase advocacy; and support an effective and efficient IL service delivery system.

- **DC ADAPT/Direct Action**

DC ADAPT/Direct Action is the local chapter of a national grass-roots community that organizes disability rights activists to engage in nonviolent direct action, including civil disobedience, to ensure the civil and human rights of people with disabilities to live in freedom.

- **DC Center for Independent Living (CIL)**

The DC CIL is a private non-profit organization that assists DC residents with significant disabilities to live independently in their homes and in their communities.

## The 2017 Olmstead Plan

Long Term Services and Supports in the District have seen significant improvements since the first Olmstead Plan was developed in 2011. In 2015, the Mayor invited the community to join the District in improving access to long term services and supports by creating the Olmstead Working Group. By incorporating feedback from community stakeholders, the District has made significant strides. From the beginning, the District has been committed to meeting and exceeding the legal mandate of Olmstead. The Working Group and this Olmstead Plan reflects the District's desire to create broad-based integration for people with disabilities in the District.

## The Vision

The District's promise of community integration goes beyond moving people out of institutions and into the community. The spirit animating the District's Olmstead Plan is founded in our recognition that people with disabilities, whether they live in a nursing facility or in the community, can and should have opportunities:

- To work real, competitive jobs, in the community, and be paid full wages for their efforts.
- To volunteer and contribute.
- To make and be friends.
- To make decisions about their lives.

By 2020, the District will boast a person-centered, user-friendly LTSS system that supports all people with disabilities who wish to live in the community, whether that means group homes or [whatever other term is used for individual homes], by providing the HCBS they need to do so.

In collaboration with the agencies, partners and initiatives described above, the Olmstead Working Group envisions a two-stage process for building a Plan that it is a vehicle for achieving this vision.

## The 2016 Plan: What We Learned

Recognizing significant gaps in core data about both the population and the current service system, the Working Group saw 2016 as the period during which the Olmstead Plan—with greater input and participation from a broad array of stakeholders—guided the city towards the knowledge base needed to make clear policy and systems decisions and then move them forward. In 2016, the Olmstead Working Group discussed at length the data points in the 2016 Plan and which agencies should be responsible for collecting that data moving forward. As a result, the Group concluded that it was necessary to more closely tie the data points to agency action steps in the Plan, so that the Plan, which is meant to be read and utilized by the community it serves, presents a clearer, more cohesive picture of how transition from an institutional setting into the community works in the District.

The Group also solicited feedback from the stakeholders and community members we serve during a mid-year Olmstead Conference held in June 2016. Much of the Conference attendees' stated concerns mirrored what the Group had discussed—that systems change, which tracked meaningful data, and avoided agencies working in silos would address many of the issues people living in transition currently face. Copies of the Working Group minutes and the presentation outlining community feedback can be found at Appendix I.

### **The 2017 Olmstead Plan**

Working with the information gathered in 2016, the Olmstead Working Group has created a multi-year Plan around the same 9 priority areas that were the focus of the 2016 Plan. Each action step in each priority area has a measurable, trackable, and meaningful goal that will lead the District into 2020 with a cross-agency system that is comprehensive and based more on an individual's preferences and concrete goals while in transition. The Plan incorporates the work accomplished through No Wrong Door, as well as the District's discharge planning efforts to ensure self-awareness and cohesiveness around the District's efforts.

To report on the progress toward the goals of the 2017 Plan, the Olmstead Working Group will continue to meet quarterly to discuss agency progress in meetings open to the public. Additionally, the quarterly reports and meeting minutes will continue to be posted to ODR's website. The District will host at least two (2) Olmstead related forums to discuss the published Plan and our progress with stakeholders each year, and the community may submit feedback there or at any time by contacting ODR or by using the Olmstead email address, [olmstead@dc.gov](mailto:olmstead@dc.gov).

## SECTION 2: The 2017 Olmstead Plan

### I. Strategic Priorities for 2017

In addition to the quantitative transition goals, the Olmstead Working Group has identified nine strategic areas in which the District must improve data collection and the provision of services and supports. While there is certainly overlap among these, for organizational purposes each is presented separately here. The nine areas (presented alphabetically) are:

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

In each strategic area, this plan details:

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

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

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

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

**Action Steps and Lead Entities.** Needed actions and the agencies and entities that will take the lead



on pursuing them, and be accountable for results.

## 2017 Olmstead Plan

### ***Priority Area #1: Develop A Person-Centered Culture Across All Long-Term Services and Supports Agencies***

#### *Why is this important?*

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

While the use of person-centered thinking is important in all service contexts, its adoption by service providers working with people transitioning out of institutionalized settings is particularly crucial. It can increase the likelihood that service plans will be used and acted upon, that updating service plans will occur “naturally,” needing less effort and time, and that the person’s ability to lead a fulfilling, independent life will be maximized.

#### *What is the Vision?*

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

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

The road to culture change is long. While a few departments have had notable success in fully embedding person-centered thinking and practice into their culture and work, the levels of awareness, capacity, and competence across the city government are uneven and can vary depending on agency or source of funding.

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

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

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

- a) The NWD team has piloted a multi-agency Person-Centered Training (PCT) program where eleven NWD PCT trainer candidates and two mentor candidates have been successfully trained and will conduct independent trainings in FY 2017. This infrastructure will allow the training initiative to be sustainable and for staff in public and community Long Term Supports and Services (LTSS) agencies to continue to be training in person-centered practices (PCP). The team also completed a PCT Alignment Analysis and a Current State of PCT Report, both of which were shared with NWD Leadership. The interagency working group on PCP continues to meet with the purpose of identifying cross-agency commonalities, gaps, and recommended practices. DC is the first state in the nation to expand PCT Learning Community to all LTSS learners. As a result of these efforts, the NWD project trained over 200 staff in NWD Person-Centered Practices from the 5 Core agencies and community partners.
- b) DHCF, in collaboration with DDS and DCOA, issued a Request for Proposals (RFP) for a new Multi-Agency Case Management System that supports NWD eligibility, enrollment and access to LTSS. An inter-agency working group developed the RFP and will select the vendor and oversee the implementation of the system.
- c) The NWD team, in partnership with the Georgetown University's National Center for Cultural Competence (NCCC), finalized a review of intake and public information approaches. NCCC provided recommendations that support better outreach and engagement with people in need of LTSS and their families, focused on approaches that reflect stronger cultural and linguistic competence. Additionally, an inter-agency subcommittee was developed to make recommendations for cross-agency approaches, with representatives from all participating LTSS agencies, with co-chairs from DBH and the NWD project team.

d) The NWD staff and cross-agency Leadership Council have been working with a marketing firm to develop a NWD Logo and Interagency Marketing Strategy with broad stakeholder input, which included over five hundred stakeholder surveys across LTSS, two community meetings, three LTSS inter-agency meetings, and a joint inter-agency/stakeholder meeting. The NWD team also produced two NWD e-newsletters sent to four hundred LTSS stakeholders.

e) The NWD team issued a Request for Proposals (RFP) for a cross-agency resource portal that includes 211 information and more, for use by government agency staff, providers, people in need of Long-Term Supports and Services (LTSS) and their families. The Resource Portal will reflect the work of the branding and marketing consultant.

f) NWD staff completed a Current State Assessment of intake and eligibility processes including Process Maps and a Crosswalk for all 5 core LTSS agencies, which was shared with NWD Leadership Council to inform the recommendations for future actions.

g) DCOA, in collaboration with DHCF and DC’s HHS contractor for Medicaid cost allocation, completed a final DCOA cost allocation plan for FY17 highlighting administrative expenditures to be claimed for federal matching. The plan was submitted to CMS for approval in September 2016. Cost allocation information was included in the DHCF/DCOA MOU, executed in September 2016.

h) DDA has created a new “front door” tool (i.e., the tool and processes for intake and eligibility) that uses nationally recognized PCT tools and aligns with all NWD expectations. This was shared with NWD Leadership Council.

**Action Step 1.1: Develop and Implement Person-Centered Policies Across All NWD Core LTSS Agencies.**

*Year 1:* Develop and recommend clear expectations and competency criteria standards for intake staff consistent with use of person-centered approaches

*Year 2:* Host community meetings to garner stakeholder feedback on the person-centered policies and procedures for all NWD Core LTSS agencies’ intake staff.

*Year 3:* Finalize model policies and procedures for all NWD Core LTSS agencies’ intake staff consistent use of person-centered approaches

**Performance Metric(s):**

- # of NWD Core LTSS agencies that have implemented person-centered service protocols
- # of NWD Core LTSS intake staff that have completed person-centered training
- # of HCBS provider staff who have completed person-centered training

**Action Step 1.2:** Add person-centered practice standards to service planning personnel’s employee performance goals in all NWD Core LTSS agencies.

*Year 1:* Develop a model of person-centered practice standards and goals that can be incorporated into employee performance measures.

*Year 2:* Offer training and technical assistance to NWD Core LTSS managers and staff on including person-centered standards and goals to support implementation of person-centered practices.

*Year 3:* Develop model person-centered position descriptions for NWD Core LTSS agencies’ service planning personnel.

**Performance Metric(s):**

- % of NWD LTSS Core Agencies’ employee performance measures linked to person-centered practices
- % of HCBS providers employee performance measures linked to person-centered practices

**Action Step 1.3:** Develop procedures and protocols for supporting family members and others in a person’s support network to ensure that plans accurately and continuously reflect the individual’s preferences and needs. (NWD)

*Year 1:* ‘Develop Person Centered Planning Implementation Guidance’ in partnership with stakeholders identifying best practices for supporting families in person-centered planning for NWD Core LTSS agencies and providers.

*Year 2:* Develop Person Centered Planning tools to aid families in learning about person-centered practices and keeping track their family member’s person-centered goals.

*Year 3:* Use the LifeCourse Framework developed through the National Supporting Families Community of Practice, which DC participates in, to finalize policies and protocols in partnership with NWD Core LTSS agencies.

| <b>Priority Area 1 Metrics:</b>   | <b>FY17</b> | <b>FY18</b> | <b>FY19</b> |
|---|-------------|-------------|-------------|
| # of core LTSS agencies that have implemented person-centered service protocols                       | 1           | 2           | 3           |
| % of NWD LTSS Core Agencies’ intake employee performance measures linked to person-centered practices | Baseline    | 10%         | 10%         |
| # of core LTSS staff that have completed person-centered training                                     | 75          | 100         | 100         |
| # of HCBS provider staff who have completed person-centered training                                  | 75          | 100         | 100         |

**Priority Area #2: Community Engagement, Outreach and Training**

*Why is this important?*

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

*What is the Vision?*

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

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

**Limited community engagement opportunities.** One of the key principles of the National Supporting Families Community of Practice is that: “Individuals and families are truly involved in policy making so that they influence planning, policy, implementation, evaluation and revision of the practices that affect them. Every program, organization, system and policymaker must always think about a person in the context of family.” The District, which participates in the National

Community of Practice, is working towards ways to more systemically engage people with disabilities, families, caregivers, advocates, providers, and other stakeholders so that our policies and practices that guide and regulate systems of support are developed with input and feedback from the people who access them.

**Current outreach misses key targets.** Finding and engaging at-risk populations and developing messages that resonate across all stakeholder groups can both be difficult. That said, current outreach and information dissemination across agencies and settings is not always sufficiently coordinated, resulting in duplication and confusion among recipients of the material. Furthermore, the District does not currently measure the effectiveness of its outreach efforts.

**Planned Training.** Community trainings tend to be general or conducted *ad hoc*, rather than following a plan that is based on a needs analysis, goal setting, and attendee feedback. There are no District-wide training goals or basic training expectations for all agency staff that set a standard of competency across the district to ensure that trainings are adequately addressing receipts needs. . Trainings are often conducted in places that are not convenient for attendees and they are rarely evaluated in a meaningful way.

*Action Steps, Lead Entities and Timeframes*

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

**Action Step 2.1:** Develop and disseminate policy and protocols to increase linguistically and culturally diverse stakeholder involvement in the development, implementation and ongoing evaluation of NWD Core LTSS agencies’ engagement and outreach activities.

*Year 1:* Develop and finalize an assessment of linguistic and cultural competence for NWD Core LTSS agencies intake processes.

*Year 2:* Develop cultural and linguistic competency factsheets of guiding principles for NWD Core LTSS agencies intake, outreach, and service planning personnel.

*Year 3:* Develop model cultural and linguistic competency policies and procedures, and a cultural and linguistic framework for NWD Core LTSS agencies to support culturally and linguistically competent practices.

**Performance Metric(s):**

- # of people reached through NWD Core LTSS agencies’ outreach activities
- # of NWD Core LTSS agencies’ outreach activities and resources presented in languages other than English

**Action Step 2.2:** Develop mandatory training for front line staff of District NWD partner agencies about the key plans and practice changes being developed through NWD.

*Year 1:* Finalize NWD Person-Centered Practices Training for Core NWD LTSS agencies.

*Year 2:* Update NWD Person-Centered Practices training surveys to better collect participant feedback, and develop a unified survey tracking tool.

*Year 3:* Update NWD Person-Centered Practices Training to reflect the participant feedback and NWD practices.

**Performance Metric(s):**

- # of NWD training sessions receiving positive participant rating

**Action Step 2.3:** Develop a unified messaging and marketing “look” for outreach materials and replicate on all No Wrong Door partner agencies’ websites. (NWD)

*Year 1:* Create NWD unified marketing and branding materials for distribution.

*Year 2:* Develop NWD webpage to be represented on all NWD Core LTSS agencies’ websites.

Year 3: Assess user experience for NWD webpage to enhance NWD webpage utility.

**Performance Metric(s):**

- # of website hits per month

**Action Step 2.4:** Maintain and respond to inquiries at the [olmstead@dc.gov](mailto:olmstead@dc.gov) e-mail address. Provide current Olmstead data online, available for public review. Host quarterly Olmstead Working Group meetings, as well as two community forums, open to the public.

**Performance Metric(s):**

- # of community members attending Olmstead-related meetings/forums

| <b>Priority Area 2 Metrics:</b>  | <b>FY17</b> | <b>FY18</b> | <b>FY19</b> |
|--|-------------|-------------|-------------|
| # of people reached through LTSS outreach activities                             | 100         | 125         | 125         |
| # of outreach activities and resources presented in languages other than English | 3           | 5           | 5           |
| # of NWD training sessions receiving positive participant rating                 | Baseline    | 25          | 35          |
| # of website hits per month  | Baseline    | 35          | 50          |
| # of community members attending Olmstead-related meetings/forums                | 60          | 75          | 90          |

**Priority Area 3: Employment**

*Why is this important?*

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

*What is the Vision?*



All working-age people should have access to – and be prepared for -- competitive and integrated employment opportunities that meets their individual interests, preferences and informed choices. Pursuing these opportunities is the first option explored in publicly-funded services and people with disabilities must have the support The District of Columbia strives to be a model employer of people with disabilities by providing appropriate supports and services to sustain the vision.

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

**Disproportionate unemployment for people with disabilities.** There is a significant gap in employment rates between DC residents with and without disabilities. According to the Census Bureau, 31% of DC residents with disabilities are employed, compared with 72% of people without disabilities. For working age District residents with cognitive disabilities (defined as having serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition) only 27% are employed.<sup>vii</sup> The most current data collected in 2013 show that only 13% of people with intellectual and developmental disabilities supported by DDA were competitively employed, slightly below the national rate of about 15%.<sup>viii</sup> Many young people with disabilities are not successfully transitioning from school to work.

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

**Larger employment trends in the District.**<sup>ix</sup> The District's economy is thriving in many respects, with an overall unemployment rate of only 6.1% and demand for middle and high-skilled jobs improving steadily. However, there are also significant disparities in our city on several key economic indicators. For example, nearly 30% of DC households earn only about half of the city's median household income. Similarly, while unemployment city-wide is low and declining, in Wards 7 & 8 it remains in the double digits at 11.8 and 14.7% respectively. Further, unemployment amongst certain populations, such as African Americans and youth is high and significantly exceeds the national average.

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

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

**Action Step 3.1:** Review and realign (if necessary) structures across the workforce development system to better support people with disabilities.

**Action Step 3.2:** Increase the capacity of staff across the Rehabilitation Services Administration (RSA) through on-site training to support best practices.

*Year 1:* Identify and develop core vocational rehabilitation curriculum training for RSA vocational rehabilitation (VR) staff to increase capacity to provide Person-Centered Training on an on-going basis. Provide regular, mandatory training for RSA vocational rehabilitation staff based on policies, procedures, protocols, best practices, and trends identified by the agency.

*Year 2:* Develop and implement a mentoring program for new staff to shadow and receive guidance from experienced colleagues.

*Year 3:* All VR staff will use Person-Centered-Thinking concepts to develop employment goals for persons served by RSA.

**Performance Metric(s):**

- % of Person-Centered Training courses completed by VR staff

**Action Step 3.3:** Increase the number of people with intellectual disabilities (IDD) and serious mental health diagnoses or serious emotional disturbance (SED) who obtain and maintain employment through better coordination of supported employment services with the Developmental Disabilities Administration (DDA) and the Department of Behavioral Health. (WIOA 1.5)

*Year 1:* Increase the number of VR Specialists to work specifically with people referred from DDA Supported Employment Services to ensure VR Specialist to Client ratio of 1:150 is maintained.

*Year 2:* Coordinate with DBH to provide training for all VR counselors regarding mental health and substance abuse treatment services available in the District. Review the DDS Protocol regarding

coordination of services between RSA and DDA, make necessary changes and provide training to all DDA Service Coordinators and VR Specialists.

*Year 3:* Assign three VR counselors to work with all people referred from DBH for evidence based supported employment services. Increase the number of VR Specialists to work specifically with people referred from DBH to ensure VR Specialist to Client ratio of 1:150 is maintained.

**Performance Metric(s):**

- # of people with serious mental health impairments (MHI) whose case is closed successfully after obtaining competitive integrated employment
- # of people with DD/IDD whose case is closed as successful after obtaining competitive integrated employment

**Action Step 3.4:** Increase the number of people with intellectual disabilities (IDD) and mental health impairments (MHI) who complete training programs that prepare them for jobs in high demand fields, increasing the number of employment placements in these fields.

*Year 1:* Obtain baseline data regarding performance outcomes for all current hospitality, health care, IT, construction and security training providers with which RSA has agreements in order to increase the number of effective training providers with agreements.

*Year 2:* Coordinate with DDA and DBH to increase the number of people with IDD or MHI served by RSA who complete training in identified high demand industries and obtain employment in these fields.

*Year 3:* Expand the provision of job readiness training for DCRSA job seekers, by both DCRSA Business Relations Unit (BRU) staff and through contracts with provider agencies. Provide training to counselors to ensure that they are able to use labor market information in assisting people to develop employment goals that are consistent with the person’s strengths, needs, resources, abilities, capabilities, and prepares the person for work that is available in high demand fields in the District economy.

**Performance Metric(s):**

- # of people of working age supported by DDA who receive employment services from RSA
- # of people supported by DBH who receive employment services from RSA
- % increase in the number of people with intellectual and developmental disabilities (IDD) supported by RSA who complete post-secondary training programs in high demand industries
- % increase in the number of people with mental health diagnoses supported by RSA who complete post-secondary training programs in high demand industries

| <b>Priority Area 3 Metrics:</b>  | <b>FY17</b> | <b>FY18</b> | <b>FY19</b> |
|--|-------------|-------------|-------------|
| % of Person-Centered Training courses completed by VR staff  | 33%         | 90%         | 100%        |
| # of people with DD/IDD whose case is closed as successful after obtaining competitive integrated employment   | 50          | 60          | 70          |
| # of people with mental health impairments whose case is closed successfully after obtaining competitive integrated employment   | 100         | 110         | 120         |
| # of people of people of working age supported by DDA who receive employment services from RSA   | 200         | 225         | 250         |
| # of people supported by DBH who receive employment services from RSA  | 500         | 525         | 550         |
| % increase in the number of people with intellectual and developmental disabilities (IDD) supported by RSA who enroll in complete post-secondary educational/training programs in high demand industries | Baseline    | 10%         | 10%         |
| % increase in the number of people with mental health diagnoses supported by RSA who complete post-secondary training in high demand industries  | Baseline    | 10%         | 10%         |

## ***Priority Area #4: Housing***

### *Why is this important?*

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

### *What is the Vision?*

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

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

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

**Lack of a housing continuum.** In the District, the most viable housing options for low-income people with long term care needs (especially those under age 55), hover at two ends of the spectrum: either in long term care facilities or in completely independent apartments or single family homes. There are currently only three Assisted Living Facilities operating under the District's EPD Waiver Program, with a total of 46 beds. "Affordable housing" may be targeted for people in the 50-80% Adjusted Median Income (AMI) level, meaning it is not affordable to people with incomes at or below 30% of the area AMI.

**Limited subsidies.** For many people with disabilities who need rental assistance, housing subsidies are not readily available. The DC Housing Authority stopped accepting new applications for housing assistance in 2013 because there was no meaningful movement on its waiting list.

**Homelessness.** Ending homelessness is one of the District's priority focus areas. In the homeless services program, the Department of Human Services assessed 40% of singles and 16% of adult heads of families entering shelters to have a disability in at least one of eight categories.<sup>x</sup> This Olmstead plan recognizes that people with disabilities living in long term care facilities who want to

return to the community, and do not have a home, may be at risk of joining DC's homeless population.

*Action Steps, Lead Entities and Timeframes*

**Action Step 4.1:** Operate and track the Safe at Home Program to target vulnerable District residents with a high risk of falls (DCOA and DHCD by December 2017).

*Year 1:* Establish a baseline for number of Safe at Home projects completed, and a method for identifying and focusing on completion of priority projects.

*Year 2:* Establish a method for tracking success of priority projects.

*Year 3:* Demonstrate reduced risk of falls as a result of successful Safe at Home program implementation.

**Performance Metric(s):**

- # of projects completed through Safe at Home

**Action Step 4.2:** Identify housing for individuals residing in nursing facilities who have been referred to ADRC's Community Transition Program because they want to live in the community (DCOA by December 2017).

*Year 1:* Shift the focus of DCOA's Housing Coordinator from general housing assistance to primarily assisting Community Transition clients in identifying housing. Establish a baseline for number of people who identified housing with the assistance of DCOA's Community Transition Program.

*Year 2:* Increase the number of people who are assisted in finding housing through the Community Transition Program by 10% compared to CY2017.

*Year 3:* Increase the number of people who are assisted in finding housing through the Community Transition Program by 10% compared to CY2018.

**Performance Metric(s):**

- # of people who, during discharge planning within DCOA's Community Transition Program, are successfully assisted in securing and sustaining permanent, affordable, suitable housing.

| <b>Priority Area 4 Metrics:</b>  | <b>FY17</b> | <b>FY18</b> | <b>FY19</b> |
|--|-------------|-------------|-------------|
| # of projects completed through Safe at Home   | Baseline    | 10%         | 10%         |
| # of people who, during discharge planning within DCOA’s Community Transition Program, are successfully assisted in securing and sustaining permanent, affordable, suitable housing. | Baseline    | 10%         | 10%         |

***Priority Area #5: Intake, Enrollment and Discharge Processes***

*Why is this important?*

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

*What is the Vision?*

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

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

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

**Staff capacity.** Staff from multiple agencies involved in multiple processes often do not have the full-system knowledge they need to effectively help people navigate through to a successful outcome. In addition, although most DC human services agencies have trained staff on person-

centered thinking and planning, the full culture shift needed to infuse all of these processes with this approach has not yet been achieved.

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

*Action Steps, Lead Entities and Timeframes*

**Action Step 5.1:** Develop a “person-centered profile” for use in NWD Core LTSS agencies with common information that can be collected by referral sources or state systems and shared to avoid duplication of effort.

*Year 1:* Develop a model person-centered profile for use across NWD Core LTSS agencies.

*Year 2:* Develop a template for agency-specific data collection protocols for the common person-centered profile information.

*Year 3:* Develop model implementation guidance on the use of person-centered profile across all NWD Core LTSS agencies.

**Action Step 5.2:** Implement an interagency case management system.

*Year 1:* Award interagency case management contract. Begin system development.

*Year 2:* Finalize system and train partner agency staff on new system for launch.

*Year 3:* Full implementation of interagency case management system.

**Action Step 5.3:** Develop guidance and training for case managers and service coordinators to ensure that the plans they create at intake and enrollment reflect a person’s preferences and needs, and plans are adjusted as necessary.

*Year 1:* For EPD Waiver case managers, implement quality assurance and monitoring strategies to review the inclusion of personal goals and health and safety risks in service plans.

*Year 2:* For EPD Waiver case managers, continue implementation of quality assurance and monitoring to review the inclusion of personal goals and health and safety risks in service plans.



*Year 3:* For EPD Waiver case managers, continue implementation of quality assurance and monitoring to review the inclusion of personal goals and health and safety risks in service plans.

**Action Step 5.4:** Increase the number of nursing facility discharges through improvements to DCOA’s Community Transition Program.

*Year 1:* Shift the focus of DCOA’s Housing Coordinator from general housing assistance to primarily assisting Community Transition clients in identifying housing. Broaden the role of community transition staff to include assisting MFP Outreach Coordinator in outreach work to nursing facilities. Draft and publish rule establishing the Community Transition Service in the EPD Waiver providing up to \$5,000 per person for household set-up and transition expenses for people transitioning from nursing facilities to the community.

*Year 2:* Implement the Money Follows the Person Sustainability Plan including broadening the role of both community transition staff and DCOA’s External Affairs and Communications Team to include targeted outreach to nursing facilities on home and community-based services (previously provided exclusively by MFP outreach coordinator). Support EPD Waiver Case Managers through training and collaboration in taking on the new role of transition coordination. Implement the Community Transition Service in the EPD Waiver providing up to \$5,000 per person for household set-up and transition expenses for people transitioning from nursing facilities to the community.

*Year 3:* Continuing to support EPD Waiver Case Managers through training and collaboration in taking on the new role of transition coordination.

**Performance Metric(s):**

- # of clients transitioned into the community with the assistance of DCOA’s Community Transition Program

| <b>Priority Area 5 Metrics:</b>   | <b>FY17</b> | <b>FY18</b> | <b>FY19</b> |
|---|-------------|-------------|-------------|
| %of EPD case managers that participated in training   | Baseline    | +10%        | +10%        |
| % of EPD waiver participants who have service plans that address their personal goals             | 86%         | 90%         | 95%         |
| % of EPD waiver participants who have service plans that address their health and safety risks    | 80%         | 86%         | 90%         |
| # of clients transitioned into the community with the help of DCOA’s Community Transition Program | 45          | 50          | 55          |

***Priority Area #6: Medicaid Waiver Management and Systems issues***

### *Why is this important?*

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

### *What is the Vision?*

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

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

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

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

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

**Unserved Populations.** In the District people diagnosed with DD, but not ID, as well as people with brain trauma/injury resulting in significant cognitive impairments after age 18 are not eligible for DDA services. If they are not physically disabled, they are not eligible for services under the EPD program either.

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

*Action Steps, Lead Entities and Timeframes*

**Action Step 6.1:** Develop the Individual and Family Supports Medicaid Waiver program for people with IDD who live in family homes, including services targeted to help families continue their support. (DDS, DHCF by December 2017)

*Year 1:* Review pre-existing service definitions (and the feasibility of adding new services) in preparation for the HCBS waiver renewal.

*Year 2:* Research individual and family support services across different jurisdictions.

*Year 3:* Develop and Initiate implementation of the Individual and Family Services (IFS) waiver.

**Performance Metric(s):**

- % decrease in average length of IDD Waiver application processes for those enrolling in waiver services in DDA

**Action Step 6.2:** Conduct training on how to access Medicaid Waiver services and troubleshoot during enrollment for agency, provider, DCOA lead agency, LTC facility, and hospital staff involved in the EPD Waiver process (DHCF, ADRC, DOH by May 2017).

**Action Step 6.3:** Assure quality in the newly implemented Participant Directed Services Program, allowing people receiving EPD Waiver services to have responsibility for managing and directing all aspects of service delivery, including who provides the services and how the services are provided (DHCF by December 2017).

**Action Step 6.4:** Implement complaint tracking and management system for the EPD Waiver Program.

| <b>Priority Area 6 Metrics:</b>                        | <b>FY17</b> | <b>FY18</b> | <b>FY19</b> |
|--|-------------|-------------|-------------|
| % decrease in average length of IDD Waiver application | 15          | 15          | 10          |

|  |          |      |      |
|--|----------|------|------|
| processes for those enrolling in waiver services in DDA (business days)                            |          |      |      |
| Average EPD and IDD Waiver enrollment times.   |          |      |      |
| # of public events/participants on LTSS system access and Medicaid Waiver protocols and processes. |          |      |      |
| # of PDS Program participants who expressed satisfaction with services                             | Baseline | +10% | +10% |
| %of EPD Waiver complaints investigated within 7 days   | 80       | 86   | 90   |
| % of EPD Waiver critical incident investigations that were completed and closed                    | 50       | 75   | 86   |

**Priority Area #7: Quality of Institutional and Community-Based Services, Providers and Workforce Leaders: DHCF, DCOA, DDS)**

**Action Step 7.1:** Reduce the number of nursing facility admissions by increasing accessibility to community-based services.

*Year 1:* Improve tracking mechanism for DCOA’s Options Counseling service and establish a baseline for number of people served through DCOA’s Options Counseling service. Note: Options Counseling is a person-centered discussion to assist an individual with understanding their long term care options and empowering them to make choices based on personal preference

*Year 2:* Increase the number of people served through DCOA’s Option Counseling service by 10% compared to CY2017. Develop a customer service tracking mechanism with the goal of correlating options counseling with reduced incidence of nursing facility admission.

*Year 3:* Increase the number of people served through DCOA’s Option Counseling service by 10% compared to FY2018, and continue to improve customer service tracking.

**Performance Metric(s):**

- # of people receiving Options Counseling service through DCOA.

**Action Step 7.2:** Assess and reduce duplication of services offered by Medicaid and DCOA (DHCF and DCOA by September 2017).

*Year 1:* Reduce duplication by tracking Case Management across DC funding sources; assisting DCOA grantees in becoming EPD Waiver providers; and establishing procedures to ensure against duplication for clients transitioning from one DC Case Management funding source to another.

*Year 2:* Establish a training and referral process for EPD Case Managers to ensure understanding of DCOA’s Senior Service Network, when it is appropriate to make referrals, and when it is appropriate for EPD Case Managers to access community service independently.

*Year 3:* Establish a baseline for tracking Medicaid service expenditures to improve service coordination and further reduce duplication in DHCF and DCOA case management services.

**Performance Metric(s):**

- # of DHCF and DCOA case management trainings completed collaboratively by both agencies annually.
- % of Medicaid beneficiaries using EPD Waiver services who also received assistance through DCOA’s Senior Service Network

**Action Step 7.3:** Review and strengthen regulatory options to more effectively deal with quality issues when they arise (DHCF, DDS, DBH, DOH by December 2016).

*Year: 1* Review agency and provider performance data from Provider Certification Reviews (PCRs), Provider Performance Reviews (PPRs), incident management and health and wellness standards to identify and address deficiencies in the DDA/DDS service delivery system.

*Year 2:* Identify specific providers with deficient performance based on year one data, and take appropriate actions, including, but not limited to, technical assistance or enhanced monitoring.

*Year 3:* As needed, update policy and procedures and amend applicable regulations to allow for stronger sanctioning of providers.

**Performance Metric(s):**

- % of waiver providers that pass certification on the initial provider certification review (PCR)
- % of people who receive the services for which they have been approved/authorized
- % decrease in number of people receiving supports from DDA in facility-based day programs (for

those spending 4 or more days per week in a day facility)

**Action Step 7.4:** Review all providers’ Language Access plans to ensure residents with limited English proficiency have access to linguistically and culturally appropriate services.

*Year 1:* Update all provider review tools by adding questions specifically addressing compliance with DDA’s Language Access plans and policies.

*Year 2:* Analyze data from the provider review tools (completed annually) to verify that all providers have Language Access plans and policies in place ensuring residents with limited English proficiency have access to linguistically and culturally appropriate services.

*Year 3:* Review case records for consumers with limited English proficiency to gain insight on what barriers still exist in terms of accessing services.

**Action Step 7.5:** Create a customer satisfaction survey to cover the five components of quality described above

**Action Step 7.6:** Strengthen assurance of EPD Waiver provider standards from provider enrollment to monitoring, and at three-year recertification.

**Action Step 7.7:** Establish EPD Waiver provider report card.

**Action Step 7.8:** Convene a monthly In-Home Supports Task Force

| <b>Priority Area 7 Metrics:</b>  | <b>FY17</b> | <b>FY18</b> | <b>FY19</b> |
|--|-------------|-------------|-------------|
| # of people receiving options counseling through DCOA  | Baseline    |             |             |
| # of DHCF and DCOA case management trainings completed collaboratively by both agencies annually                         | Baseline    |             |             |
| # of Medicaid beneficiaries using EPD Waiver Services who also received assistance through DCOA’s Senior Service Network | Baseline    |             |             |
| # of people enrolled in the 1915 (i) and EPD Waiver Adult Day Health Program   | Baseline    |             |             |
| % of EPD waiver providers that meet requirements prior to providing services   | 86          | <b>90</b>   | <b>95</b>   |

|   |          |             |             |
|---|----------|-------------|-------------|
| %of EPD waiver providers that continue to meet qualifications   | 95       | <b>100</b>  | <b>100</b>  |
| %of EPD Waiver beneficiaries selecting new provider agencies who use the provider report card to inform selection   | Baseline | <b>+10%</b> | <b>+10%</b> |
| % of waiver providers that pass certification on the initial provider certification review (PCR)  | 75%      | 80%         | 85%         |
| % of people who receive the services for which they have been approved/authorized.  | 75%      | 80%         | 85%         |
| % decrease in number of people receiving supports from DDA in facility-based day programs (for those spending 4 or more days per week in a day facility). | 5%       | 10%         | 10%         |

***Priority Area #8: Supporting Children and Youth***

***Why is this important?***

The number one predictor of post-school success for a student with a disability is paid work experience LoBianco, T., & Kienert, H. (2013). Additionally, students with disabilities must be taught requisite hard and soft skills, on a frequent basis, early and often to prepare them for the transition to the world of work. DDS/RSA is currently working with Local Education Agencies (LEAs) to create opportunities for children and youth students with disabilities to participate in a paid year-round work experience, aligned to their career interest, prior to leaving school.

***What is the Vision?***

Children and youthStudents with disabilities have the opportunity to experience, at minimum, one paid work experience in their field of interest, within in a competitive integrated environment, prior to exit from high school.

**Action Step 8.1:** Develop an inter-agency plan to ensure that students with disabilities who graduate with a certificate (rather than a diploma), have at least one community-based, integrated paid work experience prior to school exit. (WIOA 3.2)

*Year 1:* Establish a MOA with the D.C. Office of the State Superintendent of Education (OSSE) to identify schools to serve certificate track students and begin to draft MOAs with identified schools. Coordinate with D.C. Public Schools (DCPS) to provide work experiences for students in the D.C. Career Academy and for students participating in DCPS general exploration courses.

*Year 2:* Finalize MOAs with all schools that have identified students on certificate track to ensure coordination of services to provide for work-based learning experiences prior to exit from school. Collaborate in development of internship/worksites to provide work experiences.

*Year 3:* Attend pre-exit IEP meetings for all students on certificate track to ensure that appropriate integrated post-secondary activities (i.e. training, education, employment) are identified.

**Performance Metric(s)**

*(DOES, OSSE for reporting)*

- % of students with IEPs of 504 Plans receiving at least one Pre Employment Transition Service each school year
- % of students with disabilities that have a community-based, integrated paid work experience

**Action Step 8.2:** Increase the timely submission and completion of applications for adult DDA services for children with IDD who are in out of state residential facilities (DDA, DCPS).

*Year 1:* Review referrals to identify the amount of time the processing of cases for children with IDD transitioning from out of state facilities takes.

*Year 2:* Work closely with DCPS to improve the timely and accurate processing of comprehensive applications, including the submission of all relevant diagnostic documentation.

*Year 3:* Continue to work with DCPS to identify additional ways DDA can assist in streamlining the transition process.



**Action Step 8.3:** Develop NWD Person-Centered Practices curriculum and train Mentor Trainers to deliver the training to NWD Core LTSS agencies and community partners.

*Achieved: Trained Mentor Trainers and 12 PCT trainers*

*Year 1:* Offer NWD PCT training to government and provider staff and community partners at least 10x/ year.

*Year 2:* Work with various accreditation bodies to offer CEU credits for professional staff who attend NWD PCT training.

*Year 3:* Create a PCT section of the NWD webpage that includes PCT resources, including tools and webinars.

| <b>Priority Area 8 Metrics:</b>  | <b>FY17</b> | <b>FY18</b> | <b>FY19</b> |
|--|-------------|-------------|-------------|
| % of students with IEPs of 504 Plans receiving at least one Pre Employment Transition Service each school year | 75%         | 80%         | 90%         |
| # of students with disabilities that have a community-based, integrated paid work experience                   | 50          | 75          | 100         |
| #/% of applications received for youth transitioning into adult DDA services that are approved on-time         | 75%         | 85%         | 85%         |

***Priority Area #9: Wellness and Quality of Life***

**Action Step 9.1:** Increase inclusive<sup>xi</sup> daytime offerings for people with all abilities, and provide technical assistance and training to improve staff capacity at all agencies that provide community programming.

*Year 1:* Finalize and pilot “Inclusive Programming for All” training and gather feedback from stakeholders.

*Year 2:* Train at least 50% of DCOA’s grantee network on “Inclusive Programming for All” training. Develop agency-specific workgroups to assess the capacity for inclusive programming design within DCOA, DCPL and DPR programs.

*Year 3:* Pilot “Inclusive Programming for All” with DCPL and DPR programmatic staff. Develop work plan to enhance programmatic inclusiveness in DCOA, DCPL and DPR programs identified through the program assessment.

**Performance Metric(s):**

- # of new fully inclusive daytime program offerings
- % of DCOA programmatic staff trained on “Inclusive Programming for All”

**Action Step 9.2:** Identify ways to give people with disabilities and older adults in the District of Columbia better access to multiple transportation services, allowing for greater mobility with dignity and independence, and easier integration in the community

*Year 1:* DDOT will complete the accessDC study which will help identify implementation strategies to improve access to specialized transportation services to older adults and PWD.

*Year 2:* Establish a working group of partner agencies to meet regularly and implement short-term recommendations and identify funding for long term recommendations of the accessDC Study.

*Year 3:*  
Partner agencies begin to implement long term strategies of accessDC study.

**Performance Metric(s):**

- # of people using at least 2 transportation providers

| <b>Priority Area 9 Metrics:</b>  | <b>FY17</b> | <b>FY18</b> | <b>FY19</b> |
|--|-------------|-------------|-------------|
| # of new fully inclusive daytime program offerings   | Baseline    |             |             |
| % of DCOA, DCPL and DPR programmatic staff/ grantee network trained on “Inclusive Programming for All” | Baseline    |             |             |
| #/% of people with disabilities using at least 2 transportation services for which they are eligible   | Baseline    | +10%        | +10%        |

## II. 2017 Quantitative Transition Goals

The District continues to set quantitative goals that measure performance in integrating people with disabilities into the least restrictive environment possible, given each individual’s needs and the available resources. Building on their 2016 Olmstead action steps (see Appendix A), the four core service agencies (DCOA, DDS, DHCF and DBH) have set the following goals for 2017, with detail following the table:

| Agency | 2017 Goal   | Detail   |
|--------|---|--|
| DCOA   | 45 transitions from institutional settings, annually  | <ul style="list-style-type: none"> <li>Following a stay of at least 90 days (see Action Step 5.5)</li> </ul>   |
| DCOA   | Establish a baseline for number of people served through Options Counseling Services                        | <ul style="list-style-type: none"> <li>2017 is the first year collecting this information from all ADRC programs and services as an indicator of improved access to home and community-based services (see Action Step 7.1)</li> </ul> |
| DDS    | 165 transitions from day supports   | <ul style="list-style-type: none"> <li>Transition is from day supports in a congregate setting to a more integrated setting.</li> </ul>  |
| DHCF   | 30 transitions from institutional settings  | <ul style="list-style-type: none"> <li>Unduplicated count from the transition goals of other District agencies’ Olmstead goals.</li> </ul>   |
| DBH    | 70 transitions from Psychiatric Residential Treatment Facilities (PRTFs) or Saint Elizabeths Hospital (SEH) | <ul style="list-style-type: none"> <li>To home and community-based settings</li> <li>Following stays of 187 days or more from Saint Elizabeths Hospital</li> </ul>   |

DCOA:

DCOA expects to maintain its quantitative Community Transition goal of 45 for 2017, including people who have resided in a nursing facility for 90 days or more. This number does not differentiate between Money Follows the Person and Non-Money Follows the Person clients as it has in past years. DCOA is also committed to illustrating the District's efforts to help improve access to home and community-based resources by establishing baseline data for the number of people were served through options counseling service. Over the next three years, DCOA will improve its evaluation and data collection methods, with the goal of illustrating a correlation between increased/improved option counseling services and reduction in institutionalization.

#### *DDS:*

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

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

#### *DHCF:*

DHCF maintains its goal of transitioning 30 people from institutional settings. In 2016, the goal was increased from 20 to 30 to reflect the addition of the Adult Day Health Program. Based on actual discharges from Long Term Care facilities and enrollment within 60 days in Medicaid home and community-based services, this goal is consistent with performance over the year.

#### *DBH:*

DBH retained its 2016 goal in 2017 because 1) the goal is specific to people who have a length of stay at Saint Elizabeths Hospital; and 2) fewer children are being placed in PRTFs because DBH has been successful in collaborating with other agencies to provide alternative wrap-around care, when possible, which diverts children and youth from residential care and also because DBH instituted Psychiatric Residential Treatment Facility (PRTF) Placement Criteria in April 2011. All

child-serving agencies seeking PRTF placements are required to complete a specific referral form and submit it to the DC PRTF Review Committee, which is responsible for making the Level of Care determination for individuals who are eligible for Medicaid reimbursement. The committee is chaired by a psychiatrist, the DBH Associate Chief Clinical Officer, and is comprised of representatives from Child and Family Services Agency, Department of Youth Rehabilitation Services, the Office of the State Superintendent of Education, District of Columbia Public Schools, Court Social Services and a parent advocate. The criteria are used to ensure that youth initially placed in residential care as well as those reviewed for continued stay meet medical necessity for that level of care. The implementation of the DC PRTF Review Committee and the utilization of the PRTF Placement Criteria have also helped decreased the number of youth ultimately placed in PRTFs for treatment.

## Glossary of Acronyms

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

ID/DD: Individuals with Developmental and Intellectual Disabilities  
ILOB: Independent Living Older Blind Program  
ILS: Independent Living Services  
LOC: Level of Care  
LOS: Length of Stay  
LTSS: Long Term Services and Supports  
MFP: Money Follows the Person Rebalancing Demonstration Grant  
MH/BH: Mental Health/Behavioral Health  
MHCRFs: Mental Health Community Residence Facilities  
MTM: DC Non-Emergency Transportation  
NCI: National Core Indicators  
NWD: No Wrong Door  
ODR: Office on Disability Rights  
OSSE: Office of the State Superintendent for Education  
PCP: Person-Centered Practice  
PRTFs: Psychiatric Residential Treatment Facilities  
RSA: Rehabilitation Services Administration in DDS  
SILC: DC Statewide Independent Living Council  
SIM: State Innovation Model  
SNAP: Supplemental Nutrition Assistance in DHS Program  
TANF: Temporary Assistance for Needy Families in DHS  
VR: Vocational Rehabilitation  
WMATA: Washington Metropolitan Area Transit Authority

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## Endnotes

- <sup>i</sup> This does not include IDD HCBS Waiver providers.
- <sup>ii</sup> DHS assesses the following categories of disability: “Alcohol Abuse,” “Drug Abuse,” “Both Alcohol and Drug Abuse,” “Chronic Health Condition,” “Developmental,” “HIV/AIDS,” “Mental Health Problem,” and “Physical.”
- <sup>iii</sup> Out of 3,355 unique individuals who received nursing facility services in FY16 paid for by Medicaid, 2,734 received services at an in-state facility, and 643 received services at an out-of-state facility. Some individuals received services at both in-state and out-of-state facilities during the year.
- <sup>iv</sup> All transitions listed are only transitions that were facilitated by the District through MFP and NHT.
- <sup>v</sup> This total does not include assisted living facilities that do not receive Medicaid reimbursement. There are several assisted living facilities in the District that only accept private-pay patients.
- <sup>vi</sup> Led by DHCF, the SIM work brings together DOH, DBH, DHS, the Office of the DMHHS, Councilmember Yvette Alexander’s office; community-based health and social service providers; private health insurers and beneficiary advocates.
- <sup>vii</sup> 2013 American Community Survey (ACS), U.S. Bureau of the Census.
- <sup>viii</sup> John Butterworth *et al.*, StateData: The National Report on Employment Services and Outcomes (Institute for Community Inclusion (UCEDD) University of Massachusetts Boston 2014).
- <sup>ix</sup> Data provided by the DC Department on Employment Services
- <sup>x</sup> DHS assesses the following categories of disability: “Alcohol Abuse,” “Drug Abuse,” “Both Alcohol and Drug Abuse,” “Chronic Health Condition,” “Developmental,” “HIV/AIDS,” “Mental Health Problem,” and “Physical.”
- <sup>xi</sup> “Inclusive Programming’ is the integration of all people, regardless of age and regardless of functional ability, in leisure and recreational activities that are developed for the general community population. Inclusive programming includes, but is not limited to using an inclusive approach to recreation and leisure in many, diverse ways such as a.) administrative support, b.) nature of the program, c.) nature of the activities, d.) environmental/logistical considerations, and e.) programming techniques and methods—so that every resident can participate and benefit from a typical recreation or leisure experience in the community.” Gaylord, V., Lieberman, L., Aberly, B. & Lais, G. (Eds.). (2003). *Impact: Feature Issue on Social Inclusion Through Recreation for Persons with Disabilities*, 16(2) Minneapolis: University of Minnesota, Institute on Community Integration. Available from <http://ici.umn.edu/products/impact/162>.  
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