Aging and Disability Resource Center
Community Transition Team

What is the ADRC?

- The DC ADRC provides a single, coordinated system of information and access for individuals seeking long-term services and supports.
- Single Entry Point!

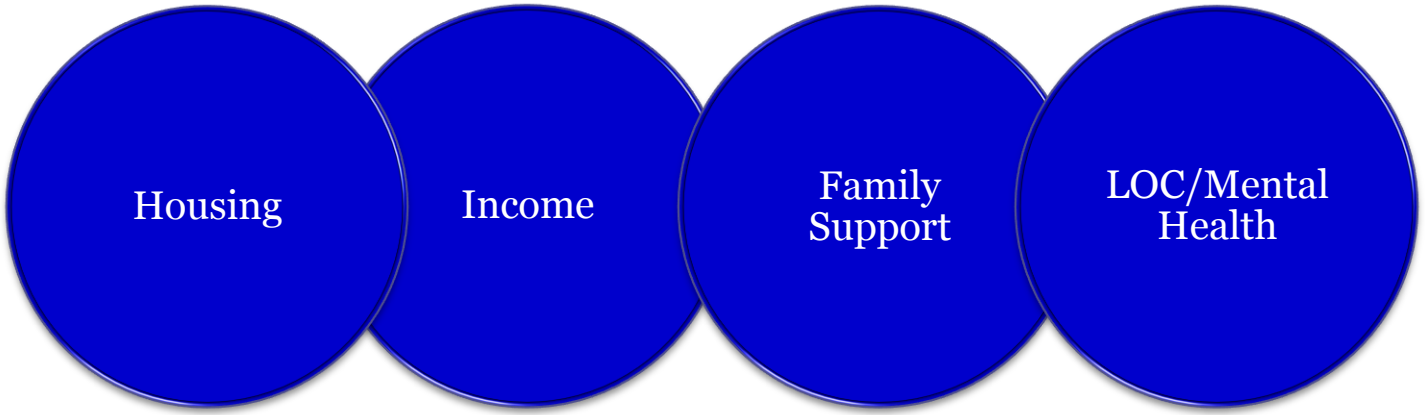
Navigating Long-term Care (LTC) Options and Supports

- Serving as visible and trusted sources of information on the full range of long-term care options;
- Providing personalized and objective advice and assistance to empower people to make decisions about their support options;
- Providing coordinated and streamlined access to all publicly-funded long-term care programs through a single intake, assessment and eligibility determination process; and
- Helping people transition from hospitals and other institutional settings into the community.

Community Transition Team

- Provides support to seniors ages 60 and over and persons with disabilities ages 18- 59 to safely transition from nursing facilities into home and community based settings
- Provides:
  - Outreach and Screening
  - Transition Coordination prior to nursing home discharge
  - Case Management after nursing home discharge

Identifying Barriers



Role of the Transition Care Specialist:

- Developing an individual service plan, collaborating with family and an interdisciplinary team that will assist consumer in transitioning to community-based living.
  - Care plan meeting
- Identification of community resources and/or housing
- Coordinating consumer intervention, consumer services and support and assist with consumer transition from nursing facility through placement in an independent setting, such as “Home and community-based services.”
  - EPD Waiver
- Providing care planning, options counseling, and transition follow-up for 90 days post-discharge.

TRANSITION CARE SPECIALIST	COMPLETED	NURSING HOME SOCIAL WORKER	COMPLETED	EPD/STATE CASE MANAGER FOLLOW-UP	COMPLETED
ADRC Informed Consent		Consumer Face Sheet		Specialty Doctor	
ADRC Rights and Responsibilities		Birth Certificate/Social Security Card		Community Pharmacy	
ADRC Release of Information		Government Issued Photo ID		Medical Equipment/Supplies	
Housing Application/Housing Resources		Updated Income Verification		Representative Payee	
Community Resources		Updated Medication Sheet		Crisis Intervention	
Case Management for Referral		Primary Care Physician (seen before discharge)		Emergency Contact List	
Food /Utility Assistance		PASSAR/Psychiatrist Assessment		Family/Friends Contact List	
Crisis Intervention Plan		Medical Equipment/Supplies (before discharge)		Bank Account	
Day Program/Support Groups		Legal Representative/Payee		Food Stamps (apply day of discharge)	
Budget Planning		Emergency/Family/Friends Contact List		End of Life Planning	
Safe Link/ /Assurance Cell-Phone Program		Metro Access/MTM		Additional Community Referrals	
Household Items/Furniture		Transfer SSI/SSDI Benefits			
Community Mapping		Food Stamps (apply day of discharge)			
End of Life Planning		Packing/Moving			
Additional Community Referrals		Discharge Summary			
Smart911					
Community Pharmacy					

Nursing Home Transition

Case Example

JD is a 62 year old male who resided at a nursing facility for 5 years. JD was concerned that he would not be able to move into a new apartment, because though he had the funds to pay for rent, he didn't have any additional money for any of the other purchases or costs associated with moving. He was also concerned about the coordination of his in home PCA services.

With the help of his Transition Care Specialist, JD was able to transition successfully into the community. Service coordination included signing the lease of his new Public Housing Unit, coordinating in home care services, and identifying community resources. JD's Transition Care specialist also assisted him in scheduling a visit to A Wider Circle, to pick out free donated furniture and household items.

Throughout this process, JD felt empowered and supported, and has been living successfully and independently in the community. JD's Transition Care Specialist providing case management for 90 days, working frequently on budgeting and other life skills.

Questions?

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