TIM FUCHS: You don't need to hear from me, but you will hear from Bruce and Darrel and we are going to talk about implementation.

So more nuts and bolts to get us started to afternoon.

Take it away, gentlemen.

DARREL CHRISTENSON: This is always the tough part as a speaker.

Right after lunch.

You've been warned.

It going to be a little cool for a while, just to keep you awake.

Not too many people have their sodas, caffeine.

I see a little caffeine, good, she sat over here.

All that table in the back they are set with caffeine.

Okay.

Everybody is good.

All right.

Good, good, good.

Hey, this afternoon, I want to share a little bit before we hear from Bruce.

A little bit about Ability360's approach on strategies for diversion and transition.

And there's always a danger in this type of portion of the program in that a speaker can talk to you so much about what they do in their neighborhood and you say, okay, that's all good and fine where you're at, but I can't I apply it where I'm at.

Hopefully I won't fall into that pit.

If I do, call me out on it.

Okay?

So I will share with you what we have done in the Phoenix area, and hopefully make it general enough that you can use it wherever you are going back home to.

Okay?

That's my goal for this portion.

So our experience with outreach to folks going through rehab is one example of a targeted approach to assisting someone to avoid institutionalization or being fast tracked from rehab to nursing home.

So we have a full-time staff person who does nothing but go up to the rehab centers and introduce the independent living philosophy.

So right off the bat, I can just hear the wheels grinding in your minds thinking, we don't have funding for a full-time person.

Or our community is too small.

We don't have rehab centers in our county.

Right?

Okay.

Nodding your heads.

Okay.

But this is part of the process in keeping people out of nursing homes or transitioning folks.

So use this information and apply it in your way of path of travel.

Okay?

So the early intervention program began as a response to an identified community need nearly 20 years ago.

First of all the name of the program, Early Intervention, this started about the same time I arrived in Phoenix, about 19 years ago, and my context from a previous center in Minnesota was early intervention is birth to five.

Right?

Birth to five is early intervention.

So my frame of reference -- no.

It's rehab and getting to folks right off the bat.

Right off the bat, we can say you can do this and you can rename it to whatever works for you in your community.

You don't have to call it early intervention.

But the point being, is that any good center is going to see a community need and be there to address those needs.

Okay?

And this can come from a trend of your information and referral calls.

Maybe you, like for us for our information and referral, our full-time staff person gets 300 calls a month for information and referral.

The trend is that about a third of those calls are housing related.

So, boom, there it tells management, it tells our president and CEO and tells our board of directors that there's something here, there's a community need.

So nearly 20 years ago, we saw that with the rehab centers in the Phoenix area, we've got a lot of folks coming through, and, you know, there's a perceived need here.

So let's identify it and see how we address it.

So program provides outreach to folks in the rehab hospitals who are newly disabled.

According to our statistics here, 60% of those of the unduplicated newly disabled individuals contacting the program have a spinal cord injury and/or a traumatic brain injury.

60%.

Okay.

That tells us who we're working with.

The visits to the rehab facilities are regularly scheduled to meet with individuals and their families shortly after a catastrophic trauma resulting in a profound disability.

So as we all know, or many of us know, that insurance certainly has changed through the years.

And probably 19 years ago, rehab stays were much longer.

Back in the day, they were probably, what, three months?

Twelve weeks?

Give or take.

Maybe more.

Okay.

Now they're probably down to three weeks.

So, for example, here we sit on August 23rd at the time of this taping, and if you had a spinal cord injury on August 1st, insurance would kick you out of your rehab stay.

Right?

Three weeks later.

Now, if you check back on your calendars to see what you were doing on August 1st, that doesn't seem like a very long time ago, and it's not.

It's not that long a time.

But that's what's happening is the trend is changing so much.

And we also need to realize who we're working with.

That's important.

So our service area, the program is integrated with services at the medical rehab facilities throughout Maricopa County, which is the Phoenix metropolitan area.

The demographics, 70% are male, 30% are female.

49% or almost half are between the ages of 31 and 54.

Starting to get a picture of who we're working with here.

71% are white.

15% Hispanic.

8% are Native American, which is pretty representative of our population in the area.

And 75% are earning less than $10,000 a year, and they are injured and not working.

And again, this is a valley wide program.

So this kind of gives a back drop of the folks we're working with.

That's really important.

In order to meet the needs and be culturally sensitive and understanding, you got to know who you're working with, otherwise you're trying to provide a service that isn't fitting your population and it not going to be as effective.

I should say, of course, this is going to change in your neck of the woods.

Okay?

The problem that's being addressed, you know, stroke, automobile accident, a drive by shooting, whatever the cause, becoming disabled means losing a significant part of one's physical, sensory or cognitive abilities.

And it can happen quickly, as we all know.

Right, it impacts the individual, marriages, families, the community, and no one is ever expecting a disability or is prepared to deal with it.

When I talk to general community groups, you know, I'm saying it's August 23rd, and you didn't wake up this morning and say, well, let's see, it's the 23rd.

I think I'm going to go out and get me a disability this afternoon.

You know, you don't plan for it.

You don't schedule it.

Right?

Sometimes it just happens.

That's part of life.

And so how do you deal with it?

And as we've said here, it affects not only the person, but the whole dynamics of folks around that person.

So these are the problems that are being addressed here in the program.

Also the medical professionals do a great job of putting bodies back together.

However, the things needed for the psychosocial adjustment to disability are not necessarily available through medical professionals or insurance companies.

And that kind of comes back to that point of people with disabilities are broken.

They need to be fixed.

And the medical profession, you know, fixes bodies back together.

And they can do surgeries and we're doing amazing things.

Don't get me wrong about that.

From where we were 40, 50 years ways go, my gosh.

I mean, some of us in the room are probably a testament to the medical advances.

I see nodding in the room.

That, you know, if you're, as I say, if you're not born with a disability, like I was, and back in the day, a lot of folks, a lot of children were not even making it.

Now kids that are born with a disability, so many more medical advances.

If that doesn't happen, midlife.

Maybe it's that car accident.

Diagnosis midstream.

And you all know the aging process.

The aging process, the more older you get, the more likely you're going to have a disability.

And you've probably talked to those civic groups or whatever in your community and you talk to seniors at the senior center.

And, like, are you a senior?

And everybody raises their hand, proud to be.

I'm 85.

Power to the people.

I'm a senior.

Proud of it.

Do you have a disability?

Nope.

How is your hearing?

What's that?

Any arthritis?

Just on rainy days and Thursdays.

But remember, I don't have a disability.

Okay.

Right.

Yeah, it's true.

You're proud to be a senior, but having a disability is a whole different connotation, and not always a good one.

So when it happens, you know, you try to minimize it or deny it or whatever the case might be.

But it's real.

And so we talk about the medical professionals who do a great job of putting things back together.

But we in this room are here to address so many of the other issues and a more holistic approach, and that's part of what we're doing with this program.

According to the National Council on Disability, unemployment rate for people with disabilities just under 70%, I think.

We have lowered it, I think it's all the way down to 69% now.

There's many times where I personally will wake up in the morning and I'm thinking, okay, what makes me so special that I'm among the elite 30% working with a disability?

Because I ain't that special.

But statistically, I am.

And when you talk about the unemployment rates in this country, right now we're hovering at about 4.3, 4.5%.

Okay.

Nationally.

If you are a part of a minority group, your unemployment rate is in the teens, 13, 15%.

If you have a disability, you're at 70%.

That has a big impact on who you're working with in the rehab centers, because you know you may have been earning a great wage and all of a sudden injury, you're in rehab, your family income drops significantly.

And that impacts you and your family.

The suicide rate for people with a spinal cord injury, significantly higher than for people without a disability.

Mentioned earlier that life has certainly changed with a spinal cord injury.

And a lot of people initially in those first three weeks think better dead than alive, and that's why we're here and we go into the rehab centers to say, look, life has changed.

It ain't over.

It's changed, but now how are you going to deal with it?

We can help.

The result, many newly disabled individuals often feel unable to cope, become isolated, like they're the only ones going through this, they go through bouts of depression, may get addicted prescription drugs or whatever, struggle to readjust, experience family turmoil and separation.

Separation and divorce, and often accept a life on public assistance.

Doesn't have to be, but initially that's what they are thinking.

So our program's purpose, measurable goals and objectives.

We introduce individuals to the independent living philosophy of self-determination right up front.

I think in the 19 years that I have been around up there, we have had two program coordinators.

One was post polio, and used a power chair and our current person for the last 14, 15 years is a gentleman with quadriplegia.

When he goes wheeling through the rehab centers, he's living proof that there's stuff after this.

So it's that self-determination right off the bat.

He and others provide the peer support.

Presents an over view of strategies, resources and services needed for living with a disability.

The great thing about Don is that he's a good looking guy, he's independent, has his own home.

He has a modified Honda Element, you know, those box on wheels, but it's modified so he's able to drive.

And he fishes a lot, and he's out there, and shares his story with everybody that will listen.

A lot of times in the rehab centers he will talk about driving and he'll take people right outside to the parking lot and show them the vehicle.

I'm telling you, when that happens, that's powerful stuff.

Don has taken his power chair, going to the parking lot with an individual in rehab, and he's coming out there like, that could happen to me?

I can do that?

You fish too?

That's sweet.

I want a part of that.

That opens the door to the possibilities that just talking about it doesn't really resonate, and he's able to show that in real life.

So we also provide information and peer support that will increase the likelihood that consumers will adapt to their disability and be diverted.

Right?

Diverted from institutional setting back into the community.

So if we can present that information, the peer support right up front, it's going to keep people from going into a nursing home in the first place.

Right?

Okay.

We also show through self-reporting that education of resources gives knowledge and self-empowerment.

Many times when Don stops by a room, he'll drop off a brochure.

I will talk more about the materials he drops off, and they're not ready to talk to him.

He comes wheeling in and they don't want any part of him, because he represents their future, and that's scary as anything.

They don't want to deal with it.

So it's like, okay, that's cool.

I will drop the materials off.

When you're ready, give me a call.

And that's fine.

We're not forcing ourselves on them.

And we integrate this through all our services and address the whole person, avoiding the institutionalization.

So we have I believe seven objectives here.

And this is information, by the way, straight off from a grant that we had years ago.

So feel free to use it and just cut and paste to write a grant.

Okay?

Yeah.

I can write a grant off this.

It's cool.

You know.

But we used to have, I believe I may have mentioned yesterday, we used to have funding through our local United Way for part of the funding for this position and program.

And this information I'm sharing now with the objectives is a part of that grant.

So objective one, in collaboration with local rehab facilities and extended care facilities conduct outreach meetings and site visits.

So we developed the relationship with staff at the rehab centers.

And I don't care really if you're in a major metropolitan area or a small community, relationship building is huge.

And I hate it, but it's true.

It's not always what you know.

It's who you know.

And if you can go in as a representative of your center and develop a rapport with people, that goes a heck of a long ways.

It really does.

So you go out and do the outreach meetings, talk about the program, the benefits, the whole 9 yards.

Objective two is to introduce the IL philosophy, independent living philosophy to newly disabled individuals.

Again, no-brainer.

Objective three, to facilitate peer mentor matches.

Not only is Don a great representative of our center, but also the numerous volunteer peer mentors that he has at his disposal to go out and meet with people.

It can be matched based on gender, on maybe where they're planning to relocate, maybe on their interests.

He matched a couple people up who had a fondness for horseback riding.

And that was a great match, because that was their point of connection.

So you never know what it can be.

Objective 4, assist Ability360 volunteer coordinator Don Price to recruit, train, and oversee new peer mentors.

So he kind of over sees getting new mentors.

And many times, as probably with your center, former consumers are eager to give back and become volunteer peer mentors for you.

Former consumers now are peer mentors.

They were the mentee.

Now they're the mentor.

It is just like an extension.

Where there's only so much you can do with staff.

But if you can get peer mentors out there and be an extension, absolutely.

Recruit them.

Really build that network.

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

Follow-up surveys, I will be quite honest, we have annual goals, but they are tough.

They are tough in that once a person moves out, you're not always able to follow up and see where they went.

You don't always get that information.

They may stay in the area.

They may move out of state and move back home.

You're not always sure.

And so having that information can be very, very difficult to gain and so that's one area that we continually struggle with, but do the best we can to do the follow-ups so that we can evaluate how we're doing.

Distribute copies of our disability survival guide.

I think that's a fairly recent website.

Just, rather than writing all this down, just go to Ability360.org.

And you can look at resources.

And resources will have our disability survival guide.

It's information that's generic enough that anybody across the country can use about a disability, but then at the back section, we happen to have a number of pages of local common resources.

So that this survival guide can be handed off, and the person can use that and, as I say, if he hands that off, they may not want any part of it right now, but if they can tuck it aside and say, I have got some materials here, I will take a look at it later, maybe in a couple days, maybe when they get home, but those, that guide, that survival guide really gives them a good back drop and some resources, common resources that they will probably need and benefit from.

So I would say, take a look at that, use what you want in your community, put your resources in there, and maybe spend the money to develop your own localized disability survival guide.

And if you have any questions, obviously give us a call.

But why try to reinvent it?

Part of it's already there.

Okay.

Objective seven.

Participate in civic commission, committee, councils and other community related organizations, meetings that focus on disability issues.

So Don also is a member of the Phoenix mayor's commission on disability issues.

He is on the spinal cord injury association of Arizona board.

He is, he facilitates a men's group that is open to all men who have any type of disability.

He's out there involved.

That's my point.

So get your folks out there and plugged in, because that's another way to, you know, get interest, and also when you have consumers, get them interested as well in the community.

Building a program.

So establish relationship with rehab centers, case managers, occupational and physical therapists and the rehab directors.

Again, relationship building.

One thing I want to say on this slide is it's changed a lot.

It being access to information about patients.

Back in the day, because we had good relations and staff knew that we had a good reputation, we're not just soliciting stuff willy-nilly, but we were legit.

They would give Don the census list for that day.

It would have the patient's name, their room number, the whole bit.

And he would be handed this roster and said, you know, go for it.

I know this is your Tuesday to be here.

That was easy.

That was great.

They knew that we were a great partner with them to provide enhanced services in the facility.

In recent years, with HIPAA guidelines, nothing.

They will not tell you a name.

They will not give you a room number.

They won't, they are not allowed to give you anything.

But we have the relationship still established that he can still roam the halls, but the HIPAA guidelines, as they are there for a purpose.

It is a good purpose.

A good purpose.

But it makes it much, much more difficult to get that connection made in the facility.

So relationship building.

Offer to do in services to educate their staff on the center services.

And if you have local colleges offering degrees related to rehab, offer to instruct the class.

If it's a community college, if it's a four year college, great resources.

You might not have thought of that.

Use it.

Have a presence at conferences, summits, health fairs.

Be as visible as possible.

If your communities are like ours, man, you're flooded with requests in the spring and the fall.

Right?

We have a health fair over here, we have a health fair over here, this apartment complex is having an informational tables and booths and stuff.

We want you to participate.

Man, it can be really, really overwhelming.

But I'd say, you know, push yourself to do the outreach.

It's a great way of marketing.

So think about that.

And sometimes, you know, it's like, man, I'm stretching my staff Saturdays or evenings, activity five to 7:00 p.m., this Saturday we have two requests, and, you know, it's pushing staff, but it's a great way of doing outreach.

And if possible, have your brochures available to the patients for rehab.

To print up marketing materials, it's a small cost for the benefit you'll get, because again, you're going to have folks that will maybe toss your materials aside right away, but they are going to come back to it, more than likely, later, and they will have that.

So the tools.

Program coordinators is the first tool.

The person with a disability and he has instant credibility.

Just by wheeling in, he's got it.

If someone comes in with either a hidden disability or no disability, the information is still there.

It's still a valid resource, but I really believe it takes on a different first impression if you have a visible disability and like Don, he's wheeling in as a quad.

It just does.

Centers for independent living programs are the next important tool.

Especially your peer mentors, independent living skills and information and referral.

Other tools, include program brochures, newsletters, survival guides, consumers are bombarded with information.

We give them a folder with brochures organized.

At first, it's like, my gosh, that's another cost.

A nice little folder with little slots, you put all the brochures in.

But, man, it's like, okay, you won me over.

I see the benefit, because you do have your home modification brochure, your main brochure, your peer mentor brochure, your survival guide, maybe your newsletter.

Put that in so that they have a nice handy packet, give it right to them and they have it tucked away in one place, they don't have materials flying all over.

It's worth it.

Interactions.

Referrals can be made by family members, the rehab staff, case managers, consumers themselves.

Doesn't matter.

Never make a visit without the consumer's knowledge or consent.

Most visits are made in the afternoon, post therapies.

So, you know, Don might work from 10 in the morning till 6:00 p.m.

are his hours.

If he tries to start at 8:00 a.m.

coming to rehab, it not happening, because everybody is down at the OT or PT.

That's just the scheduling.

Often it's a family member or members who have the most questions.

Talk with the individual themselves.

If family have questions, as much as possible, because you want to have them involved in that information sharing and with that process.

Now, having said that, there are times when maybe a spouse or something has her issues and she want to talk about or he wants to talk about, and I'm not sure how to deal with this with my spouse now going through rehab.

I'm not sure how to handle this adjustment.

And that may be a side conversation to meet their needs.

But as much as possible, try to keep everybody in the loop.

It's important for the coordinator to stay on top of resources and be knowledgeable about services.

I mean, keeping up to date with the survival guide and the resources in the back, I mean, you guys know.

You get resources, well, maybe they changed their phone number, maybe they changed their web address or they moved, and so you don't want to have bad information distributed out.

It wrecks your credibility.

I think we mentioned before, it's terrible when you have agencies that don't even call people back.

And don't make it because you gave them a bad number.

A disconnected number or something.

Keep up to date.

When possible, collect contact info from the consumer for future follow-up, if that's possible.

It important to understand and recognize the stages of grieving.

I think that's a big one too.

You're going to see the seven steps, right?

You'll see the whole range and allow people to go through those processes as they adjust and grieve the loss.

And patients are often tired, medicated, emotionally drained, and being told to be sensitive to their fatigue.

Aware, be aware of nonverbal cues.

So don't push yourself if they're not in a good position to take your visit.

Measuring outcomes.

Knowledge of consumers to be involved in their rehab planning and therapy programs.

The more involved that folks are in their program, the faster and better they're going to go through the rehab process.

If they are just lack luster and not into it, it is going to be a slow, painful process in comparison.

Encouragement to be actively involved in focusing on their future.

Tracking individuals returning to a residential setting.

So if someone want to move back to their home, perhaps you can ask about accessibility.

Maybe it is a one story home that they want to get back to.

Maybe you do have some options for home modifications that you can help them with.

It's a lot better than going to a nursing home first for that transitional temporary stay for eight years.

And observe proactive self-advocacy skills.

Self-evident on that one.

Is some of this making sense?

Okay.

Methods to gather and collate measurable results.

So regularly scheduled visits to the rehab units to meet with rehab staff for referrals to newly disabled individuals and families.

So we track the number of visits to staff, numbers of visits with unduplicated consumers, and I'm just throwing out the number, but Don meets with between 550 and almost 600 people a year.

Unduplicated count.

So in a 12-month period, you're doing 550 to 600, that's quite a few individual folks.

It may be just a 1-time visit, but nonetheless, we're giving them the information.

We track one on one meetings with the individuals and their families.

Often weekly visits while they're in rehab.

Again, he has kind of a schedule that he's built in as to which day he's going out to which facility.

And he has to do it pretty frequently because of those short-term stays now.

So he needs to pump himself out there regularly to all of them so that he doesn't miss someone through a 3-week cycle.

So plan yourself accordingly with that.

Regularly scheduled discussions with rehab staff to review and assess intervention.

And to identify specific issues that need to be addressed.

Of staff at the rehab units view our activity as an important adjunct.

They really do.

We've proven ourselves.

Maybe like a new grant, they might give you seed money and have you to prove yourself and then they can build from there.

Same thing here with the relationship building.

Facilitating focused discussions on particular aspects of independent living philosophy and support group meetings.

So we've been asked to come in to some of the rehab facilities support groups and be a presenter.

Talk about our programs, the peer mentoring, the whole 9 yards, and conduct those follow-up surveys at regular intervals, and those are, quite honestly real tough, but we do what we can.

The program uses a three pronged collaborative partner approach.

The program, number one is completely integrated with our other independent living programs.

So it's not a stand alone little silo over here that Don is doing by himself.

He is working with the other programs, peer mentoring, independent living skills, information referral, home modification, the home care attendant care program, the whole 9 yards.

Even employment and benefits.

So I mean, it is really easy if your staff are working or if you're working in a silo and you say, this is my program, this is all I do, and I don't do anything that diverts from it.

I don't do that program.

I only do this.

That's easy.

That's easy, folks.

It's much more difficult when you say, I'm aware of this program, I know about the eligibility here, I work with my co-worker on this program together with the peer mentoring.

Elizabeth and I are good teammates.

I'm up at the rehab centers, but she's the volunteer coordinator that helps with the peer mentoring, we work together to recruit and train.

That's much more difficult, but it's a heck of a lot more effective than working in a silo, if any of you are management, you better change your paradigm shift.

Make that shift to be more interactive.

We also work, number two, with medical rehab facilities, these relationships are mutually beneficial as staff refer individuals over to us.

We get a lot of that back and forth.

Three, the program collaborates with other disability related and community organizations, and many times, that can be a disability specific organization.

It might be the Spinal Cord Injury Association, the Brain Injury Alliance, it might be whoever.

And we work together there.

Diversion, the D word, diversion from institutions to community is always the bottom line goal.

A couple case examples.

How are we for time?

Okay?

So case example.

Steve met the coordinater at the rehab after he experienced a stroke.

The coordinator shared community resources and information.

Steve started mentoring other in rehab and became involved in our services such as living well with a disability, peer mentoring, the men's support group I talked about, came to work out at our sports and fitness center.

Participated in independent living classes.

He's currently pursuing a small business of creating accessible kitchen with cooking classes for people with disabilities.

Is that cool or what?

Yeah.

It's pretty darn cool.

And he's well on his way to making that happen, by the way.

Things to consider.

Yeah.

Funding.

For years this program was funded by United Way.

Currently our program revenue comes from discretionary and unrestricted dollars from our home care program.

What's really needed is the staffing.

Existence of the rehab facilities in the area.

And rehab reluctance or confidentiality, HIPAA, liability issues, that's kind of the tough one there sometimes.

Most common concerns Don has reported that folks have, housing.

Gee, that's a new one.

We haven't talked about housing needs this week.

Quality of life.

What kind of quality of life can we expect?

Sexuality and relationships.

That's one of the top issues that people are concerned about and asking about.

And the daily functionality questions.

Coordinators should be positive and living proof that there is life after a disability, however, it is important to be honest and realistic.

No cheerleader mode.

Okay.

That's where Don has to tone me down from my cheerleader mode.

He says, you know, Darrel, we got to be realistic.

We got to be honest.

It not going to be easy.

It's going to be tough.

I get that.

Okay.

He also shared with me that people are comforted in knowing that they are not alone, and that there is community out there available to support them.

You've had those instances where people feel, you know, I'm the only one out here.

Nobody understands what I'm going through.

Let them know that there are.

Technology helps reduce but not eliminate the isolation in rural populations.

Sometimes that's just tough, but technology helps.

With that regard, there's no better time to have a disability than it is now.

Because the technology is so amazing.

You can Skype and do whatever, right, on your phones and such.

The bottom line is we want to give consumers and their families tools that they can use after rehab to avoid becoming depressed, lost, and isolated, and to prevent that downward spiral of depression, drug use and isolation.

That's our bottom line.

And we're on group discussion.

So before we go to group discussion, do we have time?

BRUCE DARLING: You're fine.

DARREL CHRISTENSON: I'm good?

BRUCE DARLING: Have a conversation.

DARREL CHRISTENSON: I will.

Thanks, how much time do I have, Bruce?

BRUCE DARLING: Take what you need.

DARREL CHRISTENSON: An hour?

No.

Okay.

So questions?

Comments?

Start over here.

We haven't heard voices over here for a while.

AUDIENCE MEMBER: With your marketing materials, do you have somebody who helps you create those?

Like within your agency, do you go outside of your agency?

How do you do that?

DARREL CHRISTENSON: Good question.

We have a board of directors who three years ago maybe, chose to put resources into developing a marketing department.

And so we have folks, primarily with disabilities, who have a marketing background and are working with the program staff and management to develop materials that are consistent with the branding.

Because about two or three years ago now Ability360 had changed its name.

We were Arizona Bridge to Independent Living or ABIL.

Two or three years ago, we were re-branded.

So the marketing department has a consistent message and a look for the website, for the social media, for printed materials.

And so within the context of that, they work with the program coordinators to find a look and feel that fits the program and that includes the early intervention program.

So, yeah, we're very blessed to have an internal department of marketing, but I would say even if your center doesn't have that luxury, hopefully you can find someone in your community that maybe you can contract with that can give you a good perspective to really get that IL feel that your center specifically is looking to put out to your community.

Good question.

Thank you.

AUDIENCE MEMBER: So you and Bruce both have very large centers, and my question goes back to the siloing.

And how do you address making sure that your different departments really do understand and know what's going on in the other departments.

I don't think that's just an issue with a larger center, but with smaller centers it can be an issue, because people are busy and I just wanted to get your take on how you address that.

DARREL CHRISTENSON: Yeah.

I worked for a smaller center and did my graduate internship at an even smaller center before that.

And it's the direction that management and the board brings.

If management and board bring the philosophy of working together, then they promote that through staff training, staff in services, individual conversations, but really promote the idea of communicating with one another.

Because you're right, it so much easier to work in a silo.

And not to say that we have it down pat, because there's probably more siloing that happens than I really want to admit.

We have a staff of about 130.

Yeah.

And even within my unit of community integration, we have 10 people.

The advocacy unit has their staff.

Our employment program has their staff.

And then we have a large billing department for our home care program.

Right?

But there's probably more siloing than I really want to admit.

What it takes is continued reinforcement by management that you need to talk to each other, you need to learn what the eligibility is at the very least, what's the eligibility for this program or for that program?

And when would be a good time to refer to that program?

Who is the right consumer to refer to that program?

And keep pounding it.

Keep pounding it.

Because it doesn't happen organically often.

BRUCE DARLING: If I could, so we've done a couple of things, because it is difficult as you get bigger.

So I remember when our center was so small, there were like four of us, so we just knew what everyone was doing.

But as we grew, we had two issues, siloing and sort of acculturating people to the IL community and what we value.

We have down a few things that I think are very helpful.

Every two weeks we have an all staff kind of meeting.

So basically, it's not a big, it's a half hour, so it's just a half hour every two weeks, we're scattered through a number of offices, so we're all connected by video conference, and we have at least a section of the organization talk about what they do.

We have organization wide events that we coordinate so the things that we used to do.

The once a month sort of big dinner kind of thing where we all got together, we've sort of carried that forward as sort of organization wide events.

And then we celebrate the transition stuff, that's celebrated by everyone throughout the organization, but we also have a strong component of folks participating in the ADAPT Actions, the protest stuff.

Even if folks can't go and do that work because someone has to actually stay behind and run the place, the folks who they can help with seeing us off, putting together care baskets or care bags or something so people would have snacks or stuff with them.

So there's ways we make sure we're all connected.

The big issue for us is community based staff.

We work hard to make sure they're engaged as well, cause that covers the office based folks.

But that's one of the things we have to really pay attention to.

DARREL CHRISTENSON: There's a question behind you Tim.

AUDIENCE MEMBER: We're from Michigan.

We have a question.

We do very similar to what you are doing in Arizona.

We have specific outreach that goes to the rehab and nursing facilities.

In transition we do a lot of marketing presentation faires.

Right now we're going through what is called the nifty redesign team.

I'm curious if anybody else is going through this.

The state, our program is funded on a grant through the state.

They're looking at redesigning and doing the marketing themselves where they are supposedly going to be getting the referrals and it's going to a central intake.

From there, us CILs along with waiver, area agency and more, are going to be like in a pool.

It's supposed to be consumer choice, the consumer will choose which transition they want to work with and that's how the referrals are going to come.

So it is kind of being taken away from us so to speak.

I'm wondering if anybody else has gone through this, cause we're up in the air as to where is our program is going.

DARREL CHRISTENSON: Wow.

That's the first I've heard of a model like that.

From what you're presenting, I would say make yourself very visible.

Market the heck out of your program so that the state or whoever decides who goes where knows that you are a viable, valuable resource.

With the independent living philosophy.

Because, believe it or not, that can sell your program many times.

And so my philosophy that I tell my staff is if you do the right thing, for the right reason, the money will follow.

And sometimes we just got to put it to blind trust.

But if you do the right thing and you're doing it for the right reason, the money will follow.

And therefore, the referrals will as well.

Good question.

AUDIENCE MEMBER: Our state has always done it that way with our Money Follows the Person program.

The referrals have to go to what began as the ADRC, and then it goes to the state Money Follows the Person program, and then we get the referrals.

We haven't had trouble getting the referrals, because we're basically the only people out there that are signed up to do it.

But the types of referrals became very different when we are not allowed to go into the nursing homes and market.

So we can't do that.

So the types of referrals, because a lot of times it's the nursing home making the referrals to the state and it's the noncompliant people that they want out.

DARREL CHRISTENSON: Okay.

And definitely you can't go into a nursing home and solicit.

This program, however, is in the rehab centers.

So that's a different type of setting.

When you're marketing in the nursing homes, what we have found is that if you're working with one individual in the nursing home, because they asked for it, then you can use them as your excuse to stay in there.

So we have actually used many times the, by working with one person, that allows us to stay in the nursing home.

And what happens is that their buddies or their friends are saying, psst, this guy over here coming in from the center, you might want to talk to him.

He's helping me get out.

Oh, yeah?

I want a piece of that action.

I want out too.

When's he coming back?

He's coming back to see me on Tuesday.

Come on over at that time.

And we use that, right?

And Rocky gets us in there, right?

He helps us get out.

So that's a great way, where, you know, we can kind of string one person in to the next person, and, hey, it's totally legal.

We're not in there soliciting.

We're in there because someone has invited us to visit with them.

So we work with Rocky and his friends.

Do we have time for one more question before we want to hear from Bruce?

TIM FUCHS: I think we might have to.

DARREL CHRISTENSON: We need a break?

Sorry, Stephanie, we'll talk later.

Bruce?

Sorry, you're up.

BRUCE DARLING: That's cool.

What time is it?

Okay.

I sort of thought we were sliding into the group discussion.

So we have 15, did you want to take one more?

I'm fine with you.

DARREL CHRISTENSON: Okay.

Cool.

Thank you.

Defer to my esteemed colleague from New York.

Stephanie was over here.

Sorry.

AUDIENCE MEMBER: I would like to share this.

So what was given to me in the beginning from a social worker, a referral started off that way, and then from there on the social worker and I created this relationship where she's like, hey, so when I have people who need to get out of the nursing home, can I call you?

I'm like, sure, call me all you want.

So we created that relationship to the point where I get referrals from the social workers from the nursing home.

Which started off as a social worker calling.

DARREL CHRISTENSON: Yep.

That's great.

That's relationship building.

All right.

Bruce, I will defer my time over to my esteemed colleague.

BRUCE DARLING: Thank you.

Okay.

So we've talked a bit about how we can use our core services to do diversion.

So the core funding our IL funding or base funding to do diversion work.

We've heard about targeted programs that do outreach.

But when I think about my center, it's a variety of other services and things that are done as well.

Not just those two pieces, the specialty programs and the core funding, there are these other contracts and things we do.

One of the areas where we do a great deal of diversion is in the area of services that are provided under the Medicaid home and community based services waivers or HCBS waivers.

So how many folks are involved in the provision of like waiver services?

Community based support services?

A couple folks here.

Anyone?

Okay.

I know we are.

Not you personally, but your center.

Maybe I should be clear and broader with the question.

A number of centers are involved in that.

So one of the things that our center provides and has provided actually since before we got our federal IL funding.

Actually, even before we got a dollar of IL funding, we had waiver services and we provided service coordination.

So actually, for me, I had started as an accessibility specialist for one center, left, went to pursue a career that I was never going to do.

Paid for a master's degree that I kind of use, but whatever.

And then came back and started doing what's called, we call it now service coordination.

Then it was potentially case management, sometimes it's called care coordination or care management.

Some combination of those terms.

Any folks do that work through their centers?

We've got some folks.

So at 26, I basically started doing sort of service coordination for about 18 individuals with significant disabilities living in the community.

And the kind of calls that I would get were the church people came and took my ramp.

Okay.

And behind each of these things there is a story.

My girlfriend was taken to the hospital.

Why?

Well, I accidentally pushed her in front of a van.

These are all real.

And actually, they said she has, basically, they told us she's a vegetable.

You should see the brain damage she has.

When we got there, I asked, you do know she has cerebral palsy, right?

Because actually, that looks like brain damage on a scan.

They didn't actually seem to check on that one.

The prostitute took all my money.

My response was, oh, good, it is the beginning of the month, you're going to get more money later today.

Oh, no, I did that already.

Oh, God.

A man named Snake is harassing me and is causing seizures.

So I ended up gleefully trading for that instead of going to the hospital where someone else was giving birth.

So at the same time, one guy was being harassed at the End Zone, the bar, and another woman, who was giving birth.

I'm like, no.

You go to the hospital, I will deal with the End Zone.

And obviously, I was younger, but kind of just like this.

So you can imagine me in the End Zone looking for a man named Snake.

But it was very interesting.

It was actually a three day project.

So the thing is, okay, I really actually have to say those years of the work, doing that type of work really solidified me.

Because I had a great boss who understood independent living even though we weren't technically a center for independent living.

She totally got it and we did everything from that framework.

Although those were dollars that were very traditional and obviously other people who were doing those kinds of services didn't tend to get these kind of calls, because their people were all locked up in residential facilities.

It was a great opportunity for me to learn the resources under someone who knew a great deal.

But embedded in a lot of these calls were diversions.

And often hospitals were a significant point where we would be ending up dealing with diversions.

So rather than being just sticking with sort of the funny story side of it, we would, there's a situation where an individual, even a very simple thing.

So we were working with an older individual, she had cerebral palsy, motorized wheelchair user.

I don't remember how old, but an elderly woman.

She gets the flu.

Goes to the hospital, thank you, when you get the.

What happens when you get sick?

You get weak.

Right?

So the hospital decides she must go to the nursing facility because she can't independently transfer or she would require assistance.

Our role or my role as the service coordinator was to sit with her and they really used all of the tricks to try to push her to voluntarily go into the nursing facility.

They started the meeting by looking at her and saying, now, you know what you need to do.

And I started to talk, and they said, Mr.

Darling, please.

This is her meeting.

Let her talk.

And she reaches over and grabs my hand and starts squeezing it, because she's so fearful about losing her services and supports.

So in this setting, just being a disagreeable bastard for about an hour and a half meant they eventually gave up and said, you know what?

We'll reconvene.

Thank God it was a Friday afternoon.

On Monday, which gave her the weekend to get better.

By Monday she was able basically to go home with services and support, and it was fine.

This is a very classic kind of diversion, it was funded through the office of people with developmental disabilities, I was a service coordinator.

It would be a very classic kind of thing we could now document and do this sort of way.

There are other services and supports, in home support services, sometimes they're called home and community support specialists, habilitation specialists, independent living skills trainer, community support staff, are folks familiar with those?

Do we have those in our centers?

Old jobs.

BRUCE DARLING: Some centers that are providing those services, maybe someone is being threatened with eviction because they're not maintaining the apartment, but the person doing services in the house is helping them maintain it, that is avoiding institutional placement.

These are the kinds of things that we could be doing.

The thing that we have to look at is how we potentially track and document this.

So sort of separating out the issues of this is actually a situation that could have resulted in an institutionalization, this is kind of the daily ground of service coordination of issues per day.

So for us, so one of the things that's helpful here when you're looking at those array of services, everyone you're serving meets the level of care for institutionalization, because it's a waiver service, there is really no question in your mind whether or not it's possible for these people tend up into an institution.

Seriously, what was it?

One hole in your butt or, there's two can be a couple of things, and boom, they would end up in an institution.

Basically, these services are designed to do that.

But the work you do on a day to day basis can actually be considered diversion.

In thinking about this, how do you track these things?

So in New York we have a very significant incident reporting process, where we track, I get notifications, everyone who goes into the hospital, all these types of things that pop up.

One of the things a center can do is figure out how to dove tail those systems into the tracking systems.

Just like we dove tail the goals that are in service plans and whatever the plans are, there's a whole series of them.

How we dove tail the goals, tracking those and reporting those out through the federal reports that we do, we now can potentially add this additional piece that looks at are these types of things that we're dealing with situations that were avoiding institutionalization, is this a specific incident that we can track.

One of the great things about using this model for the centers that are engaged in it, is it's really practical, concrete information that can turn into case studies information that we can use to market the role that centers have in actually supporting folks in the community.

We can mix these in with some of the general IL stuff that we're doing to show a breadth of service across folks.

Now, some of these services may actually be funded through a managed care organization.

We're not to that point.

Any folks doing services through an MCO?

Of course.

Our trailblazer.

Maureen, cool.

All right.

So we've got a number of folks who are doing that.

So that's, we'll come back to that topic in terms of potential funding tomorrow.

I might end up calling on you all to talk about some of that.

That summarizes beyond just the core services and some of the specialty programs we're doing to do outreach for diversion, we need to look at these other contracts that we provide and that we're part of and how we can dove tail those in as well.

With that, Tim, I don't know where I am in terms of time.

TIM FUCHS: Five minutes early.

BRUCE DARLING: Any questions?

AUDIENCE MEMBER: Then, would you qualify service coordination.

I'm a service coordinator for a group of individuals with disabilities, I get a phone call, I fix the problem, like the flu woman, is that diversion?

BRUCE DARLING: The woman with the flu, I would say was totally diversion.

It wasn't even a question.

They were saying, she is going to the nursing facility today.

All they needed to do was bully her into saying yes.

And she was going to be in there, so that was very clearly.

A lot of these situations you could argue the church people taking the ramp, they were actually trying to be helpful.

It resulted in approximately eight hospitalizations, so I think that probably ended up being a diversion as well.

At the time, I didn't think that this was a diversion or anything, an outcome even.

All I was trying to do was figure out, oh my God, these are the things that are happening, we need to help people.

I think one of the things that is important in this is it's something that centers do.

I mean, so these things are funny, but we do this without dedicated funding for a lot of people throughout the year.

I think trying to capture some of that piece in terms of the importance of our services and how we're supporting people, it goes to the issue of providing those services as a community, but recognizing with that mind set, but recognizing there's a value to that work as well.

AUDIENCE MEMBER: I had Fred, one of my older clients who passed away.

But he had a hip issue, we're in the hospital for a couple hours and right away he should go to a nursing home.

I had to fight for seven and a half hours, saying no.

It is called intermittent support for Fred.

I have five staff who will see Fred over the next several days.

Oh, but they are not trained, yes, they are, it's only a hip issue, he fell, he is fine, he is not crippled.

Seven hours fighting doctors, nurses and social workers about where Fred should go for the next two to three weeks, long-term care?

Why?

He has staff.

I had to call my director to come with me and fight them at the hospital.

BRUCE DARLING: They want to empty that bed and turn it over.

Okay.

AUDIENCE MEMBER: Hi, Bruce, I had a question, just something that came to mind.

We've gotten a couple calls about people that are in the hospital and they can't come home because they say they are going to die.

They need to go on hospice.

The person says, yeah, I realize I'm terminal.

I don't want to die here.

I don't want to die in a facility.

I want to go home.

Help me go home and get the care that I need for my final days.

Sometimes doctors are totally wrong.

Could be months later and they are still hanging on.

Other times they could be days, it could be days and they can pass away.

Wouldn't that be considered a transition if they're going home?

BRUCE DARLING: The tracking of it I'm probably agnostic on.

We're still trying to sort out how we would in our own center track that.

I think luckily, since we're in Rochester, we can talk through some of the specifics of that.

I think, the idea, unless the facility has a guardianship on the individual, you know, which we've run into, so where an individual said, no, I am not leaving to go to that nursing facility.

That is a power you have.

You don't have to sign the discharge.

You can just stay.

Now, it pisses off the hospital beyond belief.

Particularly if you've occupied a hospital bed for more than a week and they want you out.

But that's a technique we've used.

The flip side is you don't have to keep me here.

And you can set up those services and supports.

The issue is whether the hospital is going to get in the way of those Medicaid services.

AUDIENCE MEMBER: You are right, we could talk about specifics, but it's been, I could see it becoming a problem where people want to go home to spend their final days and not in a facility, and they have a right to do that, I feel.

BRUCE DARLING: Obviously I think that's a valuable outcome out of that.

With that, I think we've used up our time, Tim, One more question?

PAULA McELWEE: In most places, there is in home hospice, hospice doesn't mean you have to go to another institution.

You can push for that as an advocate with that person, and you can often get that result.

BRUCE DARLING: I think that's pretty straight forward.