(COMMUNICATIONS ACCESS REALTIME TRANSLATION (CART) IS PROVIDED IN ORDER TO FACILITATE COMMUNICATION ACCESSIBILITY AND MAY NOT BE A TOTALLY VERBATIM RECORD OF THE PROCEEDINGS.)

>> TIM FUCHS: Good afternoon. I'm Tim Fuchs with the National Council for Independent Living. I want to welcome you all back to part two, implementing outreach programs, interest in the outreach to underserved. This is presented by the IL‑Net for CILs and SILCs. It's operated among ILRU, NCIL and APRIL with support from RSA with the US Department of Education. We are recording today's call so we can archive it on ILRU's website.

That archive will be up and available by Monday for you and any of your colleagues that want to listen and that includes the live PowerPoint, the captioning, and the audio of the presentation.

For those of you that are on the webinar today, you will see that we have a chat box in the bottom right‑hand corner of the screen. Whether it's any time during the presentation, you can type your questions there, and we'll take them during the Q&A break. For those of you that are on the CART screen today, you can type your questions in that chat. I'm logged in there and I will voice those questions live on the call.

And then for those of you that are on the telephone today, you will be able to ask your questions live during our Q&A breaks. So he will take all questions in the order they are received, and we'll switch back and forth between audio and written questions so that everyone gets a chance.

Okay. So if you are not on the webinar, if you are just on the phone, you are going to want to make sure that you have the PowerPoint opened in front of you. For those of you on the webinar, it will display automatically. For those of you on the phone, if you don't have it, it was sent to you in PDF and plain text. If you don't have that handy for any reason, just email me, it's Tim@NCIL.org. That's Tim@NCIL.org.

And I will get that you to right away.

Okay. I also want to just point out that in that same confirmation email, we sent you a link to an evaluation form. And our evaluation process is really important to us. We really take seriously your thoughts on the presentations and we're always looking to improve them. So please do take a moment after today's call to fill that out, that we keep them very, very brief so that they are easy and they don't take a lot of your time, but it allows us to know whether this training worked for you or not.

If you are on the webinar, there's going to be a slide at the very, very end that you can just click on. If you are on the phone, you can find that in the confirmation email.

Before I introduce our presenters for today, I just want to give a quick overview of today's call. I know that virtually all of you signed up for this as a series, but a handful of you just joined for today's presentation. So I just want to talk a bit about what we are going to cover and what we covered last week ‑‑ or excuse me, last month.

Now, remember, if you didn't hear Brad's presentation on the 26th, but it interests you, you can always go back and listen to the archived copy. So regardless of how he registered, that's up online, on ILRU's website under their on demand training and you can go back and listen to that at any time.

So anyhow, today we are going to identify areas and individuals ‑‑ or excuse me, the series identifies areas and individuals that are not receiving IL services. That's a critical part of the SPIL process. So identifying service gaps, making plans for improvement and creating programs that fill those gaps is a complex process requiring careful planning and collaboration.

And last month, Brad Williams, New York SILC director, our presenter on the 26th, shared an example of New York SILC's New York statewide process, including developing the outreach committee, gathering, analyzing with the IL network and consumers and other stakeholders and informing the state plan for independent living process. That was a great plan for that state process.

Today will focus on effective methods for CIL for unserved and underserved groups and populations that includes reporting on activities, outcomes, and impact of outreach activities and best practices of targeted outreach programs shared by the SILC and CIL directors in the state of New York.

And with us today, I am very happy to have Bruce Darling. Bruce is cofounder and president and CEO of the center for Disability Rights in Rochester and CDR is a disability rights organization and Center for Independent Living.

Heather Francisco is here with us, from the Capital District center for independence in Albany. Heather coordinates the Healthy Living Program there.

Also here from Capital District center for independence is Laurel Kelley. Laurel began her career in independent living at the center back in 1997 and was promoted to executive director in October of 2001.

And finally we have Toni McEniry who will kick off the presentation. She has been with ARISE in Syracuse since 2000. She's been working with people with disabilities for 20 years and has had several roles at the center there and since 2006, she's been the manager of the outreach and support services.

And like with Brad last month, I want to thank all of our presenters for the hard work that they have put into developing this presentation for all of us and have really enjoyed working with them over the last few months to put it together. I will turn it over to Toni to get us started. Toni?

>> TONI McENIRY: Thank you, Tim. Hi, good afternoon, everybody. I will start with ARISE's operational plan. The objective, reducing barriers, increasing access to services, enhance systemwide capacity to deliver programs to veterans with disabilities.

Veterans note numerous barriers to VA services, leaving them falling through the cracks. Community groups must increase capacity to reach vets and streamline access to needed IL services.

The disability rate is 25.2% in New York state. Of veterans with a disability, 17.1% live in poverty, as compared with 5.8% of veterans without a disability. And that's a gap of 11.3%.

Next slide, please.

ARISE's operational plan continued. January 2011, Bureau of Labor Statistics show while the unemployment rate was 9% for the general population, the rate for the era that includes veteran of Operation Iraqi Freedom OIF and Operation Enduring Freedom, OEF increased to 15.2%, up from 11.7% in December 2010.

Next slide.

Primary needs and concerns of veterans. According to 2008 needs assessment, primary needs and concerns of veterans are: Signs of PTSD often do not show until weeks or months after the veteran returns from duty. Veterans run into trouble if the window for registering with the VA has closed. Substance abuse is prevalence due to self‑medicating to alleviate anxiety and depression.

Veterans feel alone in their adjustment, feeling it is difficult for other people to understand or relate to what they have gone through.

Performed by the center for public policy and social search at central Connecticut state university, and the Connecticut department of veteran affairs.

Next slide, please. Primary needs and concerns of veterans continued. Many veterans with mental health problems do not self‑identify. Making it harder to estimate the true extent of need and meet those needs.

Many veterans face financial issues. For example, accumulated debt when returning from active duty. Some have difficulty collecting unemployment because of delays in obtaining their DD‑214 discharge papers. Many veterans returning to school discover that their GI Bill tuition waiver does not cover college fees, which makes it financially difficult to return to school.

Next slide, please.

Goal: To hire a veteran with a disability, so we gave preference in hiring to veterans. It's a 25 hour per week position with full benefits, enhancing our ability to recruit a qualified individual.

ARISE recognizes and values people for their abilities and our culture embraces diversity. Besides using our standard recruitment process with this particular position, we included reaching out to local agencies that serve veterans, such as local VA offices.

Existing resources, independent living needs, veterans with disabilities have a variety of IL service needs, housing assistance, healthcare, mental health services, substance abuse counseling, education, job training, employment assistance, and the assistance for providing for various types of benefits.

Next slide, please.

Outreach plan/project timeline. Each aspect of the plan addresses existing barriers and involves veterans, consumers and local service providers in outreach and education activities.

Number one, developing the project materials. For specific cultural, ethnic and linguistic groups, translation language services, TTY and other assistive devices, print materials in easy‑to‑read and alternate formats, approaches for sharing information with individuals with cognitive disabilities.

Number two, outreach strategies. Outreach through partners/collaborators, education, material dissemination, word of mouth.

Number three, project timeline, detailed three‑year pilot plan.

Number four, project evaluation, data collection and reporting, consumer service records, CSR, consumer satisfaction and feedback, quality assurance department.

Next slide, please, Tim.

Funding plan/project sustainability. ARISE has a 32‑year history of successfully securing funding to support our work. Grant applications, local higher education institutions, local groups, in‑kind donations, training revenue, fee‑for‑service reinvestment. This particular program is funded by the New York state education department, ACCESS‑VR.

Next slide, please.

Partnership agreements. ARISE elected to partner with agencies that, while currently providing some services to veterans do not outreach to veterans.

Next slide, please.

Experience and qualifications. ARISE currently has over 500 staff members who deliver more than 50 different programs to over 4,000 people with disabilities, their families, and the community each year. Objective. Providing comprehensive services for individuals with disabilities. Profile and needs of veterans with disabilities.

There are over 35,000 veterans living in Onondaga County. Veterans most in need of support are the least likely to seek it. This reflects either distrust of the VA or concerns about being stigmatized or being viewed as week.

These veterans are at risk of slipping into a downward spiral of family problems, job problems, and substance abuse.

Next slide.

Partnering experience. ARISE is part of a strong network of dozens of local agencies with which we coordinate information and referrals. ARISE is also a formal partner with numerous organizations that enhance outreach and access to services for individuals with disabilities.

Next slide, please.

Experience securing funding. $2,251,000 from grants and another $202,000 through United Way and fee‑for‑service.

Next slide, please. Consumer involvement and letters of support. Establishing a focus group comprised of veterans who not only provide input on our project, but reach out to veterans to increase awareness of available services.

ARISE uses a variety of strategies to reach veterans with disabilities. Each aspect of the plan addresses existing barriers and involves veterans, consumers, and local service providers in outreach and education activities.

ARISE has formed a foundation which includes an Air Force Lieutenant Colonel. This foundation significantly enhances our ability to secure more donors and raise unrestricted donations.

One of the main purposes of the foundation is to create an endowment that allows ARISE to sustain programs beyond initial funding periods and to supplement fundings.

Next slide, please.

Questions and answers.

>> TIM FUCHS: Okay. Thanks so much, Toni.

>> TONI McENIRY: You're welcome, Tim.

>> TIM FUCHS: So we will stop and do our first Q&A break now. So for those of you that are on the phone, you can press star pound to indicate you have a question, and we'll take them in the order that they are received. But I'm going to start on the web, since we have at least one pending question.

So Toni, I'm going to go back to slide 12 here. And on slide 12, you talk about your partnership agreements. Pam Taylor is wondering which agencies or what kind of agencies ARISE chose to partner with.

>> TONI McENIRY: Well, ARISE chose to partner with several agencies. We just did a partnership with the Independent Living Center in Cayuga County. The name of it escapes me right at the moment, but we want to bring our services into that county.

We partner with the Spanish Action League and we do translation services ‑‑ they do translation services for us so that we can service veterans who are of Spanish descent.

We partner with N‑ABLE. We collaborated with them for many years and we also have connections in the VA Hospital. In fact, one of our previous board members now works there in the rehabilitation department.

And I can think of some more, but I would have to email you the rest.

>> TIM FUCHS: That's good. That's a really good snapshot.

>> TONI McENIRY: Thank you.

>> TIM FUCHS: The next question on the web comes from Maria and Toni, Maria is wondering about how ARISE was able to get the endowment.

>> TONI McENIRY: Well, that would be ‑‑ oh, gee. I can't answer that question. I think ‑‑ I don't know if that was ‑‑ is a question that maybe should have been in part one or not for me. I don't know.

I have to research that and let you know how we got the endowment.

>> TIM FUCHS: Well, it just so happens that we have asked Brad to be on the line today. Brad, was that something ‑‑ was that endowment something that came out of the SPIL? I know there were funds tied to that.

>> BRAD WILLIAMS: Yes, I think the endowment was probably something that, yeah, ARISE must have leveraged themselves. It sounds like something ‑‑ you know, because actually, the very unique thing about these particular projects, and I was actually enjoying listening to, was they have a self‑sustainability aspect to them. And it sounds like ARISE, and I'm sure each one will say, how they are taking them and looking to move them forward. So it sounds like they have, in a very creative way found a way to connect with this particular community and create an endowment.

So I think they themselves have connected it, and developed it themselves, and looked to build upon it for the future. That would be ‑‑ that would be my take. So it's not connected to the state plan in any way.

>> TIM FUCHS: Okay. Thanks for clarifying.

>> TONI McENIRY: May I say something too?

>> TIM FUCHS: Of course.

>> TONI McENIRY: After this three‑year pilot is over, we are in the first quarter of the final year, we are thinking about maybe picking it up ourselves, if possible. If we ‑‑ you know, if we are successful at the end of the fourth quarter.

>> TIM FUCHS: Great. Okay. Let me remind everybody that's on the phone today that you can press star pound if you have a question. And I will give folks just a few moments to make sure before we move on.

And it looks like we have a question on the phone. We will unmute your line and then you can go ahead.

It looks like they were disconnected. Sorry about that.

>> TONI McENIRY: Oh, okay.

>> TIM FUCHS: Let me let everyone know that we have several more Q&A breaks. If you think of a question in a few moments, just enter it in the chat or hold it for the next Q&A break on the phone and we will get to it then.

So at this point, we are going to hear from the folks at Capital District. I will go ahead to slide 18. And we have Heather and Laurel with us today. And let's see, I will go lead to slide 19 and turn it over to you all. Ready when you are.

>> LAUREL KELLEY: Thanks. This is Laurel Kelley. I'm the executive director here at CDCI. I wanted to give a little bit of background before we went into our slides. Excuse me.

CDCI identified the need for healthy living about five years ago. We ‑‑ a local coalition received a grant targeted towards a specific location within Albany, which is comprised of low‑income minority families.

Their grant was to increase the help of the residents for just screening, nutrition information. There was no thought about our population. We asked to join this coalition to bring the disabled's perspective to their table. We were allowed to join with a little friction. The coalition sponsored what they called the biggest winner healthy incentive program.

They were rewarded for their healthy decisions, buying healthy food, getting screenings and such. People who met the requirements living in the neighborhood ‑‑ my phone is ‑‑ okay. And below the poverty level, who self‑identified as having a disability participated at a greater rate than nondisabled peers. This gave us a lot of clout in the coalition. We went on to work closely with this coalition and we received two small grants from them to promote healthy living within the disability community.

So our lesson learned from that, was that we needed to join coalitions, that addressed issues that have mattered to people with disabilities and not just focus on ‑‑ on things that were just related to disabilities. So not just the coalition or our friends in the disability community, but to kind of think outside the box.

Due to their disability, many of our consumers have secondary conditions, such as anxiety, depression, weight gain. When a person is having anxiety or depression, exercise seems like the last thing that they want to do.

CDCI identified through consumer input that consumers sought social contact when engaging in fitness programs, and having healthy living activities. The social contact assisted in being a motivator and it also provided a buddy or a peer to work towards goals.

Once motivated, exercise can make a positive impact in people's lives. Engaging in physical activity can ease the symptoms of anxiety and depression, as well as help individuals lose weight, and become more physically and emotionally fit. In addition, exercise and attention to nutrition and diet helps prevent or improve a number of other health problems, including high blood pressure, diabetes, and arthritis.

So the lesson learned from this is that we surveyed our consumers. We held focus groups for people. We tried to talk to everyone to get feedback on what they wanted so we could develop their program ‑‑ our program to fit their needs. So what people wanted is they wanted to have fun.

They didn't want someone to preach at them, but they wanted to have opportunities to socialize and become healthier in a nonjudgment zone.

We knew from consumer feedback and national state studies that persons with disability need access to healthy living options. And that's why we applied for the capacity building grant through our SPIL to expand the program that we started with those few small grants.

Our program is designed as an outreach model. We wanted to reach more people than our typical consumer base. We wanted to outreach to populations that we may be underserving or that are underserved generally in the state.

And in an effort to do that, we created a variety of programs which Heather who is our current healthy living coordinator is going to talk to you about in a minute.

But the objective of our outreach program was to reduce barriers and increase the inclusion and the access to health and wellness services. So to break down physical barriers, to break down attitudinal barriers and to provide our own programs as well.

Individuals with disabilities communicated that they were having barriers and that they didn't want to go ‑‑ or they couldn't use local fitness facilities. They didn't know or couldn't access education, health and wellness education programs.

So we really just wanted to outreach to people and broaden our scope.

Next slide.

The Capital District Center developed our Healthy Living Program, again, as an outreach to the greater capital region, and we really wanted to meet people where they were at, and have a lot of different programs, so we could not just be focusing in on one population.

So one of our main intentions is to make sure that things are cross disability, differences in ages, accepting and outreaching into different cultures, religion, gender and socioeconomic status.

Our programs include seminars, workshops, and they serve all populations, and Heather is going to tell about you some specific programs.

Heather, I will turn the phone over to you.

>> HEATHER FRANCISCO: Thank you. Good afternoon.

We will start with slide 21, program models and components. CDCI's Healthy Living Program increases the delivery of wellness programming for people living with disables, as well as their care takers, peer supports and service providers in the capital area.

The program model addresses nutrition, accessible exercise, system as advocacy, education, peer support and combatting different diseases. The first is an accessible and inclusive exercise center which is offered at no cost to consumers. It's available during business hours.

Once the individuals have completed intake, they are given the option to use the CDCI's exercise center independently or with friends, family, peer advocates or with the Healthy Living Program coordinator who offers peer support as requested.

The second program component consists of monthly health and wellness seminars and interactive workshops that cover a variety of independent living skills related to health promotion. Seminars feature professional and experienced peers who introduce health promotion resources and skills to support individuals with their goals.

Third program component is evidence‑based programming. The Healthy Living Program offers Stanford University's chronic disease self‑management program and diabetes management program. Programs focused on self‑management of chronic conditions, both programs run six weeks and are run at our exercise center, as well as at offsite locations across the capital area.

The fourth component of the Healthy Living Program is CDCI's aggressive outreach model which aims to serve underserved and unserved locations through healthy lifestyle models.

When we talk about aggressive outreach to underserved populations, we are in the practice of identifying underserved population through recognition of consumers served versus others and the SPIL to identify statewide underserved populations, national data and consumer membership and focus groups and when we're talking about underserved populations, being identified, what happens is the staff will collaborate to create a plan of action.

Patients that enter the capital area residents, at corporate and locally owned businesses, disability service providers, and more are designated for outreach. A minimum of one monthly outreach is conducted in both Albany and Schenectady counties. If you refer to bullet four, we speak about systemic advocacy. In order for our outreach offers to remain relevant, the Healthy Living Program remains up to date with issues facing the disability community such as changes in healthcare, benefits and entitlements, transportation and housing.

>> TIM FUCHS: Hey, Heather?

>> HEATHER FRANCISCO: Yes.

>> TIM FUCHS: This is Tim. I'm very sorry to interrupt. Your line is quiet and we are getting some static. I'm wondering if there's any way that you can possibly get closer to the phone or turn your microphone up.

>> HEATHER FRANCISCO: Sure. Let me try that. Is that any better?

>> TIM FUCHS: Oh, that's better. Thank you very much.

>> HEATHER FRANCISCO: Okay. Great. Thank you very much. So some of the resources that we used to identify relevant outreach locations, some of the places we go to are community events, developing coalitions, advocacy groups, event calendars, social media, and Facebook, of course. Our staff is active in multiple community efforts that draw new consumers to our program. Program coordinators, peer advocates and directors strategically position themselves as coalition members and on community boards to advocate for positive outcomes such as increased accessible services and inclusion of unserved and underserved groups.

On slide 21. All staff are encouraged to take part in community initiatives. Many staff are involved in multiple community projects where we are able to address local disability issues, identified by our consumers.

We take these opportunities to incorporate the independent living philosophy and universal design into our communities' project planning efforts. Our commitment to stay active in the capital region positions us to expand future outreach efforts.

And we are going to slide 22 outreach.

Healthy Living Program outreach is modeled in part after the trans‑theoretical model of behavior modification, TTM which calls for the unique service delivery system that meets people where they are at. This attracts underserved population by creating relevant programs of common interest and ensuring outreach addresses inclusion, as all community members receive outreach.

All activities are planned to incorporate usable information for individuals acting in various roles throughout the community.

Outreach includes targeting underserved consumers by meeting people where they are at, and continually expanding our program's reach into the community. We ensure that typical disability service providers rep only a portion of the outreach targets.

We value our ability to incorporate unique approaches while individuals recognize taking part in our Healthy Living Program will result in positive health outcomes in any readiness for healthy living.

It is a priority that the capital area as a whole can recognize the issues that the disability community faces when it comes to engaging in health and wellness promotion activities. Outreach to individuals is guided by independent living philosophy and the TTM this method promotes the program's commitment to individual consumers being supported through their own path towards wellness at any stage or ability level they decide they are at.

Outreach to individuals is based on interest, individual goals, personal strengths and abilities. The ideas incorporating the TTM into programming incorporates a non‑ intimidating program that is self‑directed. The ability to choose and own your efforts regardless of how small they are, leads to improved outcomes ‑‑ (Static) ‑‑ or their current ability level.

The components address inclusion, nutrition, exercise and tools to compat disease in prevalent secondary disabilities. Our program focuses on 12 services. Information and referral, accessible exercise and education center, peer supported healthy living goal planning. Monthly wellness seminars, technical assistance to the community, evidence‑based programming, interactive cooking and food growing classes, inclusive healthy hike/nature walk, transitioning youth workshop on nutrition and efficacy, inclusive and accessible fitness classes, incentive‑based programs and accessible organic community garden plots.

Slide 24.

Promotion and outreach. We have seminars based on consumer input. Outreach for seminar attendance is geared towards service providers and community stakeholders through email blasts, traditional mailings, Facebook, kickoff events, sponsorship opportunities offered to businesses and collaborative community events.

Our evidence‑based program component refers to a program that both directors and staff from each CDCI office are trained to facilitate. Stanford's chronic disease self‑management program and Stanford's diabetes management program.

Staff are trained as peer leaders through the collaboration with Sunni Albany center for excellence in aging. We have joint promotions and recruitment with excellence in aging.

Slide 25. Interactive cooking classes. A workshop component of the Healthy Living Program is the interactive cooking classes which feature whole nutrition and easy replicable meals for singles or families. This is developed with diversity as a central element. Outreach include cross‑cultural and regional specialties in the list of demonstrations. All are varied to attract a wide range of people. Examples include Cornell Cooperative Extension, Capital District community gardens and local supermarkets are some of our sponsors.

CDCI partners with the New York State Department of environmental conservation and New York state parks and recreation among others to introduce individuals in varying roles to develop a plan of action which with people and provider agencies interested in accessing outdoor recreation.

The event informed our community of the many options for free and low cost accessible inclusive outdoor recreation.

This is an example of outreach modeled after the TTM. This event solicited attendance of current consumer, potential consumer, recreational therapists, social workers, program managers, personal care aides and director staff.

For this kickoff outreach event we scheduled demonstrations by relevant businesses, agencies, State Department, staff and individual providers. Targeted outreach to recreational therapists accessibility clubs, human service clubs, disability advocacy groups and CDCI consumers.

In order to attract large numbers of people to take part, six demonstrations were scheduled for the event. Each promoting the center and their part in the kickoff to their circle. As we mentioned the New York State Department of environmental conservation universal access coordinator who presented an interactive photo information center on accessible recreational activities throughout the Adirondack park and locally. And another example is the accessible Adirondack location. He disabled and exhibit at the Adirondack camping and hiking destinations. Volunteers from New York state office of parks and recreation were included. They are on hand to distribute access pass applications for individuals in need of motorized access and no cost park entrance.

Disability resource organizations our ability founder John Robinson, a quad amputee, invited individuals with assistive cycling information to the event. They demonstrated healthy, ample trail food recipes.

This outreach was a large success with well over 120 people in our office. Slide 27, nutrition workshop for youth in transition. Youth in transition programs is an adaptable wellness workshop series composed the six 90‑minute sessions including independent living skills, nutrition education, physical fitness activities and independent living philosophy and empowerment.

It's designed for youth residing in residential treatment facilities to introduce ILC and self‑efficacy, prior to age out status. This is an ongoing effort for the population near age out.

This program was put together at the request of a residential treatment facility certified recreational therapist after she attended a CDCI lunch and learn event about our services and what we have to offer.

After the request was made, the Healthy Living Program coordinator collaborated with the residential program staff and assessed the specific needs of young adults participants residing in long‑term OMH treatment.

Residents ‑‑ the residents and young adults advocated to receive independent and healthy living information and our program coordinator gathered search by taking the above mentioned factors into account.

Major areas of study focused on deficits of healthy living knowledge, children raised in New York State Department of social service systems, child protective service and long‑term care psychiatric placement.

Healthy living transition programming was designed to provide access to nutrition information, exercise and fitness.

It also examined the prevalence of secondary conditions such as obesity related to the use of psychotropic medication and other education management plans and the prevalence of diagnosed eating disorders in the group.

Peer advocates were invited to include adult housing options, employment benefits management, and vested services.

This was in addition to weekly nutrition, and physical fitness classes, along with self‑efficacy and independent living skills development. This outreach effort has resulted in fruitful collaborations with this and other residential treatment facilities.

Attendance completion of the pilot program was excellent. 100% of the young adults completed this voluntary workshop series and reported they felt more confident in of upcoming transition and in living independently.

The facility has since requested ongoing workshops and new populations of pre‑adults and young adults enter residential placement and current populations age out. Additional groups have been requested and planned for the future.

Slide 28.

ADA accessible community gardens. This outreach effort was the result of technical assistance offered to Capital District community gardens. This technical assistance was a strategic move to promote independent living philosophy. A memo of understanding is now being signed and community gardens have donated a multi‑quad area that CDCI is in the process of making fully accessible thanks to the private donations sought for this inclusive community garden. This will be used as a working model of accessibility and organic gardening.

Specific outreach was made through this technical assistance to a non‑disability service organization on universal design procedures. We are looking forward to spring 2014 for a grand opening event, at which public officials will be invited to speak on the independent living philosophy.

>> LAUREL KELLEY: Again, this is Laurel. I'm noting that there are some questions regarding our reporting requirements. So I'm going to talk a little bit about our tracking and some successes and how we report.

So we have our staff conduct monthly reports and the Healthy Living Program actually do a quarterly report as well. And in these reports, we have staff tell us about the activities and the programs that they led for the time period, either the month or the quarter and any of the future scheduled events. And we talked, as they write in their reports, the outreach techniques used. So whether it was a face‑to‑face, an email, a combination of those things, one‑on‑one connections, something that they learned from the community or from their involvement in the coalition. Where are we getting people from it is tracked.

And then we track the CSRs with the healthy living goals and what services were provided for those consumers and we are tracking that to see how many goals are followed through. We're tracking to see what kind of goals people are wanting to do, what kind of things aren't being done. So we can adapt our services to meet those needs.

We also track the number of INRs that come in specifically for healthy living. And that's one of components that Heather didn't mention is our INR, which is a service where we try to be a clearinghouse for people who have health‑related questions, whether it be a benefit related or where is a place that they can exercise if they have mobility limitation or is ‑‑ you know, is this place successful? Is this good? Is there any way that I can afford this? Do they have a sliding scale? That kind of thing.

We also track the businesses and the agencies that are involved with us, both through their involvement at our events and also their sponsorships. So what we do is outreach to area businesses, agencies, other stakeholders and traditionally, they are either disability related or just private sector for‑profit businesses and we seek their ‑‑ either donations for our events or sponsorships for some of our lunch and learns.

And then we also track consumer feedback. We also do quality assurances quarterly, where supervisors actually call people who have used our services, either through CSRs, INRs, or have come to one of our events.

We talk to them. We call them and we talk to them and we see what they liked, what they didn't like. And how we can get them to use more of our services, wore what kind of services they would like.

We also do that with some agencies and our sponsorship, just to make sure that we are meeting their needs and so that's how we track it.

We have successes for ‑‑ so far ‑‑ the contract year, we had an increase of 113 people using the Healthy Living Program, and we had five new community programs developed, targeting underserved populations through the collaboration with our community stakeholders.

And we are on 30. Any questions?

>> TIM FUCHS: Okay. So if you have any questions, you can press star pound if you are on the phone. And thanks for the additional information on reporting Laurel.

And I think Heather, that you covered the kickoff event a little bit later on slide 26. So I'm going to see if we have any additional questions, if we need to revisit that, we will be happy to.

Okay. Laurel, Maria is asking a little bit about your staff. How many staff members do you have and what is the background of your staff?

>> LAUREL KELLEY: Well, the healthy living positions that we created through the capacity building grant is just one person, and all of our staff currently have disabilities, if that's what they are asking.

We have about 16 full and part time.

>> TIM FUCHS: Okay. Thanks. Okay. No questions on the phone. We have a few people typing. Let's see if any questions come through here before we go back.

Maria is wondering if you have any adaptive exercise equipment.

>> LAUREL KELLEY: We don't have the adaptive machines. We do have a listing of area things. We do have adaptive equipment, so we have bands and adaptive weights and things like that. And our classes are also adaptive. So they meet people where they are at and they can modify any of the classes to fit anyone's needs.

>> TIM FUCHS: Great. Thanks.

So, again, it's star pound if you are on the phone to ask a question or you can type it in the chat.

So I will give just a few more moments to make sure we answer all the questions before we go back.

It looks like we have a question on the phone. Okay, caller, we will unmute your line and then you can go ahead.

Caller, your line is open.

>> PARTICIPANT: Can you hear me now?

>> TIM FUCHS: Yep, sure can. Go ahead with your question.

>> PARTICIPANT: Actually, I have a question for the first speaker, about the veterans thing.

>> TIM FUCHS: Oh, sure. Go ahead.

>> PARTICIPANT: So my question is: How would ‑‑ how would a Center for Independent Living reach out to the ‑‑ make the first initial contact. Who would be the best person to contact to try to serve veterans? Like, for example, as the SILC, we want to do ‑‑ we want to do an exhibit at our disability of American veterans ‑‑ disabled American veterans conference but how would a CIL reach out to try to serve their local veterans? What would be the initial step to take?

>> TIM FUCHS: Okay. Good question. Toni, do you have any tips? Toni, make sure your line is unmuted. I know you muted it a few minutes ago.

>> TONI McENIRY: Okay. Can you hear me now okay?

>> TIM FUCHS: Yeah, sure can.

>> TONI McENIRY: Okay. Good. What ‑‑ in hiring a veteran, they have many contacts. That's number one. So a lot of the tips we got from the coordinator that we hired herself. We had two, as a matter of fact, so far.

And also we have ‑‑ there is a group that meets at a place called Clear Path for veterans and they have summit meetings. It's in Chittenango over here. We put up our flyers and what we do and our contact information and when we get calls, we try to invite them to our focus groups and right from there, that's how we would increase the numbers of the veterans, you know to come to ‑‑ well, we didn't have a conference, but that's one tip I could give you of how and also all the VFWs and places like that where you can go and communicate with them. Does that help you at all?

>> PARTICIPANT: Possibly. It just seems like, you know, veterans, they are sort of you know, an ancillary group. They have a lot of services to serve their own. And it seems like we don't see them a lot at the centers. So anyway, okay.

>> TONI McENIRY: You don't see them where?

>> PARTICIPANT: We don't see them coming a lot to the Centers for Independent Living because they look to the VA to get their services.

>> TONI McENIRY: That's right. You are absolutely right.

There are some, though, like I mentioned before, that will not go from ‑‑ some disabled veterans will not go to the VA because they feel that they are going to be looked upon as weak or they are not a soldier, you know, because they have PTSD and things of that nature.

And fortunately for us, we do have a veteran that had served on the board that does work at the VA who, you know, who would communicate with us and send them to us.

Now, I'm very, very happy that you brought up this question. Because I do have to say to you also that the veteran coordinators that we have had here do not really understand what outreach is. Okay?

They started to do the case management and when they were going out to the communities to the summit meetings and that place I told you about Clear Path, they misconstrued what we were trying to do because what we do is if we don't have the service here, we ‑‑ we go to an agency who does and send them there.

They didn't like that. So these ‑‑ these coordinators I'm talking about. So now I'm running the program myself and I'm not a veteran. And I should have mentioned that when I was doing the slides but I didn't know how much time we had. And so I'm doing it now and I'm finding that not only are they open and comfortable with me. You know, that ‑‑ that ‑‑ I'm able to ‑‑ because I have been working in Independent Living Center for so long, I'm able to know where to navigate them to. You see?

So to be honest with, you right now, since I took it over and we are in the first quarter of the last year, it's starting to pick up a little bit.

>> PARTICIPANT: Okay. Thank you.

>> TONI McENIRY: Oh, you are very welcome. Just call me or email me and we can talk some more if you want.

>> PARTICIPANT: Thank you very much.

>> TONI McENIRY: You're welcome.

>> TIM FUCHS: Thank you very much. I know we have another question on the phone. I have this question on the web. Heather, I will turn it over to you. Maria is wondering more about making exercise adaptive without equipment. Can you talk about where you found the expertise about finding exercises that work for people and how you adapt it to their abilities.

>> HEATHER FRANCISCO: Hi, this is Heather. It's from a peer standpoint, but what I do is when I ask people to hold classes in our exercise center, I make it very clear that the classes will be inclusive and I make sure that I'm working with people that do have the time to spend with people one‑on‑one before or after class. Another step we take is in advertisement and in email blasts and flyers. We make sure that we ask people that we are taking care of things that they feel they personally need.

>> TIM FUCHS: Okay. We have one more question waiting on the phone. So caller, let's unmute your line and you can go ahead.

>> PARTICIPANT: Hello?

>> TIM FUCHS: Yep, we can hear you.

>> PARTICIPANT: My name is Chris young and I live in a very rural area and so a lot of our veterans do not get the service they need and then when I refer them to a VA down here, they go and the paperwork is so overwhelming that they won't go back.

And also I found out just recently that the laws had changed for veterans, and that now they have to pay a fee, you know, unless they are grandfathered under a clause.

And that has caused a lot of problems in our rural area. Do you have any suggestions?

>> TONI McENIRY: You know, we have the same problem over here. I went to ‑‑ the application ‑‑ are you talking, about first of all, the application for benefits when they come home?

>> PARTICIPANT: Yes, ma'am, if they need a hearing aid, the application is ridiculous!

>> TONI McENIRY: It is.

>> PARTICIPANT: And so many of the consumers are elderly and they won't go through that process. So I have been able to find funding in other places, but it's sad that our veterans have served this country and they are not getting the services they need.

>> TONI McENIRY: That's correct. I'm finding the same thing here. I did go this morning to a senior health fair in Oneida and I had met a woman ‑‑ I don't have her card here with me. It's in my car, actually, and she told me that she does these applications.

>> PARTICIPANT: Okay.

>> TONI McENIRY: And so I said, that's great. Let me have your business card, you know? And I'm going to be calling her and see what we could do here and in Onondaga County, you know to figure out a way that we can do them, because those applications are very thick. You need to take a class to even learn how to fill them out for the vet.

>> PARTICIPANT: Yes, ma'am!

>> TONI McENIRY: The veteran too.

>> PARTICIPANT: You are right about that.

>> TONI McENIRY: Yes.

>> PARTICIPANT: Well, thank you.

>> TONI McENIRY: You're very welcome.

>> TIM FUCHS: Thank you, Toni.

>> TONI McENIRY: You're welcome.

>> TIM FUCHS: I want to make sure that we leave enough time for Bruce's presentation. If you have a question, and we didn't get to it, please go ahead and save it for the final Q&A break that we'll have after Bruce's session. Now I will turn it to Bruce.

>> BRUCE DARLING: This is Bruce Darling. I'm with the Center for Disability Rights in Rochester, New York, and I will talk a bit about our model services for people who are deaf/blind.

So Rochester has some background. Rochester has one of the largest per capita populations of deaf people in the country, and a vibrant deaf community. Years ago, it was actually described as a deaf Mecca, and in a way, it was comparable ‑‑ I think it is comparable to San Francisco for the LGBT community. We have a number of educational institutions here, school for the deaf, and NTID, and a lot of students come here, and because of the concentration of folks there's a lot of access and so people stay.

Because we have such a large deaf community, our center had established strong connections with them. So we have the deaf community is well represented on our boards and committees. We have staff providing ‑‑ deaf staff providing IL services directly to the deaf community. And, in fact, we are actually the largest noneducational employer of deaf individuals in the area. So we are very proud of the fact that we have a significant number of deaf staff and one of the things I think that has set us apart is we have deaf individuals working in jobs that are not strictly for deaf individuals. So we have people doing things like get out the vote campaign. The woman who runs that for us is deaf. Her deafness is incidental to ‑‑ she has a person with a disability who is deeply interested in getting people out to vote. We hired her because she's skilled but that sends a message through the deaf community that we are willing to provide the accommodations and we are a partner.

We also have identified and staffed a full‑time systems advocate who is devoted to deaf issues. So this individual has worked on improving local access, but also established a statewide commission on deaf, deaf/blind, hard‑of‑hearing individuals and does some national work, including giving individuals who are deaf access to become truckers, over‑the‑road truckers. So access to jobs.

Moving on to slide 32. The ‑‑ basically what happened is members of the deaf community identified that deaf/blind individuals needed services and supports. So following Columbus Day, the Columbus Day holiday, I wanted to be clear, we did not discover this issue. There were a lot of people who identified that deaf‑blind people needed services.

Basically, there were no services and supports to assist these individuals locally and we actually had individuals who were deaf and losing their vision or people who were deaf‑blind who were actually being forced to move across the country to Seattle in order to get services and supports they needed.

This issue was raised at multiple levels within our organization. It actually came up in board conversations, committee meetings, our staff were aware of it ‑‑ or became aware of it and brought it up and it also was brought up at membership meetings or our annual meeting as folks were talking about what are the needs that we need to address in our community.

So moving on to slide 33. The impact of not having these services for folks who are deaf‑blind is huge. Basically what happens is folks need to rely on family and friends to provide the support and rarely do they have formal training and the volunteer support is not necessarily consistent or reliable. Now, I want to make sure that we are clear. We are not being critical of family and friends who are providing support. It's a much needed piece of support that people have, but because it is just sort of ad hoc, something that people are volunteering to do and it is when you are available ‑‑ they are not paid to do this. They may or may not be available when the individual needs it.

The individuals also who are receiving that support from family and friends often are concerned about infringing on the time that these people are basically giving to them, and it can force them or promote them in not going out into the community, leading to isolation, depression, low self‑esteem and frustration.

So it's really ‑‑ this is ‑‑ for this group of folks, an incredibly significant issue in terms of the lack of access, and the impact that it has on their lives.

So moving on to the next slide, 34. So our center determined that developing deaf‑blind services was a priority for us. There was no funding ‑‑ you know, as we researched this, there was no funding stream available to provide these much‑needed services and supports. Actually nothing, although folks talked about there were some services around vocational rehabilitation here in New York. If you needed anything in terms of long‑term service and support, there was nothing there.

There was a general lack of awareness of the problem beyond the affected individuals. So when we started talking about it, people basically responded well, didn't Helen Keller have Ann Sullivan. Don't they have someone who just does that for them.

It was a lot of education around to explain to folks, no, people have to be paid. They have to eat. You can't just have volunteers ‑‑ these volunteers don't just pop up out of the nowhere. There was no organization championing this issue. It says locally and I mean from a policy perspective. There was a lot of interest and focus within the deaf community working on this issue but one of the things that they are ‑‑ anyone working on a policy issue, trying to change the state policies, that allowed people to get these services and supports.

And this turned ‑‑ as we looked at it, it was very consistent, part of the reason it became a priority for us it became consistent with our long‑term advocacy goal of ensuring that people had the long‑term services and supports that they need to live independent and integrated lives. So it fit in with our historical connection to the deaf community and the right of having access and this other focus on long‑term services and supports.

And the dynamics were similar.

If people don't have the access, it created dependency and isolation. The lack of access was actually preventing folks from being able to really organize and raise these issues themselves. So we really wanted to provide some support to the community to raise these issues and get their needs met.

So moving on to the next slide, 35, just a little bit of basics about support service providers.

So a service ‑‑ a support service provider or SSP can be any person, volunteer or professional trained to act as a link between the persons who are deaf‑blind and their environment. They typically work with a single individual and work as a guide and communication facilitator. They serve as the eyes and ears of the person who is deaf‑blind. They provide access to the community through assistance with travel and mobility. And then they provide visual and environmental information that may not be heard or seen by the individual who is deaf‑blind in the preferred communication style and language of the individual that they are working with.

Now, I provided a link to the American association of deaf blind who have a white paper on SSP. So for folks who are interested in getting more details on what SSPs do and how this works, there's a link there on slide 35.

So moving to slide 36, our center piloted a small‑scale program. And I mean very small scale. So we worked in partnership with deaf‑blind individuals and established a training and the ‑‑ the training and the program policies for the SSPs, the individual support service providers.

We were able to do this in part because we were building on some existing infrastructure. We had already been doing consumer‑directed attendance services. So we were very familiar with how that model worked in terms of providing supports in people's homes. We were also providing ‑‑ and in the community, we were also providing specialized supports to deaf individuals with developmental disabilities. So we had an infrastructure in place that provided the administrative end of this, what we lacked was basically dollars for SSPs to go out and do the work.

So we provided that program development and coordination as an in‑kind to the program model.

Moving to slide 36. So as I said, the biggest barrier was really identifying the funds to pay for the SSPs themselves. And the deaf community actually was very strong in this, and organized a number of small but very successful fund‑raisers where they were developing the dollars basically to pay for SSPs. So we were able to work with the deaf community. They were bringing together dollars. We were using our center pitched in as well and they were able to take surplus from some of our other fee for service programs, money that would have been sort of end‑of‑year profit as it were and channel that back into this model of SSPs.

On slide 38, the funding was extraordinarily limited. So people were able to get very limited numbers of hours of service. We didn't actually determine how people should use those services. So the deaf‑blind individual themselves determined what was important to them. Basic independent living philosophy but sometimes people want to go to an area of ‑‑ well, medical appointments are more important than exercise or more important than reading your mail or you can get more support this way. We didn't want to get into the middle of any of that, because everyone's life is different and they have very different goals.

And what people needed with the very limited hours they had, people were able to identify the thing that would have the most important impact for them. Some people used the SSPs to assist with shopping, reading mail, running and exercise, there's a model for doing that with guide rope, and attending community events and getting out into the community.

So the next slide, 39.

So basically, we had developed this model, basically as a local thing that was going on in Rochester. We ran into some situations where with the general downturn in the economy, the dollars that we had to be able to sort of bolster this program, began to dry up and it was becoming more and more difficult to support that. And, in fact, we weren't actually making significant progress at the state level in changing policy. So we wanted to raise the profile of that and the state plan for independent living public independent living process was a place where we could start raising the needs of people who were deaf‑blind.

So when we ‑‑ when the SPIL process opened up, and New York has an extensive public participation process for developing its state plan for independent living, I had served for a number of years as the SPIL committee sub‑chair on the council and have always been awed from the beginning at how extensive the process was and how for a large diverse state, we really did try to work to find ways to bring people into the mix.

So our center actually provided recommendations to the state plans suggesting that the needs of deaf‑blind individuals in our area was something, and in the state that needed to be addressed.

We also mobilized folks from the local deaf and deaf‑blind community to respond and participate and provide feedback as well to the State Department living process.

And then ultimately, the SPIL funded this deaf‑blind service model as a capacity building project through the state plan and we are extraordinarily grateful for NYSIL for doing that.

And I will talk about implementation on slide 40.

As we developed the program, we pulled together a deaf‑blind advisory council. Now, we had already been working with leaders from the deaf‑blind community over the years who were engaged in helping us develop the process. We actually took the approach that they were, you know, from the beginning, since they were the experts, they were educating us on what we needed to do. We were just formalizing a lot of the process and taking the varied input from folks and putting it into a package basically.

But the deaf blind advisory council advises our center on the program. It provides an important feedback loop for us on implementation. So if there are issues around training of the SSPs, around usage, whether the ‑‑ whether the program is diverging from what people actually need, this group actually is able to provide us that important feedback.

The other thing that this group has done is they served as a community champions for the program. So ‑‑ and important liaison for us in the community. They are trying to identify funding to meet the needs of individuals and because they are directly affected, as deaf‑blind individuals, they are the best people to talk about what this program ‑‑ what this program does and how important it is.

So they have also assisted us in identifying opportunities to do outreach, to identify additional individuals who are deaf‑blind, although Rochester is a big community in some ways, we are a small community and we often know a lot of each other, but still we have done some outreach in terms of connecting with folks who may not be traditionally of deaf culture or engaged in the deaf community, but who are deaf‑blind as well. The deaf community has continued to ‑‑ and the deaf‑blind advisory council has helped also with fund‑raising and bringing dollars in.

Moving on to slide 41, in terms of direct services, this is probably not the most exciting in terms of numbers. We are serving 17 individuals in three counties. And people ‑‑ but people receive vital services and supports that make a huge difference in their lives. So they may receive up to 20 hours of services in a month. We are currently ‑‑ so that's a big deal. We used to actually have ‑‑ when this was self‑funded and we were just using fund‑raisers we had just a few ‑‑ it was just a few hours at a time that people could actually access these services. So there's been an increase thanks to the funding through the state plan.

We are working on outreach and marketing. In part that was driven by some of the state contracting process and in the way this was funded. But we are also formalizing our program materials for rep lay indication. We think this ‑‑ we see this was a group of people whose centers have particularly not addressed the needs, at least in New York. We think a lot of parts of the country people who are deaf‑blind don't have access to needed services and supports. We are trying to take our program model and make it available to folks so that they understand how they can help out and do this.

And then the other thing that's been exciting about this is it has expanded involvement of the deaf‑blind individuals in our center. So we have, over the years, done outreach into various communities and each group of folks who come in, brings something new and we have growing awareness of the needs of that individual.

So it's exciting to be in an organization where people actually talk about the nuances of culture between say deaf individuals and deaf‑blind individuals, the difference in how that's handled and what is competent for working around deaf‑blind individuals. It's an exciting piece for us there.

The other thing that we're doing is educating our community. Again, a lot of folks think, well, of course, those people have services. And that there must be someone to assist them. And we're educating folks that that's not necessarily the case, and that there are not formal services available.

We are also educating our network and the general ‑‑ the local folks within our center about these issues as well.

Moving on to slide 42. Sustainability is probably the biggest issue that we are struggling with. We ‑‑ we are continuing ‑‑ the deaf community is continuing the small‑scale fund‑raising and although it's small scale, it's extraordinarily important when you have very little funds. We are applying for and have been successful in pulling in additional grant and foundation funding. So because the need here is so significant and people understand it in a very concrete way, I think that that has allowed us to secure additional dollars to meet the needs of this community.

We are also advocating for inclusion of SSPs in the state's application for the community first choice option.

Now, one of those ‑‑ now, of course I would have to work this in there. One of the things that New York is doing is applying for the community first choice option and it needs to provide assistance with instrumental activities of daily living which include mobility and communication. So for folks at the institutional level, who are on Medicaid, we are working to get the state to address the SSP needs that they have by incorporating this into that option.

And then beyond that, you know, we don't think ‑‑ we think that there are people who may not be at the institutional level or may not be on Medicaid, who need access to these ‑‑ these services in order to be productive, live in independently in the community and have fully integrated lives so we are advocating for a designated funding ‑‑ a dedicated funding stream in our state to provide those services and supports.

We know that the economy is not necessarily in a position to support that type of activity right now, but we wanted to start the process and basically be in the queue, so when there is a financial upturn, people ‑‑ we are in the front of people's minds about this issue.

So the work we have done, actually, parallels a lot of the work our center has done around nursing center nutrition. We are doing the program modeling, like I'm talking about what these dollars with the state plan and then we are dove tailing that with the systems advocacy and the full‑time person that's working on the deaf systems advocacy issues.

Moving on to slide 43. So basically, some lessons learned. I think one of the things that's important for our center and I think we need to think about it is how do we as centers create opportunities for people to bring issues to us.

There are a lot of people in our community who are unserved or underserved and give them an opportunity to bring those issues and raise them. For us, we have our annual meeting. We just open it up for people to have ‑‑ to provide feedback. We have an extensive committee process where folks can be engaged with us both in terms of monitoring our programs and our public policy committee. In fact our public policy committee is so full of people that the kid that we will have to rent a room from a hotel in order to hold those meetings because we have so many people who want to be engaged.

We are working with leaders from the unserved and underserved community. I think that's really important. I don't want to make it sound like everything was perfect and that we were, you know, stellar through the entire process. We have made mistakes. You know, some of the ‑‑ sometimes people are not fully aware of issues around talking about how you present an issue. So we have ‑‑ we have made those mistakes and any time you have a significant group of folks, who are working together, there are politics and personalities that get involved, but that said, we work very hard to make sure that we are enhancing the ability of people who are deaf‑blind to talk about their issues and we are not speaking for them.

In part, the reason I'm doing this is because of my involvement within the state planning process and sort of the overview of how these connect up, but at the local level, it's actually the deaf and deaf‑blind individuals connected to the program who are doing the bulk of the work on this.

So hiring staff who are directly connected to the community is also extraordinarily important. I think the ‑‑ while we had a number of deaf staff who were working in this area who could pick up the coordination, I think their connection to the leaders and their willingness to learn from the leaders in the deaf‑blind community is what made it successful. We made a general commitment to work in partnership with this group by providing staff time and resources and we were up front about that. That was a commitment on our part, but the flip side was they made a commitment and the community made a commitment to try to raise funds as well. So that ‑‑ that works ‑‑ that working together is extraordinarily important.

For us, building on our core competencies whenever possible was a critical piece of our success with this so far. The fact that we had the attendance service and the capacity, the administrative capacity to provide these services was, I think, made this a lot simpler than going off and doing something in a completely different realm.

And then I think it was important. Some people looked at the issue and said, this is such a big ‑‑ you know, there's so much need. How can you expect to do anything? I think it was important for us to acknowledge that even a small amount of assistance, even if we could just do a few hours a month, those few hours were precious to the people who we were working with and was very important to them, and made a huge difference in their lives.

So even though the scope of the problem may seem huge, making sure that you are recognizing that you can make a difference with just a little bit of support is important.

And then finally, we are linking these issues together. So talking a lot about how the issues of deaf‑blind individuals are not dissimilar from the issues of those with physical disables in terms of the pleating services and supports and how can we work together to advocate for a better world for everyone.

And so with that, I guess we turn it over to questions and answers.

>> TIM FUCHS: Thanks, Bruce. That's right.

So if you have a question on the phone, you can press star pound and while we are waiting for folks to get in the queue, I'm going to start with the questions that have come in from the web.

Bruce, Pam Taylor is asking if your center has contacted or worked with the American council for the blind or the Helen Keller national center for the deaf‑blind.

>> BRUCE DARLING: Yes, we have. The Helen Keller national center has actually come to Rochester and we met with them. One of the things that was funny was when I was researching to pull the proposal together for the state plan, I started to search and I found that they were listing us as a resource already for Rochester.

So we ‑‑ but we have worked very closely and I think that's been an important part of our success.

>> TIM FUCHS: Great. Thanks. Okay. Next question comes from Maia Santamaria, how do you identify four support service providers in New York. In Georgia they have a list but how do you all do that?

>> BRUCE DARLING: Okay. As I mentioned, we have ‑‑ we do a lot of supports in the homes. So we have recommendations that come through the deaf community, individuals may identify someone that they want to do this. We were actively re ‑‑ we will actively recruit as well. So it's a combination of giving people maximum control over people, you know, because these are people who assist them, identifying them, themselves and also identifying folks and making connections. So we have other staff who are providing in‑home support services to other deaf individuals and other models and they are getting training to be SSPs as well. So it's a combination of things there.

>> TIM FUCHS: Okay. Great. Quick follow‑up from Maia. Is there a screening process for that?

>> BRUCE DARLING: Yes, there's a screening and training process and we are making both of those available as part of this project.

>> TIM FUCHS: Perfect. Thanks.

Well York see any questions on the phone, so I will continue with these web questions.

A question from Maria and this is a common one in IL. Bruce, they find that their local deaf community doesn't typically come to the center because of perception they don't identify themselves as individuals with disabilities. I know this is something that your center has done well with. How did you succeed there in reaching out to the deaf community?

>> BRUCE DARLING: Well, you know, I think ultimately it came down to a general question about diversity in terms of hiring from the deaf community. I think we gained a lot of credible many years ago when I hired a program director who was deaf. He had been doing some in‑home support services and was extraordinarily skilled, and came on as our program director. We have had deaf people in a variety of positions and I think it's sort of the framing. I think we acknowledge how some of the language that comes from the deaf community are things that the general disability community have learned from and can learn from. So deaf pride. The deaf community was ahead of us ‑‑ of other disability groups when they were talking about pride and how ‑‑ and now we are seeing disability pride parades and that that discourse is beginning to build up in terms of being proud of who we are as opposed to sort of that more medical model approach.

So I think there's some pieces in terms of we provide broad access to the organization and we are very accessible for folks coming in. We are committed to working with the community and we have, you know ‑‑ of the 18 people who are on our boards of directors, three are from the deaf community. And they are folks who are well ‑‑ we have a ‑‑ because we have a large community, we have folks who are well placed within that community, who learned ‑‑ basically liaisons who reach out and connect us to the deaf community.

I think all of those pieces together have really built a culture here where deaf folks feel comfortable and we're connected with them.

>> TIM FUCHS: Okay. Good advice. Thank you.

All right. Still no audio questions. I have one final question on the web for the time being, anyway. Also from Maria, she's wondering, Bruce, if you can talk a bit more about the core competencies that you mentioned and the role they play in your center and with your staff.

>> BRUCE DARLING: Okay. So when I'm talking about core competencies, you know, there are some things that we do well and some things that we have very little experience or knowledge of, and I think historically, we have been very strong at the systems advocacy piece. We are really ‑‑ we have an Albany policy office. We really, working to change services and support policies for the state. So we expanded that into the focus on deaf systems advocacy with someone who is strictly working on a ‑‑ a deaf man who is strictly working on deaf system advocacy issues.

And that supported some of this. The attendant service work in the in‑home support services that we provide, those ‑‑ the fact that we had those programs meant we had an administrative infrastructure that we could build on. So instead of needing to start a program completely from scratch, we were able to say, hey, let's carve out a little bit of time from what we are doing here to provide some administrative support in terms of scheduling for the SSPs, the training and that type of piece.

So looking at what your center is good at, what you are doing already, and how you can be supporting another group or reaching out is part of the core competency piece that I was talking about.

>> TIM FUCHS: Great. Thanks for expanding.

Okay. Well, that's the end of our questions. I will go lead to slide 45 now. And this is the evaluation form that I mentioned to you. So please do fill this out. I know a number of you are participating in small groups today, and as always, we encourage that. We think it's great, but please do fill out the evaluation on your own. We want to know what each of you thinks.

If you are on the phone only, again, you can get this link to the Vovici.com survey in your confirmation email.

So I will leave that up there on slide 45. And I'm going to close by thanking all of you for being with us, both on this call, and on the call last month. Don't forget, whether it's for you or your colleagues that your centers or in your state, you can listen to the archived copy. The archive from the September 26th call that Brad Williams did is already up. And the archived version of this call, today's call will be up no later than Monday.

I want to thank all of our presenters. This has just been fantastic. Toni, Laurel, and Heather, and Bruce, thank you so much for putting together this presentation and spending this time with us today to teach us. Brad thanks for doing the same with the statewide perspective on the 26th. For all of you out there, if you have a follow‑up question, our presenters have been kind enough to provide their own contact information. You can email me, I'm at Tim@NCIL.org. That's Tim@NCIL.org.

So whether it's later today, or in a few months, don't hesitate to reach out and we'll try to get you some support as you develop these programs yourselves.

Okay. Thanks so much, everybody. Have a wonderful afternoon. Bye‑bye.