DISTRICT OF COLUMBIA

STATE PLAN ON AGING

Fiscal Years 2017 - 2018

I. VERIFICATION OF INTENT

The District of Columbia State Plan on Aging is hereby submitted for the District of Columbia for the period of October 1, 2016 through September 30, 2018. The plan includes all assurances and plans to be conducted by the District of Columbia Office on Aging (DCOA) under provisions of the Older Americans Act of 1965 as amended in 2006 (Public Law 109-365).

The State Agency named above has been given the authority to develop and administer the State Plan on Aging in accordance with all requirements of the Act and is primarily responsible for the coordination of all state activities related to the purposes of the Act. For example, the development of comprehensive and coordinated community based systems for the delivery of supportive services, including multipurpose senior centers and nutrition services, and to serve as the effective and visible advocate for the elderly in the State.

The Plan, accordingly, is hereby approved by the Mayor and constitutes authorization to proceed with activities under the Plan upon approval of the Assistant Secretary on Aging.

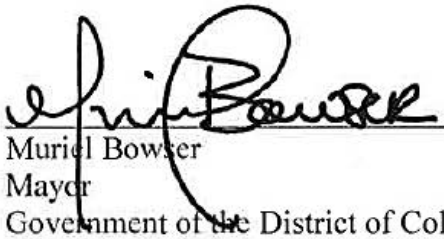
The State Plan on Aging is hereby submitted and has been developed in accordance with all federal statutory and regulatory requirements.

July 15, 2016

Laura Newland
Executive Director
District of Columbia Office on Aging

Date

I hereby approve this State Plan on Aging and submit it to the Assistant Secretary for Aging for approval.



July 15, 2016

Muriel Bowser
Mayor
Government of the District of Columbia

Date

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II. Executive Summary

A. Plan's Purpose

The District of Columbia State Plan on Aging (State Plan) is the blueprint for coordinating and delivering services and supports to be provided through the Office on Aging and covers the next two years (October 1, 2016 to September 30, 2018).

The State Plan on Aging provides a description of the District of Columbia Office on Aging's (DCOA) roles and responsibilities, challenges and focuses. The plan provides a blueprint to improve and expand quality health and social support services to older District residents (age 60 and older), people with disabilities (ages 18 to 59), and their caregivers.

B. Senior Service Delivery System

DCOA administers the provisions of the Older Americans Act (OAA) through a competitive grant making and procurement process to a Senior Service Network (SSN) comprised of 20 community-based non-profit organizations. Specifically, DCOA administers OAA core programs from Title III and Title VII—supportive services, nutrition, health promotion, caregiver support, and elder rights services—through 37 programs in the SSN. Crucial to this network are Lead Agencies that offer a broad range of legal, nutrition, social and health services. The goal of these agencies is to enhance the quality of life for older adults and their families throughout all eight wards of the District of Columbia. The agencies accomplish this goal through service delivery and widespread distribution of information about the variety of services and programs offered to older adults throughout the city.

Additionally, DCOA operates the Aging and Disability Resource Center (ADRC), which provides a coordinated system of information and access for individuals seeking long-term care services and supports. ADRC provides information, counseling, and service access to older adults, people with disabilities, and caregivers. DCOA began to manage and operate the ADRC in 2009 through a Memorandum of Understanding (MOU) with the Department of Health Care Finance (DHCF).

C. Development of the Plan

The development process for the State Plan was initiated in fiscal year 2016, following the guidelines and program instructions issued by the U.S. Administration for Community Living (ACL). Community leaders and other stakeholders look to DCOA for guidance in designing sustainable models of service, collecting data to assess critical needs, and ensuring oversight and accountability of the service delivery system. The process for developing the State Plan included the input from various stakeholders, including the DC Commission on Aging (a mayoral appointed citizen's advisory group), the Senior Service Network, consumers, residents, advocacy groups and organizations, and health and human services providers (see Attachment D which describes the community participation process).

D. DCOA Direction

The State Plan is consistent with Mayor Muriel Bowser's vision to create an Age-Friendly DC—an urban environment that promotes active and healthy aging. This movement is designed to address two significant demographic trends: urbanization and aging. The District is making investments in ten overarching domains: (1) Outdoor Spaces and Buildings, (2) Transportation, (3) Housing, (4) Social Participation, (5) Respect and Social Inclusion, (6) Civic Participation and Employment, (7)

Communication and Information, (8) Community Support and Health Services, (9) Emergency Preparedness and Resilience, and (10) Elder Abuse, Neglect and Fraud.

Additionally, the District's goal is to operate a coordinated, District-wide, No Wrong Door (NWD) system that will support all D.C. residents in need of long-term services and supports (LTSS), regardless of where they enter the system. In October 2014, D.C. received a grant from ACL to develop a three-year plan to transform current LTSS programs and processes in the District. The objectives are to design a NWD system that is: (1) Person and family-centered—connecting people with LTSS based upon what is important to and for them and their families; (2) Culturally and linguistically competent—being responsive to cultural preferences, needs, and the diverse languages spoken by people in the District of Columbia; (3) Respectful and provides excellent customer service; (4) Inclusive and integrated—supporting people to live at home, with the services they prefer and need to be independent and fully included in all aspects of their community life; (5) Community-based—linking people with LTSS through a coordinated and comprehensive network of public and private supports.

E. Federal and State Cohesion

DCOA's State Plan goals and objectives were guided by the strategic goals established by ACL's Strategic Plan for years 2013 to 2018. ACL's goals include:

1. Advocate to ensure the interests of people with disabilities, older adults, and their families are reflected in the design and implementation of public policies and programs.
2. Protect and enhance the rights of, and prevent the abuse, neglect, and exploitation of, older adults and people with disabilities.
3. Work with older adults and people with disabilities as they fully engage and participate in their communities, make informed decisions, and exercise self-determination and control about their independence, well-being, and health.
4. Enable people with disabilities and older adults to live in the community through the availability of and access to high-quality long-term services and supports, including supports for families and caregivers.
5. Implement management and workforce practices that support the integrity and efficient operations of programs serving people with disabilities and older adults and ensure stewardship of taxpayers' dollars.

DCOA and the Senior Service Network continue to work towards promoting aging in place policies that empower older adults, people with disabilities, and caregivers to make informed decisions and remain independent in their neighborhoods and communities for as long as possible. DCOA's State Plan goals and objectives are:

Goal 1: Strengthen core program operations and service coordination.

Objective 1: Evaluate internal agency operations and procedures to ensure effective and efficient program monitoring and support.
Objective 2: Assess community needs and service gaps to improve connectivity to appropriate services and supports.
Objective 3: Identify best practices and implement strategies to expand delivery of and access to services and supports.
Objective 4: Reduce duplication of services with other District Government and community-based providers.

Goal 2: Promote awareness and access to long-term care services and supports offered in the District.

Objective 1: Work closely with other District Government health and human service agencies to develop and implement strategies for a "No Wrong Door" (NWD) approach to accessing long-term care services and supports.
Objective 2: Integrate the "Alzheimer's Disease Initiative" with core programs.

Goal 3: Promote aging in place with dignity and respect.

Objective 1: Partner with District of Columbia's Homeland Security and Emergency Management Agency (HSEMA) to review and update the District Preparedness System (DPS).
Objective 2: Integrate and implement initiatives outlined in the District Olmstead Plan.
Objective 3: Support and promote efforts for the District to become a recognized Age-Friendly City.
Objective 4: Promote the development and sustainability of senior villages in the District.

Goal 4: Ensure the agency is driven by customer experience.

Objective 1: Develop and implement strategies to expand opportunities to offer input in agency decision-making process.
Objective 2: Implement person-centered practices that match other District Government health and human service agencies in accordance with the No Wrong Door work plan.

F. Challenges

In 2015, the District of Columbia estimated a population of 658,893 residents and projected an approximate net gain of 1,000 new residents per month. The older adult population (age 60 and older) in the District is approximately 16.2 percent of total population, 107,711. With baby boomers retiring and moving into the city and people living longer, the District expects the older adult population to continue to increase. The District is working to provide greater opportunities for people to age in the community, because DC has been ranked as one of the top ten most expensive cities to live in the U.S. when considering housing, transportation, food, entertainment, and healthcare costs.[1] During a survey conducted between April 18, 2016 and May 31, 2016 by DCOA, District older adults identified that housing and health services are the top two priorities for aging in the community.

[1] "Cost of Living - Washington, DC," NerdWallet, n.d. Web.

III. District of Columbia State Plan on Aging Narrative

A. Mission Statement

The mission of the District of Columbia Office on Aging (DCOA) is to advocate, plan, implement, and monitor programs in health, education, employment, and social services that promote longevity, independence, dignity, and choice for older District residents (age 60 and older), people with disabilities (ages 18 to 59), and their caregivers.

B. Vision

The District of Columbia Office on Aging (DCOA) is committed to assisting older adults and people with disabilities remain independent and involved in their neighborhoods and communities for as long as possible, commonly known as aging in place. Since 1975, DCOA has been building a network of programs and services that help District older adults age in place with programs including health, wellness, education, employment, and safety. DCOA's vision for the future embraces a strategic direction that incorporates past goals and objectives, new and innovative programs that consider current trends and baby boomer needs, as well as programs that work harmoniously with existing ones to enhance outreach, advocacy and coordination of services, and meet the special needs of low-income and multicultural populations.

C. District of Columbia Office on Aging (DCOA)

DCOA was established by the Mayor in 1975 to plan, develop, and implement programs and services for residents age 60 and older. In 2009, DCOA expanded its scope to include services for people with disabilities between ages 18 and 59.

DCOA acts as both the District's State Unit and Area Agency on Aging and is structured to carry out advocacy, leadership, management, programmatic, and fiscal responsibilities. The agency operates the Aging and Disability Resource Center (ADRC), which provides a coordinated system of information and access for people seeking long-term services and supports. Additionally, the agency funds a Senior Service Network comprised of 20 community-based non-profit and private organizations that operate 37 programs. These programs provide services that are vital and life sustaining and life enhancing for the District's older adults (age 60 and older), people with disabilities (ages 18 to 59), and their caregivers.

DCOA's annual budget is more than $40 million, which is comprised of approximately 82 percent District funds and 18 percent federal funds. In FY 2016, more than 80 percent of DCOA's budget is allocated to the Senior Service Network to provide direct services and supports in the community. The agency has 69 full-time employees who provide direct services and monitor and support DCOA funded programs and services in the community.

In FY 2015, DCOA grantees in the Senior Service Network served 17,610 older adults and the ADRC served 5,859 older adults and people with disabilities. The most requested services by older adults were community dining (formerly known as congregate meals) and home delivered meals, in-home support, case management, transportation, and health and wellness services. By comparison, the most used services were community dining and home delivered meals, wellness programs and transportation.

D. Legislative Authority

Legal Basis: DCOA is designated by the Mayor as the State and Area Agency on Aging under D.C. Law 1-24; therefore DCOA is responsible for the administration of programs under the Older Americans Act. This responsibility includes the coordination and development of the State Plan on Aging to receive federal funding under the Older Americans Act as amended.

D.C. Law 1-24, codified as amended at D.C. Official Code §§ 7-501.01 (2001) et seq., states that the District of Columbia government "shall insure a full range of health, education, employment, and social services shall be available to the aged in the District of Columbia, and the planning and operation of such programs will be undertaken as a partnership of older citizens, families, community leaders, private agencies, and the District of Columbia government." D.C. Official Code § 7-501.01 (2001).

The law established the Office on Aging as the "single administrative unit, responsible to the Mayor, to administer the provisions of the Older Americans Act (P.L. 89-73, as amended), and other programs as shall be delegated to it by the Mayor or the Council of the District of Columbia, and to promote the welfare of the aged." DC Official Code § 7-503.01 (2001).

DC Law 1-24 as amended also established the Commission on Aging, a 15 person citizen's advisory group that advises the Executive Director of the Office on Aging, the Mayor, and the Council of the District of Columbia on the needs and concerns of older Washingtonians.

E. Local Statistics and Trends

The District of Columbia has an estimated population of 658,893 residents. From 2010 to 2014, the D.C. Office on Planning estimated, using Census data, that the District's population increased by 53,683 people, of which 7,992 were age 60 years and above. The older adult population (age 60 and older) in the District is 107,117 (16.2 percent of total population), with 20,190 persons 80 years of age and older.

Between 2010 and 2014, the District experienced a high rate of people entering the city for retirement. The number of District residents 60 years and older grew 8.1 percent, which is 1.5 percent more than grade school aged residents (ages 5 to 18 years old). The cohort age 65 to 69 years old (the oldest segment of baby boomers in 2014) was the fifth fastest growing age group. An additional growth factor is that District older adults are living longer. District residents 85 years and older grew by 7.5 percent during this period.

The older adult population is expected to continue growing in the District and across the United States. By 2030, all surviving baby boomers in the U.S. will be 66 to 84 years old and are predicted to represent 20 percent (one in five) of the total population at that time.[2] In 2010, baby boomers made up 23.2 percent of the District population, evidence of a critical need to evaluate aging services necessary to foster the health of this population group. In 2014, baby boomers made up 20.2 percent of the District population. However, each age cohort of baby boomers in 2014 is larger than the same age cohort in 2010. For example, District residents 65 to 69 years old grew 16.9 percent between 2010 and 2014.

[2] "Global Age-friendly Cities: A Guide." World Health Organization (2007). n.d. Web.

DISTRICT OF COLUMBIA

POPULATION 60 YEARS AND OLDER FROM 2010 TO 2014

DEMOCRAPHIC INFO	2010	2014	Growth between 2010 and 2014	Percent of District Pop. 60 years and over
Population 60 to 64 years	30,055	32,363	7.68%	30.2%
Population 65 to 69 years	21,593	25,232	16.85%	23.6%
Population 70 to 74 years	15,553	17,206	10.63%	16.1%
Population 75 to 79 years	11,819	12,126	2.60%	11.3%
Population 80 to 84 years	9,687	8,987	-7.23%	8.4%
Population 85 years and over	10,418	11,203	7.54%	10.5%
Population 60 years and over	99,125	107,117	8.06%	100.0%
Median age of Population 60 years and over	68.9	69.6	1.02%	NA
Population 60 years and over, White	34,996	38,660	10.47%	36.1%
Population 60 years and over, African American	60,384	64,086	6.13%	59.8%
Population 60 years and over, American Indian and Alaska Native	377	445	18.04%	0.4%
Population 60 years and over, Asian	2,124	2,484	16.95%	2.3%
Population 60 years and over, Native Hawaiian and Other Pacific Islander	51	74	45.10%	0.1%
Population 60 years and over, Two or more races	1,193	1,368	14.67%	1.3%
Population 60 years and over, Female	57,737	62,109	7.57%	58.0%
Population 60 years and over, Male	41,388	45,008	8.75%	42.0%
Population 60 years and over, Veteran	16,851	16,389	-2.74%	15.3%
Population 60 years and over, with Disability living at home	29,466	34,851	18.27%	32.5%

EDUCATIONAL ATTAINMENT	2010	2014	Growth between 2010 and 2014	Percent of District Pop 60 years and over
Population 60 years and over, less than high school graduate	19,726	14,996	-23.98%	14.0%
Population 60 years and over, high school graduate, GED, or alternative	24,187	25,494	5.41%	23.8%
Population 60 years and over, some college or associate's degree	17,347	21,852	25.97%	20.4%
Population 60 years and over, bachelor's degree or higher	37,965	44,668	17.66%	41.7%

EMPLOYMENT STATUS	2010	2014	Growth between 2010 and 2014	Percent of District Pop 60 years and over
Population 60 years and over, in labor force - employed	30,630	32,349	5.61%	30.2%
Population 60 years and over, in labor force - unemployed	2,379	2,035	-14.45%	1.9%
Population 60 years and over, not in labor force	66,116	72,732	10.01%	67.9%

Source: U.S. Census Bureau, 2014 American Community Survey 1-Year Estimates and 2010 American Community Survey 1-Year Estimates

POVERTY STATUS IN THE PAST 12 MONTHS	2010	2014	Growth between 2010 and 2014	Percent of District Pop 60 years and over
Population 60 years and over, below 100 percent of the poverty level	14,160	16,486	16.43%	15.8%
Population 60 years and over, 100 to 149 percent of the poverty level	8,105	8,661	6.85%	8.3%
Population 60 years and over, at or above 150 percent of the poverty level	75,387	79,197	5.05%	75.9%

HOUSEHOLDS BY TYPE	2010	2014	Growth between 2010 and 2014	Percent of District Pop 60 years and over
Households of population 60 years and over ("Household")	67,588	71,499	5.79%	
Household, not living alone with family	26,900	29,744	10.57%	41.6%
Household, not living alone with non-family	2,704	2,788	3.14%	3.9%
Household, living alone	37,984	38,967	2.59%	54.5%
Household, owner occupied	40,485	43,757	8.08%	61.2%
Household, renter occupied	27,103	27,742	2.36%	38.8%
Population 60 years and over, living with grandchild(ren)	5,254	5,034	-4.17%	4.7%

HOUSEHOLD INCOME IN THE PAST 12 MONTHS	2010	2014	Growth between 2010 and 2014	Percent of District Pop 60 years and over
Household, with earnings	33,591	35,821	6.64%	50.1%
Household, with Social Security income	41,972	42,756	1.87%	59.8%
Household, with Supplemental Security Income	5,069	6,292	24.12%	8.8%
Household, with cash public assistance income	1,217	2,002	64.56%	2.8%
Household, with retirement income	30,820	31,817	3.23%	44.5%
Household, with Food Stamp/SNAP benefits	7,570	10,582	39.79%	14.8%
Mean Social Security income (dollars)	$14,149.00	$15,588.00	10.17%	
Mean Supplemental Security Income (dollars)	$7,394.00	$7,657.00	3.56%	
Mean cash public assistance income (dollars)	$5,084.00	$3,171.00	-37.63%	
Mean retirement income (dollars)	$37,192.00	$41,845.00	12.51%	

Source: U.S. Census Bureau, 2014 American Community Survey 1-Year Estimates and 2010 American Community Survey 1-Year Estimates

F. Issues and Challenges

1. Abuse, Neglect and Financial Exploitation

The U.S. Department of Justice and U.S. Department of Health and Human Services indicate that the exploitation and abuse of vulnerable adults affects approximately five million Americans each year. However, incidents are widely unreported due to fear, embarrassment, protection of family who are perpetrating the crime and denial. In fact, studies suggest that only 1 in 14 cases of elder abuse are reported or come to the attention of authorities.[3] In the absence of a large-scale, national tracking system, studies of prevalence and incidence of abuse, neglect, and exploitation of older Americans conducted over the past few years by independent investigators have been critical in helping to understand the magnitude of this problem. In Fiscal Year 2014, the District of Columbia Adult Protective Services (APS) reported 831 cases of abuse, neglect, self-neglect and exploitation of vulnerable adults, not including unreported incidents.

2. Aging in Place

Community living offers important health and financial benefits for older adults and people with disabilities, as well as for the entire District community. The opportunity for older adults to maintain meaningful relationships in their neighborhoods and maintain familiar comforts of daily living has emotional, social, and health benefits. According to the U.S. Department of Housing and Urban Development, "civic engagement… can reduce mortality; increase physical function, muscular strength, and levels of self-rated health; reduce symptoms of depression and pain; and increase life expectancy."[4]

Community living for older adults and people with disabilities also benefits the larger District community by reducing the need for unnecessary nursing home placements and the significant expense associated with nursing home care. Genworth Insurance Company's 2016 Cost of Care Survey reported that in the District of Columbia the median annual rate for home health aide services was $54,912 compared to $121,363 for a semi-private room in a nursing home, and trends show the disparity is growing.[5] Over the past five years, the average increase in annual cost of a private nursing home room has far exceeded the rate of inflation, which means high costs for consumers and increased pressure on government entitlement programs.

3. Alzheimer's disease and related dementia

Alzheimer's disease (AD), a progressive, degenerative disease of the brain and the most common dementia, is a difficult disease to manage—for the individual, the family and for governmental and non-governmental agencies and service providers mandated to help alleviate the resulting burdens. According to the Alzheimer's Association, in 2014 approximately 9,200 individuals in the District 65 years and older live with Alzheimer's.[6] People who reach the age of 85 without incidence of dementia have a twenty-fold greater short-term risk for developing dementia than those who reach the age of 65 without dementia. Furthermore, approximately 27,000 individuals care for a person with Alzheimer's disease and related dementia (ADRD) and close to 31 million hours of unpaid care was provided in 2013.[7] Alzheimer's disease was ranked the 7th leading cause of death in the District of Columbia in 2011.

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[3] Richard J Bonnie and Robert B Wallace, "Elder Mistreatment." *National Academies Press (US)* (2003): n. pag. Web.
[4] Measuring the Costs and Savings of Aging in Place. U.S. Department of Housing and Urban Development, n.d. Web.
[5] Long Term Care Costs & Cost of Care in 2016. Genworth Insurance Company, Apr. 2016. Web. 16 June 2016.
[6] "2014 Alzheimer's Disease Facts and Figures." Alzheimer's & Dementia 10.2 (2014). Alzheimer's Association. Web.
[7] Ibid.

4. Caregiver Support

More than 65 million people, 29 percent of the U.S. population, provide care for a chronically ill, disabled or aged family member or friend during any given year and provide an average of 20 hours of care per week. Caregiving families—families in which one member has a disability—have median incomes that are more than 15 percent lower than non-caregiving families. In every state, including the District of Columbia, the poverty rate is higher among families with members with a disability than among families without.

5. Falls Prevention

Across the nation, falls among older adults are the leading cause for both fatal and nonfatal injuries. Falls among older adults may lead to severe physical and cognitive health problems that result in extended stays in hospitals and long-term care facilities. An older adult's hospital stay after a fall could last up to 15 days; and in the case of hip fractures, the most common fall related injury, stays may extend to 20 days. Studies indicate that individuals 75 years and older who fall are four to five times more likely to be admitted to a long-term care facility for greater than a year. An article in the American Journal of Epidemiology found that fall-related "injuries are directly related to the loss of independence and may further limit mobility due to fear of falling." Furthermore, the World Health Organization reports that "loss of autonomy, confusion, immobilization and depression" are common in patients experiencing "post-fall syndrome," and leads to further restrictions in daily activities. The D.C. Chief Medical Examiner reported that in 2013, 70 percent of accidental deaths among District residents ages 65 years and older were due to falls, making it the leading cause of older adult deaths for the fourth year in a row.

6. Housing

Since 1999, there have been over 2,000 public and private subsidized units reserved for older adults in D.C. The city now has 50 subsidized apartment developments totaling over 7,000 units. Many older adults are aging in place in these facilities and will require in-home support services. According to the D.C. Department of Housing and Community Development's (DHCD) Five Year Consolidated Action Plan for fiscal years 2011-2015, the goal for special needs housing for elderly, disabled and homeless is 895 units. In addition, over half of elderly homeowners live in homes over 30 years old. Most do not have handicapped features or amenities, and are "house rich but cash poor." In 2012, the DC Fiscal Policy Institute found that nearly 30 percent of District homeowners 60 years and older spend more than half of their income on housing, which is known as a "severe housing cost burden."[8] Results of the State Plan Community Survey (see Attachment D) support the importance of affordable housing in the senior community. One in three survey respondents identified housing as the number one priority for aging in the community; and when asked "What services and/or supports do you believe are missing in the community that would allow District seniors to age in place?" affordable housing was the most common answer, with 15.6 percent of respondents answering with housing.

7. Hunger

Older adult hunger is an important issue affecting 15.8 percent of older adults or 10.2 million older adults nationally. Older adults are more likely to face hunger if they are low-income, a racial or ethnic minority, living in the South or Southwest United States, a younger senior (ages 60-69), divorced or separated, a grandparent raising a grandchild, or person with disabilities. This is especially significant as older adults who face hunger are significantly more likely to have diabetes, depression, high blood pressure, congestive heart failure, or a heart attack, and more likely to report fair or poor general health,

[8] Reed, Jenny. "Disappearing Act: Affordable Housing in DC Is Vanishing Amid Sharply Rising Housing Costs." (n.d.): n. pag. DC Fiscal Policy Institute, 7 May 2012. Web.

gum disease, asthma, and at least one activity of daily living (ADL) limitation. In the District, one in five older adults reported that they faced the threat of hunger in 2014.[9]

8. Social Isolation and Underserved Populations

Social Isolation has proven negative impacts on physical and mental health, particularly for older adults. Studies indicate that feelings of loneliness are linked to poor cognitive performance and quicker cognitive decline. Additionally, research suggests that long-term illnesses and issues of mobility are associated with social isolation. According to a 2015 study by Brigham Young University, living alone had a greater impact to a person's health, increasing mortality risk by 32 percent. One study indicates that, "Despite… greater residential kinship ties, [African American and Hispanic older adults'] network size, network range and number of friends appear to be much smaller." Barriers to accessing programs include socioeconomic issues, such as transportation options outside of the family, and education. In the District, the majority of older adults, 54.5 percent, live alone. Social isolation impacts demographic groups differently. LGBTQ older adults are twice as likely to live alone and face isolation. According to a 2011 national health study on LGBTQ older adults, 53 percent of responders indicated they feel isolated from others. The District is estimated to have the largest percentage of LGBTQ residents in the nation, approximately 10 percent of the total District population. Racial minority older adults have an increased perception of isolation and social disconnectedness.[10]

9. Transportation

To maintain independence, all people, including old adults, need transportation options. A survey by the American Public Transportation Association determined that 82 percent of respondents 65 years of age or older are very concerned about becoming "stranded" and unable to travel short distances when they can no longer drive. These concerns have been validated by a study which found that seniors age 65 and older who no longer drive make 15 percent fewer trips to the doctor, 59 percent fewer trips to shop or eat out, and 65 percent fewer trips to visit friends and family, than drivers of the same age.[11] According to the 2010 Census, more than one third (37 percent) of District older adults had no personal vehicle at their disposal.

G. Services and Supports

DCOA administers the Older Americans Act (OAA) core services—supportive services, nutrition, health promotion, caregiver support, and elder rights—through the Senior Service Network (SSN), comprised of 20 community-based non-profit and private organizations that operate 37 programs. These programs provide vital and life sustaining services and supports for the District's older adults (age 60 and older), people with disabilities (ages 18 to 59), and their caregivers.

In FY 2016, DCOA commissioned a needs assessment and feasibility study to help identify older adult needs in the District and how the District can best meet those needs. The final report will analyze the District's demographic trends, program services and supports, facility capabilities and opportunities, and national best practices. The needs assessment will help identify service gaps and community demands that will inform the agency's future service provision.

[9] Dr. James P. Ziliak and Dr. Craig G. Gundersen. "State of Senior Hunger in America 2014: An Annual Report." (2016): n. pag. National Foundation to End Senior Hunger. Web.

[10] Christina E. Miyawaki "Association of Social Isolation and Health across Different Racial and Ethnic Groups of Older Americans." U.S. National Library of Medicine, Nov. 2015. Web.

[11] Linda Bailey, "Aging Americans: Stranded Without Options." Surface Transportation Policy Project (2004): n. pag. Web.

Each of the services and supports are organized in the following three categories. Refer to Attachment G for a complete list of services, and refer to Attachment F for a complete list of providers in the SSN.

1. Customer Information, Assistance and Outreach

DCOA provides information, assistance, and outreach for a variety of long-term care needs to older adults, people with disabilities, and caregivers regarding long term care services and supports offered in the District.

a) Advocacy and Elder Rights—provides legal support and advocacy for elder rights for District residents age 60 or older that need assistance with relevant state laws, long-term planning, complaints between residents/families and nursing homes and other community residential facilities for older adults (LTC Ombudsman—Title VII Funding).
b) Assistance and Referral Services—provides information on, connection to, and assistance with accessing home and community-based services, long-term care options, and public benefits for District residents age 60 or older, people with disabilities between the ages of 18 and 59, and caregivers.
c) Community Outreach and Special Events—provides socialization, information, and recognition services for District residents age 60 or older, people with disabilities between the ages of 18 and 59, and caregivers in order to combat social isolation, increase awareness of services provided, and project a positive image of aging (SHIP Funding).

2. Home and Community-Based Supports

DCOA provides services for District residents who are 60 years of age or older so that they can live as independently as possible in the community including health promotion, case management services, nutrition, homemaker assistance, wellness, counseling, transportation, and recreation activities.

a) Caregivers Support—provides caregiver education and training, respite, stipends, and transportation services to eligible caregivers (Title III E Funding and Alzheimer's Disease Initiative).
b) Day Programs—provides programs at adult day health and senior centers, which allow District residents age 60 or older to have socialization and access to core services (Title III B and E Funding).
c) In-Home Services—provides home health and homemaker services for District residents 60 years of age and older to help manage activities of daily living (Title III B Funding).
d) Lead Agencies and Case Management—provides core services and supports, such as case management, counseling services health promotion, and nutrition counseling and education, for District residents age 60 or older, people with disabilities between the ages of 18 and 59, and caregivers (Title III B and E Funding).
e) Senior Wellness Centers/Fitness—provides socialization, physical fitness, and programs that promote healthy behavior and awareness for District residents age 60 or older (Title III D Funding).
f) Supportive Residential Services—provides emergency shelter, supportive housing, and aging-in-place programs.
g) Transportation—provides transportation to life-sustaining medical appointments and group social and recreational activities for District residents age 60 or older (Title III B Funding).

3. Nutrition Services

DCOA provides meals, food, and nutrition assistance to District residents 60 and over to maintain or improve their health and remain independent in the community.

a) Community Dining—provides meals in group settings such as senior wellness centers, senior housing buildings, and recreation centers for District residents age 60 or older (Title III C Funding).
b) Home-delivered Meals—provides District residents age 60 or older who are frail, homebound, or otherwise isolated meals delivered directly to their home (Title III C Funding).
c) Nutrition Supplements—provides nutrition supplements each month for District residents 60 and over who are unable to obtain adequate nutrition from food alone.
d) Commodities and Farmers Market—the Commodity Supplemental Food Program provides a monthly bag of healthy, shelf-stable foods to low-income District residents; the Senior Farmers Market Nutrition Program provides vouchers to participants in the Commodity Supplemental Food Program to purchase fresh produce at local farmers markets (CSFP Funding).

H. Efforts to Improve the System

1. Within DCOA and the Senior Service Network

a) Alzheimer's Disease Initiative

In October 2014, DCOA was awarded a competitive grant by the Administration for Community Living (ACL) to further develop a dementia-capable system of long-term services and supports (LTSS). DCOA's Alzheimer's Disease Initiative was successful in reaching its goal to increase access to home and community-based services and supports for individuals with Alzheimer's Disease and Related Dementias (ADRD) throughout FY15. Through the Initiative, DCOA launched five pilot programs: 1) A "Cluster Care" model of service for individuals living in high-density residential communities and living alone with ADRD (ended because there was no population to suit this program); 2) Money Management/Rep Payee Program provides money management training and representative payee support to people experiencing ADRD and has enrolled 10 individuals 3) Sibley's Club Memory program—a stigma-free social club for people with early-stage Alzheimer's disease, mild cognitive impairment or other forms of dementia and their spouses, partners and caregivers—has successfully expanded to Wards 7 and 8, and has enrolled 80 new members; 4) Saturday Respite programs were developed and established in both Wards 7 and 8; and 5) The Behavioral Symptom Management training program was approved to provide professional Continuing Education Credits (CEUs) by the DC Board of Nursing Assistive Personnel to Personal Care Aides and the National Association of Social Work (NASW) for Licensed Social Workers and presented trainings to 180 professionals and family caregivers. After year one of the grant, DCOA worked with ACL to replace the Cluster Care program with a pilot Dementia Navigator program. Dementia Navigators will provide dementia training for family caregivers, cross training for the senior service network and community partners utilizing DCOA's Behavior Symptom Management Training Program, outreach and awareness, and direct service planning and referral as needed.

b) Case Management Task Force

In FY16, DCOA started a Case Management Task Force to discuss the District's case management offerings through Medicaid's Elderly and Persons with Physical Disabilities (EPD) Waiver and DCOA's Lead Agencies. The goal of the task force is to identify and address ongoing community concerns, and

to reduce duplication of case management services. The task force is composed of DCOA's Senior Service Network and Aging and Disability Resource Center social workers and case managers. DCOA will continue to meet monthly with the task force.

c) ConnectorCard

In FY15, DCOA replaced "Call-N-Ride," a subsidized paper coupon system for low- to moderate-income residents, with a program called the ConnectorCard. The ConnectorCard is a DCOA-subsidized debit card that is loaded with up to $100 per month, with each participant making contributions based on his/her income. The ConnectorCard provides older adults with greater choice and flexibility by opening access to a broader range of transportation options without needing a reservation 24 hours or more in advance. In addition, Seabury Resources for Aging has received additional funding through a grant from the National Capital Region Transportation Planning Board to expand the ConnectorCard program.

d) Needs Assessment

In FY16, DCOA commissioned a needs assessment to be completed by September 30, 2016 that was awarded to the Center for Aging, Health and Humanities at the George Washington University School of Nursing (GW). The goal of the needs assessment is to identify high-value areas for improvement, expansion and/or innovation. GW plans to accomplish this by analyzing demographic and economic trends, program services and supports, facility capabilities and opportunities, and national best practices. Furthermore, GW will design and use a survey tool to identify current and future service gaps, and will organize focus groups and interviews with various stakeholders.

e) Nutrition Task Force

In FY15, DCOA established the Nutrition Task Force to bring together stakeholders to address issues related to older adult nutrition and hunger. The Task Force used meal program participation data to develop and implement policy reforms and system changes to decrease food waste, improve systems of tracking, and meet customer needs. DCOA will continue to work with the Task Force to adjust eligibility criteria and programming to ensure nutrition programs reach older adults in greatest need. The group will continue to discuss innovative strategies to improve the current programing to reach working seniors and baby boomers.

f) Options Counseling Integration

Options Counseling is a decision-support process to help people make informed choices in long term care services and supports that reflect their own preferences, strengths and values. Key components of Options Counseling include a personal interview, assistance with identification of choices available, assistance with developing an individual plan, link to desired services, and follow up. A grant from the U.S. Administration for Community Living in 2011 acted as the catalyst for establishing this service within the ADRC. Since its inception, Options Counseling has grown from two staff members providing Options Counseling as a distinct service, to a person-centered approach that all ADRC social work staff is trained on and use daily when working with their community transition, hospital discharge, and social work clients. Through the No Wrong Door initiative, DCOA is engaged with other District Government health and human service agencies in streamlining understanding of and implementation of person-centered practices throughout the District's network of long-term services and supports, including the point of intake, completion of assessments, service delivery, and follow up. DCOA's many years of experience with Options Counseling has provided a strong foundation for our staff to understand new concepts presented in future No Wrong Door/Person-Centered Counseling trainings and implementation.

2. In collaboration with other District Government agencies

a) Adult Protective Services (APS)

In FY16, key leaders within DCOA's Aging and Disability Resource Center (ADRC) and DC's Department of Human Services' Adult Protective Services (APS) have collaborated to improve communication between agencies and with stakeholders. Starting as a monthly meeting for discussions about complex cases, the DC agency collaboration grew into a comprehensive forum for cross-trainings to ensure a clear understanding of the respective responsibilities of ADRC and APS; creating inter-agency policies and procedures; and developing DCOA/APS trainings and outreach materials for DCOA's grantees, other DC agencies, and the public. The working group expects this partnership to continue to grow into 2018, as both DCOA and DHS programs continue to evolve under the No Wrong Door system. Currently there are several communication plans in place due to the absence of a common case management database that both DCOA and DHS can use to assist with providing streamlined services. As the No Wrong Door initiative works toward integrating case management database systems, it is expected that communication among DC agencies and grantees will continue to become more streamlined and customer service will continue to improve.

b) Community Transitions

In FY15, DCOA's Aging and Disability Resource Center successfully expanded the Community Transition Team that assists older adults and people with disabilities in their transition from long-term care settings back to the community. The program provides significant post-discharge case management services up to one year after the date of discharge to ensure sustained independence and quality of life. In November 2014, the District's Money Follows the Person Demonstration (formerly housed at the Department of Health Care Finance) merged with the DCOA Nursing Home Transition Program to create one unified entity: the Community Transition Team. The convergence of these two teams ensures more effective and streamlined management which has contributed to a higher number of transitions, improved utilization of housing vouchers in comparison to previous years, and improved inter-agency collaboration between DCOA and DHCF. Since November 2014, ADRC managers have focused on merging the teams by working closely with the full Community Transition team to develop new case assignment procedures, offer new trainings, and conduct weekly team meetings to help with team building and professional development. Efforts have been successful. The Money Follows the Person (MFP) Demonstration exceeded the Center for Medicare and Medicaid's (CMS) 2015 calendar year benchmark (35 total transitions), by successfully assisting 36 older adults and people with disabilities to transition from institutional settings back into the community. This is the first time in the history of the Demonstration that the CMS benchmark has been met and exceeded by the District.

c) District Preparedness System (DPS) Enhancement Project

Over the last 3 years, the District of Columbia Homeland Security and Emergency Management Agency (HSEMA) has been collaborating with stakeholders to develop, implement, and socialize the District Preparedness System (DPS). However, preparedness planning approaches and products vary significantly within the District, potentially contributing to duplication of effort and inconsistent outcomes. In order to elevate some of these issues, HSEMA has initiated the DPS Preparedness Planning Enhancement Project. The purpose of this project is to develop key enhancements to the DPS intended to align strategic and operational doctrine to ensure that the suite of plans are fully synchronized and provide a comprehensive planning foundation. DCOA is a critical stakeholder, providing expertise on risks and impacts to the aging and physically disabled communities in the District.

d) Elderly and Persons with Physical Disabilities (EPD) Waiver

DCOA is working in collaboration with other District Government agencies to improve customer service to DC residents by streamlining the Elderly and Persons with Physical Disabilities (EPD) Waiver enrollment process and building understanding of the complex EPD Waiver enrollment process among clients, professionals, caregivers and other stakeholders. Collaborative work includes: participating in weekly meetings with DHCF and the Department of Human Services' Economic Security Administration (ESA) to discuss and improve the enrollment process; coordinating monthly community trainings on the new enrollment process; and hiring and training additional Medicaid Enrollment Specialists, who provide in-person enrollment assistance to EPD Waiver applicants. The Medicaid Enrollment Specialists have fielded more than 1,901 referrals since June 1, 2015, when the new enrollment process began, and submitted more than 579 EPD Waiver applications to ESA. In May 2015, ADRC hired five Medicaid Enrollment Specialists, one Medicaid Lead, and one Clinical Social Work Supervisor to assist with the expanded enrollment responsibilities. In September 2015, DCOA hired three more Medicaid Enrollment Specialists and two more Information and Referral/Assistance (I&R/A) specialists. With the increased number of staff and responsibility, the Medicaid Lead position was converted to a Medicaid Enrollment Supervisor, and an I&R/A Supervisor was hired to help manage the unexpectedly high volume of EPD Waiver intakes.

e) Medicaid-Funded Adult Day Health

Since the summer of 2015, ADRC has worked closely with DHCF to create an Adult Day Health Program (ADHP) enrollment process so DC residents receiving State Plan Medicaid or EPD Waiver who request, and are eligible for ADHP services, are able to enroll in a timely manner. As requested by DHCF, and to ensure ADHP attendees did not lose their ADHP Medicaid funding as of January 1, 2015, ADRC conducted enrollment activities with 100+ ADHP attendees in FY16 including 30+ in-person expedited enrollment visits in December 2015, and obtained all necessary documentation for each of the referrals received. DCOA and DHCF have worked together to conduct community trainings on this new process to ensure professionals, Medicaid beneficiaries, and other stakeholders understand it. DCOA and DHCF meet weekly to discuss process improvements and data collection; and DCOA attends monthly ADHP provider meetings to ensure we are communicating well with the directors of the agencies that provide ADHP services.

f) Olmstead Community Integration Plan

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. In 2015, the District created an Olmstead Working Group to make recommendations for revisions to the Olmstead Plan for 2016, and into the future. 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 Government agencies and community stakeholders, including people with disabilities and advocates for people with disabilities.

g) Safe at Home Program

In FY16, DCOA and the Department of Housing and Community Development (DHCD) partnered to develop and implement a new home adaptation program called Safe at Home. The program promotes aging-in-place for older adults (age 60 years and older) and people with disabilities (18 to 59 years old) by providing up to $10,000 in home accessibility adaptation grants to reduce the risk of falls and reduce barriers that limit mobility. Program participants work with an Occupational Therapist (OT) to identify potential fall risks and mobility barriers in their home and then work with a general contractor to

complete the recommended adaptations. DCOA plans to serve at least 100 District residents through the Safe at Home Program in FY16.

h) Transportation Collective

In FY16, DCOA began working with other District Government transportation agencies to identify opportunities for greater collaboration and coordination around services for District older adults and people with disabilities. The Transportation Collective is comprised of staff from DCOA, District Department of Transportation (DDOT), Department of Health Care Finance (DHCF), Washington Metro Area Transit Authority (WMATA), Department of Parks and Recreations (DPR), DC Taxi Cab Commission, and Age-Friendly DC. The Transportation Collective will work to align eligibility criteria, provide consistent communication and outreach on transportation options, and identify gaps, if any, in transportation offerings for older adults and people with disabilities. Moreover, the Collective will work to identify strategies to create more reliable and affordable transportation options for older adults.

3. With federal and District-wide stakeholders

a) Age-Friendly DC Initiative

The District completed the Age-Friendly D.C. (AFDC) Strategic Plan and submitted the proposal to the World Health Organization (WHO) and AARP on December 3, 2014. The initial 2012-2014 listening phase of the age-friendly initiative engaged nearly 4,000 residents through community forums, focus groups, surveys, and neighborhood walks. Using opinions, concerns and ideas from District residents and stakeholders as a baseline, the AFDC Task Force incorporated the wisdom of academics, government officials and community leaders to develop a comprehensive and thoughtful series of goals and objectives in each of the ten domains. Since completing the strategic plan, government officials and community leaders have been working together to implement and evaluate progress in each domain. In 2017, the WHO will review DC's progress and results and determine whether to designate DC as an Age-Friendly City.

b) Benefits Check Up

In FY15, DCOA partnered with the National Council on Aging (NCOA) to customize their unique and widely used product, BenefitsCheckUp®, to the District. BenefitsCheckUp® offers a comprehensive, online service to screen older adults and people with disabilities for public benefit eligibility and access to local and federal programs. The tool caters to people with limited income. BenefitsCheckUp® includes more than 2,000 public and private benefits programs from all 50 states and the District of Columbia. DCOA's customized version of the website went live at the end of FY2015 at www.BenefitsCheckUp.org/dcoa. DCOA developed and implemented a plan to inform and connect District residents to the new service.

c) Money Smart for Older Adults

In FY15, DCOA successfully expanded the "Money Smart for Older Adults" pilot program, a training program offered through a formal partnership with the Federal Deposit Insurance Corporation and the Consumer Financial Protection Bureau. DCOA's Elder Abuse Prevention Committee (EAPC) successfully trained more than 1,000 people in the Money Smart for Older Adults program. Training sessions for older adults were conducted at 27 locations across all eight Wards of the District. In addition, the Money Smart for Older Adults training was included as an entire track of workshops at the Senior Symposium sponsored by the DC Office on Aging on May 13, 2015. EAPC members conducted the training and facilitated the sessions throughout the day and more than 195 older adults participated in the workshops. EAPC also hosted two "train the trainer" classes for social workers, case managers, and

other volunteers who expressed interest in taking the class and conducting Money Smart for Older Adults workshops in the District. In FY 16, DCOA's goal is to train an additional 1,000 District older adults and caregivers using the Money Smart program.

d) Senior Villages

In FY15, DCOA partnered with Capital Impact Partners to successfully deliver 20 hours of technical assistance each month to four villages, organize quarterly peer-to-peer knowledge exchanges building local leadership capacity, and produce the District's first "How to Start a Village" guide book entitled "Explore, Discover, Act: How to start a Village in the District of Columbia." DCOA engaged all nine established villages, four villages in development, business partners, and community leaders to strengthen relationships and develop clear lines of communication. In addition to the guide, DCOA is hosting a web-based, interactive map for residents to find a village in their neighborhood. In FY16, DCOA continues to strengthen its relationship with villages by dedicating a full-time staff member of the Community Outreach team to offer technical assistance, organize quarterly peer-to-peer knowledge exchanges, and educate the community of the village model.

I. Results of Objectives for Previous State Plan, 2013-2016

The "District of Columbia State Plan on Aging, FY 2013-2016" focused on enhancing services and activities in the areas of in-home services, public safety, consumer assistance, long-term care, health promotion/disease prevention, hunger prevention, and employment. Of the 147 strategies mapped across 15 objectives, DCOA was able to fully and partially accomplish 84 percent of all strategies. Highlights include:

- Successfully advocated for the enactment of legislation to address flaws in the real property tax sales process thatwere resulting in the loss of their homes through foreclosure due to relatively small sums of unpaid real property taxes. Based on Legal Counsel for the Elderly's (LCE) analysis of the tax sale lists provided by Office of Tax and Revenue (OTR), the number of tax sales of properties coded as "senior" fell from 26 in 2013 to just 9 in 2014, a reduction of over 70 percent.
- Eliminated the home delivered meals wait list and further expanded this program to weekend services for non-frail customers.
- Consolidated transportation services and acquired a new fleet of 21 vehicles.
- Reduced food waste in the Senior Wellness Centers by nearly 20 percent through the "What a Waste" program.
- In collaboration with DHCF and community stakeholders, developed and implemented a new enrollment process for the Elderly and Persons with Physical Disabilities (EPD) Waiver.

IV. Goals, Objectives, Strategies, and Performance Measures

The development of the State Plan's goal, objectives, strategies and performance measures were developed using guidelines issued by the U.S. Administration for Community Living (ACL), in collaboration with community stakeholders through surveys and public meetings, and the evaluation of strategic priorities outlined by Mayor Muriel Bowser. In each goal and objective, strategies focus on quality management measures by working with community stakeholders and District Government agencies to ensure efficient and effective delivery of Older Americans Act (OAA) core services—supportive services, nutrition, health promotion, caregiver support, and elder rights services (see Attachment G for definitions and listing of DCOA services and supports). DCOA is becoming a more data driven agency through continuous programmatic and financial assessment of ongoing programs, and identifying areas for improvement and innovation.

Goal 1: Strengthen core program operations and service coordination.

Objective 1: Evaluate internal agency operations and procedures to ensure effective and efficient program monitoring and support.

Strategies**:**

a. Work with agencies in similar jurisdictions across the country to review procedures and identify best practices for monitoring Older Americans Act (OAA) core services: supportive services, nutrition, health promotion, caregiver support, and elder rights services.
b. Review and update the DCOA Grants Manual and DCOA Service Standards incorporating federal and local policies, and implement programmatic and fiscal reporting best practices, where appropriate.
c. Organize educational opportunities for grantees in the Senior Service Network to review changes.
d. Work with grantee providing legal and LTC ombudsman services to update laws, regulations, policies and procedures in accordance with Administration for Community Living's new rules, effective July 2016.
e. Review and revise, as needed, programmatic and fiscal monitoring tools for each program.
f. Design and implement regular programmatic and fiscal reporting training programs for grantees in the Senior Service Network.
g. Establish regular meetings that bring together Program Directors providing similar core services.
h. Increase DCOA staff's professional knowledge and skills to monitor grantees through trainings.

Objective 2: Assess community needs and service gaps to improve connectivity to appropriate services and supports.

Strategies:

a. Review findings and implement recommendations, when appropriate, of DCOA's FY 2016 Needs Assessment by George Washington University.

b. Design and implement an annual demographic survey that will allow DCOA to regularly update the Needs Assessment.
c. Establish policies and procedures for Lead Agencies to perform the annual demographic survey.
d. Work with D.C. Office of Planning to identify demographic and geographic trends of District older adults.
e. Analyze service utilization of OAA core services—supportive services, nutrition, health promotion, caregiver support, and elder rights services—and population trends to identify any gaps in services.
f. Ensure grantees in the Senior Service Network are organizing focus groups and community town halls with District older adults to evaluate consumers' needs and demands.
g. Work with other District Government agencies to identify and target services and supports for underserved communities including: LGBTQ, Veterans, and returning citizens in the District.

Objective 3: Identify best practices and implement strategies to expand delivery of and access to services and supports.

Strategies**:**

a. Work with agencies in similar jurisdictions across the nation to review innovative programs and identify best practices for delivering OAA core services: supportive services, nutrition, health promotion, caregiver support, and elder rights services.
b. Evaluate the FY 2016 Restaurant Community Dining Program pilot—a nutrition program that allows participants to attend restaurants around the District as an alternative to traditional community dining settings.
c. Research the elasticity of and legal ability to implement consumer cost-sharing requirements to DCOA's core services.
d. Conduct public outreach campaigns to receive feedback and educate District residents of consumer cost-sharing at DCOA.
e. Work with Transportation Collective and other transportation providers in the District to identify opportunities to streamline existing services and create new services.
f. Continue to monitor and amend procedures used by Medicaid Enrollment Staff (MES) to assist District older adults and people with disabilities through the Medicaid enrollment process.

Objective 4: Reduce duplication of services with other District Government and community-based providers.

Strategies**:**

a. Review older adult related services and supports administered by District Government agencies to identify areas of duplication.
b. Identify Medicaid eligible recipients who receive the same or similar services from multiple District Government agencies.
c. Work with District Government agencies to design and implement procedures that connect older adults to services in the appropriate funding source.
d. Review and amend, where appropriate, program's eligibility requirements to streamline enrollment process with similar programs and reduce overlap.

e. Perform an outreach campaign to educate District older adults of impacts of duplication and plans to improve the system.

Outcomes and Performance Measures:

1. Each Lead Agency captures 10 percent of their Ward's older adult population during the annual demographic survey.
2. Each grantee in the Senior Service Network organizes at least one focus group or community town hall by FY 2018.
3. Increase the accuracy and decrease the time needed to process grantees' monthly invoices.
4. Perform quarterly programmatic or fiscal reporting trainings for grantees in the Senior Service Network.
5. Perform quarterly meetings with Program Directors who provide similar core services.
6. Identify all programs to implement consumer cost-sharing opportunities by FY 2018.
7. Implement consumer cost-sharing procedures for appropriate programs by FY 2019.
8. By FY 2018, draft policies that will reduce occurrences of single service being paid for by multiple agencies.
9. Educate community of action plan by FY 2019.

Goal 2: Promote awareness and access to long-term care services and supports offered in the District.

Objective 1: Work closely with other District Government health and human service agencies to develop and implement strategies for a "No Wrong Door" (NWD) approach to accessing long-term care services and supports.

Strategies**:**

a. Continue to build and strengthen the NWD Leadership Council within District government.
b. Participate in monthly meetings with other agencies: Leadership Council, Person-Centered Practices Workgroup, Stakeholder Engagement Workgroup, IT Integration Workgroup, Marketing and Outreach Workgroups.
c. Develop and implement clear cross-system expectations and competency criteria for all staff involved in Person-Centered Counseling (PCC).
d. Develop and implement statewide cross-agency strategies, including cross training, for educating managers and other key staff from public and community agencies and referral sources about PCC and Person-Centered Practices.
e. Establish clear expectations to ensure the ongoing meaningful involvement of key stakeholders in the development, implementation and ongoing evaluation of the NWD system.
f. Establish performance measures across systems that measure satisfaction with interactions with the LTSS system, time from first contact to services, and collaborations and referrals between systems/referral sources.
g. Develop cross-agency process and work flows that improve coordination and integration of functions while reducing or eliminating duplication of efforts in intake, screening, eligibility determinations, application processes, case management, service authorization, and Continuous Quality Improvement (CQI).

h. Monitor project impact to assess progress, system growth and enhancement, improved experiences for people in need of LTSS and their families, and outcomes achieved over the 3 years of the project.

Objective 2: Integrate the "Alzheimer's Disease Initiative" with core programs.

Strategies**:**

a. Develop sustainability model for Alzheimer's Disease Initiative programs to include cross training of DCOA's Senior Service Network and frontline community members.
b. Improve identification of and data tracking protocol for clients with Alzheimer's disease and related dementias (ADRD).
c. Develop a strategic outreach and target marketing plan to improve knowledge of DCOA as an entry point to access ADRD programs and educational resources.
d. Establish policy and grantee requirements that are inclusive of individuals with ADRD and their caregivers.

Outcomes and Performance Measures:

1. Fully implement amendments to Intake & Referral (I&R) process that identify ADRD clients and streamline program delivery by FY 2018.
2. Complete an integration and sustainability action plan for Alzheimer's Disease Initiative by FY 2018
3. Ensure DCOA participation in all NWD focus areas by attending and contributing at all monthly meetings: Leadership Council, Person-Centered Practices Workgroup, Stakeholder Engagement Workgroup, IT Integration Workgroup, Marketing and Outreach Workgroups.
4. Complete review and modification of all DCOA outreach materials to ensure they match NWD materials by FY 2018.
5. Complete development of cross system measures that evaluate client satisfaction with interactions with the LTSS system by FY 2019.

Goal 3: Promote aging in place with dignity and respect.

Objective 1: Partner with District of Columbia's Homeland Security and Emergency Management Agency (HSEMA) to review and update the District Preparedness System (DPS).

Strategies**:**

a. Research and review qualitative and quantitative data to identify critical areas of risk for District older adults and people with disabilities.
b. Work with the District Recovery Steering Committee to review and monitor the goals, objectives and targets identified in Health and Social Services and Housing Recovery Support Functions (RSFs).
c. Participate in District-wide emergency and recover workshops and trainings.
d. Review and amend, where appropriate, DCOA's Continuity of Operations Plan (COOP).
e. Work with HSEMA to educate appropriate grantees in the Senior Service Network of the emergency and recovery plans.

Objective 2: Integrate and implement initiatives outlined in the District Olmstead Plan (refer to Attachment H for copy of plan).

Strategies**:**

a. Determine methodology to evaluate housing needs for individuals who have been referred to the Aging and Disability Resource Center because they want to live in the community.
b. Increase inclusive daytime programming offerings and provide technical assistance and training to improve staff capacity at Adult Day Health providers, Senior Wellness Centers, Senior Centers, public libraries and DPR recreation centers.
c. Assess and align the capacity of transportation providers to support the transportation needs of people with disabilities.
d. Develop a discharge manual to be used by both institutional and community-based professionals.
e. Identify gaps and develop recommendations to improve the discharge process.

Objective 3: Support and promote efforts for the District to become a recognized Age-Friendly City.

Strategies**:**

a. Participate in each of the ten Age-Friendly DC domains: 1) Outdoor Space and Buildings, 2) Transportation, 3) Housing, 4) Social Participation, 5) Respect and Social Inclusion, 6) Civic Participation and Employment, 7) Communication and Information, 8) Community Support and Health Services, 9) Emergency Preparedness and Resilience, and 10) Elder Abuse, Neglect and Fraud.
b. Work with District Government agencies and community stakeholders to implement and monitor initiatives outlined in the Age-Friendly DC Strategic Plan.
c. Assist with outreach and education to inform the community of Age-Friendly DC's progress.
d. Coordinate with District residents ages 60 and above to participate in evaluation and survey opportunities for Age-Friendly DC.

Objective 4: Promote the development and sustainability of senior villages in the District.

Strategies**:**

a. Coordinate learning exchange opportunities with village leaders to share lessons and experiences in organizational development.
b. Offer technical assistance to the network of villages in the District.
c. Organize outreach and educational forums with community leaders to promote the creation of new villages, particularly in underserved communities.

Outcomes and Performance Measures:

1. Ensure DCOA representation at each of the ten Age-Friendly DC Domain Committees.
2. Receive Age-Friendly City recognition by the World Health Organization by FY 2019.
3. Conduct quarterly peer-to-peer learning opportunities for senior villages.

Goal 4: Ensure the agency is driven by customer experience.

Objective 1: Develop and implement strategies to expand opportunities to offer input in agency decision-making process.

Strategies**:**

a. Organize the Senior Service Network and other community stakeholders in a Performance Management Taskforce.
b. Identify effective outreach mechanisms and data collection tools for customers to deliver feedback and responses.
c. Identify areas in decision-making process to engage customers.
d. Research and construct a qualitative survey tool for customers of OAA core services: supportive services, nutrition, health promotion, caregiver support, and elder rights services.
e. Develop protocols for delivering and collecting the qualitative survey in a statistically significant way.
f. Update and implement current Aging and Disability Resource Center annual customer satisfaction survey.

Objective 2: Implement person-centered practices that match other District Government health and human service agencies in accordance with the No Wrong Door work plan.

Strategies**:**

a. Create a District-wide Person-Centered Profile for use in all human services for youth and people with disabilities, veterans and elders with common information that can be collected by referral sources or state systems and shared to avoid duplication of effort.
b. Create one or more resource portals through which community and public referral sources, youth and adult state agency program staff, families, people with disabilities, elders and veterans can conduct a comprehensive review and identify private/community resources and informal supports in an up-to-date resource database.
c. Develop cross-system guidelines and protocols to facilitate and ensure informed choice from available options to assist in the development of a Person-Centered Plan.
d. Train trainers to develop capacity across public, private and community systems to provide Person-Centered Counseling.
e. Develop multiple approaches for training and coaching staff to ensure that Person-Centered practices are consistently employed and evaluated, redesigning processes that are not reaching desired outcomes

Outcomes and Performance Measures:

1. Complete trainings on person-centered practices for DCOA and Senior Service Network staff.
2. Complete qualitative survey tool by FY 2018.
3. Train at least four DCOA trainers and at least 35 direct service DCOA staff (Social Workers, Case Managers, Medicaid Enrollment Specialists, and Information and Referral/Assistance Specialists) in the NWD Person-Centered Counseling module by FY 2018.
4. Ensure that trained staff members receive follow-up training and evaluation of skills as prescribed by the NWD Initiative by FY 2019.

Attachment A

STATE PLAN ASSURANCES AND REQUIRED ACTIVITIES

Older Americans Act, As Amended in 2006

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2006.

ASSURANCES

Sec. 305(a) - (c), ORGANIZATION

(a)(2)(A) The State agency shall, except as provided in subsection (b)(5), designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area.

(a)(2)(B) The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

(a)(2)(E) The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(ii) The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals and older individuals residing in rural areas.

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.

States must assure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306(a), AREA PLANS

(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-

(A) services associated with access to services (transportation, health services **(**including mental health services**)**, outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);

(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance; and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall--

(I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;

(II) describe the methods used to satisfy the service needs of such minority older individuals; and

(III) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).

(4)(B)(i) Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on--

(I) older individuals residing in rural areas;

(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(IV) older individuals with severe disabilities;

(V) older individuals with limited English proficiency;

(VI) older individuals with Alzheimer’s disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(VII) older individuals at risk for institutional placement; and

(4)(C) Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) Each area agency on aging shall provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with

disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities.

(6)(F) Each area agency will: in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the area agency on aging with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

(9) Each area agency on aging shall provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title.

(11) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

(13)(A) Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

(13)(B) Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency--

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(ii) the nature of such contract or such relationship.

(13)(C) Each area agency on aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships.

(13)(D) Each area agency on aging shall provide assurances that the area agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships.

(13)(E) Each area agency on aging shall provide assurances that the area agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

(14) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(15) provide assurances that funds received under this title will be used-

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

(17)Each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

Sec. 307, STATE PLANS

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(7)(B) The plan shall provide assurances that--

(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;

(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and

(iii)mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(10) The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11)(A) The plan shall provide assurances that area agencies on aging will--

(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;

(ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and

(iii)attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

(11)(B) The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(11)(D) The plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals;

(11)(E) The plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--

(A) public education to identify and prevent abuse of older individuals;

(B) receipt of reports of abuse of older individuals;

(C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and

(D) referral of complaints to law enforcement or public protective service agencies where appropriate.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include--

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—

(A) identify individuals eligible for assistance under this Act, with special emphasis on—

(i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;

(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;

(iv) older individuals with severe disabilities;

(v) older individuals with limited English-speaking ability; and

(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who--

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall

(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made--

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)

(1) The State plan shall provide an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.

(2) The State plan shall provide an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle.

(3) The State plan shall provide an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

(4) The State plan shall provide an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.

(5) The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for--

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order

REQUIRED ACTIVITIES

Sec. 307(a) STATE PLANS

(1)(A) The State Agency requires each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and

(B) The State plan is based on such area plans.

Note: THIS SUBSECTION OF STATUTE DOES NOT REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.

(2) The State agency:

(A) evaluates, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) has developed a standardized process to determine the extent to which public or private programs and resources (including Department of Labor Senior Community Service Employment Program participants, and programs and services of voluntary organizations) have the capacity and actually meet such need;

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas). Note: "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.

(5) The State agency:

(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

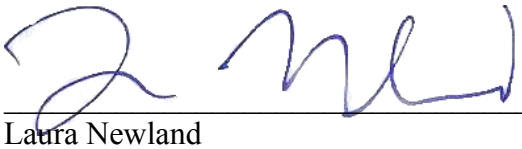
(6) The State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency--

(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;

(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.



July 15, 2016

Laura Newland
Executive Director
District of Columbia Office on Aging

Date

Attachment B

STATE PLAN INFORMATION REQUIREMENTS

States must provide all applicable information following each OAA citation listed below. The completed attachment must be included with your State Plan submission.

Section 305(a)(2)(E)
The mechanisms for ensuring that preference will be given to providing services to older individuals with the greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, and older individuals with limited English proficiency) include:

- The DCOA Grant Policy Manual—policies, procedures, standards and practices that govern grant recipients—outlines the primary target recipients.
- Grantees submit detailed monthly reports using the Comprehensive Universal Reporting Tool (CURT) that includes updates on persons served.

Section 306(a)(17)
The mechanisms for ensuring that the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery include:

- The DCOA Grant Policy Manual requires each grantee to submit an Emergency Preparedness Plan for the organization, including shelter in place provisions.
- DCOA works with grantees that operate a facility to develop and maintain a Continuity of Operations Plan (COOP).
- DCOA is a critical stakeholder in the District of Columbia Homeland Security and Emergency Management Agency's (HSEMA) regular review and update of the District Preparedness System (DPS).

Section 307(a)(2)
DCOA develops a budget mark for services and supports to be delivered in the community. The Federal grants provided under Older Americans Act (OAA) are allocated by need, types of programs, size and impact of the program, and population. The grantees are required to submit a proposal outlining allocation of funds, targets and methods for delivering service, and other details provided in DCOA guidelines. Proposals under a competitive bid process are reviewed by an independent panel; and proposals under continuation grants are reviewed by DCOA grant monitors. Both use a structured evaluation process and tool that is submitted to the Executive Director for final approval of the grant.

Section 307(a)(3)
Does not apply to DCOA.

Section 307(a)(10)
Does not apply to DCOA.

Section 307(a)(14)
Of the estimated 107,117 seniors (age 60 and above) in the District, approximately 59.8 percent identify as African Americans and 11.4 percent speak a language other than English at home. An estimated 15.8 percent of seniors are below the federal poverty line. Refer to table on page 10 titled "POPULATION 60 YEARS AND OLDER FROM 2010 TO 2014" for greater details.

Section 307(a)(21)
There is no identified Native American tribe or reservation in the District of Columbia.

Section 307(a)(29)
See response to Section 306(a)(17).

Section 307(a)(30)
DCOA is a supporting partner in the District's Preparedness Framework. The Executive Director of DCOA works with the Deputy Mayor of Health and Human Services—the primary entity on the District Recovery Steering Committee responsible for Health and Social Services Recovery Support Functions—to develop and review emergency preparedness plans in the District. District Recovery Steering Committee is part of the District of Columbia's Homeland Security and Emergency Management Agency (HSEMA) governing structure for the District Preparedness System (DPS).

Section 705(a)(7)
DCOA contracts with AARP's Legal Counsel for the Elderly (LCE) to provide legal and LTC ombudsman services. The DCOA Grants Manual and DCOA Service Standards set parameters and guidelines for delivering services in accordance with federal and local rules and regulations. DCOA monitors programmatic and financial operations of grantees on monthly and quarterly.

Attachment C

DC Office on Aging Budget Allocation Narrative

DC Office on Aging (DCOA) develops a budget mark for services and supports to be delivered in the community. The grantees are required to submit a proposal outlining allocation of funds, targets and methods for delivering service, and other details provided in DCOA guidelines. Proposals under a competitive bid process are reviewed by an independent panel; and proposals under continuation grants are reviewed by DCOA grant monitors. Both use a structured evaluation process and tool that is submitted to the Executive Director for final approval of the grant. Beginning in FY 2018, DCOA will compete all grants on a schedule through FY 2020.

The Federal grants provided under Older Americans Act (OAA) are allocated by need, types of programs, size and impact of the program, and population.

- Title III B is allocated to administrative support, case management, counseling, health promotions, congregate meals, home delivered meals services for weekdays and weekends.
- Title III C1 and C2 are allocated to contractors producing and delivering congregate meals and home delivered meals services.
- Title III D is allocated to health promotion and wellness services.
- Title III E caregivers grants are specific for Caregiver Case Management, Caregiver supplemental and Caregiver respite services.
- Title VII is specific for abused elderly and Ombudsman services.

Refer to Attachment F—Senior Service Network by Budget Chapter—to see what grantees in the network received federal funding.

Attachment D

Community Participation in the State Plan Development Process

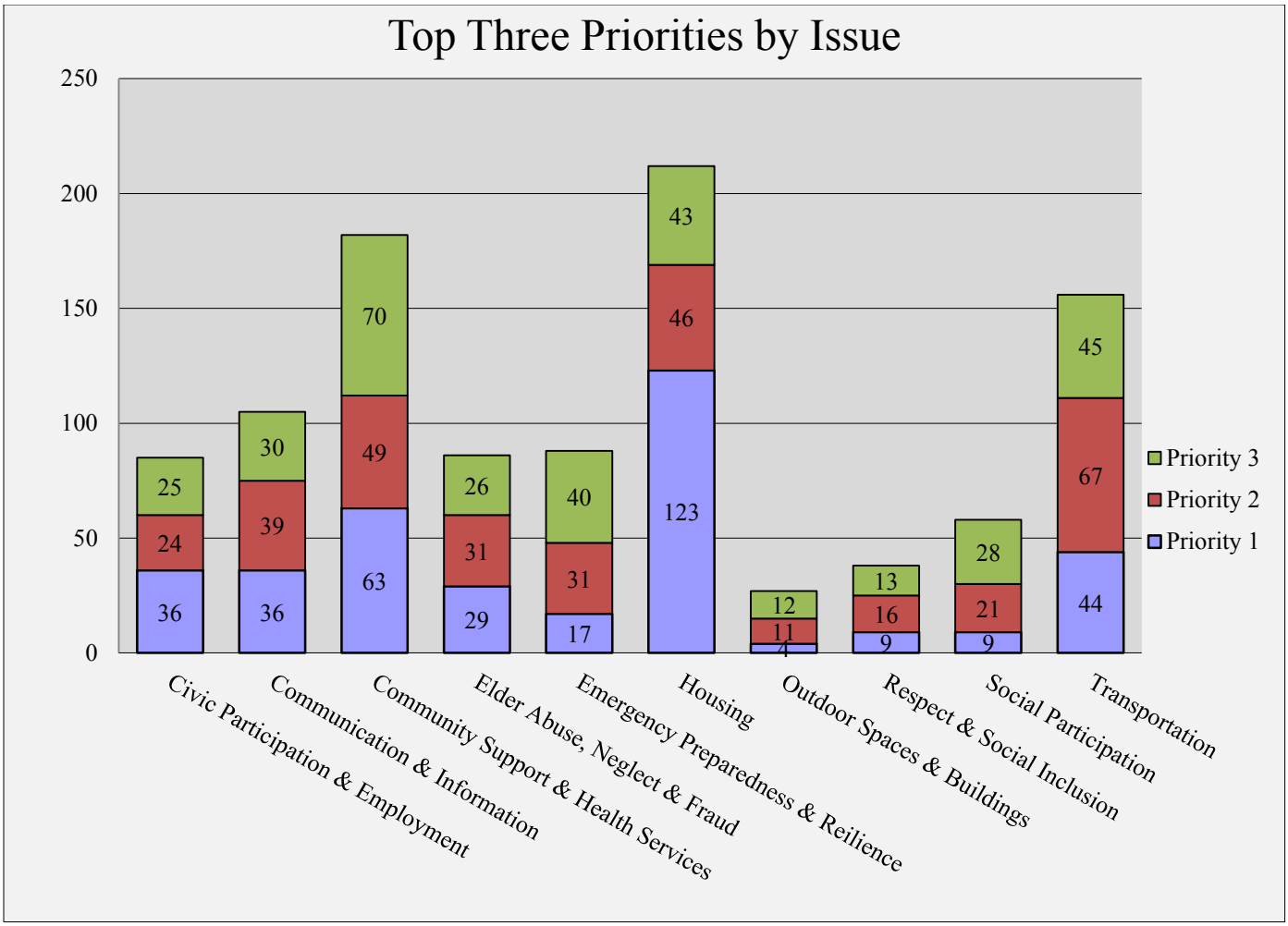
The development process for the State Plan was initiated in fiscal year 2016, following the guidelines and program instructions issued by the U.S. Administration for Community Living (ACL). Community leaders and stakeholders look to DCOA for guidance in designing sustainable models of service, collection of data to assess critical needs, and to ensure oversight and accountability of the service delivery system. The process for developing the State Plan included the input from citywide stakeholders, including the DC Commission on Aging, the Senior Service Network, consumers, residents, advocacy groups and organizations, and health and human services providers.

In accordance with Older Americans Act Regulations (Sec. 1321.27), DCOA hosted several community meetings in all eight wards of the city. The meetings were informative and provided valuable information that aided the development of this plan.

Public Meeting Schedule for 2016:
March 22 – Senior Village Executive Directors Meeting
March 23 – Commission on Aging
April 4 – Washington Senior Wellness Center in Ward 7
April 7 – Hattie Holmes Senior Wellness Center in Ward 4
April 8 – Congress Heights Senior Wellness Center in Ward 8
April 11 – Vida Senior Center and Bernice Fonteneau Senior Wellness Center in Ward 1
April 12 – Hayes Senior Wellness Center in Ward 6 and At-Large Community Meeting
April 13 – Meeting with Lead Agency Directors
April 14 – Ward 4 Mini-Commission on Aging and St. Albans Community Dining Program in Ward 3
April 19 – Asian and Pacific Islander Senior Center in Ward 2
April 22 – Model Cities Senior Wellness Center in Ward 5

Additionally, DCOA produced the State Plan Community Survey. The survey was distributed in all eight wards and made available online. The survey was available in English, Spanish, and Mandarin. Paper copies were filled out at senior wellness centers, local AARP chapters, senior villages, recreation centers, DCOA's Health Fair, DHCD's Housing Expo, Caregivers Forum, and other events DCOA and Age-Friendly DC attended. Both paper and web-based surveys were available to the public between April 18, 2016 and May 31, 2016 (44 calendar days). DCOA received 468 completed surveys.

The survey focused on identifying service gaps, gauging elasticity of cost-sharing opportunities, improving communication techniques, and soliciting feedback on the direction of the agency. One in three survey respondents identified housing as the number one priority for aging in the community. The top three issues, in order of response, are Housing (33 percent ranked number 1), Transportation (20 percent ranked number 2), and Community Support & Health Services (21 percent ranked number 3).

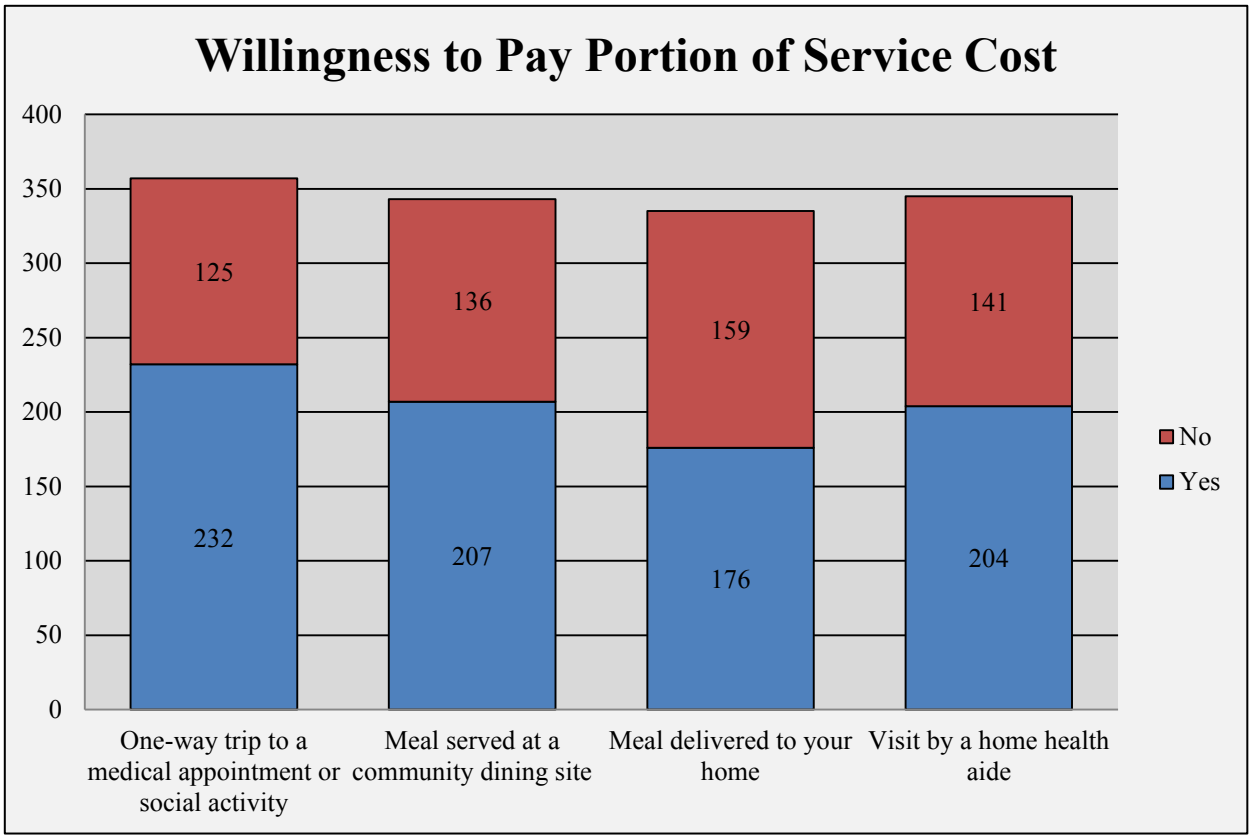


When asked "What services and/or supports do you believe are missing in the community that would allow District seniors to age in place?" Affordable housing was the most common answer, with 15.6 percent of respondents answering with housing:

- "We need housing for middle class people or people in-between middle and low income so all seniors have a choice of senior housing."
- "Affordable housing or shelters where affordable housing is not available."
- "Senior designated housing assistance."

When asked if a respondent "would be willing to pay a portion of the cost" for DCOA's more popular services, the majority of respondents said yes in each of the four services. Transportation received the greatest willingness for customers to participate in sharing cost. Nearly two in three survey respondents (65 percent) would be willing to pay a portion of the cost for transportation to a medical appointment or social activity.

Finally, DCOA worked closely with the DC Commission on Aging— a 15 person citizen's advisory group that advises the Executive Director of the Office on Aging, the Mayor, and the Council of the District of Columbia on the needs and concerns of older Washingtonians. DCOA solicited their feedback through the survey, requested assistance disseminating the survey to constituent groups, and submitted draft state plans for Commissioners' review. DCOA presented updates and requested additional comments during monthly Commission meetings between March and July, 2016.


Willingness to Pay Portion of Service Cost
400
350
300
250
200
150
100
50
0
125
232
136
207
159
176
141
204
No
Yes
One-way trip to a medical appointment or social activity
Meal served at a community dining site
Meal delivered to your home
Visit by a home health aide

State Plan Community Survey

D.C. Office on Aging (DCOA) is currently in the process of developing the State Plan on Aging. The plan will outline the agency's work over the next two years towards accomplishing Mayor Bowser's vision to create an urban environment that promotes active and healthy aging. DCOA needs your help to identify and develop goals and objectives that meet the demands of the senior community in DC. Please answer the questions below and share your thoughts and ideas. Thank you for your help and your support.

1. Please prioritize the ten issues below in order of importance to age in the community. Use numbers 1 through 10, with 1 being the highest priority to you and 10 being lowest priority to you. Use each number only once.

_____**Civic Participation and Employment** — promotion of paid work and volunteer activities for older residents and opportunities to engage in formulation of policies relevant to their lives.

_____**Communication and Information** — promotion of and access to the use of technology to keep older residents connected to their community and friends and family, both near and far.

_____**Community Support and Health Services** — access to homecare services, clinics and programs to promote wellness and active aging.

_____**Elder Abuse, Neglect and Fraud** — prevention and prosecution of financial exploitation, neglect, and physical, sexual and emotional abuse of seniors.

_____**Emergency Preparedness and Resilience** — information, education and training to ensure the safety, wellness and readiness of seniors in emergency situations.

_____**Housing** —housing options for older residents, aging in place and other home modification programs.

_____**Outdoor Spaces and Buildings** — accessibility to and availability of safe recreational facilities.

_____**Respect and Social Inclusion** — programs to support and promote ethnic and cultural diversity, along with programs to encourage multigenerational interaction and dialogue.

_____**Social Participation** — access to leisure and cultural activities and opportunities for older residents to participate in social and civic engagement with their peers and younger people.

_____**Transportation** — safe and affordable modes of private and public transportation.

2. What issue did you rank number 1? Why?

_____

_____

3. What would you like to see DCOA accomplish over the next two years?

_____

_____

_____

4. How can DCOA improve outreach and communications with District seniors?

_____

_____

_____

5. What service(s) and/or support(s) do you believe is missing in the community that would allow District seniors to age in place?

_____

_____

_____

6. Please circle either YES or NO to indicate if you would be willing to pay a portion of the cost for the services listed below:

a. One-way trip to a medical appointment or social activity:	YES	NO
b. Meal served at a community dining site:	YES	NO
c. Meal delivered to your home:	YES	NO
d. Visit by a home health aide:	YES	NO

7. Is there anything you would like to tell DCOA as the agency is developing a two-year State Plan?

_____

_____

_____

_____

_____

GOBIERNO DEL DISTRITO DE COLUMBIA
OFICINA PARA LAS PERSONAS MAYORES

Encuesta Comunitaria sobre el Plan de la Ciudad

La Oficina para las Personas Mayores (DCOA por sus siglas en inglés) se encuentra en el proceso de desarrollar el Plan de la Ciudad para personas de mayor edad. Este plan delineará el trabajo que realizará la DCOA en los próximos dos años para llevar a cabo la visión de la alcaldesa Bowser de generar un ambiente urbano que promueva una vida activa y saludable. La DCOA necesita su ayuda para identificar y desarrollar metas y objetivos que cumplan con las demandas de las personas mayores en DC. Por favor, conteste las siguientes preguntas y comparta sus inquietudes e ideas con nosotros. Gracias por su ayuda y apoyo.

1. Favor de priorizar los diez problemas de la parte inferior en orden de importancia para las personas mayores. Use los números del 1 al 10, utilizando el número 1 como la prioridad más importante y el número 10 como la menos importante. Use cada número sola una vez.

_____**Participación Cívica y Empleo**—difusión de trabajos pagados, voluntariados para la población de adultos mayores y oportunidades que los incluyan en la creación de políticas que beneficien para el beneficio de sus vidas.

_____**Comunicación e Información**— promoción de y acceso al uso de tecnologías para mantener a esta población conectada con su comunidad, amigos y familiares que están cerca y lejos.

_____**Apoyo Comunitario y Servicios de Salud**—acceso a servicios para el cuidado en el hogar, clínicas y programas que promuevan bienestar y una vida activa.

_____**Maltrato, Negligencia y Fraude**—prevención y enjuiciamiento de explotación financiera, descuido, abuso sexual y emocional de las personas mayores.

_____**Preparación para Emergencia y adaptación**—información, educación y entrenamiento sobre seguridad, bienestar y preparación de las personas mayores en caso de emergencia.

_____**Vivienda**—opciones de vivienda para personas mayores de edad, sin abandonar el hogar y otros programas de modificación del hogar.

_____**Espacios al Aire Libre y Edificios**—acceso y disponibilidad de instalaciones recreacionales seguras.

_____**Respeto e Inclusión Social**—programas que promuevan el apoyo la diversidad étnica y cultural, como también programas que estimulen la interacción y el diálogo entre diferentes generaciones.

_____**Participación Social**—acceso a actividades culturales y de tiempo libre y oportunidades para personas mayores para participar en actividades sociales y cívicas con sus compañeros y jóvenes.

_____**Transporte**—medios seguros y económicos de transporte privado y público.

2. ¿Qué problema usted seleccionó como número 1? ¿Por qué?

_____
_____
_____

3. ¿Qué metas quiere que la DCOA cumpla en los próximos dos años?

_____
_____
_____

4. ¿Cómo puede la DCOA mejorar su alcance comunitario con las personas mayores del Distrito?

_____
_____
_____

5. ¿Qué servicio(s) y/o apoyo usted piensa que falta en la comunidad que le permitiría a las personas mayores disfrutar su edad sin abandonar su casa?

_____
_____
_____

6. Favor de marcar SÍ o NO para indicar si usted estaría dispuesto de pagar una parte del costo de los servicios mencionados en la parte inferior:

a. Un pasaje de ida a una cita médica o del seguro social: SÍ NO
b. Comida servida en un comedor comunitario: SÍ NO
c. Servicio de comida entregada en su casa: SÍ NO
d. Visita de un asistente de la salud: SÍ NO

7. ¿Le gustaría compartir alguna información adicional con DCOA, ya que es la agencia responsable en desarrollar este Plan de la Ciudad de dos años?

_____

_____

_____

_____

州立计划社区问卷调查

哥伦比亚特区年长者办公室（DCOA）目前正在制定“年长者州立计划”。该项计划将描述今后两年内年长者办公室完成 Bower 市长创建促进积极和健康老年生活城市环境愿景的工作。DCOA需要您帮助确定和制定符合哥伦比亚特区年长者社区需求的长期和短期目标。请回答以下问题，分享您的想法和观点。谢谢您的帮助和支持。

1. 请按照对于社区中年长者的重要性排列以下十个问题。请使用 1-10 **数字**，**其中**“1”**表示**对您最重要，“10”**表示**对您最不重要。每个数字仅使用一次。

_____**公民参与和就业** — 促进年长者居民有偿工作、义工活动和参加与他们的生活相关的政策制定的机会。

_____**交流和信息** — 促进和利用技术，使年长者居民与自己的社区、身边和远方的朋友和家人保持联系。

_____**社区支持和健康服务** — 接受健康护理服务和诊所服务以及参加促进身心健康和积极老年生活的计划。

_____**年长者虐待、疏忽和欺诈** — 预防和起诉对年长者的财务剥削、忽视以及身体、性和情感虐待。

_____**紧急情况准备和适应力** — 提供信息、教育和培训，以确保年长者在紧急情况下的安全、身心健康和充分准备。

_____**住宅** — 年长者居民的住宅选择、就地养老和其他家居改装计划。

_____**户外空间和建筑** — 安全娱乐设施的提供和使用。

_____**尊重和社会包容** — 支持和促进种族和文化多元化计划以及鼓励多代人之间的交往和对话的计划。

_____**社会参与** — 参与休闲和文化活动以及利用供年长者参与同龄人和年轻人的社交和公民活动的机会。

_____**交通** — 安全和可负担的私营和公共交通模式。

2. **您排在第一位的**问题是什么？为什么？

_____

_____

3. **您希望今后两年哥**伦比亚特区年长者办公室（DCOA）**取得哪些成就？**

_____

_____

_____

4. 哥伦比亚特区年长者办公室（DCOA）能够怎样改进对特区年长者的宣传和交流工作？

_____

_____

_____

5. 您认为社区中缺少哪些帮助特区年长者就地养老的服务和/或支持？

_____

_____

_____

6. 请圈选“是”或“否”，说明您是否愿意支付下列服务的部分费用：

a.	前往就诊或社交活动的单程交通：	是　否
b.	在社区餐饮室供应的餐饮：	是　否
c.	送至您家中的餐饮：	是　否
d.	家庭健康助理家访：	是　否

7. 是否有任何在哥伦比亚特区年长者办公室（DCOA）制定两年州立计划时您希望他们了解的情况？

_____

_____

_____

_____

APPROVED 7/15/16

Attachment E

DISTRICT OF COLUMBIA OFFICE ON AGING
ORGANIZATIONAL CHART

OFFICE OF THE EXECUTIVE DIRECTOR

Laura Newland
Executive Director

Commission on Aging

Sara Tribe Clark, LCSW
Associate Director of ADRC

Gerald Kasunic
Deputy Associate Director of ADRC

Garret King, J.D.
Chief of Staff

Michael Kirkwood
General Counsel

Tanya Reid
Executive Assistant

AGING & DISABILITY RESOURCE CENTER (ADRC)

Information & Referral Assistance Supervisor
Dominique Vinson

Customer Service Communications Specialists
Adebukunola Adenariwo
Cheryl Arnold
Sherri Ellerbe, MA
Luanne Greenaway
Vadonia Mallory
Vivian McCarter
Doreen Tinner

Medicaid Enrollment Supervisor
Lourdine Jean-Francois, LCPC

Medicaid Enrollment Specialists
Mia Butler
Maria Ellis
Becky Hazlett
Katrice Jefferson
Charlotte Morgan
Shante Trumpet
Natasha Webb
Vacant (1)

Staff Assistants
Mamie Garrett

Supervisory Social Worker
Felicia Cowser, MSW, LICSW
Christian Tamasco, LICSW

Transition Care Specialists
Ramona Butler, LGSW
Angela Fields
Melanie Gilliam, LGSW
Vanessa Hicks-Edwards, MSW, LGSW
Jemila Meekins, LGSW
Janell Scott, MSW, LICSW
Rolanda Wray, LGSW
Jasmine Wilson, LGSW

Transition Case Managers
Mary McLain
Vacant (1)

Transition Coordinator
Ekundayo Akinola
Emma Baxter
Lolita White

Management Assistant
Vacant (1)

Program Coordinator
Sakena McWright
Margaret Woods

Community Outreach Specialist
Gale Cooke

Employment Specialists
Maria Anderson
Ronald Kelly

Financial & Grants Specialist
Lea Girma Mengistu, CPA

Housing Coordinator
Plathon Watson

Public Health Analyst
Gwendolyn Noonan-Jones, MSW, LGSW

Social Worker
Mayra Vasquez

Receptionist
Antonette Dozier

Data Quality Assurance Coordinator
Aweke Wudineh

Brian Footer, MPA
Director of Policy, Planning, & Evaluation

POLICY, PLANNING, & EVALUATION

Data Quality Assurance Coordinator
Vacant (1)

Olamide Ogbara
Resource Allocation Officer

BUDGET & FINANCE

Resource Allocation Analysts
Nkwenti Sanga, Ms.M, MA
Regat Hagos, MBA
Vacant (1)

GENERAL SERVICES

IT Specialist
Yolanda Lyles

Human Resources Officer
Fredline Lebrun, J.D.

Facility Services Specialist
Samuel L. Taylor, Jr.
Nigel A. John

Aurora Delespin-Jones
Program Manager

PROGRAMS & GRANTS

Program Analysts
Maxine Crowder
Lynn Khoo
Jennifer Adu

Public Health Nutritionists
Jacqueline Geralnick, MPH, RD
Gargi Parikh, MPH, RD, CDE

Program Coordinator
Kay-Anne Spence

Federal Grant Project Lead
Brittany Kitt, MSW

Special Projects Coordinator
Linda Irizarry, LGSW

Brittany Donald
Director of Communications

EXTERNAL AFFAIRS & COMMUNICATIONS

Community Relations Specialist
Krystal Branton, M.Ed., MSW

Customer & Information Service Specialist
Darlene Nowlin

Community Outreach Specialist (Team Lead)
Alice Thompson

Community Outreach Specialists
Sandra Lee
Mark Bjorge

ATTACHMENT F

Senior Service Network by Budget Chapter

CONSUMER INFORMATION, ASSISTANCE AND OUTREACH

	Title III				Title VII
Advocacy	**B**	**C**	**D**	**E**	
Legal Counsel for the Elderly (LCE)	X				
LCE's Ombudsman Program					X
Assistance and Referral Services					
East River Family Strengthering Collaborative (ERFSC) MIPPA					
George Washingotn University MIPPA					
Seabury Resource for the Aging MIPPA					
George Washington University HICAP					

HOME AND COMMUNITY-BASED SUPPORT

	Title III				Title VII
Caregiver Support	**B**	**C**	**D**	**E**	
Home Care Partner's DC Caregivers Institute				X	
IONA's Alzheimers Program					
The Downtown Cluster's Alzheimers Program					
Home Care Partner's Alzheimers Program					
Day Programs					
The Downtown Cluster's Geriatric Day Care Center	X			X	
Zion Baptist Enterprize	X				
So Others Might Eat (SOME) Senior Center	X				
VIDA Senior Center	X				
First Baptist Senior Center	X				
In-home Services					
Home Care Partner's AL-CARE	X				
SOME Homebound Senior Program	X				
Lead Agency					
Terrific Inc. Ward 1	X			X	
Terrific Inc. Ward 2	X			X	
IONA Senior Services Ward 3	X			X	X
Terrific Inc. Ward 4	X			X	
Seabury for Aging Services Ward 5	X			X	
Seabury for Aging Services Ward 6	X			X	
ERFSC Ward 7	X			X	
Family Matters Ward 8	X			X	
Senior Wellness Center					
Mary Center Inc. - Bernice Fontaneau SWC Ward 1			X		

VIDA Senior Services - Hattie Holmes SWC Ward 4			X		
Providence Hospital - Model Cities SWC Ward 5			X		
Howard University - Hayes SWC Ward 6			X		
ERFSC - Washington SWC Ward 7			X		
Providence Hospital - Congress Heights SWC Ward 8			X		
University of the District of Columbia's Body Wise					

Supportive Residential Services

Seabury Resources for Aging - Home First Residence/AIP					
SOME - Kuehner Place (Shelter for Abused Elderly)					
Home Care Partner's Home Adaptation Program					

Transportation

Seabury Resources for Aging's Seabury Connector	X				

NUTRITION

	Title III				Title VII
Congregate Meals	**B**	**C**	**D**	**E**	
ERFSC Weekend Nutrition					
Washington DC Jewish Community Center					
Contractor (FY16 - Dutchmill and Catholic Charity)		X			

Home-delivered Meals

Contractor (FY16 - Moms Meals and Catholic Charity)		X			
IONA transportation					
Seabury Resources for Aging's Seabury Connector					

Commodities and Farmers Market

Capital Area Food Bank					

Supplemental

IONA					

ADVOCACY

SERVICE DEFINITION

Under the District of Columbia Plan on Aging, Long Term Care Ombudsman program, advocacy is a service aimed at protecting and securing the rights, benefits and entitlements of District nursing home and community residence facility (CRF) residents 60 years old and older.

Advocacy services are provided on a personal level to an individual requiring representation in a situation over which a disagreement has arisen or where rights may have been violated. Advocacy services may also be provided on an issue level, by identifying and attempting to resolve policy, regulatory, and/or legislative changes to strengthen the position of older persons.

Advocacy services are provided in nursing homes and CRFs.

SERVICE OBJECTIVE

The objective of advocacy is to protect and secure rights, benefits, and entitlements of older persons on a personal level and through issue resolution.

SERVICE UNIT (1 HOUR)

The unit of service for advocacy is one hour of service spent in a nursing home or CRF visiting residents, resolving complaints, providing in-service training to nursing home staff, attending residents' or family meetings.

In calculating units of service, the time spent outside the facility recording and following up on complaints, supervising and training volunteers, and traveling to and from the homes shall not be counted. Units of service may not be subdivided below one half (1/2) unit.

SERVICE AREA

Advocacy service is available to all eligible nursing home and CRF residents of the District of Columbia 60 years old and older, subject to available staff and priorities for service.

SERVICE LOCATION

Advocacy service may be provided in nursing homes and community residence facilities. Advocacy service providers must take all possible steps to make sure residents of all sectors of the District of Columbia have substantially equal access to this service.

SERVICE PRIORITIES

Advocacy service funded by the D.C. Office on Aging is available only to District of Columbia residents 60 years of age or older. To conserve Office on Aging funds, service should be provided only to those who would not qualify for advocacy service under any other program.

In particular, priority shall be given to those individuals most socially and economically disadvantaged, with special emphasis on low-income minority elderly.

SERVICE STANDARDS

Advocacy service includes the staff, goods, facilities, services and supports necessary to protect and secure the rights, benefits, and entitlements of eligible clients. Advocacy service must meet or exceed the following standards and include the following components:

- Receiving requests for service and completing the intake process;
- Conducting outreach in nursing homes, and community residence facilities;
- Investigating cases in which disagreements have occurred or rights may have been violated;
- Developing, implementing and monitoring plans of action to **remedy** disagreements or to correct possible rights violations;
- Researching issues of importance to older persons;
- Educating and informing the public about issues of concern to older people;
- Developing and implementing strategies to resolve issues of concern to older persons;
- Recruiting and training volunteers to implement the advocacy objectives.
- Providing information about other programs and services for which the client might be eligible, referring the client to proper services as necessary, and providing assistance to the client in gaining public benefits;
- Maintaining records, collect contributions, prepare reports, and perform other administrative efforts necessary to provide advocacy services.
- All requests for assistance must be processed within two (2) working days of receipt, including identification of possible eligibility for advocacy service funded from a source other than the Office on Aging, and beginning the investigation of the facts surrounding the request for assistance.

- All client records must be kept in a secure location to protect confidentiality.

- Clients, family members, and caretakers must be provided with information on how other needed services (e.g., Medicare, Medicaid, SSI, transit, housing, legal assistance, energy assistance, etc.) may be obtained.

- Clients, family members, and/or caretakers must be informed of agency procedures for protecting confidentiality and other matters germane to the client's decision to accept services.

- Agencies must provide the opportunity for other organizations, individuals, etc., to make voluntary contributions to help defray the cost of providing advocacy service, thereby making additional service available to others.

- All staff providing the service must be fully trained and professionally qualified.

- The agency must maintain, follow, and continually update training and supervision program to make sure advocacy staff are full trained and familiar with agency procedures.

- All records of participant services, costs, and agency procedures must be reviewed monthly or more regularly, if needed.
- The agency must keep the Office on Aging continually informed of the issues in which it is involved.

PROHIBITED SERVICE COMPONENTS

For purposes of Office on Aging planning and reimbursement, advocacy service may not include providing financial, legal, or other service or advice (except for referral to qualified agencies or programs).

CASE MANAGEMENT

SERVICE DEFINITION

Under the District of Columbia State Plan on Aging, case management service is a community-based long-term care service that provides on-going arrangement, management and coordination of services rendered to functionally-impaired District residents 60 years old or older. Case management services are generally provided to a participant after the completion of a comprehensive assessment (see Comprehensive Assessment definition) in the participant's home by a case manager or service coordinator, who functions as part of a care team, consisting of a nurse practitioner, family and friend caregivers, and other professionals and paraprofessionals involved in the care of the participant. Case management services are generally provided to the participant on a scheduled basis, semi-monthly or more frequently as needed.

SERVICE OBJECTIVE

The objective of case management is to see that needed services are delivered to allow the participant to maintain the maximum functioning and independence of which he or she is capable and to maintain the participant's life-style and relationships with family and friends, to the greatest extent possible. The service is intended to prevent unnecessary or premature institutionalization.

SERVICE UNIT (1 HOUR)

The unit of service for case management is one hour of service provided to an eligible participant. Hours of service provided may include the time spent in reviewing the case, meeting with the participant, arranging and coordinating services and following up with the participant, family, friends, or service providers.

For example, if a service coordinator spends 30 minutes talking to an agency about providing homemaker services to the participant, 30 minutes completing a service initiation form, 90 minutes meeting with the participant's family to work out a schedule for homemaker services, and one hour visiting the older person to explain the service to be rendered, the worker has provided 3.5 units of service (.5 hours + .5 hours + 1.5 hours + 1 hour). NOTE: Units of service should be rounded off to the nearest 1/2 unit.

SERVICE LOCATION

Case management service may be provided in a community facility or in the home of the participant.

If case management service is provided in a community facility, space should be adequate for providing individual and/or group sessions, and to allow for comfort and confidentiality. The

facility must meet or exceed all applicable District of Columbia requirements for licensing and certifications and must be reasonably free of architectural and psychological barriers.

If case management is provided as an in-home service, the participant may be living in the home of a relative, friend, or other caretaker. The case management service provider must respect the participant's right of privacy and confidentiality to the greatest extent possible.

SERVICE AREA

Case management service is available to all eligible residents of the District of Columbia, subject to available staff and priorities for service (see below). However, specific providers of case management services may be assigned specific areas of the District from which to enroll participants. Case management service providers must take all possible steps to make sure residents of all sectors of the District of Columbia have equal access of this service.

SERVICE PRIORITIES

Case management funded by the D.C. Office on Aging is available only to functionally-impaired District of Columbia residents 60 years of age or older. To conserve Office on Aging funds, service should be provided only to those who would not otherwise qualify for this service under any other program.

Functional impairment shall be judged using the following criteria:

- The individual has difficulty carrying out the normal activities of daily living, which puts him or her at risk of institutionalization or continued inappropriate institutionalization; and
- The participant, his or her family and friends are unable to provide case management services; and
- Case management services are judged necessary to maintain an individual in the community.

In particular, priority shall be given to referrals from hospitals, nursing homes, and other Office on Aging grantees and to those individuals most socially and economically disadvantaged.

SERVICE STANDARDS

Case management service includes the staff, goods, facilities, services and supports necessary to arrange, coordinate and manage services planned for participants. Case management services must meet or exceed the following standards:

- Receive requests for service and complete the intake process;

- Inform participants, family members, and/or caretakers of agency procedures for protecting confidentiality, for reviewing progress against the plan of care,
- participant rights, and other matters germane to the participant's decision to accept services;
- Participate as a member of participant's plan of care team;
- Include participants, family members, and friends in the development and implementation of the plan of care, as appropriate;
- Assess the need for and initiate protective arrangements;
- Arrange and rearrange the services to be delivered to participants, as prescribed in the plan of care;
- Coordinate services provided to the participant by agencies, family and friends;
- Monitor the services delivered to the participant, including identification and resolution of problems with the provider of services;
- Provide supportive counseling to participant and family as appropriate;
- Provide participants, family members, and caretakers with information about other programs and services for which the participant might be eligible (e.g. Medicare, Medicaid, SSI), refer the participant to the proper service as necessary (e.g.,transit, housing, legal assistance, energy assistance, etc.), and provide assistance to the participant in gaining public benefits;
- Inform participants, family members, and/or caretakers of the cost of providing case management service and offer them the opportunity to make voluntary contributions to help defray the cost, thereby making additional service available to others;
- Provide telephone reassurance and friendly visiting to participants as part of the case management program;
- Conduct outreach in nursing homes, hospitals and agencies funded by the Office on Aging;
- Secure all case management plans and other participant records in a safe location to protect confidentiality;
- Review all participant records of care, service costs, sources of funds, and agency procedures weekly, or more often if needed;

- Maintain records, collect participant contributions, prepare reports, and other administrative efforts necessary to provide case management services;

- Maintain, follow, and continually update a training and supervision program to make sure case management staff are fully trained and familiar with agency procedures; and

- In the event the case manager determines a client to be in crisis and cannot provide the intervention, or because of the client's unwillingness to accept services for other reasons, the case manager must:

    - Contact by phone the appropriate crisis intervention agency once this determination is made.

    - Submit a written referral as a follow-up to the telephone call to the crisis intervention agency within five working days of the initial call.

    - Contact the crisis intervention agency within two weeks of the initial referral call to ensure an appropriate intervention was initiated.

PROHIBITED SERVICE COMPONENTS

For purposes of Office on Aging planning and reimbursement, case management service may not include any of the following components:

- Serving ineligible individuals;

- Providing psychotherapy counseling, unless provided by a licensed, certified, or specially trained therapist; or

- Providing medical, financial, legal, or other service or advice (except for referral to qualified individuals, agencies or programs).

COMPREHENSIVE ASSESSMENT

SERVICE DEFINITION

Under the District of Columbia Plan on Aging, comprehensive assessment is an evaluation service, provided to District residents 60 years and older, in order to (1) identify physical, economic, social and psychological problems which affect the individual's ability to carry out the normal activities of daily living, and (2) identify the resources available to assist in resolving the identified problems. Comprehensive assessment services are provided to participants who have multiple, long-term problems and who appear to be in need of case management services (see Case Management definition). Trained personnel, using a standardized format approved by the District of Columbia Office on Aging, provide comprehensive assessment service. The service is generally conducted in the participant's place of residence by a service coordinator, case manager, nurse-practitioner, or by a combination of these professionals and paraprofessionals.

SERVICE OBJECTIVE

The objective of comprehensive assessment is to identify the problems of and resources available to multiple-impaired individuals for the purpose of prescribing the necessary services to allow the participant to achieve and maintain the maximum functioning and independence of which he or she is capable. This service, combined with case management services, is intended to prevent unnecessary or premature institutionalization.

SERVICE UNIT (1 HOUR)

The unit of service for comprehensive assessment is one hour of service worker's time spent conducting assessment interview(s) with an eligible participant, family or friends. Service workers may include service coordinators, case managers, nurse-practitioners, and/or other professionals or paraprofessionals necessary to conduct a thorough and complete assessment. Time spent in preparing for the interview and following up on the assessment may not be counted as service units.

For example, if a participant is screened as a candidate for case management services and a service coordinator and nurse-practitioner make a home visit to conduct the assessment, spending 2 hours together conducting the assessment interview, and the service coordinator spends another 45 minutes interviewing the participant's son to complete the assessment form, 4.75 service units have been delivered (2 hours x 2 workers + .75 hours x worker). NOTE: Units of service must be rounded off to the nearest 1/4 unit.

SERVICE LOCATION

Comprehensive assessment will be conducted most frequently in the participant's place of residence, but may also be conducted in a community facility.

If comprehensive assessment service is provided in a community facility, space should be adequate for providing individual and/or group sessions, and to allow for comfort and confidentiality. The facility must meet or exceed all applicable District of Columbia requirements for licensing and inspections, and must be reasonably free of architectural and psychological barriers.

If comprehensive assessments are provided in the participant's place of residence, the service provider must respect the participant's right of privacy and confidentiality to the extent possible.

SERVICE AREA

Comprehensive assessment service is available to all eligible residents of the District of Columbia, subject to available staff and priorities for service.

SERVICE PRIORITIES

Comprehensive assessment service funded by the D.C. Office on Aging is available only to District of Columbia residents 60 years of age or older and to their families and caretakers.

To conserve Office on Aging funds, service should be provided only to those who would not otherwise qualify for this service under any other program.

In particular, priority shall be given to referrals from hospitals, nursing homes, and other Office on Aging grantee agencies, and to those individuals most socially and economically disadvantaged, with special emphasis on low-income minority elderly.

SERVICE STANDARDS

Comprehensive assessment service includes the staff, goods, facilities, services and supports necessary to conduct a comprehensive evaluation of each eligible participant's condition. Comprehensive assessment services must meet or exceed the following standards:

- Receive and process requests for service within five (5) working days of receipt, including identification of possible eligibility for comprehensive assessment service funded from another source other than the Office on Aging;

- Inform participants, family members, and/or caretakers of agency procedures for protecting confidentiality, for reviewing progress against the plan of care participant rights, and other matters germane to the participant's decision to accept services;

- Start the assessment, using the standard Office on Aging approved comprehensive assessment instrument, within five (5) working days after receipt of application;

- Conduct the initial and periodic comprehensive assessment interviews with participants, family, and friends as appropriate;

- Participate as part of the plan of care team;

- Develop a comprehensive assessment plan for each new participant within thirty (30) working days after enrollment; the plan must include a schedule for comprehensive reassessment sessions;

- Reassess participant needs annually or more frequently, with revisions made in the plan as necessary; any observed changes must be immediately noted in the plan of care;

- Recommend and arrange specialized evaluations (i.e., physical, psychological, vision, etc.) of the participants as indicated by the assessment interview;

- Recommend specific services needed by the participant as a result of the assessment interview (without regard to the service's availability);

- Provide participants, family members, and caretakers with information about other programs and services for which the participant might be eligible (e.g. Medicare, Medicaid, SSI), refer the participant to the proper service as necessary (e.g., transit, housing, legal assistance, energy assistance, etc.) , and provide assistance to the participant in gaining public benefits;

- Inform participants, family members, and/or caretakers of the cost of providing comprehensive assessment service and offer the opportunity to make voluntary contributions to help defray the cost, thereby making additional service available to others;

- Conduct outreach in nursing homes, hospitals, and agencies funded by the Office on Aging;

- Secure all comprehensive assessment plans and other participant records in a secure location to protect confidentiality;

- Review all records of participant services, costs, and agency procedures monthly, or more often if needed;

- Maintain records, collect contributions, prepare reports, and other administrative efforts necessary to provide assessment services;

- Maintain, follow, and continually update a training and supervision program to make sure comprehensive assessment staff are fully trained, professionally supervised, and familiar with agency procedures; and

- Provide comprehensive assessment services with agency personnel who are qualified by education, training or professional experience in a related field.

PROHIBITED SERVICE COMPONENTS

For purposes of Office on Aging planning and reimbursement, comprehensive assessment service may not include providing medical, financial, legal, or other service of advice (except for referral to qualified agencies or programs).

CONGREGATE MEALS

SERVICE DEFINITION

Congregate Meals (1 Meal) - Provision, to an eligible client or other eligible participant at a nutrition site, senior center or other congregate setting, of a meal which:

- complies with the Dietary Guidelines for Americans (published by the Secretaries of the Departments of Health and Human Services and Agriculture;

- provides, if one meal is served, a minimum of 33 and 1/3 percent of the current daily Recommended Dietary Allowances (RDA) as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences;

- provides, if two meals are served, together, a minimum of 66 and 2/3 percent of the current daily RDA; although there is no requirement regarding the percentage of the current daily RDA which an individual meal must provide, a second meal shall be balanced and proportional in calories and nutrients; and,

- provides, if three meals are served, together, 100% of the current daily RDA; although there is no requirement regarding the percentage of the current daily RDA that an individual meal must provide, a second and third meal shall be balanced and proportional in calories and nutrients.

SERVICE OBJECTIVE

The objective of congregate meal service is to provide a nutritious mid-day meal, improve or maintain nutritional status and maintain the maximum functioning and independence of elderly individuals.

SERVICE UNIT (1 MEAL)

The unit of service for a congregate meal is one complete meal provided to one eligible participant. A complete meal is one that meets or exceeds one-third of the current daily Recommended Dietary Allowances, National Academy of Sciences, Revised 1989, for the male 51 +, as well as standards set by the D.C. Office on Aging. For example, if 35 meals are delivered to the congregate meal service center and are served to 33 eligible participants and two center staff members or meal service volunteers under age 60, only 33 service units (complete meals served to eligible participants) may be counted. Units of congregate meal service may not be subdivided (e.g., into half-meals).

ELIGIBILITY

While there is no means testing for participation in the Elderly Nutrition Program (ENP), services are targeted to older people with the greatest economic or social need, with special attention given to low-income minorities.

In addition to focusing on low-income and other older persons at risk of losing their independence, the following individuals may receive service:

- a spouse of any age;
- disabled persons under age 60, who reside in housing facilities occupied primarily by the elderly where congregate meals are served;
- disabled persons who reside at home and accompany older persons to meals; and,
- meal service volunteers.

SERVICE LOCATION

Congregate meal service shall be provided in a suitable facility which meets the following criteria established by the D.C. Office on Aging:

- The nutrition center should be accessible within the target area, preferably within walking distance for the participants or on a public transportation route.
- The center should serve a minimum of 25 eligible participants each day for the congregate meal. If fewer than 25 eligible participants are served, the exception shall be justified by documentation that the target population is less than 25 persons and that no other centers are available.
- The center shall meet the minimum standards of the District of Columbia's Building, Fire, and Department of Consumer and Regulatory Affairs regulations, and a Certificate of Occupancy must be obtained.
- Nutrition centers may be located in senior centers, geriatric day care centers, housing projects, recreation centers, churches, and other locations approved by the D.C. Office on Aging**.** Meals are served between 11 AM and 1 PM Monday through Friday.
- Generally, a contract caterer provides meals to nutrition centers with the D.C. Office on Aging. In approved situations, other sources of meals and means of delivery can be used.

SERVICE AREA

Congregate meal service is available to all residents of the District of Columbia age 60 and over and to their spouse if he or she attends the nutrition center with the elderly person (subject to available spaces and SERVICE PRIORITIES below.) Specific providers of congregate meal service are assigned sub-areas of the District from which to accept participants. Participants are encouraged to attend the nutrition center closest to their residence, but are not required to do so.

Meals are provided in nutrition centers throughout the District of Columbia under the Nutrition and Supportive Service Projects. Therefore, congregate meals units of service are reported by nutrition centers through the Nutrition and Supportive Service Projects**.**

SERVICE PRIORITIES

Priority for congregate meal service should go to those individuals who are most in need and unable to prepare or purchase adequate meals for themselves.

In particular, priority shall be given to referrals from Geriatric Assessment and Case Management Sites, nutrition and supportive services outreach staff, and to those individuals 60 and older who are most socially and economically disadvantaged, with special emphasis on low-income minority elderly.

SERVICE STANDARDS

Congregate meal service includes staff, goods, facilities, services and supports necessary to serve a complete mid-day meal to each individual enrolled in the program. Meals are reserved for participants to allow for planning and accountability. The meal service shall meet or exceed the following standards:

- Applicants must be referred to the nutrition center nearest their residence;
- Congregate meal service delivery must be coordinated with the District caterer;
- A client intake and nutrition screening shall be conducted for each participant to determine eligibility and updated at least annually.
- The nutrition site shall maintain a system of meal reservations and meals served to allow for accurate planning and accountability by the Lead Agency and the District caterer.
- The nutrition site shall meet criteria set forth under SERVICE LOCATION.

- Congregate meals shall be served within two hours after delivery, if catered, or within two hours, if prepared on site. During transportation of meals, while holding meals and when serving meals, HOT food temperatures should be 140ºF or greater and COLD food temperatures should be 45 ºF or less. All meals, including those held for latecomers, should be served by 1 p.m.

- In addition to serving a complete mid-day meal in a group setting, the site shall offer two or more activities daily (e.g., Recreation/ Socialization, Nutrition Education, Counseling, etc.) as posted on a preplanned calendar.

- Special programs must be planned and coordinated in conjunction with congregate meals, including (but not limited to) nutrition education, health education, and other health and social supportive services and activities.

- Participants shall have an opportunity to take part in the Senior Service Neighborhood Advisory Council (SSNAC).

- Recreation and socialization activities must be coordinated with nutrition centers and other service providers.

- Meals shall be served as planned and delivered.

- For sites not served by a District caterer, meals shall meet or exceed one-third of the RDA, and any additional standards set by the D.C. Office on Aging, as certified by a licensed and registered dietitian.

- Copies of menus as served, other than those furnished by a District caterer, shall be retained for a period of three years.

- Participants shall be provided with information on how needed services may be obtained, and shall be provided assistance in gaining access to those services.

- The site shall have adequate space and operable equipment for the program, including range, oven, refrigerator, sink, tables, and chairs, where applicable.

- When food is prepared on-site, the site shall be licensed and inspected by the Department of Consumer and Regulatory Affairs and certified as a food service establishment. Current food service inspection reports by the Department of Consumer and Regulatory Affairs shall be posted. All required certificates must be on file and available for review at all times.

- The site shall have a pleasant environment, adequate lighting, and pleasing decor.

- The site shall be accessible and free of both physical and psychological barriers, insofar as possible.

- The site shall have locked, sanitary, and secure storage space available for supplies and caterer's equipment (if catered).

- The site, including restrooms, shall be maintained in a clean and sanitary condition.

- The site shall be available a minimum of 4 hours daily Monday through Friday.

- The site shall operate under the auspices of the D.C. Office on Aging's Lead Agency responsible for the service area.

- The center shall have a plan of operation, describing coordination with other community resources and programs.

- The older population in the area should support the center location by participating, volunteering, or helping to sponsor the center. The recipients of services should be involved as much as possible in assisting the center manager in planning and developing relevant programs, and in neighborhood outreach.

- The sponsor of the center, in cooperation with the Lead Agency, shall contribute program support by developing neighborhood awareness, involving churches, organizations, and other interested persons. Sponsorship should also include providing space, utilities, maintenance, incidental expenses, recruitment of volunteers, programming activities, and service development.

- The specific role of the sponsor in the nutrition center is defined by the Lead Agency in its project plan.

- Personnel and volunteers associated with the congregate meal service shall be trained in the sanitary handling of food, fire safety, and basic first aid, particularly in dealing with choking and coronary attacks. Center managers and assistant center managers shall have current food handlers' certificates.

- All staff providing the service must be fully trained and professionally qualified; a licensed registered dietitian/licensed nutritionist should be available at least as a consultant.

- The agency must maintain, follow, and continually update a training and supervision program to make sure staff are fully trained and familiar with agency procedures.

- All records of participant services, costs and agency procedures shall be reviewed monthly, or more often if needed.

- The grantee agency shall provide training and supervision of nutrition center staff, or coordinate training provided by others.

- The grantee agency shall reconcile the records of nutrition centers and the caterer to make sure the number of meals delivered agrees with the number of meals received.

- Participants, family members, and/or caretakers shall be informed of the cost of providing congregate meal service and shall be offered the opportunity to make voluntary contributions to help defray the cost, thereby making additional service available to others.

- Participants, family members, and/or caretakers shall be informed of agency procedures for protecting confidentiality, accounting for participant contributions, and other matters germane to the participant's decision to accept services.

- The grantee agency shall ensure each center has paid or volunteer staff qualified to provide the service.

- The grantee agency shall interpret program policy for staff based at nutrition centers.

- The grantee agency shall maintain records, reserve meals, collect contributions from centers, prepare reports, and perform other administrative activities necessary to see that congregate meal services are provided.

PROHIBITED SERVICE COMPONENTS

For purposes of Office on Aging planning and reimbursement, congregate meal service may not include any of the following components:

- Taking meals (or allowing meals to be taken) from the congregate meal service center to be consumed in the participant's home; and,

- Providing meals to ineligible persons.

COUNSELING

SERVICE DEFINITION

Under the District of Columbia Plan on Aging, counseling service is a problem identification and resolution service, provided by professionally trained workers, to District residents 60 years of age and older, their family members, or their caretakers, who need emotional support and guidance to develop and strengthen the older person's capacity for personal and emotional functioning. Counseling is not a separate program, but a service that involves help provided by trained personnel working as part of a community-based program providing other services, i.e., social, nutritional, or health services. Counseling may be provided on a scheduled basis, or as needed.

SERVICE OBJECTIVE

The objective of counseling is to develop and strengthen an older person's emotional and personal capacity for functioning to allow the participant to maintain the maximum functioning and independence of which he or she is capable.

SERVICE UNIT (1 HOUR)

The unit of service for counseling is one hour of service provided to an eligible participant. Hours of service provided may include the time spent in preparing for the session, meeting with the participant, and following up with the participant, family, or friends.

For example, if an agency service worker spends 30 minutes preparing for a meeting with the family of an eligible older person, 30 minutes meeting with them, and 30 minutes discussing the results of the meeting with the older person, the worker has provided 1.5 units of service (.5 hours + .5 hours + .5 hours). NOTE: Units of service may not be subdivided below 1/2 unit.

SERVICE LOCATION

Counseling service may be provided in a community facility or in the home of the participant.

If counseling service is provided in a community facility, space should be adequate for providing individual and/or group sessions, and to allow for comfort and confidentiality. The facility must meet or exceed all applicable District of Columbia requirements for licensing and inspections, must be reasonably free of architectural and psychological barriers, and must be the site for one or more additional services for the elderly.

If counseling service is provided as an in-home service, the participant may be living in the home of a relative, friend, or other caretaker. However, the counseling service provider must respect the participant's right of privacy and confidentiality to the greatest extent possible.

SERVICE AREA

Counseling service is available to all eligible residents of the District of Columbia, their families, and caretakers, subject to available staff and priorities for service (see below). Counseling service providers must take all possible steps to make sure residents of all sectors of the District of Columbia have equal access to this service.

SERVICE PRIORITIES

Counseling service funded by the D.C. Office on Aging is available only to District of Columbia residents 60 years of age or older and to their families and regular caretakers. To conserve Office on Aging funds, service should be provided only to those who do not otherwise qualify for this service under any other program.

In particular, priority shall be given to referrals from hospitals, doctors, Geriatric Assessment and Case Management Sites, and to those individuals most socially and economically disadvantaged, particularly low-income minority elderly.

SERVICE STANDARDS

Counseling service includes the staff, goods, facilities, services and supports necessary to carry out the program. Counseling service must meet or exceed the following standards:

- Receive and respond to requests for service within three (3) working days of receipt, including identification of possible eligibility for counseling service funded from another source other than the Office on Aging;

- Inform participants, family members, and/or caretakers of agency procedures for protecting confidentiality, for reviewing progress against the plan of care, participant rights, and other matters germane to the participant's decision to accept services;

- Start evaluating the need for specific types of counseling within three (3) working days after receipt of application;

- Conduct an assessment of the participant's social and family circumstances;

- Develop a counseling plan for each new participant within five (5) working days after enrollment; the plan must include a schedule for counseling sessions;

- Provide supportive counseling, family counseling, and group counseling, as needed or requested;

- Reassess participant needs every six (6) months or more frequently, with revisions made in the plan as necessary; any observed changes must be immediately noted in the plan of care;

- Provide telephone reassurance and friendly visiting to participants as part of the counseling program;

- Provide other supportive services as needed including -- but not limited to--outreach, placement, advocacy assistance, education (i.e., crime prevention, health, literacy and consumer education);

- Provide participants, family members, and caretakers with information about other programs and services for which the participant might be eligible (e.g. Medicare, Medicaid, SSI), refer the participant to the proper service as necessary (e.g.,transit, housing, legal assistance, energy assistance, etc.) , and provide assistance to the participant in gaining public benefits;

- Participants, family members, and/or caretakers must be informed of the cost of providing counseling service and must be offered the opportunity to make voluntary contributions to help defray the cost, thereby making additional service available to others;

- Secure all counseling plans and other participant records in a secure location to protect confidentiality;

- Maintain records, collecting participant contributions, preparing reports, and other administrative efforts necessary to provide counseling services;

- Provide counseling services with agency personnel who are qualified by education, training or professional experience in a related field; and

- In the event that the counselor determines a client is in crisis and cannot provide the intervention necessary to stabilize the situation due to the client's unwillingness to accept service for other reasons, the counselor must:

    - Contact by phone the appropriate crisis intervention agency once this determination is made.

    - Submit a written referral as a follow-up to the telephone call to the crisis intervention agency within five working days of the initial call.

    - Contact the crisis intervention agency within two weeks of the initial referral call to ensure the appropriate intervention was initiated.

PROHIBITED SERVICE COMPONENTS

For purposes of Office on Aging planning and reimbursement, counseling service may not include any of the following components:

- Providing psychotherapy counseling, unless provided by a licensed therapist;

- Providing medical, financial, legal, or other service or advice (except for referral to qualified agencies or programs).

GERIATRIC DAY CARE

SERVICE DEFINITION

Under the District of Columbia State Plan on Aging, geriatric day care is a therapeutic service provided to functionally-impaired District residents 60 years of age and older, in order to avoid or forestall institutionalization. Geriatric day care involves care and supervision, provided during the day, by professionally-qualified personnel, in a suitable facility. Geriatric day care is a more intense level of care than center-based social and recreation services.

SERVICE OBJECTIVE

The objective of geriatric day care is to provide supervision, socialization, rehabilitation, training, therapy and supportive services to create a therapeutic environment in which functionally-impaired older persons can achieve and maintain the maximum functioning and independence of which he or she is capable, in a community setting.

SERVICE UNIT (1 HOUR)

The unit of service for geriatric day care is one hour of care provided to one eligible participant. This care may include providing supervision, socialization, rehabilitation, training, therapy and supportive services to an eligible participant.

For example, if an eligible participant arrives at a day care program at 10:00 a.m. and participates in adult day care services such as art therapy, music therapy, and other therapeutic or supportive services until 2:00 p.m., the units of day care service are 4. This is calculated by counting the number of hours that the participant received service. NOTE: Units of service may not be further subdivided (below 1/2 unit).

SERVICE AREA

Geriatric day care is available to all eligible residents of the District of Columbia, subject to available spaces and priorities for service (see below). Specific providers of geriatric day care services may be assigned sub-areas of the District from which to enroll participants.

SERVICE LOCATION

Geriatric day care must be provided in a suitable facility. The facility should be as free as possible of architectural and psychological barriers. It should be secure from outside interference during the hours of day care operation. Space should be adequate for carrying out required group and individual participant activities without crowding. Offices should provide sufficient space and security to allow comfort and confidentiality for the participants during counseling. The facility must meet or exceed all District of Columbia requirements for licensing, inspection, and certification, as applicable.

SERVICE PRIORITIES

Geriatric day care funded by the D.C. Office on Aging is available only to functionally-impaired District of Columbia residents 60 years of age or older who are able to maintain themselves with some assistance (i.e., who are usually able to attend to toilet and feeding without assistance), who are not bedfast, and who represent no threat to themselves or others.

Priority for geriatric day care services should go to those individuals who meet the above conditions who are otherwise at risk for institutionalization if they do not receive geriatric day care services.

In particular, priority shall be given to referrals from hospitals, doctors, Geriatric Assessment and Case Management Sites, and to those individuals most socially and economically disadvantaged, particularly low-income minority elderly.

In determining the level of impairment, an individual should be judged moderately to severely impaired on the basis of whether he or she has one or both of the following problems:

- The individual has definite psychiatric symptoms or moderate intellectual impairment. The individual may be able to make routine decisions, but cannot carry out the activities of daily living or handle major problems without supervision.

- The individual has one or more disabilities, diseases, or illnesses that restrict the ability to carry out the activities of daily living.

SERVICE STANDARDS

Geriatric day care includes the staff, goods, facilities, services and supports necessary to carry out the plan of care developed for each older individual enrolled. Geriatric day care must meet or exceed the following standards:

- Receiving requests for admission and completing the intake process;

- Conducting a comprehensive assessment of the participant's social circumstances, economic condition, medical history, physical status;

- Testing and evaluating specific functional limitations (and retesting as necessary);

- Developing a plan of care for each participant;

- Re-evaluating the plan of care periodically, and modifying it as necessary;

- Providing supportive counseling, family counseling and group psychotherapy as necessary;

- Providing such personal care and supervision as required by the plan of care, including therapy, drug supervision, injections, and other services (provided that medical or nursing services shall only be provided by a qualified and licensed professional);

- Serving a complete mid-day meal (see Congregate meals definition for specifics);

- Providing social, recreational, physical, or other activities and therapies as part of the plan of care;

- Providing or arranging transportation to the geriatric day care facility in the morning and transportation to the participant's home in the evening, as necessary;

- Providing information about other programs and services for which the participant might be eligible, referring the participant to proper services as necessary, and providing assistance to the participant in gaining public benefits;

- Referring the participant to a physician or medical facility for needed specialized health care or treatment;

- Providing limited telephone reassurance and friendly visiting to participants who are unable to come to the geriatric day care facility for a temporary period;

- Providing other supportive services and activities as needed by the participant to carry out the plan of care including -- but not limited to -- outreach, emergency shopping, serving snacks, arranging and supervising field trips, advocacy, health education, exercise, adapted sports, and working with family and friends of the participant to see that time away from the geriatric day care facility contributes to the plan of care; and

- Maintaining records, collecting contributions, preparing reports, and other administrative efforts necessary to provide day care services.

- Developing a preliminary plan of care for each new participant within five (5) working days after enrollment.

- Completing a final plan of care (incorporating therapy plans) for each new participant within fifteen (15) working days after enrollment.

- Keeping all plans of care and other participant records in a secure location to protect confidentiality.

- Reassessing participant needs every six (6) months or more frequently, with revisions made in the plan of care as necessary.

- Reviewing the geriatric day care center caseload whenever a vacancy arises (or more frequently) to ensure that participants are being served in priority order.

- Providing participants with information on how needed services (e.g., Medicare, Medicaid, SSI, transit, prosthetic or rehabilitative devices, housing, etc.) may be obtained, and must be provided assistance in gaining access to those services.

- Participants, family members, and/or caretakers must be informed of agency procedures for protecting confidentiality, reviewing progress against the plan of care, and other matters germane to the participant's decision to accept services.

- Participants, family members, and/or caretakers must be informed of the cost of providing geriatric day care services and must be offered the opportunity to make voluntary contributions to help defray the cost, thereby making additional service available to others.

- All staff providing the service must be fully trained and professionally qualified.

- The agency must maintain, follow, and continually update a training and supervision program to make sure day care staff are fully trained and familiar with agency procedures.

- All participants' records on level of care, service costs, sources of funds, and agency procedures must be reviewed weekly, or more often if needed.

PROHIBITED SERVICE COMPONENTS

For purposes of Office on Aging planning and reimbursement, geriatric day care may not include any of the following components:

- Providing nursing care, unless provided by a Registered Nurse, Licensed Practical Nurse, or Home Health Aide;

- Providing medical services, unless provided by a Medical Doctor, Podiatrist, or Doctor of Osteopathy;

- Providing care outside the geriatric day care facility (e.g., in the participant's home).

HEALTH PROMOTION

SERVICE DEFINITION

Under the District of Columbia State Plan on Aging, health promotion is a community service program provided to District residents 60 years of age or older, designed to promote healthy behaviors and lifestyles through health education and physical fitness provided by health related professionals and/or trained workers. Health promotion that involves a range of structured programs and activities to educate the elderly on how to develop healthy lifestyles to prevent and/or control disease will be provided in a community-based setting. Health promotion services are provided on a scheduled basis for groups.

SERVICE OBJECTIVE

The objective of health promotion is to promote healthy behaviors through educational programs and activities aimed at enhancing physical and emotional well being through classes, activities and programs (e.g. nutrition, medication management and physical fitness).

SERVICE UNIT (1 HOUR)

The unit of service for health promotion is one hour of service provided to an eligible participant.

Health promotion is a program conducted by a health-related professional and/or trained person to promote better health by providing accurate and culturally sensitive accident prevention, drug and alcohol abuse prevention, medication management, and smoking cessation information to participants in a group setting. Screening for hypertension/high blood pressure (HBP), diabetes and high cholesterol and exercise programs are other health promotion activities.

SERVICE LOCATION

Health Promotion services shall be provided in an accessible community-based facility which meets or exceeds all applicable District of Columbia requirements of licensing and inspections, is reasonably free of architectural and psychological barriers, and will be the center for one or more additional services for the elderly, preferably within walking distance for the participants or on a public transportation route.

SERVICE AREA

Specific agencies are assigned geographic service areas. Participants are encouraged, but not required, to attend a program near their residence.

SERVICE PRIORITIES

Health Promotion services funded by the D.C. Office on Aging are available only to District of Columbia residents 60 years of age or older, who are able to maintain themselves and who represent no threat to themselves or others. In particular, priority shall be given to those individuals most socially and economically disadvantaged, with emphasis on low-income minority elderly.

SERVICE STANDARDS

Health Promotion service includes the staff, equipment, facilities, services and supports necessary to carry out the program and must meet or exceed the following standards:

- Physical activity sessions shall be held a minimum of two times a week.
- An intake process shall be developed and completed to make sure eligible applicants know about conditions for participation.
- The health promotion activities program shall be planned as a well-rounded set of activities and sessions designed to appeal to the needs of the elderly population in the service area.
- Program procedural instruments (e.g., personnel manual, affirmative action plan, etc.) shall be developed within three (3) months after initial opening of the program, and shall be updated annually thereafter.
- A citywide health resource file shall be developed within six (6) months of operation, and shall be updated semi-annually thereafter.
- All participant records shall be kept in a secure location to protect confidentiality.
- Participants, family members, and caretakers must be provided with information on how other needed services (e.g., Medicare, Medicaid, SSI, transit, housing, legal assistance, energy assistant, etc.) may be obtained.
- Participants, family members, and/or caretakers must be informed of agency procedures for protecting confidentiality, for reviewing progress against the plan of care, participant rights, and other matters germane to the participant's decision to accept services.
- The grantee must maintain, follow, and continually update training and supervision programs to make sure health promotion staff are fully trained and familiar with agency procedures.

- All records of participant services, costs, and agency procedures must be reviewed monthly or more often if needed.

- The grantee shall develop and distribute monthly calendars of scheduled activities and events;

- The grantee shall implement and report all sessions accurately.

- The grantee shall maintain records, collect participant contributions, and prepare reports and other administrative efforts necessary to provide health promotion activities.

- Each grantee shall plan and schedule at least three health promotion activities per week.

PROHIBITED SERVICE COMPONENTS

For purposes of Office on Aging planning and reimbursement, health promotion service may not include any of the following components:

- Providing medical services.

- Providing financial, legal, or other service or advice (except for referral to qualified agencies or programs).

- Services that exceed a two-hour period, except for planned all day activities.

HEAVY HOUSECLEANING

SERVICE DEFINITION

Heavy housecleaning service is an in-home service provided to frail and vulnerable District residents 60 years of age and older who are infirm, disabled, chronically-ill or mentally impaired, in order to create a habitable environment. Heavy housecleaning service provides a one-time only thorough cleaning of living quarters that pose serious sanitation, safety and health risks.

SERVICE OBJECTIVE

The objective of heavy housecleaning service is to provide the necessary assistance and cleaning to enhance comfort for the client and accessibility to home health personnel into the clients' home. Heavy housecleaning service will allow elderly persons to remain in their homes without risk of health hazards, and prevent premature institutionalization.

SERVICE UNIT (1 HOUR)

The unit of service for heavy housecleaning service is one hour of cleaning service provided by licensed and bonded workers to an eligible participant. In calculating the hours of service provided, the time spent in preparing for the heavy housecleaning and traveling to the participant's home shall not be counted.

SERVICE AREA

Heavy housecleaning service is available to all eligible residents of the District of Columbia, subject to available workers and priorities for service.

SERVICE LOCATION

Heavy housecleaning service is to be provided in the home of the participant, in which he/she is either the lessee or principal occupant.

SERVICE PRIORITIES

Heavy housecleaning service funded by the D.C. Office on Aging is available on a one-time only basis only to District of Columbia residents 60 years of age or older who are unable to perform this service due to chronic illness, frailty, or mental impairment. Priority for heavy housecleaning service should go to those individuals who are referred by Homemaker Services, and the Geriatric Assessment and Case Management sites and to those individuals most socially and economically disadvantaged with emphasis on low-income minority elderly.

SERVICE STANDARDS

Heavy housecleaning includes the staff, materials, services and supports necessary to carry out the heavy housecleaning. Components of the service may include the following and heavy housecleaning service must meet or exceed the following standards:

- Removal of old books, clothing, newspapers, magazines and broken dishes/glassware. When appropriate, light hauling is available for rugs, chairs and mattresses.
- Cleaning of kitchen appliances, (including defrosting of refrigerator) and washing, drying, and stacking glassware, pots, pans and dishes.
- Dusting, sweeping/vacuuming and scrubbing linoleum and tile covered floors.
- Washing windows and mirrors.
- Collecting and bagging soiled clothing.
- Stacking books, magazines, et al., not earmarked for trash.
- Transporting bags earmarked for trash pick-up to secured designated area.
- Hauling designated items to a trash drop-off site (when appropriate).
- Extermination of roaches, lice and rodents when necessary.
- All requests for service must be processed within 3 working days of receipt.
- An intake form must be completed for all clients requesting heavy housecleaning service.
- Participants must be provided information about other programs and services, for which the participant may be eligible and referred for proper services, as necessary.
- Records must be maintained, contributions must be collected, reports must be prepared, and other administrative duties must be performed as necessary to provide heavy housecleaning service.

PROHIBITED SERVICE COMPONENTS

Heavy housecleaning service may not include any of the following components:

- Repair of plumbing fixtures, i.e. toilets, faucets etc.

- Repair of broken windows, doors, stairs or railings.
- Hauling of broken appliances or furniture such as sofas, and washers/dryers.
- Light housecleaning on a regular basis.
- Extensive preliminary sorting and packing of articles (i.e., clothing, jewelry, glassware, and dishes).
- Yard work or sidewalk maintenance.

HOME-DELIVERED MEALS

SERVICE DEFINITION

Home Delivered Meals (1 Meal) - Provision to an eligible client or other eligible participant at the client's place of residence, a meal which:

- complies with the Dietary Guidelines for Americans (published by the Secretaries of the U.S. Departments of Health and Human Services and Agriculture;

- provides, if one meal is served, a minimum of 33 and 1/3 percent of the current daily Recommended Dietary Allowances (RDA) as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences;

- provides, if two meals are served, together, a minimum of 66 and 2/3 percent of the current daily RDA; although there is no requirement regarding the percentage of the current daily proportional in calories and nutrients; and,

- provides, if three meals are served, together, 100 percent of the current daily RDA; although there is no requirement regarding the percentage of the current daily RDA which an individual meal must provide, a second and third meal shall be balanced and proportional in calories and nutrients.

Home-delivered meals are coordinated throughout the District of Columbia under the supervision of Lead Agencies. Therefore, units of home-delivered meals service are reported by nutrition centers through the Lead Agencies.

Meals are to be delivered and/or served between 10:00 a.m. and 2:00 p.m. Monday through Friday and weekends.

Generally, food for home-delivered meals is prepared by a caterer under contract to the Office on Aging, and is delivered by the Lead Agency or another Office on Aging contractor or grantee (see Transportation of Home-Delivered Meals definition). In approved situations, other sources of meals and means of delivery can be used.

SERVICE OBJECTIVE

The objective of home-delivered meals service is to provide a nutritious meal to improve or maintain nutritional status and to maintain the maximum functioning and independence of the homebound individual.

SERVICE UNIT

The unit of service for home-delivered meal service is one complete meal delivered to one eligible participant. A complete meal is one that meets or exceeds one-third of the Recommended Dietary Allowance, National Academy of Sciences, Revised 1989, for a male, 51 +, as well as standards set by the D.C. Office on Aging .

For example, if 35 meals are prepared but 33 are served to eligible participants, 33 service units (complete meals delivered to eligible participants) may be counted. Units of home-delivered meals service cannot be subdivided (e.g., into half-meals). Meals that are not delivered, because the participant is not at home may be delivered to other eligible participants. Therefore, there may be instances when a participant could receive more than one meal in a day.

ELIGIBILITY:

Home-delivered meal service funded by the D.C. Office on Aging is available only to District of Columbia residents 60 years of age or older (and their spouses, if in the best interest of the homebound older person) who are determined to be in need, according to the following criteria:

- Physical inability to prepare meals, which may be caused by:
    - impaired vision, hearing, or mobility
    - general lassitude,
    - dependence on medications and/or other life supports,
    - medical needs,
    - therapy (causing appetite loss),
    - moderate or severe senile dementia, or
    - other ailments such as alcoholism and drug dependence;

- Emotional inability, which can be temporarily or permanently disabling to a degree that affects the ability to acquire, prepare and consume well-balanced meals (many emotional disorders commonly in older persons -- depression, alcoholism, and drug dependence -- result in loss of appetite, apathy, and lassitude);
- Other inabilities which can include the absence of a homemaker, family, or friends to assist with shopping and preparation of food, a lack of adequate money to pay for enough food, lack of transportation for shopping, lack of facilities to store, prepare and maintain foods safely, and unawareness of proper nutrition practices.

- Degree and nature of illness, disability and isolation;

- Duration of need for home-delivered meal service; and

- Individual is not qualified for (or has inadequate resources to purchase) "meals-on-wheels" services funded from another source.

SERVICE LOCATION

The home-delivered meals service is provided in the client's home.

SERVICE AREA

Home-delivered meal service is available to all residents of the District of Columbia age 60 and over, subject to available spaces and priorities for service (see below). Lead Agencies are assigned subareas of the District from which to accept participants and to monitor meal assembly and delivery. Participants are assigned to the Lead Agencies responsible for the area of their residence.

SERVICE PRIORITIES

In particular, priority shall be given to referrals from Geriatric Assessment and Case Management Sites, referrals from Lead Agency outreach staff, and to those individuals most socially and economically disadvantaged, with emphasis on low-income minority elderly.

SERVICE STANDARDS

Home-delivered meal service includes the staff, goods, facilities, service and supports necessary to ensure the delivery of a complete mid-day meal to each older homebound individual determined to be eligible for a meal. Home-delivered meal service must meet or exceed the following standards:

- Clients or responsible person shall be informed of the time limit for this service; the need for home visit, and an in-home assessment by a social worker or other qualified person every six months or more often, if needed.

- Meals shall be served as planned.

- Meals shall meet or exceed one-third of the daily RDA, as certified by a registered dietitian or nutritionist, and comply with the Dietary Guidelines for Americans.

- Participants shall be provided with information on how needed services (e.g., Medicare, Medicaid, SSI, transit, housing, etc.) may be obtained, and shall be provided assistance in gaining access to those services.

- Participants, family members, and/or caretakers shall be informed of the cost of preparing home-delivered meals and shall be offered the opportunity to make voluntary

contributions to help defray the cost, thereby making additional service available to others.

- The agency shall maintain, follow, and continually update a training and supervision program to make sure staff are fully trained and familiar with agency procedures.

- All records of participant services, costs, and agency procedures shall be reviewed monthly, or more often if needed.

- Food temperatures should be adequately maintained during transportation. Hot foods should be 140ºF or higher and cold foods should be 45ºF or less during transportation. Hot and cold foods should not be combined at any time for any reason.

- An intake process shall be conducted, and shall include nutrition screening, to determine each participant's eligibility, according to the criteria outlined under Service Eligibility (see above); and obtain proper documentation to support the need for meals within 5 working days of the application/request;

- Assemble a complete meal from prepared bulk food for delivery to eligible individuals, except when provided preplated by caterer;

- Arrange for delivery of meals;

- Provide information about other programs and services for which the meals participant might be eligible, and refer the participant to proper services as necessary;

- Coordinate home-delivered meals service with the District caterer and the transportation of meals provider;

- Interpret program policy;

- Train and supervise nutrition center staff, or coordinate training provided by others;

- Order supplies, maintain an adequate stock of supplies, and provide secure storage for supplies;

- Reconcile the records of preparation sites and the delivery agencies to make sure the number of meals delivered agrees with the number of meals received; and

- Maintain records, collect contributions from centers, prepare reports, and perform other administrative activities necessary to see that home-delivered meals are assembled and delivered to eligible participants.

- Home-delivered meal slots will not be held for clients who are hospitalized.

PROHIBITED SERVICE COMPONENTS

For purposes of Office on Aging planning and reimbursement, home-delivered meal service may not include any of the following components:

- Removing foods from insulated containers before arrival at delivery location.

- Providing financial, legal, or other service or advice (except for referral to qualified agencies or programs.)

HOME HEALTH SERVICE

SERVICE DEFINITION

Home health service is an in-home maintenance service providing medical care and treatment to vulnerable District residents 60 years of age and older who are infirm, disabled, or chronically ill, in order to avoid or forestall institutionalization. Home health service involves planned and regularly scheduled medical, nursing, and other therapeutic service, provided according to a plan of care prescribed by a physician, in the participant's home, by professionally qualified personnel working under the supervision of a Public Health Agency.

SERVICE OBJECTIVE

The objective of home health service is to provide the necessary health care to allow the participant to maintain the maximum functioning and independence of which he or she is capable, in familiar surroundings.

SERVICE UNIT (1 HOUR)

The unit of service for home health service is one hour of service provided by a nurse, therapist, or home health aide to an eligible participant. In calculating the hours of service provided, the time spent in preparing for the visit, traveling to the participant's home, and returning to the home health worker's home shall not be counted.

For example, if a grantee provides 90-minute visits to 50 eligible older people in one day, it has provided 75 units of service (50 x 1.5 hours). If one of those provided care is only 59 years old (even though functionally impaired), the home health service provider has provided only 73.5 service units, according to this definition. NOTE: Units of service may not be further subdivided (below 1/2 unit).

SERVICE AREA

Home health service is available to all eligible residents of the District of Columbia, subject to available staff and priorities for service.

SERVICE LOCATION

Home health service must be provided in the home of the participant. The participant may be living in the home of a relative, friend, or other caretaker. However, the home health service provider must respect the participant's right of privacy and confidentiality to the extent possible.

Home health service providers must take all possible steps to make sure residents of all sectors of the District of Columbia have equal access to this service.

SERVICE PRIORITIES

Home health service funded by the D. C. Office on Aging is available only to District of Columbia residents 60 years of age or older, as prescribed by his or her physician, who would not otherwise qualify for this service under any other program.

Priority for home health service should go to those individuals meeting the above conditions who are otherwise eligible for admission to an Intermediate Care Facility if they do not receive home health service.

In particular, priority shall be given to referrals from hospitals, doctors, Geriatric Assessment and Case Management Sites, and to those individuals most socially and economically disadvantaged, with emphasis on low-income minority elderly.

SERVICE STANDARDS

Home health service includes the staff, goods, facilities, services and supports necessary to carry out the plan of care developed for each older individual enrolled. Components of the service may include the following. In addition, home health service must meet or exceed the following standards:

- Receiving requests for service and completing the intake process;
- Conducting an in-home comprehensive assessment of the participant's social circumstances, economic conditions, medical history, physical status, mental status, and ability to perform the activities of daily living (including family needs);
- Testing and evaluating functioning in specific areas of concern (e.g., vision, hearing, range-of-motion);
- Developing a plan of care for each participant;
- Administering and supervising medication and treatment, following the overall medical plan of care, including treatment, rehabilitation, medication, injection, and other medical care necessary for the participant's safety and comfort;
- Providing personal care as specified in the plan of care, including bathing, grooming, and assistance in the activities of daily living;
- Providing instruction and guidance to the participant, family, and other caretakers on preventive health care, including nutrition, accident prevention, and use of health and social service resources;

- Providing information about other programs and services for which the participant might be eligible, referring the participant to proper services as necessary, and providing assistance to the participant in gaining public benefits;

- Referring the participant to a physician or medical facility for needed specialized health care or treatment;

- Coordinating with other service providers for needed supportive services;

- Re-evaluating the plan of care periodically, and modifying it as necessary; and

- Maintaining records, collecting contributions, preparing reports, and other administrative efforts necessary to provide home health services.

- The grantee must meet and comply with all required rules, regulations, and standards set by the cognizant accrediting agency.

- All requests for service must be processed within three (3) working days of receipt, including identification of possible eligibility for home health service funded by a source other than the Office on Aging.

- Comprehensive assessment and a plan of care must be completed within seven (7) working days after receipt of application.

- A plan of care and other participant records must be kept in a secure location to protect confidentiality.

- The home health service caseload must be reviewed whenever a vacancy arises (or more frequently) to make sure priority participants are being served.

- Participant needs must be reassessed every six (6) months or more frequently, with revisions made in the plan of care as necessary; any observed changes must be immediately noted in the participant plan of care.

- Participants must be provided with information on how other needed services (e.g., Medicare, Medicaid, SSI, transit, housing, prosthetic or rehabilitative devices, etc.) may be obtained, and must be provided assistance in gaining access to those services.

- Participants, family members, and/or caretakers must be informed of grantee procedures for protecting confidentiality, for reviewing progress against the plan of care, and other matters germane to the participant's decision to accept services.

- Participants, family members, and/or caretakers must be given the opportunity to learn how to perform some of the non-medical tasks performed by the home health worker, in order to give the participant and the informal support network a chance to function independent of grantee agency's service.

- Participants, family members, and/or caretakers must be informed of the cost of providing home health service and must be offered the opportunity to make voluntary contributions to help defray the cost, thereby making additional service available to others.

- All staff providing the service must be fully trained and professionally qualified.

- The grantee must maintain, follow, and continually update a training and supervision program to make sure homemaker staff are fully trained and familiar with agency procedures.

- All records of participant services, costs, and agency procedures must be reviewed monthly, or more often if needed.

PROHIBITED SERVICE COMPONENTS

Home health service may not include any of the following components:

- Providing home health services to older people eligible under another program (e.g., Social Services Block Grant, Medicaid, Medicare, or private insurance), unless on a temporary basis, until eligibility is confirmed;

- Providing friendly visiting or telephone reassurance services, except as incident to delivery of the in-home service;

- Providing cosmetology service: makeup, hair-dressing, or barbering;

- Providing transportation for the home health service participant;

- Providing assistance with home repair or maintenance, appliance repair, heavy-duty cleaning, furniture moving, or other heavy work;

- Providing lawn care, garden care, raking or snow removal; or

- Providing financial, legal, or other service or advice (except for referral to qualified agencies or programs).

HOMEMAKER

SERVICE DEFINITION

Homemaker service is an in-home maintenance service provided to vulnerable District residents 60 years of age and older who are infirm, disabled, or chronically ill, in order to avoid or forestall institutionalization. Homemaker service involves planned and regularly-scheduled light housekeeping (including washing dishes, dusting, making bed, changing linen, laundering, vacuuming/sweeping, minimal ironing, washing bowl/basin/tub, mopping, etc.), provided according to a plan of care, in the participant's home, by trained personnel working under the supervision of a certified homemaker/home health agency**.**

SERVICE OBJECTIVE

The objective of homemaker service is to provide the necessary support in the activities of daily living to allow the participant to maintain the maximum functioning and independence of which he or she is capable, in familiar surroundings.

SERVICE UNIT (1 HOUR)

The unit of service for homemaker service is one hour of service provided by a homemaker to an eligible participant. In calculating the hours of service provided, the time spent in preparing for the visit, traveling to the participant's home, and returning to the homemaker's home shall not be counted.

For example, if an agency provides 90-minute visits to 50 eligible older people in one day, it has provided 75 units of service (50 x 1.5 hours). If one of those provided care is only 59 years old (even though functionally impaired), the homemaker service provider has provided only 73.5 service units, according to this definition. NOTE: Units of service may not be further subdivided (below 1/2 unit).

SERVICE AREA

Homemaker service is available to all eligible residents of the District of Columbia, subject to available staff and priorities for service (see below).

SERVICE LOCATION

Homemaker service must be provided in the home of the participant. The participant may be living in the home of a relative, friend, or other caretaker. However, the homemaker service provider must respect the participant's right of privacy and confidentiality to the extent possible.

Homemaker service providers must take all possible steps to make sure residents of all sectors of the District of Columbia have equal access to this service.

SERVICE PRIORITIES

Homemaker service funded by the D.C. Office on Aging is available only to District of Columbia residents 60 years of age or older, who would not otherwise qualify for this service under any other program.

Priority for homemaker service should go to those individuals meeting the above conditions who are otherwise at risk of institutionalization if they do not receive homemaker service.

In particular, priority shall be given to referrals from Geriatric Assessment and Case Management Sites and other providers in the Senior Service Network, from the Office on Aging, and to those individuals most socially and economically disadvantaged, with particular emphasis on low-income minority elderly.

SERVICE STANDARDS

Homemaker service includes the staff, goods, facilities, services and supports necessary to carry out the plan of care developed for each older individual enrolled. Components of the service may include the following. In addition, homemaker service must meet or exceed the following standards:

- Receiving requests for service and completing the intake process;
- Conducting an in-home comprehensive assessment of the participant's social circumstances, economic conditions, medical history, physical status, mental status, and ability to perform the activities of daily living;
- Developing a plan of care for each participant;
- Re-evaluating the plan of care periodically, and modifying it as necessary;
- Providing supportive home management and maintenance, personal care, meal planning and preparation, and other supportive services identified in the plan of care;
- Providing information about other programs and services for which the participant might be eligible, referring the participant to proper services as necessary, and providing assistance to the participant in gaining public benefits;
- Referring the participant to a physician or medical facility for needed specialized health care or treatment;

- Maintaining records, collecting participant contributions, preparing reports, and other administrative efforts necessary to provide homemaker services;

- The grantee must meet and comply with all required rules, regulations, and standards set by the cognizant accrediting agency.

- All requests for service must be processed within three (3) working days of receipt, including identification of possible eligibility for homemaker service funded from a source other than the Office on Aging.

- Comprehensive assessment and a plan of care must be completed within seven (7) working days after receipt of application.

- A plan of care and other participant records must be kept in a secure location to protect confidentiality.

- The homemaker service caseload must be reviewed whenever a vacancy arises (or more frequently) to make sure priority participants are being served.

- Participant needs must be reassessed every six (6) months or more frequently, with revisions made in the plan of care as necessary; any observed changes must be immediately noted in the participant's plan of care.

- Participants must be provided with information on how other needed services (e.g., Medicare, Medicaid, SSI, transit, housing, prosthetic or rehabilitative devices, etc.) may be obtained, and must be provided assistance in gaining access to those services.

- Participants, family members, and/or caretakers must be informed of grantee's procedures for protecting confidentiality, for reviewing progress against the plan of care, and other matters germane to the participant's decision to accept services.

- Participants, family members, and/or caretakers must be given the opportunity to learn how to perform the tasks performed by the homemaker, in order to give the participant and the informal support network a chance to function independent of agency service.

- Participants, family members, and/or caretakers must be informed of the cost of providing homemaker service and must be offered the opportunity to make voluntary contributions to help defray the cost, thereby making additional service available to others.

- All staff providing the service must be fully trained and professionally qualified.

- The grantee must maintain, follow, and continually update a training and supervision program to make sure homemaker staff are fully trained and familiar with agency procedures.

- All records of participant services, costs, and agency procedures must be reviewed monthly, or more often if needed.

PROHIBITED SERVICE COMPONENTS

For purposes of Office on Aging planning and reimbursement, homemaker service may not include any of the following components:

- Homemaker service provided to those eligible under another financing program (e.g., Social Services Block Grant, Medicaid, or Medicare), unless on a temporary basis, until eligibility is confirmed;

- Providing nursing care, unless provided by a Registered Nurse, Licensed Practical Nurse, or Qualified Home Health Aide as part of the plan of care;

- Providing medical services, unless provided by a Medical Doctor, Podiatrist, or Doctor of Osteopathy as part of the plan of care;

- Nail or foot care of diabetics;

- Providing friendly visiting or telephone reassurance services, except as incident to delivery of the in-home service;

- Providing cosmetology services: Makeup, hair-dressing, or barbering;

- Providing transportation for the homemaker service participant;

- Providing home or appliance repair services;

- Providing lawn care, garden care, raking or snow removal;

- Providing assistance with heavy-duty cleaning, furniture moving, or other heavy work; or

- Providing financial, legal, or other service or advice (except for referral to qualified agencies or programs).

LEGAL SERVICES

SERVICE DEFINITION

Under the District of Columbia State Plan on Aging, legal services are aimed at protecting and securing the rights, benefits and entitlements of District of Columbia residents 60 years of age and older.

Legal services are provided through individual or class case representation in such areas of law as retirement, welfare, health, nutrition, probate, and protective services, by an attorney or by personnel supervised by an attorney. A second component of individual representation is assisting the client through the public benefits application, recertification, and/or appeal process. Legal services may also prevent legal problems from developing.

SERVICE OBJECTIVE

The objective of legal services is to protect and secure rights, benefits, and entitlements of older persons through personal representation and preventive measures.

SERVICE UNIT (1 HOUR)

The unit of service for local services is one hour of staff time spent representing an eligible client. Hours of service provided may include the time spent in preparing for a session, meeting with the client, and following up with the client and other parties involved.

For example, if a legal services worker spends 2 hours investigating the reasons an eligible older person is not receiving SSI benefits, plus 3 hours getting the benefits released, the worker has provided 5 units of legal services.

NOTE: Hours spent on administrative tasks or advocacy efforts not related to a specific client may not be counted as service units. Units of legal services should be rounded off to the nearest 1/4 unit (15 minutes).

SERVICE AREA

Legal services are available to all eligible residents of the District of Columbia 60 years of age and older, subject to staff availability and priorities for service (see below).

SERVICE LOCATION

Legal services may be provided in a community facility or in the client's home. Legal services providers must take all possible steps to make sure residents of all sectors of the District of Columbia have approximately equal access to this service.

SERVICE PRIORITIES

Legal services funded by the D.C. Office on Aging are available only to District of Columbia residents 60 years of age or older. To conserve Office on Aging funds, service should be provided only to those who would not otherwise qualify for this service under any other program.

In particular, priority shall be given to those individuals most socially and economically disadvantaged, with particular emphasis on low-income minority elderly.

SERVICE STANDARDS

Legal services include the staff, goods, facilities, services and supports necessary to protect and secure the rights, benefits, and entitlements of eligible clients. Components of the service may include the following and the services must meet or exceed the following standards:

- Receiving requests for service and completing the intake process;
- Conducting outreach in senior housing, senior centers, and other sites where older persons congregate;
- Investigating cases in which legal matters are at issue;
- Developing, implementing and monitoring plans of action to resolve or prevent legal issues from interfering with the safety or happiness of an eligible client;
- Educating and informing the public about legal issues of importance to older persons and of legal services funded by the District of Columbia Office on Aging;
- Providing information about other programs and services for which legal services clients might be eligible, referring clients to proper services as necessary, and providing assistance to clients in gaining public benefits;
- Developing materials and conducting training for volunteers, community workers and others in substantive law and advocacy skills; and
- Maintaining records, collecting client contributions, preparing reports, and other administrative efforts necessary to provide legal services.
- All requests for assistance must be processed within two (2) working days of receipt, including identification of possible eligibility for legal services funded from another sources than the Office on Aging, and beginning the investigation of the facts surrounding the request for assistance.

- All client records must be kept in a secure location to protect confidentiality.

- Clients, family members, and caretakers must be provided with information on how other needed services (e.g., Medicare, Medicaid, SSI, transit, housing, legal assistance, energy assistance, etc.) may be obtained, and must be provided assistance in gaining access to those services.

- Clients, family members, and/or caretakers must be informed of agency procedures for protecting confidentiality and other matters germane to the client's decision to accept services.

- Clients, family members, and/or caretakers must be informed of the cost of providing legal services and must be offered the opportunity to make voluntary contributions to help defray the cost, thereby making additional service available to others.

- All staff providing the service must be fully trained and professionally qualified; staff who are not attorneys qualified to practice before the bar must be supervised by such an attorney.

- The agency must maintain, follow, and periodically update a training and supervision program to ensure legal services staff are fully trained and familiar with agency procedures.

- All records of participant services, costs, and agency procedures must be reviewed monthly or more often if needed.

PROHIBITED SERVICE COMPONENTS

For purposes of Office on Aging planning and reimbursement, legal services may not include any of the following components:

- Providing individual case representation to older persons who can afford to obtain legal services elsewhere (except in public benefit and protective services cases, or in other cases in which the older person cannot retain competent legal assistance from a private attorney); or

- Providing individual case representation to persons who could be served using funds received from another financing program (e.g., legal services corporation).

LITERACY

SERVICE DEFINITION

Under the District of Columbia State Plan on Aging, literacy is a community service program provided to District residents 60 years of age or older, designed to provide remedial literacy training by teaching older adults how to read and write, instructing them on how to use and understand various printed and written information, and to improve basic math computation and problem solving skills necessary to perform everyday tasks. Trained tutors will provide the literacy service.

SERVICE OBJECTIVE

The objective of literacy services is to enhance seniors' ability to read and write and to develop basic literacy skills that are necessary for them to continue to function in society and for some, in the workforce. Also for those at higher literacy proficiency levels it will increase their knowledge base, through literacy classes, computer literacy, English as a Second Language (ESL) activities and programs.

SERVICE UNIT (1 HOUR)

The unit of service for literacy is one hour of service provided to an eligible participant. Hours of service may include the time spent preparing for literacy sessions, conducting the literacy sessions and evaluating the sessions and the individual work of the participants.

For example, if a literacy tutor spends 30 minutes preparing a lesson plan, sixty minutes teaching participants literacy skills and 30 minutes reviewing and evaluating the participants' work, the tutor has provided two hours of literacy services (.5 hours +1 hour + .5 hours = 2). Note: Units of service may not be subdivided below ½ unit.

Literacy is a program conducted by literacy tutors trained to teach older adults basic literacy skills such as how to read, and how to develop information processing skills that adults use to achieve a wide range of literacy tasks. These tasks may include instructions on completing job applications, developing resumes, how to use public transportation schedules and choose the appropriate routes. Screening to determine literacy levels, computer and quantitative literacy skills training and teaching English for Speakers of other Languages (ESOL) or English as a Second Language (ESL) are other literacy activities.

SERVICE LOCATION

Literacy services must be provided in an accessible community-based facility which meets or exceeds all applicable District of Columbia requirements of licensing and inspections, is reasonably free of architectural and psychological barriers, and is the center for one or more additional services for the elderly.

SERVICE AREA

Specific agencies are assigned geographic service areas. Participants are encouraged, but not required, to attend a program near their residence.

SERVICE STANDARDS

Literacy service includes the tutors, supplies, equipment, facilities, resources and supports necessary to carry out the program and must meet or exceed the following standards:

- An intake process shall be developed and completed to determine the literacy needs of the participants and make sure eligible applicants know about conditions for participation.

- The literacy activities shall be planned as a well-rounded set of activities and sessions designed to appeal to the needs of the elderly population in the service area.

- Each program shall plan and schedule one or more activities per week at each literacy site.

- Program procedural instruments (e.g., literacy assessments, instructional lesson plans, etc.) shall be developed prior to offering literacy, and shall be updated annually thereafter.

- All participant records shall be kept in a secure location to protect confidentiality.

- Participants, family members, and caretakers must be provided with information on how other needed services (e.g., Medicare, Medicaid, SSI, transit, housing, legal assistance, energy assistant, etc.) may be obtained.

- Participants, family members, and/or caretakers must be informed of agency procedures for protecting confidentiality, for reviewing progress against the individual literacy plan, participant rights, and other matters germane to the participant's decision to accept services.

- Participants, family members, and/or caretakers shall be informed of the cost of providing literacy services and must be offered the opportunity to make voluntary contributions to help defray the cost, thereby making additional service available to others.

- The agency must maintain, follow, and continually update training and supervision programs to make sure the literacy tutors are fully trained and familiar with agency procedures.

- All records of participant services, costs, and agency procedures must be reviewed monthly or more often if needed.

- The agency shall maintain records, collect participant contributions, and prepare reports and other administrative efforts necessary to provide literacy activities.

PROHIBITED SERVICE COMPONENTS

For purposes of Office on Aging planning and reimbursement, literacy services may not include any of the following components:

- Providing check writing or bill paying services.

- Providing financial, legal, or other service or advice (except for referral to qualified agencies or programs).

MINOR HOME REPAIR

SERVICE DEFINITION

Under the District of Columbia State Plan on Aging, minor home repair service is a health and safety home repair service provided to District residents 60 years of age and older to ensure healthy and safe living conditions. Minor home repair service involves making minor interior and/or exterior repairs (including repairing minor leaks in plumbing or roofing; cleaning and repairing gutters and down spouts; repairing minor problems with heat or hot water systems; securing loose rails, stairs or boards; minor painting; installation of deadbolt locks; making minor electrical repairs; etc.) to homes or apartments owned and occupied by the elderly in order to alleviate threats to health or safety. The program is not available to renter-occupied houses owned by the elderly.

SERVICE OBJECTIVE

The objective of minor home repair service is to provide necessary minor home repairs in order to allow elderly persons to remain in their homes without risk of health or safety hazards.

SERVICE UNIT (1 DWELLING REPAIRED)

The unit of service for minor home repair service is one dwelling unit (home owned and occupied by seniors) repaired.

SERVICE AREA

Minor home repair service is available to all eligible residents of the District of Columbia, subject to available workers and priorities for service (see below).

SERVICE LOCATION

Minor home repair service must be provided in the home the participant occupies. It may not be provided in homes rented to others. Minor home repair service providers must take all possible steps to make sure elderly homeowners of all sectors of the District of Columbia have equal access to this service.

SERVICE PRIORITIES

Minor home repair service funded by the D.C. Office on Aging is available only to District of Columbia residents 60 years of age or older, who own the homes they occupy, and who (because of financial constraints) are unable to pay for this service from commercial home repair companies.

Priority for minor home repair service should go to those individuals meeting the above conditions who are living in unhealthy or unsafe conditions, and to those individuals most socially and economically disadvantaged, with emphasis on low-income minority elderly.

SERVICE STANDARDS

Minor home repair service includes the staff, materials, facilities, services and supports necessary to carry out the repairs necessary. Minor home repair service must meet or exceed the following standards and include the following components:

- Receiving requests for service and completing the intake process;
- Conducting an on-site assessment of need, including an interview of the prospective participant(s) and determination of the feasibility of making necessary repairs;
- Preparing a work order which describes the minor repair work to be done;
- Contracting with an appropriate company or individual for the needed repair work;
- Monitoring the work of the contractor and evaluating the quality and timeliness of repair work performed;
- Providing information about other programs and services for which the participant might be eligible, and referring the participant to proper services as necessary; and
- Maintaining records, collecting contributions, preparing reports, and other administrative efforts necessary to provide minor home repair services.
- All requests for service must be processed within three (3) working days of receipt, including identification of possible eligibility for minor home repair, rehabilitation, or weatherization service funded from source other than the Office on Aging.
- Participant needs must be thoroughly assessed, including financial needs and other available resources.
- All participant records must be kept in a secure location to protect confidentiality.
- Repair work must be subcontracted with a company or individual with the documented capacity to perform the needed work.
- The agency and its subcontractors must meet and comply with all rules, regulations, and standards set by the District of Columbia for building, construction, and home repair organizations, including necessary bonding.

- All persons providing minor home repair service must be fully trained, properly supervised, and professionally qualified.

- Participants and/or family members must be informed of the cost of providing minor home repair service and must be offered the opportunity to make voluntary contributions to help defray the cost, thereby making additional service available to others.

- Participants must be provided with information on how other housing-related services (Housing and Community Development loans, energy assistance programs, and low-interest loans from banks or other financial institutions) may be obtained.

- Participants and family members must be informed of the agency's procedures for protecting confidentiality, participants' rights, and other matters germane to the participants' decision to accept the service.

- The agency must maintain, follow, and continually update a supervision program to make sure agency staff, subcontractors and their repair staffs are familiar with agency procedures.

- All records of participant service, costs, and agency procedures must be reviewed monthly or more often if needed.

PROHIBITED SERVICE COMPONENTS

For purposes of Office on Aging planning and reimbursement, minor home repair service may not include any of the following components:

- Major home repair, including construction of any type;

- Installation of major equipment (furnace, air conditioning, etc.) without specific approval from the Office on Aging;

- Repair of small appliances (e.g., hair dryer, toaster, etc.);

- Lawn care, garden care, raking or snow removal;

- Providing or arranging transportation services for participants;

- Providing assistance with cleaning, furniture moving, or other home management work; or

- Providing financial, legal, health, or other service or advice (except for referral to qualified agencies or programs).

NUTRITION COUNSELING

SERVICE DEFINITION

Nutrition Counseling (1 Hour) – Provision of individualized advice and guidance to individuals who are at nutritional risk because of their health or nutritional history, dietary intake, medications use or chronic illnesses, about options and methods for improving their nutritional status, performed by a health professional in accordance with state law and policy.

SERVICE OBJECTIVE

The objective of nutrition counseling is to develop and strengthen the participants' capacity to develop methods for improving their nutritional status which will allow the participant to maintain the maximum functioning and independence of which he or she is capable.

SERVICE UNIT (1 HOUR)

The unit of service for nutrition counseling is one hour of service provided to an eligible participant. Hours of service provided may include the time spent in preparing for the session, meeting with the participant, and following up with the participant, family, or friends.

For example, if an agency Nutritionist spends 30 minutes preparing for a meeting with the family of an eligible older person, 30 minutes meeting with them, and 30 minutes discussing the results of the meeting with the older person, the Nutritionist has provided 1.5 units of service (.5 hours + .5 hours + .5 hours). NOTE: Units of service may not be subdivided below 1/2 unit.

Maximum units shall be 1 ½ per individual per consultation in a congregate facility or 2 ½ units in a home setting for a home delivered meal recipient.

ELIGIBILITY

Nutrition counseling is available to eligible residents 60 years or older who are at nutritional risk, subject to availability of staff and priorities for services.

SERVICE LOCATION

Nutrition counseling may be provided in a community facility or in the home of the participant.

If nutrition counseling service is provided in a community facility, space should be adequate for individual sessions, to allow for comfort and confidentiality. The facility must be the site for one or more additional services for the elderly.

If nutrition counseling service is provided as an in-home service, the participant may be living in the home of a relative, friend, or other caretaker. However, the nutrition counseling service provider must respect the participant's right of privacy and confidentiality to the extent possible.

SERVICE PRIORITIES

Nutrition counseling funded by the D.C. Office on Aging is available only to District of Columbia residents 60 years of age or older and to their families and caretakers. To conserve Office on Aging funds, service should be provided only to those who would not otherwise qualify for this service under any other program.

SERVICE STANDARDS

Nutrition counseling service includes the staff, goods, facilities, services and supports necessary to carry out the program. Nutrition counseling service must meet or exceed the following standards:

- All requests for service must be processed within three (3) working days of receipt, including identification of possible eligibility for nutrition counseling service funded from a source other than the Office on Aging.

- A nutrition assessment must be completed within five (5) working days after receipt of request.

- A nutrition counseling plan must be developed for each new participant within five (5) working days after enrollment; the plan must include a schedule for follow-up nutrition counseling.

- All nutrition counseling plans and other participant records must be kept in a secure location to protect confidentiality.

- Participants' needs must be reassessed every six (6) months or more frequently if needed, with revisions made in the plan as necessary; any observed changes must be immediately noted in the plan of care.

- Participants, family members, and caretakers must be provided with information on how other needed services (e.g., Medicare, Medicaid, SSI, health promotion, nutrition, safe use of medication, wellness program, legal assistance, etc.) may be obtained.

- Participants, family members, and/or caretakers must be informed of agency procedures for protecting confidentiality, for reviewing progress against the plan of care, participant rights, and other matters germane to the participant's decision to accept services.

- All agency personnel providing nutrition counseling must be qualified, by educational, degree and be a DC licensed nutritionist and/or dietitian.

- Participants, family members, and/or caretakers must be informed of the cost of providing nutrition counseling service and must be offered the opportunity to make voluntary contributions to help defray the cost, thereby making additional services available to others.

- In the event that the nutrition counselor determines a client is in crisis and cannot provide the intervention necessary to stabilize the situation due to the client's unwillingness to accept service for other reasons, the counselor must:

    ○ Contact by telephone the appropriate health care providers once this determination is made.

    ○ Submit a written referral as a follow-up to the telephone call to the health care providers within five (5) working days of the initial call.

    ○ Contact the crisis intervention agency within two weeks of the initial referral to ensure the appropriate intervention was begun.

PROHIBITED SERVICE COMPONENTS

For purposes of Office on Aging planning and reimbursement, nutrition counseling service may not include any of the following components:

- Providing psychotherapy counseling, unless provided by a licensed therapist;

- Providing unlicensed medical services; or

- Providing social, financial, legal, or other service or advice (except for referral to qualified agencies or programs).

NUTRITION EDUCATION

SERVICE DEFINITION

Nutrition Education (1 Session) - A program to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants and/or caregivers in a group setting overseen by a dietitian or individual of comparable expertise.

SERVICE OBJECTIVE

The objective of nutrition education is to develop, strengthen and promote healthy behaviors through culturally sensitive and accurate educational programs and activities aimed at enhancing the quality of life by developing healthier food choices and dietary habits, through good nutrition.

SERVICE UNIT (1 SESSIOIN)

The unit of service for nutrition education is one session provided by a professionally trained worker to an eligible participant or group. A session is a planned activity available to one or all senior citizens who wish to participate. The time of the session is determined by the published schedule of activities for the center.

Nutrition education shall be offered twice yearly (semi-annually) at a minimum and shall not exceed 12 sessions annually (one per month) per congregate nutrition site.

ELIGIBILITY

- Nutrition education services are available to all residents of the District of Columbia who are 60 years of age and older, subject to available space.

- In particular, priority shall be given to those individuals most socially and economically disadvantaged, with emphasis on low-income minority elderly.

SERVICE LOCATION

Nutrition education services must be provided in a community-based facility which meets or exceeds all applicable District of Columbia requirements of licensing and inspections, is reasonably free of architectural and psychological barriers, and is the center for one or more additional services for the elderly.

SERVICE AREA

Specific agencies are assigned geographic service areas. Participants are encouraged, but not required, to attend a program near their residence.

SERVICE STANDARDS

Nutrition education service includes the staff equipment, facilities, services and supports necessary to carry out the program. Nutrition education services must meet or exceed the following standards:

- An intake procedure must be developed to ensure eligible applicants know about conditions for participation.

- The nutrition education activities program must be planned as a well-rounded set of activities and sessions designed to appeal to the needs of the elderly population in the service area.

- Each program must plan and provide nutrition education on at least a semi-annual basis at each site as presented on a preplanned calendar of activities for participants in the elderly nutrition program;

- Program procedural instruments (e.g., personnel manual, affirmative action plan, etc.) must be developed within three (3) months after initial opening of the program, and must be updated annually thereafter.

- A citywide health resource file must be developed within six (6) months of operation, and must be updated semi-annually thereafter.

- All participant records must be kept in a secure location to protect confidentiality.

- Participants, family members, and caretakers must be provided with information on how other needed services (e.g., Medicare, Medicaid, SSI, transit, housing, legal assistance, energy assistant, etc.) may be obtained.
- The agency must maintain, follow, and continually update a training and supervision program to make sure nutrition education staff and are fully trained and familiar with agency procedures.

- All records of participant services and costs, and agency procedures must be reviewed monthly or more often, if needed.

PROHIBITED SERVICE COMPONENTS

For purposes of Office on Aging planning and reimbursement, nutrition education service may not include any of the following components:

- Providing medical services
- Providing financial, legal, or other service or advice (except for referral to qualified agencies or programs).

RECREATION AND SOCIALIZATION

SERVICE DEFINITION

Under the District of Columbia State Plan on Aging, recreation and socialization service is a community service program provided to District residents 60 years of age and older, designed to meet individual and social needs for continued growth and development, to reinforce a sense of dignity and independence and to reduce isolation. Recreation and socialization is a center-based service that involves a range of structured and unstructured programs and activities provided by trained personnel working as part of a community-based program providing other social services (recreation and socialization may not be a separate program).

SERVICE OBJECTIVE

The objective of recreation and socialization is to provide supervision, socialization, training, and a supportive atmosphere to reinforce older persons' sense of dignity and independence, for both the well elderly and the functionally impaired.

SERVICE UNIT (1 HOUR)

The unit of service for recreation and socialization is one one-hour session provided to one eligible participant. The time of the session is determined by the published schedule of activities for the center.

For example, if an agency arranges two morning activities from 9:30 to 11:00, and one of these activities is attended by 10 persons 60 years old and older while the other is attended by 8 eligible participants, the agency has provided 27 units of recreation and socialization service (1 session @ 1.5 hours x 10 participants = 15 units plus 1 session @ 1.5 hours x 8 participants = 12 units). NOTE: For purposes of reporting and reimbursement, recreation and socialization service units may not be counted in less than 1/2 units.

SERVICE LOCATION

Recreation and socialization service must be provided in a community facility or some other place within the District of Columbia, which meets or exceeds all applicable District of Columbia requirements of licensing and inspections, is reasonably free of architectural and psychological barriers, and is to be the site for one or more additional services for the elderly.

SERVICE AREA

Recreation and socialization service is available to all residents of the District of Columbia who are 60 years of age and older, subject to available space. Specific agencies are assigned geographic service areas. Participants are encouraged, but not required, to attend a program near their residence.

SERVICE PRIORITIES

Recreation and socialization service funded by the D.C. Office on Aging is available only to District of Columbia residents 60 years of age or older, who are able to maintain themselves and who represent no threat to themselves of others. In particular, priority shall be given to those individuals most socially and economically disadvantaged, with emphasis on low-income minority elderly.

SERVICE STANDARDS

Recreation and socialization service includes the staff, goods, facilities, services and supports necessary to arrange, coordinate and manage services planned for participants. Recreation and socialization service must meet or exceed the following standards:

- The recreation and socialization activities program shall be planned as a well-rounded set of activities and sessions designed to appeal to the elderly population in the service area.

- Each site shall plan and schedule at least two activities each day a congregate meal is served, unless health promotion or another activity takes up the program day.

- Program procedural instruments (e.g., personnel manual, affirmative action plan, etc.) shall be developed within three (3) months after initial opening of the program, and must be updated annually.

- An intake procedure shall be developed to make sure eligible applicants for participation know about any conditions for participation and any waiting list.

- A citywide resource file shall be developed within six (6) months of operation, and must be updated semi-annually thereafter.

- All participant records shall be kept in a secure location to protect confidentiality.

- Participants, family members, and/or caretakers shall be provided with information on how to obtain needed services (e.g., Medicare, Medicaid, SSI, transit, housing, legal assistance, energy assistance, etc.).

- Participants, family members, and/or caretakers shall be informed of agency procedures for protecting confidentiality, for reviewing progress against the plan of care, participant rights, and other matters germane to the participant's decision to accept services.

- Participants, family members, and/or caretakers shall be informed of the cost of providing recreation and socialization service and must be offered the opportunity to make

voluntary contributions to help defray the cost, thereby making additional service available to others.

- The agency shall maintain, follow, and continually update a training and supervision program to make sure recreation and socialization staff are fully trained and familiar with agency procedures.

- Staff and participants should be trained to carry out the scheduled recreation and socialization activities;

- All records of participant services, costs, and agency procedures shall be reviewed monthly, or more often if needed.

- Programs should be planned, developed, scheduled and implemented for recreation and socialization activities that are suitable for elderly participants;

- Recreation and socialization activities that are suitable for elderly participants should be planned, developed, scheduled, and implemented.

- .A monthly calendar of scheduled events shall be developed and distributed;

- Social and recreational activities shall be arranged with and for participants (e.g., arts and crafts, educational and recreational games, outings and parties, etc.);

- All recreation and socialization activities shall be supervised;

- Other supportive services shall be provided as needed (including -- but not limited to -- outreach, consumer education, placement, advocacy assistance, telephone reassurance, and friendly visiting);

- Maintain records, collect participant contributions, prepare reports, and other carry out other administrative efforts necessary to provide recreation and socialization services.

PROHIBITED SERVICE COMPONENTS

For purposes of Office on Aging planning and reimbursement, recreation and socialization service may not include any of the following components:

- Providing health care or medical services; or

- Providing financial, legal, or other service or advice (except for referral to qualified agencies or programs).

TRANSPORTATION AND ESCORT

SERVICE DEFINITION

Under the District of Columbia State Plan on Aging, transportation and escort is a specialized curb-to-curb transportation service provided to lower-income District residents 60 years of age and older in carrying out the activities of daily living. Transportation and escort involves specialized transportation and assistance, provided by trained personnel, in suitable vehicles.

SERVICE OBJECTIVE

The objective of transportation and escort is to provide specialized transportation to functionally impaired persons so they can achieve and maintain the maximum functioning and independence of which they are capable, in the community.

SERVICE UNIT (1 ONE-WAY TRIP)

The unit of service for transportation and escort is a one-way trip, provided to one eligible participant (i.e., one person-trip).

For example, if the transportation program picks up two eligible participants in the morning, takes them to the doctor, then to the pharmacy, and home, it has provided 6 units of service (2 persons x 3 one-way trips to these people). If one of those transported is only 59 years old, the transportation has provided only 3 service units, according to this definition.

SERVICE AREA

Transportation and escort is available to all eligible residents of the District of Columbia, subject to available spaces and priorities for service (see below). A Lead Agency is designated by the Office on Aging in each Ward for determining user and trip eligibility. In cooperation with these Lead Agencies, the transportation and escort service provider must take steps necessary to make sure this service is equally accessible in all sectors of the District of Columbia.

SERVICE LOCATION

Not applicable.

SERVICE PRIORITIES

Transportation and escort funded by the D.C. Office on Aging is available only to lower-income District of Columbia residents who are 60 years of age or older or who are handicapped and non-ambulatory of any age. In addition, transportation and escort service is restricted to those who also meet the following five criteria:

- Transportation is not available through the individual's immediate household;
- The individual cannot afford private transportation;
- The individual is mobility-impaired and in need of door-to-door service,
- The individual has no reasonable access to public transportation;
- The individual might be endangered in trying to use public transportation.

In addition, priority for transportation and escort services should go to those individuals meeting the above conditions for the following high-priority transportation and escort purposes:

- Medical care trips, especially to hospitals and clinics for check-ups, basic medical service, and repetitive treatments;
- Essential shopping trips, especially to purchase food, prescription drugs, health-related support devices and necessary clothing, and
- Essential personal business trips, especially trips related to Social Security, income support, food stamps, banking and access to District government offices.

In particular, priority shall be given to referrals from hospitals, doctors, Office on Aging Grantees, and to those individuals most socially and economically disadvantaged, with emphasis on low-income minority elderly.

SERVICE STANDARDS

Transportation and escort includes the staff, goods, vehicles, facilities, services and supports necessary to provide specialized transportation for each eligible individual. Transportation and escort service must meet or exceed the following standards and include the following components:

- Receiving requests for service from Lead Agencies;
- Preparing a pick-up schedule and confirming the schedule with the appropriate Lead Agency;
- Assigning pick-ups to drivers and vehicles;
- Assisting participants in boarding and leaving the vehicle;

- Recruiting and training drivers, dispatchers, maintenance workers, and other personnel necessary to carry out the service;

- Developing and maintaining necessary policies and materials to make sure drivers and other employees understand and comply with Office on Aging procedures and service priorities;

- Storing and maintaining vehicles to make sure they are safe and available for service;

- Providing information about other programs and services for which the participant might be eligible, and referring the participant to proper services as necessary; and

- Maintaining records, collecting contributions, preparing reports, and other administrative efforts necessary to provide transportation to sites and activities.

- Coordinating this transportation service with other transportation services in the service area.

- The service must operate between the hours of 7:00 a.m. and 6:00 p.m. on weekdays;

- Service must be curb-to-curb;

- All pick-ups must take place not later than 15 minutes after the scheduled time;

- Passengers must be given whatever help is necessary to allow them to board and debark from the vehicle with maximum safety and comfort;

- All drivers must be properly licensed;

- All drivers and escorts must be helpful and courteous to passengers at all times;

- All wheelchairs, walkers, and other appliances must be properly secured when the vehicle is in motion;

- Vehicles must be operated with due regard for the comfort and safety of the passengers;

- Vehicles must be properly maintained and licensed at all times;

- Vehicles must be inspected at regular intervals, to ensure safety;

- Vehicles must have proper liability insurance;

- All participant records must be kept in a secure location to protect participant confidentiality;

- The agency must maintain, follow, and continually update a training and supervision program to make sure drivers are fully trained, properly supervised, and fully familiar with agency procedures;

- All participant records, vehicle records, financial records, and agency procedures must be reviewed weekly, or more frequently if needed.

- Participants, family members, and/or caretakers must be informed of the cost of providing geriatric day care services and must be offered the opportunity to make voluntary contributions to help defray the cost, thereby making additional service available to others.

For Lead Agencies, their role in this service includes the following:

- Performing intake interviews to determine basic eligibility for the service;

- Requesting this service for eligible individuals;

- Making home visits to reassess the individual continued eligibility for the transportation program, and/or to gather data for other service needs.

PROHIBITED SERVICE COMPONENTS

For purposes of Office on Aging planning and reimbursement, transportation and escort may not include any of the following components:

- Transportation of ineligible individuals (see service priorities, above); or

- Transportation of eligible individuals to social, recreational, or other events not related to medical, essential shopping, or essential personal business needs (see Service Priorities, below).

- Transporting a wheelchair patient without an escort.

TRANSPORTATION OF HOME-DELIVERED MEALS

SERVICE DEFINITION

Under the District of Columbia State Plan on Aging, transportation of home-delivered meals is a transportation service which transports pre-plated meals to home-bound District residents 60 years of age and older, by appointment, by qualified personnel in suitable vehicles, in order to improve or maintain nutritional status.

SERVICE OBJECTIVE

The objective of transportation of home-delivered meals is to provide safe and reliable delivery of a nutritious mid-day meal to improve or maintain nutritional status and to maintain the maximum function and independence of a homebound individual.

SERVICE UNIT

The unit of service for transportation of home-delivered meals is one meal delivered to one eligible participant.

For example, if 35 home-delivered meals are scheduled for delivery, but 2 meals cannot be delivered, only 33 service units (meals delivered to the homes of eligible participants) may be counted. If 35 home-delivered meals are scheduled for delivery, but only 33 meals are picked up from the caterer, only 33 service units can be counted.

ELIGIBILITY

Transportation of home-delivered meal service funded by the D.C. Office on Aging is available only to District of Columbia residents 60 years of age or older who are unable to attend a congregate nutrition Center. Eligibility for home-delivered meal service is determined by the Lead Agency.

SERVICE AREA

Home-delivered meal service is available to all residents of the District of Columbia age 60 and over, subject to available funds and priorities for service (see below). Specific providers of transportation of home-delivered meals may be assigned subareas of the District in which to deliver meals.

SERVICE PRIORITIES

Transportation of home-delivered meal service funded by the D.C. Office on Aging is available only to District of Columbia residents 60 years of age or older who are unable to attend a congregate nutrition center.

Priority for transportation of home-delivered meal service should go to those meals which cannot be delivered through the Lead Agencies' delivery systems.

In particular, priority shall be given to referrals from Lead Agencies for those individuals most socially and economically disadvantaged, with emphasis on low-incomes minority elderly.

SERVICE STANDARDS

Transportation of home-delivered meals includes the staff, goods, vehicles, services and supports necessary to deliver a pre-plated mid-day meal to each older person scheduled by the lead agency to receive a home-delivered meal. Transportation of home-delivered meals must meet or exceed the following standards:

- Intake forms shall be in agency files for all clients receiving a home-delivered meal.

- The agency shall maintain a weekly roster of names and addresses of seniors receiving home-delivered meals grouped according to route.

- The agency shall maintain, follow, and continually update a training and supervision program to make sure staff are fully trained and familiar with agency procedures and standards;

- All records of participant services, costs, and agency procedures shall be reviewed monthly, or more often if needed.

- All meals shall be delivered to the eligible participant or to the participant's caretaker (i.e., meals may not be left outside the participant's door). If the client is not home, the meal should be given to the next eligible client.

- Meals shall not be re-packaged before arriving at clients' home.

- Meals must be delivered within two (2) hours of breaking the seal on a caterette, with precautions taken to make sure food temperatures are maintained at safe levels; maximum holding time and temperature for all foods will be determined by the Office on Aging.

- Meals shall be delivered as planned. Agencies transporting home-delivered meals may not add or subtract food items.

- Food carriers shall be approved by the Office on Aging, properly maintained and thoroughly cleaned each day of service.

- Drivers shall be properly licensed and bonded.

- Vehicles shall be properly maintained (as to safety and cleanliness), licensed and insured.

- Requests for transportation of home-delivered meals are received from the appropriate Lead Agency;

- Delivery schedules are prepared and confirmed with the appropriate Lead Agencies;

- Pre-plated meals from the District caterer or other approved source are picked up and transported to the home of participants in properly-equipped vehicles;

- If the participant does not respond to receive the meal or in case of a participant emergency, contact the Lead Agency and/or the Office on Aging;

- The delivery schedule received from Lead Agencies should be reconciled with the caterer (or other approved source of meals) to ensure the number of meals to be delivered agrees with the number of meals received;

- Drivers, dispatchers, maintenance workers, and other personnel necessary to carry out the service must be recruited and trained;

- Necessary policies and materials to ensure drivers and other employees understand and comply with Office on Aging procedures and service priorities must be developed and maintained;

- Records, reports, and other administrative efforts necessary to deliver home-delivered meals must be prepared and maintained as needed.

PROHIBITED SERVICE COMPONENTS

For purposes of Office on Aging planning and reimbursement, transportation of home-delivered meals may not include any of the following components:

- Providing friendly visiting or telephone reassurance services, except as incident to delivering a meal;

- Transportation of individuals;

- Providing financial, legal, or other service or advice (except for referral to qualified agencies or programs);

- Preparing meals; or

- Replating or modifying meals as prepared for delivery.

TRANSPORTATION TO SITES AND ACTIVITIES

SERVICE DEFINITION

Under the District of Columbia State Plan on Aging, transportation to sites and activities is a service provided to District residents 60 years of age and older, in order to allow these individuals to participate in various programs and activities within the boundaries of the District of Columbia. Transportation to sites and activities involves scheduled transportation provided by trained personnel in suitable vehicles.

SERVICE OBJECTIVE

The objective of transportation to sites and activities is to provide specialized transportation and assistance to older District residents so they can participate in nutrition, social, and recreation services, in order to maintain the maximum functioning and independence to which they are capable in a community setting.

SERVICE UNIT (1 ONE-WAY TRIP)

The unit of service for transportation to sites and activities is a one-way trip, provided to one eligible participant (i.e., one person-trip). For example, if the transportation program picks up 150 eligible participants in the morning, takes them to the appropriate nutrition center for the congregate meal and other site activities and returns them to their homes in the afternoon, it has provided 300 units of service (one-way trips) to these people. If the transportation provider also takes 50 of these eligible participants to and from an activity scheduled by the site (e.g., a special event), it has provided 400 units of service (300 + 100 one-way trips). If one of those transported to and from the nutrition center is only 59 years old, the transportation provided amounts to only 398 units of service, according to this definition.

SERVICE LOCATION

Not applicable

SERVICE AREA

Transportation to sites and activities is limited to the activities and/or services within the District of Columbia.

SERVICE PRIORITIES

Transportation to sites and activities funded by the D.C. Office on Aging is available only to District of Columbia residents who are 60 years of age or older. Priority shall be given to those individuals most socially and economically disadvantaged, with emphasis on low-income minority elderly.

SERVICE STANDARDS

Transportation to sites and activities includes staff, goods, vehicles, facilities, services and support necessary to provide transportation for each eligible individual. Transportation to sites and activities must meet or exceed the following standards.

- Receive requests from senior clubs, organizations and other service providers;
- Prepare pick-up schedule and confirm schedule with appropriate personnel;
- Assign driver and vehicle;
- Assist participants in boarding and leaving the vehicle, including, as necessary, personal assistance in negotiating stairs, ramps, and other architectural features for the program site and the point of destination;
- Recruit and train drivers and other personnel necessary to carry out the service;
- Develop and maintain necessary policies and materials to make sure drivers and other employees understand and comply with the Office on Aging's policies and procedures including the service priorities;
- Provide storage and maintenance of vehicles to make sure they are safe and available for service;
- Provide information regarding other programs and services for which the participant might be eligible, refer participant to proper services as necessary; and
- Maintain records, preparing reports, and other administrative efforts necessary to provide transportation t sites and activities.
- The service must generally operate between the hours of 8:00 a.m. and 4:00 p.m. on weekdays.
- Service must be curb-to-curb (i.e., drivers must provide assistance to make sure the passenger can board and debark from the vehicle with maximum safety and comfort.
- All pick-ups must take place not later than 15 minutes after the scheduled time, weather and road conditions permitting.
- All drivers must be properly licensed.
- All drivers must be helpful and courteous to passengers at all times.

- Vehicles must be operated with due regard for the comfort and safety of the passengers.
- Vehicles must be properly maintained and licensed at all times.
- Proper liability insurance coverage must be maintained for all vehicles.
- Vehicles must be inspected at regular intervals to ensure safety.
- Vehicles must be safely and securely stored when not in use.
- All participant records must be kept in a secure location to protect participant confidentiality.
- The agency must maintain, follow, and continually update a training supervision program to make sure drivers are fully trained, properly supervised, and fully familiar agency procedures.
- All participant records, vehicle records, and agency procedures must be reviewed weekly or more frequently, if needed.
- Participants, family members, and/or caretakers must be informed of the cost of providing transportatioin services and must be offered the opportunity to make voluntary contributions to help defray the cost, thereby making additional service available to others.

PROHIBITED SERVICE COMPONENTS

For purposes of Office on Aging planning and reimbursement, transportation to sites and activities may not include any of the following components:

- Providing transportation for an ineligible individual (see service priorities below); or
- Providing transportation beyond the boundaries of the District of Columbia.

WEEKEND CONGREGATE MEALS

SERVICE DEFINITION

Weekend Congregate Meals (1 Meal) -- Provision, to an eligible client or other eligible participant at a nutrition site, senior center or some other congregate setting, a meal which:

- complies with the Dietary Guidelines for Americans (published by the Secretaries of the U.S. Departments of Health and Human Services and Agriculture);

- provides, if one meal is served, a minimum of 33 and 1/3 percent of the current daily Recommended Dietary Allowances (RDA) as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences;

- provides, if two meals are served, together, a minimum of 66 and 2/3 percent of the current daily RDA; although there is no requirement regarding the percentage of the current daily RDA which an individual meal must provide, a second meal shall be balanced and proportional in calories and nutrients; and,

- provides, if three meals are served, together, 100 percent of the current daily RDA; although there is no requirement regarding the percentage of the current daily RDA that an individual meal must provide, a second and third meal shall be balanced and proportional in calories and nutrients.

SERVICE OBJECTIVE

The objective of weekend meal service is to provide a nutritious mid-day meal to improve or maintain nutritional status and to maintain the maximum functioning and independence of the individual.

SERVICE UNIT (1 MEAL)

The unit of service for weekend meal service is one complete meal provided to one eligible participant. For example, if 125 meals are prepared at the weekend meal service site and are served to 123 eligible participants and to two site staff members, only 123 service units (complete meals served to eligible participants) may be counted. Units of weekend meal service cannot be subdivided (e.g., into half-meals).

ELIGIBILITY

Persons 60 years of age and older residing in DC are eligible to participate in the weekend congregate meals program, targeting those with greatest economic or social need. In addition to

focusing on low-income and other older persons at risk of losing their independence, the following individuals may receive service including;

- a spouse of any age;

- disabled persons under age 60, who reside in housing facilities where congregate meals are served that are occupied primarily by the elderly;

- disabled persons who reside at home and accompany older persons to meals; and nutrition service volunteers.

SERVICE LOCATION

Weekend meal service must be provided in a suitable facility which meets the following criteria established by the Office on Aging for congregate meal programs:

- The weekend meal center should be centrally located in the target area, preferably within walking distance for the participants or on a public transportation route.

- The center must meet the minimum standards of the District of Columbia's Building, Fire, and Department of Consumer and Regulatory Affairs regulations, and a certificate of occupancy must be obtained.

- When food is prepared on-site, the center shall be licensed and inspected by the Department of Consumer and Regulatory Affairs and certified as a food service establishment. Current food service inspection reports by the Department of Consumer and Regulatory Affairs must be posted. All required certificates must be on file and available at all times for review.

- The center must have adequate space and operable equipment for the program, including range, oven, refrigerator, sink, tables, and chairs.

- The center must have locked, sanitary, and secure storage space available for supplies and caterer's equipment (if catered).

- The center must have a pleasant environment, adequate lighting, and pleasing decor.

- The center must be accessible and free of both physical and psychological barriers, insofar as possible.

- The center, including restrooms, must be maintained in a clean and sanitary condition.

SERVICE PRIORITIES

Weekend congregate meal service funded by the D.C. Office on Aging is available only to District of Columbia residents 60 years of age or older (and their spouses) who are able to attend a weekend nutrition center.

Priority for weekend meal service should go to those individuals who are unable to prepare or purchase adequate meals for themselves.

In particular, priority shall be given to those individuals who are most socially and economically disadvantaged, who are not regular participants in the weekday congregate meal program, and to referrals from Lead Agencies and Geriatric Assessment and Case Management Center.

SERVICE STANDARDS

Weekend congregate meal service includes the staff, goods, facilities, services and supports necessary to serve a complete mid-day meal to each older individual enrolled. Weekend congregate meal service must meet or exceed the following standards:

- Information about other programs and services, including assistance to gaining public benefits, shall be provided.

- Records of contributions collected, intakes, nutrition screening and administrative reports shall be maintained.

- Client intake must be updated at least annually.

- Meal reservation system and sign-in must be maintained and used for basis of contracting meals.

- Meals must meet or exceed one-third of the RDA, as certified by a licensed and registered dietitian/nutritionist.

- Meals must be served within two (2) hours after preparation.

- One or more activities must be provided daily, in addition to the meal, and posted on a preplanned monthly calendar.

- Participants, family members, and/or caretakers must be informed of the cost of providing weekend meal service and must be offered the opportunity to make voluntary contributions to help defray the cost, thereby making additional service available to others.

- Participants, family members, and/or caretakers must be informed of agency procedures for protecting confidentiality, accounting for participant contributions, and other matters germane to the participant's decision to accept service.

- The agency must maintain, follow, and continually update a training and supervision program to make sure staff are familiar with agency procedures.

- All records of participants' services, costs, and agency procedures must be reviewed monthly, or more often if needed.

- The center should serve a minimum of 50 eligible participants each day for the weekend meal.

- The center must be available for a minimum of four (4) hours on both Saturday and Sunday.

- The center must have a plan of operation, describing coordination with other community resources and programs.

- The older population in the area should generally support the weekend meal center location by participating, volunteering, or helping to sponsor the center. The recipients of services should be involved as much as possible in assisting the center manager in planning and developing relevant programs, and in neighborhood outreach.

- The sponsoring agency of the weekend meal center must contribute program support by developing neighborhood awareness (involving churches, organizations, and other interested persons), provision of space, utilities, maintenance, incidental expenses, recruitment of volunteers, programming activities, and service development. The specific role of the sponsoring agency in the nutrition center is defined by the agency in its project plan.

- Personnel and volunteers associated with the weekend meal service should be trained in the sanitary handling of food, fire safety, and basic first aid, particularly in dealing with choking and coronary attacks.

PROHIBITED SERVICE COMPONENTS

For purposes of Office on Aging planning and reimbursement, weekend congregate meal service may not include any of the following components:

- Taking meals (or allowing meals to be taken) from the weekend meal service center to be consumed in the participant's home;

- Providing meals to ineligible persons;

- Providing friendly visiting or telephone reassurance service, except as incident to confirming a meal reservation;

- Providing social, financial, legal, or other service or advice (except for referral to qualified agencies or programs).

WEEKEND HOME-DELIVERED MEAL SERVICE

SERVICE DEFINITION

Home Delivered Meals (1 Meal) - Provision to an eligible client or other eligible participant at the client's place of residence, a meal which:

- complies with the Dietary Guidelines for Americans (published by the Secretaries of the Department of Health and Human Services and the United States Department of Agriculture.)

- provides, if one meal is served, a minimum of 33 and 1/3 percent of the current daily Recommended Dietary Allowances (RDA) as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences;

- provides, if two meals are served, together, a minimum of 66 and 2/3 percent of the current daily RDA; although there is no requirement regarding the percentage of the current daily proportional in calories and nutrients; and,

- provides, if three meals are served, together, 100 percent of the current daily RDA; although there is no requirement regarding the percentage of the current daily RDA which an individual meal must provide, a second and third meal shall be balanced and proportional in calories and nutrients.

SERVICE OBJECTIVE

The objective of weekend home-delivered meals service is to provide nutritious meals to eligible residents to improve or maintain nutritional status and to maintain the maximum functioning and independence of the homebound individual.

SERVICE UNIT

The unit of service for weekend home-delivered meal service is one complete meal delivered to one eligible participant.

NOTE: Since two meals are delivered on Saturday (for Saturday and Sunday), two units are earned for a single weekend per eligible participant.

For example, if 35 (2 pack) meals are prepared but only 33 (2 packs) are served to eligible participants, for the weekend, 66 service units (complete meals delivered to eligible participants) may be counted. Meals that are not received because the participant was not home or was unable to accept the meal cannot be counted as service units (see Transportation of Home-Delivered

Meals definition). Units of weekend home-delivered meals service cannot be subdivided (e.g., into half-meals).

ELIGIBILITY

Weekend home-delivered meal service funded by the D.C. Office on Aging is available only to District of Columbia residents 60 years of age or older (and their spouses, if in the best interest of the homebound older person) who are determined to be in need, according to the following criteria:

- Physical inability to prepare meals, which may be caused by:
    - impaired vision, hearing, or mobility
    - general lassitude,
    - dependence on medications and/or other life supports,
    - medical needs,
    - therapy (causing appetite loss),
    - moderate or severe senile dementia, or
    - other ailments such as alcoholism and drug dependence;

- Emotional inability, which can be temporarily or permanently disabling to a degree that affects the ability to acquire, prepare and consume well-balanced meals (many emotional disorders common in older persons -- depression, alcoholism, and drug dependence -- result in loss of appetite, apathy, and lassitude);

- Other inabilities which can include the absence of a homemaker, family, or friends to assist with shopping and preparation of food, a lack of adequate money to pay for enough food, lack of transportation for shopping, lack of facilities to store, prepare and maintain foods safely, and unawareness of proper nutrition practices.

- Other Determinants: Special Considerations may be given to the:
    - degree and nature of illness, disability and isolation;
    - duration of need for home-delivered meal service; and
    - to individuals not qualified for (or has inadequate resources to purchase)"meals on-wheels" services funded from another source.

SERVICE LOCATION

Weekend home-delivered meals are provided in client’s home.

SERVICE AREA

Lead Agencies are assigned subareas of the District from which to accept participants and to monitor meal assembly and delivery. Participants are assigned to the Lead Agency responsible for the area of their residence.

SERVICE PRIORITIES

In particular, priority shall be given to referrals from Geriatric Assessment and Case Management Sites, referrals from Lead Agency outreach staff, and to those individuals most socially and economically disadvantaged, with emphasis on low-income minority elderly.

SERVICE STANDARDS

Weekend home-delivered meal service includes the staff, goods, facilities, services and supports necessary to ensure the delivery of a complete mid-day meal to each older homebound individual determined to be eligible for a meal. Weekend home-delivered meal service must meet or exceed the following standards:

- Client's need shall be reassessed by a social worker or other qualified person at least every six months to determine continuing need for service.

- Meals shall be served as planned.

- Meals shall meet or exceed one-third of the RDA, as certified by a registered dietitian or nutritionist as well as standards set by the D.C. Office on Aging .

- Participants shall be provided with information on how needed services (e.g., Medicare, Medicaid, SSI, transit, housing, etc.) may be obtained, and shall be provided assistance in gaining access to those services.

- Participants, family members, and/or caretakers shall be informed of the cost of preparing home-delivered meals and shall be offered the opportunity to make voluntary contributions to help defray the cost, thereby making additional service available to others.

- All staff preparing the meals shall be fully trained and qualified.

- The agency shall maintain, follow, and continually update a training and supervision program to make sure staff are fully trained and familiar with agency procedures.

- All records of participant services, costs, and agency procedures shall be reviewed monthly, or more often if needed.

- An intake process to determine each participant's eligibility, according to the criteria outlined under Service Eligibility (see above), shall be conducted;

- A complete meal from prepared bulk food for delivery to eligible individuals shall be prepared;

- Delivery of meals shall be arranged;

- Information about other programs and services for which the meals participant might be eligible, and referral to proper services as necessary shall be provided;

- Weekend home delivered meals service shall be coordinated with caterer and the transportation of meals provider;

- Staff shall interpret program policy;

- The records of preparation sites and the delivery agencies shall be reconciled in order to ensure the number of meals delivered agrees with the number of meals received; and

- Records shall be maintained, contributions collected from users, reports prepared and other administrative activities necessary for weekend home-delivered meals shall be carried out.

PROHIBITED SERVICE COMPONENTS

For purposes of Office on Aging planning and reimbursement, weekend home-delivered meal service may not include any of the following components:

- Providing meals to ineligible persons;
- Providing friendly visiting or telephone reassurance services, except as incident to confirming a meal reservation;

- Providing transportation for delivery of home-delivered meals (see Transportation of Home-Delivered Meals definition);

- Providing financial, legal, or other service or advice (except for referral to qualified agencies or programs);

- Providing case management services for weekend homebound meal participants with multiple needs.

WELLNESS: HEALTH PROMOTION

SERVICE DEFINITION

Wellness: Health Promotion service is a comprehensive program of core classes in physical exercise, nutrition, and health dialogues for District of Columbia residents 60 years of age or older. Staffed by professional and trained personnel in health and wellness modalities, e.g., exercise physiology, kinesiology, and nutrition, services are designed to enhance and integrate physical, social and emotional well-being; promote good health habits; help seniors to be better informed health consumers; and, help to prevent unnecessary and costly medical encounters. Wellness: Health Promotion services will be provided on a scheduled basis.

SERVICE OBJECTIVE

The objective of Wellness: Health Promotion is to promote physical, social and emotional well-being through elements and activities such as, physical exercise, nutrition counseling, health education and smoking cessation which are designed to promote good health habits and a healthy lifestyle.

SERVICE UNIT (1 HOUR)

A unit of service for Wellness: Health Promotion is one hour of service provided to an eligible participant during wellness activities held at the center or off site.

NOTE: Units of service may not be subdivided below 1/2 units.

SERVICE AREA

Wellness: Health Promotion services are available to all eligible residents of the District of Columbia who have enrolled in the wellness program.

SERVICE LOCATION

Wellness: Health Promotion services will be conducted in a community facility. Space must be adequate for providing individual and/or group sessions and to allow for comfort and confidentiality.

The facility must meet or exceed all applicable District of Columbia requirements for licensing and inspections, and must be reasonably free of architectural or psychological barriers.

SERVICE PRIORITIES

Wellness: Health Promotion services funded by the D.C. Office on Aging are available only to District of Columbia residents who are 60 years of age and older. To comply with the laws and regulations governing Older American's Act programs, services should be targeted to those individuals who are the most socially and economically disadvantaged, with emphasis on low-income minority elderly.

SERVICE STANDARDS

Wellness: Health Promotion includes the staff, goods, facilities, services and supports necessary to carry out the program and must meet or exceed the following standards:

- Orientations shall be conducted so that potential enrollees may be briefed on the program and scheduled activities.

- When an eligible participant consents to enroll, an Intake Form (D.C. Office on Aging Client Services Information Systems form) must be completed. Only one enrollment process is needed to participate in all aspects of the Wellness: Health Promotion program.

- A customized Wellness: Health Promotion Plan must be developed for each new participant at the time of enrollment using the Lifestyle Assessment or similar health and fitness assessment tool that alerts participants to issues and identifies problematic areas within their wellness system.

- All grantee personnel providing Wellness: Health Promotion service must be qualified by education, training or certification, applicable under D.C. Law (e.g., physician, nurse, nutritionist, social worker (M.S.W.), health educator, psychologist, and certified physical fitness instructor).

- Peer leaders must be trained for the services rendered.

- Core classes, seminars, workshops and screenings in physical fitness, nutrition and health dialogues shall be developed using factual, culturally sensitive and interactive methodologies. Activities shall be conducted by health related professional and trained personnel.

- Participants must be informed of the cost of providing services and offered the opportunity to make voluntary contributions to support the program.

- The grantee must maintain and continually update its training program to make certain

that Wellness: Health Promotion staff are fully trained, professionally supervised and familiar with agency procedures.

- A system of recordkeeping for programmatic and administrative services shall be developed and used.

- Participant's records must be kept in a secure location to protect confidentiality.

- All records of participant services, costs and agency procedures shall be maintained and reviewed periodically.

- Quality assessments shall be conducted as mandated by grant award.

- Information about other programs and services for which the participant might be eligible shall be made available to the participant and referrals to the services made as necessary.

- Support group sessions shall be conducted as scheduled or requested.

- Individual consultations shall be made available to participant as needed.

- A structured forum for family and friends to learn about the aging process shall be conducted as a part of client education.

- Educational research projects that validate results of specific behavioral changes shall be conducted as approved by the D.C. Office on Aging.

- The grantee shall maintain records, collect participant contributions, prepare reports and perform other administrative duties as stated in grant award.

- Intergenerational activities that support better understanding of youth and senior citizens shall be available.

- Methods of training of Senior Service Network health educators and nutritionists shall be provided, upon request.

- Grantee shall participate in outreach such as community days, health fairs and other community-oriented activities.

PROHIBITED SERVICE COMPONENTS

For purposes of D.C. Office on Aging planning and reimbursement, Wellness: Health Promotion services may not include any of the following components:

- Serving ineligible individuals.

- Providing psychotherapy unless provided by a licensed therapist.
- Providing medical services.

Contents

Executive Summary

In 1990, the Americans with Disabilities Act (ADA) prohibited state and local governments from discriminating against people with disabilities and/or excluding 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 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

The District's Office of Disability Rights (ODR) has responsibility for developing and submitting the city's Olmstead Compliance Plan to the Mayor for approval. To support this effort, and include a broad array of voices in the process, in August 2015 Mayor Muriel Bowser created an Olmstead Working Group, charged with making recommendations for revisions to the Olmstead Plan for 2016, and into the future.

Which People are the Focus of DC's Olmstead Plan?

In fiscal year 2014, 21,496 people were directly served in some way by the District government with Medicaid-funded services commonly considered to be supportive of people with disabilities.[i] Among these individuals:

- About 1 in 5 were receiving support in an institutional setting, such as a nursing home, psychiatric residential treatment facility or intermediate care facility.
- The remaining 82% were living in a community-based setting.
- 1,016 people entered institutional care and 357 transitioned from such care to life in the community.

The Olmstead Plan is intended to focus, in particular, on people with disabilities who are living in institutions or at risk of institutionalization. In the District of Columbia, there are currently 3,650 people with disabilities whose level of need qualifies them for institutional care, but who are receiving services designed to enable them to remain in the community instead. These people represent the group considered most "at risk" of institutionalization.

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 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.

The District's system for providing this range of services 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.

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

If an individual is living at home or elsewhere in the community, information about long term services and supports (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 city'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 the DC Office on Aging and has eight satellite offices around the city, one in each Ward.

For people with disabilities who are temporarily in an institutional care setting, the District government has established processes to help them transition to a less restrictive environment:

- *For people with intellectual and developmental disabilities,* DDS coordinates transition planning and support.
- *For people over the age of 60 or adults with physical disabilities,* transition assistance is conducted by staff in the facility in conjunction with the ADRC.
- *For youth with mental health issues being discharged from Psychiatric Residential Treatment Facilities (PRTFs),* DBH coordinates a process to ensure they are successfully integrated back into the community.
- *For people discharged from Saint Elizabeths Hospital,* transition planning starts from the day of admission through a community-based Core Service Agency (CSA).

Improving Long Term Services and Supports

The District has yet to achieve its goal of fully seamless access to Long Term Services and Supports.

Many individuals and families seeking this help encounter a fragmented, inconsistent and siloed system that requires multiple assessments and applications as well as lengthy delays in approval. Once enrolled, the quality of services can be inconsistent. Residents who have limited English proficiency may face additional barriers in accessing linguistically appropriate services.

The Olmstead Plan details these 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 No Wrong Door. 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).

In partnership with these efforts, the Olmstead Working Group will pursue a two-stage process for building a Plan that is a vehicle for achieving a seamless system:

Phase I: Establishing the Needed Knowledge Base

Recognizing significant gaps in core data about both the population and the current service system, the Working Group sees 2016 as the period during which the Olmstead Plan – with greater input and participation from a broad array of stakeholders – drives the city towards the knowledge base that will be required to make needed policy and systems decisions and then move them forward. Where there is already sufficient data to inform clear objectives, the 2016 Plan includes this information. Where data are not available, this plan establishes a marker so that the gap can be addressed in the near future.

Phase II: Development of the 2017 Olmstead Plan

With improved data – or a plan to secure this information where it does not yet exist – the District will be positioned to articulate and move forward a comprehensive set of improvements to the city's system of Long Term Services and Supports for people with disabilities.

2016 Olmstead Plan

The 2016 Olmstead Plan builds on efforts currently in progress under the 2015 plan. As such, agencies' quantitative transition goals have been updated for 2016 and are as follows:

Agency	2016 Goal	Detail
DCOA	45 transitions from institutional settings	• Following a stay of at least 90 days • 35 transitioned through the Money Follows the person (MFP) program. • 10 transitioned non-MFP.
DCOA	200 consultations to support transition planning	• 100 consultations in hospitals for people with any length of stay. • 100 consultations in nursing facilities for people with stays under 90 days.
DDS	100 transitions from day supports	• Transition is from day supports in a congregate setting to a more integrated setting.
DHCF	30 transitions from institutional settings	• Unduplicated count from the transition goals of other District agencies' Olmstead goals.
DBH	70 transitions from Psychiatric Residential Treatment Facilities (PRTFs) or Saint Elizabeths Hospital (SEH)	• To home and community-based settings • Following stays of 187 days or more from Saint Elizabeths Hospital

In addition to these quantitative 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. In each strategic area, the Plan lays out the backdrop, the vision, the data, the key problems, the actions steps and the entities that will take the lead on pursuing them and be accountable for results. The action steps and envisioned baseline data and measures are summarized here for each priority area.

Priority Area #1: A Person-Centered Culture

Action steps:

1. Develop and implement clear expectations, competency criteria, standards, policies and protocols for all LTSS staff in the consistent use of person-centered approaches to service and planning, including using principles of supported decision-making[ii] (regardless of whether individuals have guardians or other substitute healthcare decision-makers) (NWD/DDS by September 2016).

2. Add person-centered practice standards to District personnel job descriptions for staff in key LTSS agencies (NWD/DDS by September 2016).

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/DDS by September 2016).

Suggested Baseline data/metrics:

- #/% of core LTSS agencies that have implemented person-centered service protocols.
- #/% of performance measures (for agencies and providers) linked to person-centered practice and the use of supported decision-making.
- #/% of core LTSS agencies and staff that have completed training.
- #/% of HCBS provider staff who have completed training.

Priority Area #2: Community Engagement, Outreach and Training

Action steps:

1. Develop and promulgate policy and protocols to increase linguistically and culturally diverse stakeholder involvement in the development, implementation and ongoing evaluation of engagement and outreach activities (NWD/DDS by December 2016).

2. Develop mandatory training for front line staff of District *No Wrong Door* partner agencies about the key plans and practice changes being developed through NWD. (NWD/DDS by December 2016).

3. Develop a unified messaging and marketing "look" for outreach materials and replicate on all *No Wrong Door* partner agencies' websites (NWD/DDS by December 2016).

4. Launch and publicize an "Olmstead-comments-and-questions" email address that is

permanently live. ODR will collect comments and present them to the Olmstead Working Group's quarterly meetings for review (ODR by January 2016 and each subsequent quarter).

Suggested Baseline data/metrics:

- % of customers and # of caregivers reached through outreach and training.
- #/% reached who are not currently connected to services but may be at-risk.
- % of outreach meetings conducted in languages other than English.
- % of sessions receiving positive participant rating.
- # of active website information links, total and per agency; # of hits/month.

Priority Area #3: Employment

Action steps:

1. Review and realign (if necessary) structures across the workforce development system to better support people with disabilities. (WIC by December 2016).

2. Increase the capacity of staff across the system, focusing on managers and supervisors in developmental disability and vocational rehabilitation programs through a train-the-trainer model and virtual community of practice to reinforce onsite training and provide virtual coaching to support best practices (DDS by December, 2016).

Suggested Baseline data/metrics:

- #/% of people referred from DDA to RSA who maintain employment and have their cases successfully closed.
- #/% of people referred from DBH to RSA who maintain employment and have their cases successfully closed.
- # of people jointly served by RSA, DDA, DBH, DOES, DCPS.
- #/% of working-age people with disabilities in competitive, integrated employment.
- # of new, customized employment opportunities created with District support.
- #/% of people with intellectual and developmental disabilities (IDD) supported by RSA to enroll in post-secondary educational programs to reach employment goals of their choice.

Priority Area #4: Housing

Action steps:

1. Evaluate and improve access to the Handicapped Accessibility Improvement Program (HAIP), which provides assistance for housing adaptations costing $10,000-$30,000 (DHCD by December 2016).

2. Implement environmental accessibility program to fund expedited housing adaptations up to $10,000 per person (DCOA and DHCD by January 2016).

3. Determine methodology to evaluate housing needs for individuals who have been referred to the ADRC because they want to live in the community (DCOA by December 2016).

Suggested Baseline data/metrics:

- #/% of people with disabilities whose discharge from an institutional setting is prevented only by lack of housing.
- #/% of people who, during discharge planning, are successfully helped to secure permanent, affordable, suitable housing.
- % of existing affordable DC housing stock (units) that is fully ADA compliant and accessible to this population.
- % of planned housing stock (units) that will be fully ADA compliant and accessible to this population.
- #/% of people with disabilities who lack access to housing choices, whether limited by income and/or accessibility.

Priority Area #5: Intake, Enrollment and Discharge Processes

Action steps:

1. Develop a "person-centered profile" for use in District LTSS agencies with common information that can be collected by referral sources or state systems and shared to avoid duplication of effort (NWD/DDS by December 2016).

2. 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 (NWD/DDS by December 2016).

3. Develop a discharge manual to be used by both institutional and community-based professionals in collaboration with the Interagency Council on Homelessness (ICH) and make recommendations to improve the process, if needed (DCOA, DHCF, DBH, DOH, DDS, ICH by December 2016).

Suggested Baseline data/metrics:

- % of relevant DC agency staff and providers receiving training on HCBS services and discharge procedures.
- Average EPD and IDD Waiver enrollment times.
- # of public events/participants on LTSS system access and Medicaid Waiver protocols and processes.

Priority Area #6: Medicaid Waiver Management and Systems issues

Action steps:

1. Research a new 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 2016).

2. Research trach-dependent residential supports in the IDD Waiver and for DOH/HRLA regulations (DDS, DOH by December 2016).

3. Develop training on how to access Medicaid Waiver services and troubleshooting for agency and provider staff involved in the EPD Waiver process (DHCF, ADRC, DOH by May 2016).

4. Develop and implement a Participant Directed 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 2016).

Suggested Baseline data/metrics:

- % decrease in average length of IDD and EPD Waiver application processes.
- % of cases for which intake processes are followed 100% of the time.
- #/% of people who have DD, but not ID, as well as people who are not elderly, do not have physical disabilities, or have brain trauma that occurred after the age of 18.

Priority Area #7: Quality of Institutional and Community-Based Services, Providers and Workforce

Action steps:

1. Assess and reduce duplication of services offered by Medicaid and DCOA (DHCF and DCOA by September 2016).

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

3. Review all providers' Language Access plans to ensure residents with limited English proficiency have access to linguistically and culturally appropriate services (DHCF and DDS by December 2016).

4. Create a customer satisfaction survey to cover the five components of quality described above (Olmstead Working Group by December 2016).

Suggested Baseline data/metrics:

- #/% of ICF/IDDs that pass certification and licensing reviews with only standard level deficiencies or better.
- #/% of adult day health recertifications completed within designated timeframes.
- % of people who receive the services for which they have been assessed/referred.
- % of mandatory, annual HBCS training requirements that providers meet.
- #/% of people receiving supports from DDA spending fewer days/week in facility-based day programs.

Priority Area #8: Supporting Children and Youth

Action steps:

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 (DDS/RSA, DC public and charter schools, and DOES by December 2016).

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, CFSA by December 2016).

3. Develop NWD Person-Centered Practices curriculum and train 2 NWD staff to deliver the training to public LTSS agencies, community partners (NWD/DDS by December 2016).

Suggested Baseline data/metrics:

- #/% of youth receiving employment services in an integrated environment.
- #/% of students with disabilities who graduate with a certificate (rather than a diploma), who

have at least one community-based, integrated paid work experience prior to school exit.
- # and ages of children and youth with intellectual disabilities currently in nursing facilities.
- #/% of youth in out of state residential facilities for whom submission and completion of applications for adult DDA services is completed at least 2 years before they age out.

Priority Area #9: Wellness and Quality of Life

Action steps:

1. More broadly implement a medical home primary care model successfully piloted with adults with IDD in community based residential settings (DDS, DHCF by December 2016).

2. Increase inclusive daytime programming offerings and provide technical assistance and training to improve staff capacity at Adult Day Health providers, Senior Wellness Centers, Senior Centers, public libraries and DPR recreation centers (DPR, DCPL, DCOA, DDS by December 2016).

3. Assess and align the capacity of transportation providers to support the transportation needs of people with disabilities (DDS with DDOT, DCOA, WMATA, MTM by December 2016).

Suggested Baseline data/metrics:

- #/% of medical professionals using the medical home primary care model.
- #/% of inclusive daytime program offerings.
- #/% of people with disabilities using various transportation mechanisms.

SECTION 1:
Overview

I. What is an Olmstead Plan?

In 1990, the Americans with Disabilities Act (ADA) was signed into law, prohibiting state and local governments from discriminating against people with disabilities and/or excluding them from participating in, or receiving benefits from, government services, programs, or activities. One part of the federal regulations implementing the ADA requires state and local governments to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[iii] This is often called the ADA's "integration mandate."

Nearly 10 years later, disagreement over what the integration mandate required made its way to the U.S. Supreme Court. In *Olmstead v. L.C.,*[iv] the Supreme Court ruled that people with disabilities have the right, under certain circumstances, to live and receive care in the community rather than in an institutional setting. In this 1999 decision, the Supreme Court also indicated that states could have a "comprehensive, effectively working plan" to demonstrate compliance with the ADA's integration mandate. These plans are often referred to as "Olmstead plans."

Under Olmstead, states must provide services to people with disabilities in integrated settings, within certain limits:

- First, the person must want community-based services.
- Second, a person's treatment team must consider community-based services appropriate.
- Third, it must be reasonable to accommodate the community-based services, taking into account state resources and the needs of others with disabilities.

More than half of the states have an Olmstead Plan to ensure that services, programs, and structures comply with the vision and directives of the integration mandate.

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.

On January 2, 2015, Muriel Bowser was inaugurated as the eighth Mayor of the District of Columbia. Under her leadership, the District created an Olmstead Working Group to make recommendations for revisions to the Olmstead Plan for 2016, and into the future. The 2015 Olmstead Plan and the Addendum to the 2015 Olmstead Plan can be found at Appendix A.

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 B.

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 2016 iteration. ODR will continue to coordinate the reporting required under the Olmstead Plan and submit recommendations to the Mayor as appropriate.

Which People are the Focus of DC's Olmstead Plan?

There is currently no single source of data on the number of people in the District of Columbia who have a disability. Estimates vary based on the definition of disability that is used, whether people self-identify as having a disability, and other factors. The ADA uses an expansive definition of disability because it is a comprehensive civil rights law.

While all District residents are supported by a city that is fully accessible, in fiscal year 2014, 21,496 people were directly served in some way by the District government with Medicaid-funded services commonly considered to be supportive of people with disabilities.[v] Among these individuals:

- About 1 in 5 (approximately 4,000 people, or 18% of the estimated total) were receiving support in an institutional setting, such as a nursing home, psychiatric residential treatment facility or intermediate care facility.
- The remaining 82% (approximately 17,000 people) were living in a community-based setting.
- 1,016 people entered institutional care and 357 transitioned from such care to life in the community.

The Olmstead Plan is intended to focus, in particular, on people with disabilities who are living in institutions or at risk of institutionalization. In the District of Columbia, there are currently 3,650 people with disabilities (or 21% of those currently living in the community) whose level of need qualifies them for institutional care, but who are receiving services designed to enable them to remain in the community instead. For purposes of this 2016 plan, these people represent the group considered most "at risk" of institutionalization.

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 C.

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.[vi] 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 2014,[vii] the District spent a total of $781 million in Medicaid funds on these services; $245 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 45% of total Medicaid funds spent on LTSS were spent on institutional care while 55% 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.[viii] 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 living with disabilities (age 18-59), and their caregivers. In addition, the 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 5,860 people, 23% 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 2015, DDA served 2,303 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 2015 RSA served 9,075 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)
  - 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)

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 St. 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 illnesses. In fiscal year 2015:

  - Total bed capacity: 292
  - Average daily census: 275
  - Total new admissions: 458 admissions in total (38 per month)
  - Total discharges to the community: 464 discharges in total (39 per month):
    - 1-20 days: 48 (10%)
    - 21-90 days: 253 (55%)
    - 90+ days: 163 (35%)
  - Median length of stay (LOS): for "discharge cohort" (measured at discharge) was 58 days and average LOS was 483 days. Median LOS for individuals remaining in care at end of fiscal year 2015 (9/30/15) was 466 days and their average LOS was 2400 days.
  - Average cost per person/funding source: The per diem rate for all individuals in care (both forensic and civil) was $901.

  Through Medicaid, the District also pays for inpatient psychiatric care for youth in 50 facilities (known as psychiatric residential treatment facilities, or PRTFs), all of which are located outside of the District. In fiscal year 2014:

- Total Census: 128 District youth were in PRTF placements
- Total new admissions monthly: 6.3 admissions per month
- Total discharges to the community:
  - 1-20 days: one youth
  - 21-90 days: 14 youth
  - 90+ days: 113 youth
- Average length of stay: 8 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 2014:

- 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 2014 for Medicaid-paid services:

- Total number of DC-based facilities: 21[ix]
- Total bed capacity: 2,770
- Total current census: 2,717 total users in Q4
- Total new admissions: 975
- Total transitions to the community:[x]
    - 1-20 days: 0 individuals
    - 21-90 days: 7 individuals
    - More than 90 days: 51 individuals
- Average length of stay: 537 days
- Average cost per person per day: Medicaid paid $193.50/person per day for nursing facility services.

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 enable 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: $192,837,582

- 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. A complete listing of EPD Waiver services can be found in Appendix E. For fiscal year 2015 (as of October 1, 2015):

    - Enrollees: 2,006
    - Cap: 4,960
    - Total budgeted: $26,488,352
    - Total spent: $26,703,283

- *The Money Follows the Person Program* (MFP) supports individuals who are making the transition from institutional care to an HCBS setting. The intensive wrap-around services also include funds to cover "set-up" costs incurred as part of the transition. Since 2008, the Demonstration has provided transition coordination services for over 200 Medicaid beneficiaries to return to the community.

- **"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 illness are described separately below.

    - Number of state plan enrollees receiving Long Term Services and Supports: 15,315 in fiscal year 2014.

- **Assisted Living**[xi]

  Assisted living facilities (ALFs) provide housing, health and personalized assistance according to individually developed service plans. These facilities vary greatly in 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 2014, across the three facilities:

- Total bed capacity: 61
- Total current census: 34
- Total new admissions: 16

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 illness 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* which supplements the income of low-income older adults and individuals with disabilities to help them pay for housing in licensed Adult Foster Care Home (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. For example, the Department of Behavioral Health provides a range of housing options for individuals with mental illness 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) initiative described above. 51 are currently being used, and the remainder will be used by new MFP participants in fiscal year 2016 . 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.

- **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 illness 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 DC Office on Aging and Department of Parks and Recreation combine to 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 combine to offer a variety of day services for adults with intellectual disabilities, frail elderly, people with physical disabilities, and people with mental health diagnoses. These services all work to support individuals in living 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 group 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 city'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 the DC Office on Aging and has eight satellite offices around the city, one in each Ward. The ADRC's Information and Referral/Assistance Unit uses "Person-Centered Options Counseling" and refers people to:

- 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.

The DC Office on Aging also uses Benefits Checkup through its Senior Service Network and the ADRC to help people identify which services they might be eligible for (including local and federal

programs) that are close to where they live. Benefits Checkup uses a simple online questionnaire; users do not have to provide identifying information such as name or social security number. The system identifies eligibility matches for all available home and community-based services in the District.

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 had already been served by DDA, admission to a nursing home would trigger 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 the 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 his or her legally authorized representative, social worker, medical professional, and 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 program, Money Follows the Person Program, 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 has yet to achieve its goal of fully seamless access to Long Term Services and Supports. Many individuals and families seeking this help encounter a fragmented, inconsistent and siloed system that requires multiple assessments and applications as well as lengthy delays in approval. Once enrolled, the quality of services can be inconsistent. Residents who have limited English proficiency may face additional barriers in accessing linguistically appropriate services.

Section 2 of this Plan details these 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 city 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.

- **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 20th "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 use 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 G.

- **State Innovation Model (SIM)**

  In a year-long, federally funded planning process, multiple agencies and stakeholders[xii] 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.

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 three years, the District has been working to create an active, broad-based "Supporting Families of People with Intellectual and Developmental Disabilities Across the Lifespan Community of Practice (the DC SFCoP). 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 IL services. The goals for the DC SILC this year 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.

The 2016 and 2017 Olmstead Plans

While Long Term Services and Supports in the District have seen improvements since the first Olmstead Plan was developed in 2011, much work remains to be done.

The Vision

By the end of 2017, the work under the Olmstead Plans results in a person-centered, user friendly LTSS system that supports all people with disabilities to maintain their independence as long as possible in their homes; and remain fully included members of their communities.

But the Olmstead promise of community integration is more than just moving people out of institutions and into group homes in the community. The spirit of Olmstead means recognizing that all people with disabilities can and should be a part of the community and have lives that are full of 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.
- To have a full life in a place where people with disabilities are encouraged to have hopes and dreams and are supported to reach their goals.

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.

Phase I: Establishing the Needed Knowledge Base

Recognizing significant gaps in core data about both the population and the current service system, the Working Group sees 2016 as the period during which the Olmstead Plan – with greater input and participation from a broad array of stakeholders – drives the city towards the knowledge base that will be required to make needed policy and systems decisions and then move them forward. Where there is already sufficient data to inform clear objectives, the 2016 Plan includes this information. Where data are not available, this plan establishes a marker so that the gap can be addressed in the near future.

Phase II: Development of the 2017 Olmstead Plan

With improved data – or a plan to secure this information where it does not yet exist – the District will be positioned to articulate and move forward a comprehensive set of improvements to the city's system of Long Term Services and Supports for people with disabilities.

The District will continue reporting its progress on the goals identified in the 2016 Olmstead Plan on a quarterly basis. In 2016, the quarters end on March 31, June 30, September 30, and December 31. The Office of Disability Rights will post quarterly reports within 45 days of these dates. In addition, ODR will post a year-end report within 45 days of the end of the calendar year, summarizing the District's progress for the year.

The Olmstead Working Group will continue to meet on at least a quarterly basis (after the quarterly reports are posted) to review and discuss the District's progress. By September 30, 2016, the Olmstead Working Group will present any recommendations for the 2017 Olmstead Plan to the Mayor (through the Deputy Mayor for Health and Human Services) for consideration.

SECTION 2:
The 2016 Olmstead Plan

I. 2016 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 2015 Olmstead goals (see Appendix A), the four core service agencies (DCOA, DDS, DHCF and DBH) have set the following goals for 2016, with detail following the table:

Agency	2016 Goal	Detail
DCOA	45 transitions from institutional settings	• Following a stay of at least 90 days • 35 transitioned through the Money Follows the person (MFP) program. • 10 transitioned non-MFP.
DCOA	200 consultations to support transition planning	• 100 consultations in hospitals for people with any length of stay. • 100 consultations in nursing facilities for people with stays under 90 days.
DDS	100 transitions from day supports	• Transition is from day supports in a congregate setting to a more integrated setting.
DHCF	30 transitions from institutional settings	• Unduplicated count from the transition goals of other District agencies' Olmstead goals.
DBH	70 transitions from Psychiatric Residential Treatment Facilities (PRTFs) or Saint Elizabeths Hospital (SEH)	• To home and community-based settings • Following stays of 187 days or more from Saint Elizabeths Hospital

DCOA:

DCOA's goals for 2016 have shifted more than those of other agencies due to structural changes in the way services are delivered. DCOA's 2015 goal of 210 transitions included 30 MFP, 30 non-MFP, and 150 transitions from hospitals. The funding for DCOA's hospital discharge program ended in 2015, so DCOA is now working with DC hospitals and sister agencies to assist hospitals in fulfilling their legal obligations to provide transition services to their customers. DCOA involvement with hospital transitions shifted to a consultation role. Consultations may include, but are not limited to, discussion about options for home and community-based services and how to access them; developing appropriate contacts; trouble-shooting discharge planning; and providing general advice to social workers and family members in the discharge planning process.

Like hospitals, nursing facilities have a legal responsibility to provide discharge planning services to their residents. In order to focus resources on the most difficult cases, DCOA's nursing home transition team works with people who have resided in a nursing facility 90 or more days. DCOA also continues to provide consultation to nursing facilities, residents, and caregivers, for residents with nursing facility stays of less than 90 days.

DCOA relies on referrals from nursing homes, individuals, and caregivers, for transition care services requests and does not refuse consultations for hospital discharge planning or for nursing facility transitions. As a result, the goals are projections of the number of consultations DCOA expects in 2016 based on the number of referrals and requests DCOA received in 2015.

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's 2016 goal of transitioning 30 people from institutional settings is a deliberate increase from its 2015 goal of 20. The increase is based on the addition of the Adult Day Health Program (ADHP) in 2015 and the expected demand for ADHP by residents in institutional settings.

DBH:

DBH reduced its 2016 goal by 10 from 2015 because 1) the goal is specific to people who have a length of stay of 187 days (6 months) or more from 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.

II. Strategic Priorities for 2016

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 lays out:

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.

1. A Person-Centered Culture

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 in our city 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, they 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 its culture and work, looking across the city government, awareness, capacity and competence in this area is uneven and can vary depending on agency or source of funding. There are no specified cross-system expectations or performance measures in this area for District agencies.

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):

1. Develop and implement clear expectations, competency criteria, standards, policies and protocols for all LTSS staff in the consistent use of person-centered approaches to service and planning, including using principles of supported decision-making[xiii] (regardless of whether individuals have guardians or other substitute healthcare decision-makers) (NWD/DDS by September 2016).

2. Add person-centered practice standards to District personnel job descriptions for staff in key LTSS agencies (NWD/DDS by September 2016).

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/DDS by September 2016).

Measuring Progress Going Forward

Baseline data and planned metrics to evaluate improvements in the use of person-centered approaches are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- #/% of core LTSS agencies that have implemented person-centered service protocols.

- #/% of performance measures (for agencies and providers) linked to person-centered practice and the use of supported decision-making.

- #/% of core LTSS agencies and staff that have completed training.

- #/% of HCBS provider staff who have completed training.

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 when the experience is not lived.

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 that government commitments in these areas 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. Much of the planning around community engagement work currently leaves key decision-makers (i.e. people with disabilities, service recipients, caregivers and families) out of the process altogether. In addition, participation in decision-making is often limited to formal work development and comment periods, which are not accessible to a broad range of stakeholders.

Current outreach misses key targets. Finding and engaging at-risk populations can be difficult, as is developing messages that resonate across all stakeholder groups. That said, current outreach and information dissemination across agencies and settings is not coordinated, resulting in duplication and confusion among recipients of the material. Further, there are few opportunities for in-person exposure to the Long Term Services and Supports that are available – outreach efforts are almost exclusively through printed materials as well as electronic, TV, radio, and social media communication. The District does not currently measure the effectiveness of its outreach efforts.

Planful 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. 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.

Building on this work:

1. Develop and promulgate policy and protocols to increase linguistically and culturally diverse stakeholder involvement in the development, implementation and ongoing evaluation of engagement and outreach activities (NWD/DDS by December, 2016).

2. Develop mandatory training for front line staff of District *No Wrong Door* partner agencies about the key plans and practice changes being developed through NWD. (NWD/DDS by December, 2016).

3. Develop a unified messaging and marketing "look" for outreach materials and replicate on all *No Wrong Door* partner agencies' websites (NWD/DDS by December, 2016).

4. Launch and publicize an "Olmstead-comments-and-questions" email address that is permanently live. ODR will collect comments and present them to the Olmstead Working Group's quarterly meetings for review (ODR by January 2016 and each subsequent quarter).

Measuring Progress Going Forward

Baseline data and planned metrics to evaluate improvements in community engagement, outreach and training are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- % of customers and # of caregivers reached through outreach and training.

- #/% reached who are not currently connected to services but may be at-risk.

- % of outreach meetings conducted in languages other than English.
- % of sessions receiving positive participant rating.
- # of active website information links, total and per agency; # of hits/month.

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 employment also increases connections to the community, builds self-confidence and can lower rates of isolation and depression. Our city 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 the purchase of goods and services.

What is the Vision?

All working-age people have access to – and are prepared for -- competitive and integrated employment 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 have the support they need to do so. The District of Columbia strives to be a model employer of people with disabilities.

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.[xiv] Only 13% of people with intellectual and developmental disabilities supported by DDA were competitively employed, slightly below the national rate of about 15%.[xv] Many young people with disabilities are not successfully transitioning from school to work.

Support structures need strengthening. Agencies and community providers working to support

employment for people with disabilities need targeted support to build capacity, ensure efforts utilize best practices in the field and 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.[xvi] The District's economy is thriving in many respects, with an overall unemployment rate of only 6.8% 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

As described in Section I, the District is an *Employment First* state with multiple initiatives and collaborations underway seeking to improve employment outcomes for youth and adults with disabilities. Building on this work:

1. Review and realign (if necessary) structures across the workforce development system to better support people with disabilities. (WIC by December 2016).

2. Increase the capacity of staff across the system, focusing on managers and supervisors in developmental disability and vocational rehabilitation programs through a train-the-trainer model and virtual community of practice to reinforce onsite training and provide virtual coaching to support best practices (DDS by December, 2016).

Measuring Progress Going Forward

Baseline data and planned metrics to evaluate improvements in employment for people with disabilities are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- #/% of people referred from DDA to RSA who maintain employment and have their cases successfully closed.
- #/% of people referred from DBH to RSA who maintain employment and have their cases successfully closed.
- # of people jointly served by RSA, DDA, DBH, DOES, DCPS.
- #/% of working-age people with disabilities in competitive, integrated employment.
- # of new, customized employment opportunities created with District support.
- #/% of people with intellectual and developmental disabilities (IDD) supported by RSA to enroll in post-secondary educational programs to reach employment goals of their choice.

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 identify rental 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 61 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.

Environmental accessibility. In cases where people with disabilities have identified housing, but there are accessibility issues, it is often difficult to access needed home modification funds. In fact, some residents are unable to leave institutions due to lack of modifications such as grab bars or ramps. While the District does have programs that provide funds for such modifications, they are for limited populations (e.g., only for people on the EPD or ID/DD Waivers) and/or funds may be difficult to access because of program design.

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.[xvii] 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

1. Evaluate and improve access to the Handicapped Accessibility Improvement Program (HAIP), which provides assistance for housing adaptations costing $10,000-$30,000 (DHCD by December 2016).

2. Implement environmental accessibility program to fund expedited housing adaptations up to $10,000 per person (DCOA and DHCD, by January 2016).

3. Determine methodology to evaluate housing needs for individuals who have been referred to the ADRC because they want to live in the community (DCOA by December 2016).

Measuring Progress Going Forward

Baseline data and planned metrics to evaluate improvements in housing are listed here without

numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- #/% of people with disabilities whose discharge from an institutional setting is prevented only by lack of housing.
- #/% of people who, during discharge planning, are successfully helped to secure permanent, affordable, suitable housing.
- % of existing affordable DC housing stock (units) that is fully ADA compliant and accessible to this population.
- % of planned housing stock (units) that will be fully ADA compliant and accessible to this population.
- #/% of people with disabilities who lack access to housing choices, whether limited by income and/or accessibility.

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

One of the primary objectives of the *No Wrong Door* initiative is the development of agency process and work flows that improve coordination and integration of functions while reducing or eliminating duplication of efforts in intake, screening, eligibility determinations, application processes, case management and other areas. Building on this work, the District will:

1. Develop a "person-centered profile" for use in District LTSS agencies with common information that can be collected by referral sources or state systems and shared to avoid duplication of effort (NWD/DDS by December, 2016).

2. 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 (NWD/DDS by December, 2016).

3. Develop a discharge manual to be used by both institutional and community-based professionals in collaboration with the Interagency Council on Homelessness (ICH) and make recommendations to improve the process, if needed (DCOA, DHCF, DBH, DOH, DDS, ICH by December, 2016).

Measuring Progress Going Forward

Baseline data and planned metrics to evaluate improvements in intake, enrollment and discharge processes are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- % of relevant DC agency staff and providers receiving training on HCBS services and discharge procedures.
- Average EPD and IDD Waiver enrollment times.
- # of public events/participants on LTSS system access and Medicaid Waiver protocols and processes.

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 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 with developmental disabilities and brain injury can have difficulty accessing services through the DDA or EPD Waiver program, even though they may be at significant risk for institutionalization. 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

Both DHCF and DDS have identified a need to procure a new case management system that can also perform critical quality management functions, and interface with existing eligibility and payment systems for the Medicaid program. Such a system should improve the efficiency in the operations of the Medicaid Waiver programs, quality assurance and subsequent satisfaction with service delivery.

Under No Wrong Door, District agencies will be collaborating to improve stakeholder engagement, outreach, marketing and communication regarding all LTSS services.

Building on this work:

1. Research a new 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, 2016).

2. Research trach-dependent residential supports in the IDD Waiver and for DOH/HRLA regulations (DDS, DOH by December, 2016).

3. Develop training on how to access Medicaid Waiver services and troubleshooting for agency and provider staff involved in the EPD Waiver process (DHCF, ADRC, DOH).

4. Develop and implement a Participant Directed 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 2016).

Measuring Progress Going Forward

Baseline data and planned metrics to evaluate improvements to Medicaid Waiver management and systems are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- % decrease in average length of IDD and EPD Waiver application processes.
- % of cases for which intake processes are followed 100% of the time.
- #/% of people who have DD, but not ID, as well as people who are not elderly, do not have physical disabilities, or have brain trauma that occurred after the age of 18.

7. Quality of Institutional and Community-Based Services, Providers and Workforce

Why is this important?

People with disabilities rely on critical services and supports, as well as on the people who are employed to help them carry out basic personal care needs and activities of daily living. From receiving health care treatments, to accomplishing everyday tasks at home, to obtaining and maintaining employment, people who are dependent on someone else for support in critical areas are especially vulnerable to the quality of those services.

Quality, consumer-directed care and supports will lead to greater health and well-being; poor quality service can lead to depression, lack of self-confidence and reduced functioning. Quality services help ensure that people with disabilities will have a higher likelihood of achieving their dreams and being integrated in the community.

What is the Vision?

The goal of the District's LTSS service delivery system is to provide high quality care and services that are consistent with people's needs and preferences and promote independence and quality of life in the most integrated settings. Quality means:

- *Reliability:* will the person arrive on time?
- *Competence:* Is the person properly trained in the specific support needs? Is the person properly supervised?

- *Safety:* has the agency complied with required background checks? Is equipment properly maintained?
- *Respect:* Does the agency embrace and ensure the dignity and rights of people are respected and protected?
- *Choice:* are there a sufficient number of provider agencies available to provide needed supports when they are needed?

These are just a few of the questions that must be answered in the affirmative for people who rely on a service system.

What are Some of the Challenges the District Faces?

Workforce turnover and availability. In both institutions and among HCBS providers, maintaining high quality, high performing staff is a challenge, as is filling vacancies. With five major hospitals located in DC, there is significant competition for qualified providers to deliver clinical services including nursing, physical, occupational and speech therapy and mental health services. Licensing and regulatory requirements, while intended to ensure quality, can sometimes slow the recruitment of new providers of these services.

Service Gaps, Duplication and Underutilization. The District's current system is not fully aligned. There are gaps in services for some populations, duplication of other services, or services that are underutilized, and varying performance standards depending on the source of funding. For example, Medicaid does not fund case management outside of the two Medicaid Waivers, leaving some individuals without this critical support. At the same time, some individuals may be receiving case management from two or more agencies as not all case management is funded through Medicaid.

Meeting Quality Standards. Virtually all LTSS providers must comply with a panoply of Federal and District regulations that set standards for provider qualifications and quality of care. However, a robust regulatory environment does not, by itself, guarantee that services are high quality, consumer-focused and designed around the needs of the individual. Disparate, complicated standards and certification and licensing requirements across District agencies contribute to the problem.

Services for Individuals with Limited English Proficiency. The District must increase its capacity to provide multi-lingual LTSS as increasing numbers of people with limited English proficiency age and require more services.

Action Steps, Lead Entities and Timeframes

1. Assess and reduce duplication of services offered by Medicaid and DCOA (DHCF and DCOA by September, 2016).

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

3. Review all providers' Language Access plans to ensure residents with limited English proficiency have access to linguistically and culturally appropriate services (DHCF and DDS by December, 2016).

4. Create a customer satisfaction survey to cover the five components of quality described above (Olmstead Working Group by December, 2016).

Measuring Progress Going Forward

Baseline data and planned metrics to evaluate improvements in the quality of providers are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- #/% of ICF/IDDs that pass certification and licensing reviews with only standard level deficiencies or better.
- #/% of adult day health recertifications completed within designated timeframes.
- % of people who receive the services for which they have been assessed/referred.
- % of mandatory, annual HBCS training requirements that providers meet.
- #/% of people receiving supports from DDA spending fewer days/week in facility-based day programs.

8. Supporting Children and Youth

Why is this important?

Ensuring that children and youth with disabilities are fully and equally integrated into the life of our city sends the clear message that the District values them. Encouraging and challenging all children

and youth with disabilities to succeed academically will position them for success in the workforce and in life. Individuals with high school diplomas are less likely to be institutionalized or dependent on public benefits down the road. Further, seamless coordination between secondary school systems and adult service delivery systems can ensure a smooth transition for students with disabilities from child to adult supports, thus lowering the risk of institutionalization and the need for emergency or crisis services.

What is the Vision?

Children and youth with disabilities, and their families, will be supported so they can achieve self-determination, interdependence, productivity, integration, and inclusion in all facets of community life, including competitive, integrated employment.

What are Some of the Challenges the District Faces?

Information-sharing. There is limited data and information sharing across agencies working with transitioning youth and there remains low public awareness of the need for students to be trained on workforce competencies, and have a paid work experience prior to exit from high school.

Service gaps. Employers have limited capacity to work with students with disabilities who have complex needs, and limited job coaching is available to support on the job training for most students. Further, the city does not offer comprehensive peer-to-peer support for families to help them identify and connect with needed formal and informal supports for their children and youth with disabilities. And, families have further identified a need for better coordinated services and supports across the lifespan, particularly during the transitions from infant and toddler services to school, from school to employment and, as needed, to adult services.

Limited end goals. Guardianship is often seen as the only option for parents of children with disabilities rather than self-determination and supported decision-making.

Action Steps, Lead Entities And Timeframes

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 (DDS/RSA, DC public and charter schools, and DOES by December, 2016).

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, CFSA by December, 2016).

3. Develop NWD Person-Centered Practices curriculum and train 2 NWD staff to deliver the training to public LTSS agencies, community partners (NWD/DDS by December, 2016).

Measuring Progress Going Forward

Baseline data and planned metrics to evaluate improvements in supporting children and youth are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- #/% of youth receiving employment services in an integrated environment.
- #/% of students with disabilities who graduate with a certificate (rather than a diploma), who have at least one community-based, integrated paid work experience prior to school exit.
- # and ages of children and youth with intellectual disabilities currently in nursing facilities.
- #/% of youth in out of state residential facilities for whom submission and completion of applications for adult DDA services is completed at least 2 years before they age out.

9. Wellness and Quality of Life

Why is this important?

Full community integration for people with disabilities is inextricably linked to good health, wellness and a host of other "intangibles" that contribute to the feeling that one has a high quality of life. While it may be difficult to define "high quality of life" precisely – and certainly the definition varies by individual – there are some core pillars, including: accessible, effective health care; abundant opportunities for recreation (indoor and outdoor); healthy and nutritious meals; and convenient and easy transportation to work, play and personal appointments. These are among the staples of a high quality life that all residents of the District should equally enjoy.

What is the Vision?

People with disabilities will have opportunities to fully engage in their communities and connect

with others in ways that are meaningful and aligned with their personal choices and desires. People with disabilities will have access to a wide range of integrated services to ensure their health, well-being and quality of life.

What are Some of the Challenges the District Faces?

Health and Wellness Disparities. Across the country, and no less true in the District, people with disabilities are more likely to experience difficulties or delays in getting the health care they need; to not have had recommended annual check-ups and tests; to be overweight or obese, have lower rates of participation in fitness activities, and to use tobacco. People with disabilities are also more likely to have high blood pressure, experience psychological distress, and receive less social and emotional support.[xviii]

Community Integration and Engagement. In the District, 34% of adults with ID who participated in the National Core Indicators survey reported that they had no friends other than family or paid staff; this is higher than the national the rate of 24%.[xix]

Limits in Transportation. While the District offers a wide array of transportation options, the programs are not aligned with each other. For example, WMATA's MetroAccess program has specific requirements, which are also used by Transport DC, operated by the Taxi Commission, but DCOA's transportation program operated by its grantee Seabury, does not use the same guidelines. This is also true of the transportation services offered by Medicaid for medical appointments. Knowledge about the nuances of available programming is not consistent across agencies and as a result, some services are oversubscribed, while others are underutilized. In order to fully leverage the District's transportation services for people with disabilities, the District must align and focus each entity's transportation offerings.

Action Steps, Lead Entities and Timeframes

1. More broadly implement a medical home primary care model successfully piloted with adults with IDD in community based residential settings (DDS, DHCF by December, 2016).

2. Increase inclusive daytime programming offerings and provide technical assistance and training to improve staff capacity at Adult Day Health providers, Senior Wellness Centers, Senior Centers, public libraries and DPR recreation centers (DPR, DCPL, DCOA, DDS by December 2016).

3. Assess and align the capacity of transportation providers to support the transportation needs of people with disabilities (DDS with DDOT, DCOA, WMATA, MTM by December, 2016).

Measuring Progress Going Forward

Baseline data and planned metrics to evaluate improvements in the wellness and quality of life are listed here without numerical values, as markers for the 2017 Olmstead Plan. During 2016, the Olmstead Working Group will develop specific strategies for gathering these data.

- #/% of medical professionals using the medical home primary care model.
- #/% of inclusive daytime program offerings.
- #/% of people with disabilities using various transportation mechanisms.

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

Endnotes

[i] The number of unique individuals receiving any institutional or community-based care that is paid for by Medicaid.

[ii] Supported decision making is supports, services, and accommodations that help an adult with a disability make his or her own decisions, by using friends, family members, professionals, and other people he or she trusts to help understand the issues and choices, ask questions, receive explanations in language he or she understands, and communicate his or her own decisions to others. *See e.g.,* Jonathan G. Martinis, *Supported Decision-Making: Protecting Rights, Ensuring Choices*, Bifocal: A Journal of the ABA Commission on Law and Aging, Vol. 36, No. 5, 107-110 (May-June 2015), *available at*: https://www.americanbar.org/content/dam/aba/publications/bifocal/BIFOCALMay-June2015.authcheckdam.pdf (last visited January 6, 2016).

[iii] 28 C.F.R. § 35.130(d)

[iv] 527 U.S. 581 (1999)

[v] The number of unique individuals receiving any institutional or community-based care that is paid for by Medicaid.

[vi] This does not include IDD HCBS Waiver providers.

[vii] Due to a claims lag, fiscal year 2015 Medicaid expenditures were not available at the time of publishing.

[viii] 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."

[ix] Out of 3,529 unique individuals who received nursing facility services in FY14 paid for by Medicaid, 2,996 received services at an in-state facility, and 575 received services at an out-of-state facility. Given the overlap, some individuals received services at both in-state and out-of-state facilities during the year.

[x] All transitions listed are only transitions that were facilitated by the District through MFP and NHT.

[xi] 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.

[xii] 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.

[xiii] See endnote ii for a definition of supported decision making.

[xiv] 2013 American Community Survey (ACS), U.S. Bureau of the Census.

[xv] John Butterworth *et al.,* StateData: The National Report on Employment Services and Outcomes (Institute for Community Inclusion (UCEDD) University of Massachussetts Boston 2014).

[xvi] Data provided by the DC Department on Employment Services

[xvii] 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.”

[xviii] Healthy People 2020, Disability and Health, available on-line at: http://healthypeople.gov/2020/TopicsObjectives2020/overview.aspx?topicid=9

[xix] http://www.nationalcoreindicators.org/states/DC/.