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**Independent Living Research Utilization**

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# IL-NET

CIL-NET · SILC-NET

## Community Integration: A Holistic Approach to the New Core Services for Transition & Diversion

*Differences and Similarities between Transition & Diversion,  
Providing for Diversion and Transition through Existing Core  
Services, and Reporting Diversion vs. Transition*

August 23, 2017  
Atlanta, GA

Presenters:  
Darrel Christenson  
Michelle Crain  
Bruce Darling

# Providing Diversion & Transition Through Existing Services



The Original Core Services—

- Information & Referral
- Peer Support
- Independent Living Skills Training
- Individual Advocacy
- Systems Advocacy

You are already providing these. Nothing is new.

# Information & Referral

- Knowledge is Power.
- Learning about the Disability Community, Resources, Services and Programs is vital to both populations.
- CIL services internally assist in BOTH keeping consumers in the community AND moving consumers back into the community.
- Referrals to community partners/ resources also achieve BOTH objectives.
- CILs need to be knowledgeable to assist consumers.

# Peer Counseling/Support

- Who better to assist consumers than peers?!
- CILs are represented by a majority of persons with disabilities – a built-in base.
- Both populations learn from individuals who have “been there, done that.”
- Shared experiences and stories are powerful ways to learn and grow confidence.
- Volunteer Peer Mentors are useful extensions of staff – recruit and train them to assist.

# Independent Living Skills (ILS) Training



- IL skills include: financial management, cooking, goal setting, transportation, sexuality, social skills etc.
- Teaching IL skills reduces the reliance on others. (parents, attendants and other paid professionals, etc.)
- Increases skills and abilities for one's self.
- Increases confidence and self-esteem.
- Increases safety and independence.

# Individual Advocacy

- Assists both populations by speaking up for one's needs and desires (stay out of/ move out of an institution)
- Learning how to advocate and know that your needs are valid.
- CILs teach self advocacy skills AND advocate WITH (not for) the consumer.
- Expressing empowerment and confidence.

# Systems Advocacy

- Making communities more accessible and inclusive so individuals can make use of the information, resources, and skills they acquire through IL services.

# Embrace Diversion / Transition!

If you have concerns about your CIL providing Diversion or Transition...

- As you see, even without additional funding, you are already doing it through the original Core Services.
- Consider the role of Ancillary Programs such as: Home Care Services, rehabilitation visits, Employment & Benefits to Work, Empowering Youth, Socialization through recreation, home modifications, ADA technical assistance,
- Many of you have these and others to assist in achieving these goals and objectives.

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## **Community Integration: A Holistic Approach to the New Core Services for Transition & Diversion**

*Approaches for Identifying and Assisting At-Risk Individuals*

**August 23, 2017  
Atlanta, GA**

**Presenter:  
Michelle Crain**

# Identifying At-Risk Individuals

## Why is it necessary to identify consumers who are “at risk?”

- The most apparent answer is to assist consumers in maintaining their choice to live in a community-based setting.
- And now, to indicate compliance with the new core service of assisting individuals with significant disabilities who are at risk of entering institutions so they may remain in the community.

# Identifying At-Risk Individuals, cont'd.

- Like many Centers for Independent Living (CILs) around the country, LIFE Inc. was already convinced that the independent living services we provide keep or divert consumers from institutional settings.
- Since it's such an essential part of who we are and what we do as a CIL, prior to the Workforce Innovation and Opportunity Act, we didn't make it a standard practice of asking the consumer, "Do you think you are at risk of going into an institutional setting?"

# Identifying At-Risk Individuals, cont'd. 2



WIOA's requirement to identify individuals who are at risk of institutional placement lead to dialogue among other CILs and prompted the questions:

- How do we demonstrate for certain that CIL services are the reason consumers are able to maintain their freedom in the community—after all, consumers may access numerous community resources that are not disclosed to CIL staff and are just as instrumental to institutional diversion?

# Identifying At-Risk Individuals, cont'd. 3

- How can CILs, as objectively as possible, tie diversion to the independent living services we provide?
- What are the at-risk factors associated with institutional placement?

# Identifying At-Risk Individuals, cont'd. 4



In 2015, LIFE Inc. created an At-Risk Survey that we thought would serve several purposes.

- The At-Risk Survey could be a standardized tool to assist Texas CILs in identifying consumers, who, because of their current life circumstances, have increased odds for institutional placement.

# Identifying At-Risk Individuals, cont'd. 5

- During this time, the Texas Network of CILs, the State Independent Living Council, and the Texas Department of Assistive and Rehabilitative Service (Designated State Unit) were engaged in the Common Outcomes and Return on Investment Project, which developed a framework for consistently counting, collecting, and reporting CIL services.
- Diversion was one of those outcomes.

# Identifying At-Risk Individuals, cont'd. 6



- The At-Risk Survey could also be used to help IL staff to better assist the consumer in developing an Independent Living Plan (ILP) that addresses those “at risk” factors; thus, diverting consumers from institutional placement.

# Identifying At-Risk Individuals, cont'd. 7



In creating LIFE's At-Risk Survey, we looked at several research studies and surveys that addressed nursing home placement of older adults. These were typically:

- Too lengthy
- Based on the medical model
- Helpful in identifying at-risk factors

What we wanted:

- Short
- Simple
- Common at-risk factors

# Identifying At Risk Individuals

## The At-Risk Survey

- After the survey was completed, LIFE staff and other CIL Directors reviewed the draft and made recommendations for change.
- The survey consists of two components:
  - Summary of risk factors and tabulated score.
  - Scoring detail that captures individual score assigned to each risk factor.
- See handouts, “Maintaining Community-Based Living – Identifying the At Risk Consumer” and “FAQs: Utilizing the At-Risk Survey.”

# Survey Assesses Risk Factors

- The survey consists of 14 questions that assess risk factors:
  1. Does the consumer feel that he or she is at risk of institutionalization?
  2. Has the consumer been institutionalized in a long-term care facility within the last 12 months?
  3. Is the consumer homeless?
  4. Has the consumer been diagnosed with one or more of the following health conditions:
    - Coronary Heart Disease
    - Fractures Due to Falling

# Survey Assesses Risk factors, cont'd.

- Decubitus
  - Diabetes
  - Stroke
  - Cancer
  - Incontinence
  - Mental Illness
  - Alzheimer's
5. Has the consumer been hospitalized for any of the health conditions mentioned above within the last 12 months?

# Survey Assesses Risk Factors, cont'd. 2



5. Has the consumer made 6 or more visits to the emergency room within the last 12 months?
6. Does the consumer need assistance with 3 or more activities of daily living and does not currently have a care provider?
7. Is the consumer 65 years of age or older?
8. Does the consumer have difficulty taking medications as prescribed?

# Survey Assesses Risk Factors, cont'd. 3



10. Does the consumer live alone?
11. Is the consumer's current housing situation suitable?
12. Is the consumer's income sufficient enough to cover basic living expenses such as rent, utilities, and food?
13. Does the consumer has a history of drug or alcohol abuse?
14. Does the consumer has informal supports?

# Training Has Been Ongoing

- Staff tested the At-Risk Survey prior to its implementation in September 2015 and training has been ongoing, along with discussions on how to improve the survey's efficacy.

# Other Approaches of Identifying At-Risk Individuals

- Self-Identification Only – Keeping it simple! Some CILs may feel that they lack the staff capacity to engage in the completion of more forms and documentation. Asking the consumer if he/she is at risk of losing independence in the community, from the outset, can save time.
- The key to this approach is *making sure that staff, as well as the consumer, understands what makes an individual at risk.*

# Other Approaches of Identifying At-Risk Individuals, cont'd.

- Identifying At Risk through Referrals – For example, if a Consumer is referred to the CIL by Adult Protective Services (APS) or Social Security for Payee Services, the CIL may identify the individual as at risk.
- Early Intervention Programs – Ability360 in Arizona, administers an early intervention program in collaboration with rehabilitation hospitals to serve individuals after acquiring a profound disability.

# Other Approaches of Identifying At-Risk Individuals, cont'd. 2

- Relocation from Nursing Homes to Community Programs – CILs with relocation programs may routinely identify newly transitioned consumers as at risk.
- Anyone who has been institutionalized automatically has risk factors that can cause return to the institution.

# Assisting At-Risk Individuals

- The At-Risk Survey is now a part of LIFE's intake process when opening a Consumer Service Record (CSR).
- Asking the consumer if he/she is "at risk" is only one aspect of the assessment and is not the only criteria for determining if the consumer is "at risk." We utilize the survey in conjunction with other information obtained during the intake process to get a better picture of the consumer's "at-risk" status.

# Tell Consumers About Their Options

- Most consumers don't come into our CILs saying that they have a goal to stay out of the nursing home. If the assessment identifies that consumer as "at risk," and he/she has goals that do not address any of those factors, we simply inform the consumer of our concerns and offer to help develop a more comprehensive ILP.
- Consumers always have the right to say, "No," but they should be made aware of their options.

# Opening a CSR to Address “At Risk” Factors



- If an individual is only requesting Information and Referral (I&R), staff is not required to complete the survey.
- However, if I&R requests are frequent and depending on the nature of the requests, then LIFE staff encourages the consumer to open a CSR in order to address any potential “at-risk” factors.

# Staff Issues with At-Risk Survey

- Why aren't more significant disabilities included in Question 4 on the survey?
- The questions seem to be personal and invasive. How do we approach this with consumers?
- What if the score identifies the consumer as "at risk," but the identified needs are services the Center does not provide?
- The scoring system may need to be more technical.
- More at-risk factors need to be included.

# Purpose of the Survey

- The purpose of the survey is for the CILs to implement a standardized approach in identifying consumers who are at risk of institutionalization and to assist CIL staff in developing an ILP with that consumer that will stabilize the consumer's living situation and maximize resources that will address those "at-risk" factors.

# Martha M: At-Risk Exercise

## Demographics:

- 53-year-old female
- Divorced
- No children or siblings
- Temporarily residing in Motel 6
- No alternate contacts
- Referred to CIL by APS

**At-Risk Factors?**

**Goals Established?**

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## **Community Integration: A Holistic Approach to the New Core Services for Transition & Diversion**

### ***Implementation Strategies for Diversion and Transition***

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# Ability360's Rehab Outreach

- Ability360's experience with outreach to individuals going through rehabilitation is one example of a targeted approach to assisting someone to avoid institutionalization (being fast-tracked from rehab to nursing home).
- Use this information and apply it your way in your CIL.

# Early Intervention Program at Ability360



- The Early Intervention program began as a response to an identified community need nearly 20 years ago.

# Early Intervention Program at Ability360, cont'd.



- The program provides outreach to individuals in the rehabilitation hospitals who are newly disabled.
  - Sixty (60%) percent of the unduplicated newly disabled individuals, contacted in the program, have had a spinal cord injury (SCI) and/or traumatic brain injury (TBI).
  - Visits to rehabilitation facilities are regularly scheduled to meet with individuals and their families shortly after a catastrophic trauma resulting in a profound disability.

# Service Area and Demographics



## Service Area:

- The program is integrated with the services at medical rehabilitation facilities throughout Maricopa County/ Phoenix metropolitan area.

## Demographics:

- 70% males / 30% females
- 49% between ages 31-54
- 71% white, 15% Hispanic, 8% Native-American = representative of the population
- 75% earning less than \$10,000 (injured, not working)
- Valley-Wide

# The Problem Being Addressed

- A stroke, an automobile accident, a drive-by shooting, whatever the cause, becoming disabled means losing the use of a significant part of one's physical, sensory, or cognitive ability.
- It can happen quickly, and it impacts individuals, marriages, families, and the community. No one is ever expecting a disability or is prepared to deal with it.

# The Problem Being Addressed, cont'd.

- Medical professionals do a great job at putting bodies back together. However, the things needed for the psychosocial adjustment to disability are not necessarily available through medical professionals or insurance companies.

# According to the National Council on Disability...



- The unemployment rate for persons with disabilities is just under 70%
- The suicide rate for persons with a spinal cord injury is significantly higher than for persons without a disability.

The result — many newly disabled individuals often feel unable to cope, become isolated, go through bouts of depression, struggle to readjust, experience family turmoil and separation, and often accept a life on public assistance.

# Early Intervention Program's Purpose, Measurable Goals, and Objectives



Ability360's program. . .

- Introduces individuals to the Independent Living Philosophy of self-determination,
- Provides peer support, and
- Presents an overview of strategies, resources, and services needed for living with a disability.

# Early Intervention Program's Purpose, Measurable Goals, and Objectives, cont'd.



- Ability360's program. . .
  - Provides information and peer support that increases the likelihood that consumers will adapt to their disability and be diverted from institutional setting back into the community.
  - Shows through self reporting that education of resources gives knowledge and self-empowerment.
  - Integrates all of our services and addresses the whole person, avoiding institutionalization.

## OBJECTIVE 1:

- In collaboration with local rehabilitation facilities and extended care centers conduct outreach meetings/site visits.

## OBJECTIVE 2:

- Introduce Independent Living Philosophy to newly disabled individuals.

## **OBJECTIVE 3:**

- Facilitate peer mentor matches.

## **OBJECTIVE 4:**

- Assist Ability360 Volunteer Coordinator to recruit, train, and oversee new peer mentors.

# Program Objectives, cont'd. 2

## OBJECTIVE 5:

- Conduct follow-up surveys post discharge to assess and evaluate adaptation and community integration, and re-intervene where appropriate.

## OBJECTIVE 6:

- Distribute copies of Ability360's Disability Survival Guide.\*

\* <http://ability360.org/wp-content/uploads/2016/05/2016-DSG-Disability-Survival-Guide-V3-accessible.pdf>

# Program Objectives, cont'd. 3

## OBJECTIVE 7:

- Participate in civic commission, committee, council, or other related community-oriented organization meetings that focus on disability issues.

# Building the Program

- Establish relationship with rehab centers, case managers, occupational and physical therapists, and rehab directors.
- Offer to do "in services" to educate their staff on CIL services. If you have local colleges offering degrees related to rehabilitation, offer to instruct a class.
- Have a presence at conferences, summits, health fairs, etc. Be as visible as possible.
- If possible, have your brochures available to the patients in the rehab.

# Tools

- The program coordinator is the first tool: a person with a disability has instant credibility.
- The CIL's programs are the next important tool, especially peer mentors, IL skills, and I&R.
- Other tools include: program brochures, newsletters, and disability survival guides. Consumers are bombarded with information. We give them a folder to keep brochures organized.

- Referrals can be made by family members, rehab staff, case managers, or the consumer themselves.
- Never make a visit without the consumer's knowledge and consent. Most visits are made in the afternoon, post-therapies.
- Often it is a family member or members who have the most questions.
- It is important for the Coordinator to stay on top of resources and be knowledgeable about services.

# Interactions, cont'd.

- When possible, collect contact information from the consumer for follow up in the future.
- It's important to understand and recognize the stages of grieving.
- Patients are often tired, medicated, and emotionally drained. Be sensitive to their fatigue (aware of non-verbal cues.)

# Measuring Outcomes

- Knowledge of consumers to be involved in their rehab planning and therapy programs.
- Encouragement to be actively involved in focusing on their futures.
- Tracking individuals returning to a residential setting.
- Observing proactive self-advocacy skills.

# Methods to Gather and Collate Measurable Results



- Regularly scheduled visits to rehab units to meet with rehab staff for referrals to newly disabled individuals and their families.
- One-to-one meetings with newly disabled individuals and their families; often weekly visits while they are in rehab.

# Methods to Gather and Collate Measurable Results, cont'd.



- Regularly scheduled discussions with rehab staff to review and assess intervention, and to identify specific issues that need to be addressed. The staffs at rehab units view our activity as an important adjunct.
- Facilitating focused discussions on particular aspects of Independent Living Philosophy in support group meetings.
- Conducting follow-up surveys at regular intervals.

# The Program Uses a Three-Pronged Collaborative Partner Approach



1. The program is completely integrated with Ability360's other independent living programs.
2. The program collaborates with medical rehabilitation facilities. These relationships are mutually beneficial as staff refer individuals to Ability360.
3. The program collaborates with other disability-related and community organizations.

Diversion from institutions to the community is always the bottom line goal.

# Case Example – Steve

- Steve met Coordinator in rehab after he experienced a stroke.
- Coordinator shared community resources and information.
- Steve started mentoring others in rehab and became involved in Ability360 services such as:
  - Living Well with a Disability
  - Peer Mentoring
  - Men’s Support Group
  - Sports & Fitness Center
  - IL Classes

# Case Example – Steve, cont'd.

- Steve is currently pursuing a small business of creating an accessible kitchen with cooking classes for persons with disabilities.

# Things to Consider

- Funding
  - Early years the program was funded by Valley of the Sun United Way.
  - Currently, program revenue comes from discretionary and unrestricted dollars from the Home Care Program.
- Staffing needed.
- Existence of rehab facilities in your service area.
- Rehab reluctance (confidentiality/HIPPA/liability issues).

# Most Common Concerns of Consumers



- Housing
- Quality of life
- Sexuality/ Relationships
- Daily Functionality Questions

# Most Common Concerns of Consumers, cont'd.

- The Coordinator should be positive and living proof that there is life after disability. However, it is important to be honest and realistic—no cheerleader mode.
- People are comforted in knowing they are not alone, that there is a community out there available to support them.
- Technology helps reduce, but not eliminate, the isolation of rural populations.

# Bottom Line

We want to give consumers and their families tools they can use after rehab to avoid becoming depressed, “lost” and isolated. Prevent the downward spiral of depression, drug-use, and isolation.

# Group Discussion

- Let's brainstorm some implementation strategies.

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***Strategies For Tracking and Reporting Services  
to Support  
Transition and Diversion***

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**Presenters:  
Paula McElwee  
Michelle Crain**

# How will you report achievements?

- Does your most recent grant request or report include your center's goals related to institutional transition and diversion? You may want to examine that.
- Does your center's strategic plan reflect your plans for building a transition and diversion program?
- Do individual Independent Living Plans (or goals, if the individual waived a plan) include consumer goals and objectives related to transition or diversion?

# How will you report achievements?



cont'd.

- Are you keeping track of consumer goals set and goals met related to consumers who are transitioning or avoiding institutionalization? Can you pull that information from your consumer database easily?
- What community relationships does the individual need in order to transition to or maintain living in the community?
- What is the center's role in identifying and working with other partners in the community?

# How will you report challenges?

- What barriers exist in your community specific to transition and diversion?
- What systems advocacy is needed in order to improve the rate of transition back to the community?
- What systems advocacy is needed to enhance diversion and the ability of individuals to avoid institutionalization?
- How will you find people who want to stay in the community who are at risk of institutionalization?

# How will the new Program Performance Report (PPR) be addressed?

## DRAFT REPORT—

- The preliminary information from the Independent Living Administration/ACL lists three new categories of transition as part of the core services.
- The record keeping indicates the number of individuals requesting the service, the number receiving the service, and of those receiving the service, the number with a significant disability.
- There is also a section titled Achievements, listing goals set, met, or in progress in significant life areas, including “community based living.”
- The glossary includes “at-risk” and “diversion” related to transition.

# Are these elements really core services?

- Or are diversion and deinstitutionalization “outcomes” rather than core services?
- Because the law calls them core services we do need to include them in that key list of core services.
- However, when we measure what is happening, we are looking for outcomes for individual consumers to:
  - Avoid institutional placement.

Or

- Get out of institutional placement

# How will you measure progress?

- Comparison with prior report
- Work plan for the next year
- How the work plan goals, objectives, and action plans are consistent with the current SPIL.
- What individual outcomes are achieved.

# Can you collect this information now?

- Are you keeping track of the three components of transition – moving from an institution, preventing institutionalization, and youth transition?
- Does your staff understand the distinctions and enter the information consistently?

# Let's drill down in those regulations again...



## INSTITUTIONAL TRANSITION

“**Facilitate** the transition of individuals with significant disabilities from **nursing homes and other institutions to home and community-based residences, with the requisite supports and services.**”

# A little more from the regulations...

“This process may include

- providing services and supports that a consumer identifies are needed to move from an institutional setting to community based setting,
- including systems advocacy required for the individual to move to a home of his or her choosing;....”

## Let's drill down, cont'd.

### INSTITUTIONAL DIVERSION

“Provide assistance to individuals with significant disabilities **who are at risk of entering institutions so that the individuals may remain in the community.**”

# A little more from regulations

“A determination of who is at risk of entering an institution should include **self-identification by the individual** as part of the intake or goal-setting process.” (**ASK** the individual if they are at risk of institutionalization.)

# For an individual to “count” you must:

- Record on an intake document their desire to leave the institution.

Or

- Record on an intake document that they are at risk of being institutionalized.
- Record one or more of the goals of the individual related to transition/diversion, whether or not they waive an IL plan.
- Provide other core services, as needed and desired by the person, which assist them in this transition or avoiding institutionalization.

# There must be a Consumer Service Record (CSR)



- This record may be paper or electronic or a mix.
- You are allowed to scan documents with a signature.
- The consumer will need to confirm with a signature that they:
  - Have a significant disability.
  - Received voter information.
  - Received information regarding how to complain through the Client Assistance Program
  - Are either waiving or accepting a written plan.
- Most centers capture all this in a single intake checklist.

# Who has access to this CSR?

- The consumer.
- The staff working directly with the consumer.
- The managers overseeing the staff work.
- Your funders.

If you get a request from the DSE or ACL to provide consumer records, your contracts and grant assurances usually specify that you must provide the CSR, and at the CIL's expense.

# Day 2 Wrap Up

# CIL-NET Attribution

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