**Doin’ the Diversion Dance from Rehab to Community:
One Center’s Approach to Early Intervention in Rehab Facilities**

**Presented by Darrel Christensen and Don Price**

**September 29, 2016**

>> TIM FUCHS: Good afternoon, everybody. This is Tim Fuchs with the National Council On Independent Living. Thanks for being with us today. I want to welcome you to our latest CIL net teleconference, doing the diversion dance from rehab to community. This one center's approach. Today's presentation is brought to you by the ill net training and technical assistance project for CILs and SILCs. As many of you know, IL NET is operated through a partnership among ILRU in Houston, Texas, NCIL in Washington D.C. in APRIL and Little Rock Arkansas and support is provided by ACL at the U.S. Department of Health and Human Services. We are recording today's call as we always do so that we can archive it and that will be posted on ILRU's website within 48 hours of the end of the call. Usually much sooner. So you can review that or share it with others once it's posted. We'll also take several breaks during the call today to take your questions, and there's a few ways that you can ask questions today. You can type them in the chat, and that's the text box underneath the list of participants, and just type out your question or comment and hit enter. You can do that any time during the call but we will wait until the Q&A breaks to address those questions. Also if you're on the full-screen CART today, there's a chat feature there as well. I'm logged in there as Tim and you can ask your questions again any time during the call. If you're on the phone you can press \*# to ask a question and we'll take those in the order received and I'll review these instructions each time we take a Q&A break. So there is a companion PowerPoint for the presentation today. You'll want to make sure to have that handy. If you're on the webinar, which most of you are, that will display and turn slides automatically. If you're on the phone or watching the full-screen CART you'll definitely want to have the PowerPoint handy. That was in the confirmation email sent to you and if you don't have that in front of you for any reason you can email me at tim@ncil.org and I'll send a copy over to you.

 Finally, before we get started, I just want to highlight our evaluation form. So we have a simple evaluation at the end of the call. That also was linked in the confirmation email, but a little simpler, there's a live link at the end of the PowerPoint today, and you can click on that. It only takes a minute or two to fill out. Many of you have done it before. So if you would take a minute to do that today we would really appreciate it.

 Okay. Well, I'm really excited for today's call. This is really a piece of this whole diversion conversation that we all need to have right now, and this is just one aspect, but it's a very successful aspect and we think it's relevant and happy to have Darrel and Don today to talk about their early intervention program and rehab facilities. Darrel Christenson is, of course, vice president of community integration for Ability360. Many of you knew Ability360 as ABIL, and the Center for Independent Living in Phoenix, Arizona, and the whole Phoenix area. He's also a member of Arizonans for housing partnership, a member of NCIL's board and served on NCIL's housing subcommittee for many past eight years.

 Don Price works for Ability360 as well. Don leads the early intervention coordination program there -- or is the early intervention coordinator, excuse me, position he has held for 11 years, and Don enjoys helping other people and letting those with new injuries know there is life after disability. Don is also active with the Arizona spinal cord injury association and is currently the president of their board.

 So, Darrel and Don, thank you so much for putting together today's presentation. We appreciate it opinion I'm going to go ahead to slide 3 and turn it over to Darrel Christenson who will get us started today. Darrel?

 >> DARREL CHRISTENSON: Welcome, everybody, that's here. I know time is valuable and I appreciate you taking part of your day to listen in. Good to see the participation level here.

 What we want to do is to share what we've done here in the Valley of the Sun for the past number of years and make our comments relevant for you, whether you have an early intervention program already working in rehab facilities or maybe a rehab facility is a number of miles away from you and you don't have such luxury of a staff person to be specific to this type of work. But we want to answer your questions during the Q&A session and just kind of share what we've done so that you can have similar programming in your community. And so in slide 3, we say what we'll learn, how CILs can use the new 5th core service of transition and diversion to assist folks in rehab facilities to relocate to the setting of their choice. And here's where rehab facilities have standards that they want to get people back into the community. They don't want to go to nursing homes. So that's working in partnership with rehab facilities is in their best interest as well.

 The best practices in setting up funding, implementing a successful outreach program to folks in the rehab facilities.

 Three, strategies to develop relationships and regional linkages that are so important to connect rehab patients to CILs and other resources in the community.

 And the fourth objective is to help with helpful online tools and resources that will be available to consumers as they return home from rehab.

 Slide 4 starts by saying that, you know, this all started with us 17 years ago, over 17 years ago, as a -- I'm sorry, if we can move to Slide 4. I'm sorry. There we go.

 As a response to identified community needs a number of years ago, and I think like many centers, we do surveys of our consumers in the community so that we can be responsive to our specific community needs, and this was one way in which we were able to get the feedback and respond to it.

 Slide 5, a couple things here in looking at sort of the demographics and who we're serving, but the program actually, as we say here, 60% of the unduplicated newly disabled individuals that Don works with in his program either have spinal cord injury and/or traumatic brain injuries. 60%. And to give a context to that, each year Don sees about 550, close to 600 different unduplicated individuals going through rehab. So 60% there is a large number with spinal cord injuries and traumatic brain injuries.

 And also the visits to the rehab facilities are regularly scheduled to meet with the individuals and certainly with their families shortly after trauma that really changes life as we all know, and he'll talk more about that.

 In Slide 6, the service area again is integrated with all of our programs here at the center and with the medical rehab facilities throughout Maricopa County which covers the Phoenix metropolitan area. I think recent numbers show that we have about 4.3 million people here in the Valley. So we're serving a lot of folks that are in the rehab facilities and wanting to move back out. When we break it down over the years, we've seen that demographically 70% of them are male with only 30% being female. And about half, or 49%, are between the ages of 31 and 54. Demographics also are representative of our total population here with 71% being white, 15% identifying as being Hispanic, and 8% Native American with a number of reservations and the native population here as well. And certainly to nobody's surprise, I think, 75% are earning less than $10,000 a year, and that's, of course, because folks are injured and not working at the time that we visit them. And, of course, we're working Valley-wide. So that's kind of the layout of the demographics.

 The problems that are being addressed are in Slide 7, please, and, again, I'm preaching to the choir, but whether it's a stroke, an automobile accident, drive-by shootings, whatever the case may be, acquiring a disability means losing a significant part of one's physical, sensory or cognitive abilities, and it can happen quickly, as we know. It impacts the individual, marriages, families, and community. So Don certainly will talk about how his work is not just with that individual but with the whole family system as they're also coping with the disability, and we never expected -- or prepared for it. So it happens at any time.

 Slide 8. You know, medical professionals do a great job of putting bodies back together. But the things that are not necessarily addressed are psychosocial adjustments by the medical professions and insurance companies, and they're whipping people through rehab quite quickly now as opposed to years ago when rehab stays were much longer. So that's where you come in as a Center for Independent Living to help meet those needs.

 Slide 9, please. So according to the National Council On Disability, the unemployment rate, as we know, is nearly 70%. Suicide rate for people with spinal cord injuries is significantly higher than for persons without a disability. And as a result, newly injured folks with disabilities often feel that they're not able to cope. They feel isolated. They go through bouts of depression. Struggle to adjust. Experience family turmoil and separation. And often accept a life on public assistance. And we're here to change that right away before they get settled into that negative mode of thinking.

 So at this time, Tim, we'll go to Slide 10 and open it up for Q&A, just for starters here.

 >> TIM FUCHS: Great. So if there are any questions on that introduction from Darrel, you can press \*# if you're on the phone or time them in the chat, and the chat feature is available both on the webinar platform below the list of participants and also on the full-screen CART. So we'll give a few seconds to see if there are any questions from the audience. Again, you can press \*# if you're on the telephone or type your question in the chat.

 Okay. Darrel, Ann is wondering, how did you create the outreach program to the rehab facility?

 >> DARREL CHRISTENSON: Well, we started by using our reputation -- our positive reputation as a Center for Independent Living in serving people across all disabilities, and since we were well-known commodity in the disability community and the medical community we were able to strike up relationships with key folks in the rehab facilities, and I think Don can talk more about that -- the importance of having those relationships. So it was relationship building, really.

 >> TIM FUCHS: Okay. Good. And Donna is wondering how you all identify where these folks are?

 >> DARREL CHRISTENSON: Don will be talking about that, but we have a number of rehab facilities here in the Valley, and so we are working with the prominent ones and making regular visits there, and again this will be a piece that Don will be talking about shortly.

 >> TIM FUCHS: Okay. Great. We'll give it just a few more seconds. Like I mentioned at the beginning of the call, we'll have several Q&A breaks, two more, one during the presentation and one at the end. Give it just a few more seconds to see if anything comes in.

 Looks like we have a question on the phone. Let's go there. Caller, you can go ahead. Oops, looks like they took it away. Okay. Well, that was kind of an early Q&A break, and like I said, we'll have a couple more. I'm going to go ahead to Slide 11 and turn it over to Don. Don?

 >> DON PRICE: Thank you, Tim, and I want to echo Darrel in thanking you all for joining us today. I also want to thank Darrel for coming up with the catchy title, doin' the daw vur shurn dance. I think he thought about it at 4:00 in the morning. We were thinking about setting up a webcam so Darrel could demonstrate the dance but we decided against that. We didn't want to break anything in the office here. Our idea is to teach you guys the steps to the dance and then you guys can take it over and hopefully have this great success wherever you are because it's really, really important program.

 I would just like to introduce myself a little bit more because I think it's relevant to my position. I am, because you can't see me, I am a person with spinal cord injury. I am a person with quadriplegia. I sustained a spinal cord injury diving into a Lake in my home state of Wisconsin when I was 18 years old, and I'm now -- I turned 53 yesterday. So I've been using a wheelchair for 34 years. I had an experience going through the rehab process in Milwaukee, Wisconsin, and then ended up in Arizona. So that does play into my position as early intervention coordinator. And then just one more thing I'd like to point out. In a lot of areas around here, when you say early intervention, they assume you're working with children. A lot of the people here will just make that assumption. So I always have to point out when we're talking about early intervention n this case we mean early on after onset of a disability. I make that clarification because it can be confusing sometimes.

 So looking at this next slide, we'll start out here. Ability360's program introduces individuals to the Independent Living philosophy of self-determination and we're so familiar with IL philosophy but it's completely to somebody who is in the hospital in rehab. They have eafnt give a thought to disability, much loss the difference between the medical model and IL philosophy. So it's a big eye opener for them when we can come in and talk to them about that and in our pillars of consumer choice an control. Our program provides peer support and presents an overview of strategies, resources and services needed for living with a disability. People are just thrown into this new world of disability, and we provide so much support for them with this program.

 So if we can go to the next slide, please. Ability360's program also provides information and peer support that increases the likelihood that consumers will adapt to their disability and be diverted, the keyword there, from institutional settings back into the community. It's the old saying that we are familiar with that knowledge is power, and we want to arm these people with as much power as they can have.

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

 And we integrate all of our services and address the whole person, avoiding institutionalization. You know, many of these measurables are very subjective and somewhat hard to quantify, but we do know through self-reporting that the program does impact people's lives. They tell us so directly. It's really hard to kind of measure because we don't have a control group, you know, this group didn't receive our support and this group did. So that's one of the things that makes it hard to keep measurables. But we want to introduce them to sort of a new normal of life with a disability, and that life can be productive and there is life after a disability.

 So next slide, please. When we set up the program we came up with seven objectives, and I would just like to go through those seven with you. These might be helpful for your own programs if you're looking to set up an early intervention program. First objective, in collaboration with local rehab facilities and extended care centers conduct outreach meetings and site visits. As Darrel said earlier, rehab places are very competitive. They want us to come in and help them. They want to have successful discharges of their patients. That's where we can come in and offer them our support so they see us as valuable partners.

 Objective number 2: Introduce Independent Living philosophy to newly disabled individuals. You know, we really strive to get to people while they're still in the early stages of adjusting to a disability, but that also is sort of a subjective term. Sometimes we aren't able to reach people while they're still in the rehab hospitals, but we can get to them shortly after they've been discharged. Sometimes they'll contact us or sometimes we'll hear from, say, outpatient therapies as well that they're working with somebody that needs some assistance, needs some support. So, again, early -- early is a subjective term, but we try to get to them as soon as possible while they're still in rehab.

 If we can go on to the next slide, please. Objective number 3 is to facilitate peer mentor matches, and we have a wonderful peer mentor program here, as I'm sure many of you do, as it's a core service. So we want to integrate that in the rehab hospitals whenever possible and keep our peer mentors busy.

 Objective number 4: Assist Ability360 volunteer coordinator to recruit, train, and oversee new peer mentors. It's interesting because so often when we work with somebody and have -- set up a peer mentor with them, they see such a benefit in it that they say, oh, I'd love to do this some time. I'd really enjoy coming back to the hospital in the future and doing this so I can help somebody else out. So we recognize in certain people this skill, this mentoring skill and this desire to help out. So we try to recruit them whenever possible and have them go through our training down the line when they're ready for it and to keep them as peer mentors. So we recognize and we look for these people that would be great peer mentors in the future.

 Next slide, please. Objective number 5 is to conduct follow-up surveys post discharge to assess and evaluate adaptation and community integration, and reintervene when possible or when needed. So we do try to track our consumers whenever possible. This can be very tricky, as you might imagine, because patients are moved. Sometimes they don't know where they're going to be discharged to. Some have difficulty with communication or don't have access to maybe a phone or Internet. So we try to, whenever possible, follow up with them, but it is not always possible, and it's a very dynamic situation. Many people are in the Valley -- here in Phoenix just for rehab and will be moving out to another area. So it's sometimes hard to follow up with them, but we try to do that whenever possible.

 Objective number 6: We have what we created called the disability survival guide, and so we try to distribute as many copies of that as we can to people in rehab. We put this together many years ago, and we've recently updated. We do have a link here available in the slideshow and you will be able to see that on our website in PDF form. But for our use we have it in printed form, and that goes out to everybody that we meet in the rehabs, and it's really -- I think it's amazing -- an amazing manual, amazing guide that we put together. There is information on different areas of -- like employment or housing, transportation, those type of things. But also there are some stories, people that have been there and done that, you know, people that have gone through rehab and gone out and just gone and -- gone into employment or into parenthood and those type of things. So it's really an important guide for them. They can read through that, and they can also get tips on how to best navigate the field of rehab. And another really great thing is at the end there's a resource guide, and that includes information on other Centers for Independent Living across the country and those here in the State of Arizona.

 >> DARREL CHRISTENSON: I think if I could add to the audience that this is a tremendous type of guide because, think about it, when you are a person going through rehab after a spinal cord injury, traumatic brain injury, what is it is, your life has been turned upside down. And prior to this you had no idea, really, about what's involved in the disability community. You had probably no reason to think about disability and resources and housing, transportation, employment, and how this all affects you as now a newly injured person with a disability. So rather than sitting in rehab and then shuffling off to a nursing home, this disability survival guide gives people hope and information, and like Don says, that knowledge is power, and it really turns heads because they had no idea that so much was involved and so much was available to them. So I think that's certainly a point to stress that whatever resources you have in your community you need to develop this type of a guide to give to people to show them there's folks out there that can help them in this transitional phase.

 >> DON PRICE: Thank you, Darrel. I hope you'll take some time and look through it, because I think it will give you some ideas of what maybe you can put together if you don't have something like this already, and it includes some really great pictures. I mean, sometimes just looking at a photo of people out there doing it and -- it will make a big difference just for somebody to realize, hey, there is life after disability. So take a look at that if you can. All right?

 Next slide, please. Objective 7, our final objective we listed, is to participate in civic commissions, commit committees, councils and other related community organizations that focus on disability issues. This is important because you want to stay involved in the community. Networking really helps. So the more things you can be involved with, I think the better it is. You can create alliances. You also maintain awareness of resources in the community and what the community needs are, because they can be changing at different times. And, of course, you give other agencies an idea of what you're doing. It's a really good way to put yourself out there and show that Ability360 or whatever center you are is doing great things in the community. So it's great to stay involved in as many of those opportunities as you can.

 Next slide, please. So we had a question earlier on how did we establish this program? Ours was actually started 17 years ago. Now, I've been doing the job -- I think it's 12 years now. So the program was actually established before I got here, but as Darrel said, it was our reputation that initially got us into the rehabs, but since that time there's been numerous different rehabilitation centers that have opened up. So what we've done is we've gone in to establish a relationship with these rehab centers. We've met with case managers. We've met with occupational therapists and physical therapists. We've met with the doctors and rehab directors and we let them know who we are and what our program is all about. Again, as we talked about earlier, they want us there. They see us as a good resource for them and a way to maintain their competitive advantage. One way to do it as well is offer to do in-services to educate their staff on what Independent Living Centers are and what your programs are specifically. I offer to go in and do these -- usually they're at lunchtime and the staff will gather around and then you'll have a chance to present to them. Sometimes they expect you to bring lunch, but that's not a big deal. It's a really great opportunity to meet a lot of people and let them know what you're doing.

 Another way to reach out is to find any kind of educational institutions in your area that have classes pertaining to rehabilitation. So, for example, there are some universities or colleges around here that teach physical therapy students or occupational therapy students. So I get an opportunity to go in there and talk to them about Independent Living philosophy and what our programs are so that when they go out into the field they're already familiar with Ability360, and they're familiar with Centers for Independent Living, and they understanded Independent Living philosophy, and so that's a really great way to kind of pave the future for our program and to keep up those relationships in the different rehab hospitals.

 >> DARREL CHRISTENSON: With that, too, if I could add, you know, just go into it with the mindset that you have valuable services that they and their patients can benefit from, that you have something valuable to bring to the table as a Center for Independent Living. So you're a very important part of the community, the resources, and, oh, by the way, it happens to be a 5th core service for us, but most importantly, like Don is saying, be visible out there and tout yourself, because our services are important for these patients.

 >> DON PRICE: One caveat to that is to not take on their responsibilities, if I can say it that way. You know, they have case managers in the rehab hospitals that are responsible for helping with certain services. We don't want to allow them to push those off on us necessarily. We want to be there to help, but we don't want to be their source for placing people in accessible apartments, for example, and we get that sometimes where some case manager will call us up and say, "Hey, one of our consumers is being discharged today. Where can we put them? Do you have any housing available?" Expecting us to have some magic bullet. And that's something you have to be very careful of, too. We want to be part of their transition team, but we don't want to take that responsibility from them. Some people get the IL philosophy and some people just never with. And so it's just important to have at least a few allies in whatever facility you're going to be working with, because a lot of the referral are going to be coming from them.

 So if we can go to the next slide, please. Tools for taking into the rehabs. The program coordinator is the first tool. I realize I just called myself a tool. But a person with a disability obviously has that instant credibility. It's the whole peer mentor philosophy that we know. And so I remember distinctly my rehab experience, and that was 34 years ago. It's such an emotionally charged time that it's seared into your mind, and I will never forget the feelings I had. So it allows me to go in and hear from therapists there all the time that even though I have information, a lot of times the patients will just say, well, you don't understand, you aren't in my shoes, you don't know. Really, as a person with a disability going back into the rehabs, I take away that excuse. I mean, I have -- they can't say that to me because I have experienced it. And that's where that connection really comes in. That's where having somebody with a disability going back into the rehabs is so important.

 The programs, the Center for Independent Living's programs, brochures are the next important tool. So you want to be sure to let people know that all of your programs are available to them. That's the peer mentors and the IL skills training and information and referral and all the cores and then any other programs that you have available like we have our own modification program that a lot of people are very interested in. So those are important tools as well.

 Other tools that you can take in... brochures, newsletters, as we mentioned our disability survival guides. Consumers are just bombarded with information while they're there. So what we do is we put together a folder with our brochures, and we have a magazine that we put out quarterly. We include that. And our business card, contact information. That sort of thing.

 Another really kind of neat resource that I can share with people is my accessible vehicle. A lot of times people don't -- never even thought about driving with adaptive equipment. So they'll come out and take a look at my adapted -- I have a Honda Element with that hand controls. That's an eye opener for many people and I use that as a tool as well. So there's a lot of things you can use as tools to take into the hospitals with you.

 Finally, I talked -- when I talk to students in rehab, in rehab classes, I always tell them the best thing you can do when working with somebody that's in the hospital bed or in the wheelchair is to get down to their level, to look at them eye to eye rather than standing over them, because that's a power exchange, and so when I come in, I'm sitting in my wheelchair, looking at them eye to eye. So they see me at that same level. And they also see me as somebody that's been there and is coming back, as somebody out there living my life. I think that's the big advantage with this program.

 So with that, our next slide, I think, is another question and answer session. So hopefully we've answered some of your questions already, but we would love to have some more.

 >> TIM FUCHS: All right. Thanks, Don.

 So you can press \*# to ask a question on the phone, or type your question in either of the chat boxes. During our last session, in fact right after the last Q&A break, Julie was wondering what your verifiable outcomes are from your visits. I know we're going to talk about that in the next slides. Anything you want to mention or should we wait until you address in that next piece, Don?

 >> DON PRICE: I think, Julie, we just covered the seven objectives, and then we'll talk a little bit more about outcomes as well. So stay tuned.

 >> TIM FUCHS: Okay. Great. Thanks.

 Looks like we have a question on the phone. Let's go there.

 >> CALLER: Tim, can you hear us?

 >> TIM FUCHS: We sure can.

 >> CALLER: okay. Doris go ahead.

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 >> CALLER: I have one question, when you say you're working with populations to divert them, I hear you saying you're working with people or you're doing outreach to rehab centers, but does this -- a lot of people aren't in a hospital or, you know, a rehab hospital for very long and end up in nursing homes. Do you include people who are within a certain point in your -- in their stay at a nursing home as part of your diversion. The reason partly I'm asking this is gets to the bigger question of in the 5th core service how are we defining diversion?

 >> DARREL CHRISTENSON: Doris, this is Darrel. Good to hear from you. You know, with the 5th core service, obviously there's the component of the youth. There's keeping people out of nursing homes, and getting people out of nursing homes, and this is the part that -- and this is the part that keeps people out of nursing homes. So there currently, as Don has said, are in rehab stays are much shorter than they used to be, but armed with the information, the peer mentoring, the other services that we offer, it gives them really a more optimistic, realistic perspective about life after that short stay in rehab, rather than -- rather than going from rehab to nursing home. And then as we many times know, it's easy to get ingrained into that mode of thinking in a nursing home where that's it for life, that's all you can expect, and there's nothing else there. So the diversion piece and doing the diversion dance is to dance your way out of rehab and back into the community right away without having to go to a nursing home at all. Don?

 >> CALLER: Final -- also wanted to ask what kinds of facilities? What kinds of facilities? Can you give us an idea what kinds of facilities you're talking about as rehab facilities?

 >> DON PRICE: Oh, yes, this is Don. I'll jump in here. The facilities that we're talking about mainly are neurorehab facilities and there are a number of them here in Phoenix. In fact, I really -- there's no way I can meet the need to visit all of them. However -- and getting to your question again, I will go visit anybody that calls and refers me to see somebody, whether they're in the neurorehab hospital or whether they're in a nursing home or a SNF or whether they're even at home and it kind of gets to my point earlier where the term early intervention is sort of subjective. Because sometimes consumers are not receptive to talking to anybody for long after -- it could be two years before somebody even wants to consider talking to somebody that's a mentor. And so oddenly we'll get a call. I went through rehab two years ago, but I didn't want to talk to you then. But I do want to talk to you now. So I'm in a nursing home now. Can you come out and give me some information. So we will definitely meet with that person and consider that part of early intervention as well. So, you know, it's a moving target. It's a broad spectrum of people, but our ideal viz sit to catch people in the neurorehab centers, but that doesn't mean that we won't reach out to the nursing homes or even people in their private homes.

 >> DARREL CHRISTENSON: And also to add -- to add another little piece is that we're fortunate enough to have another part-time person in the nursing homes to help people get out and back into the community, and that's the reintegration from nursing home program. So that's another part of what we do here at the Center, another part of the 5th core. So if a person happened -- okay, for example, if a person happened to go through rehab, didn't have any community options to go home or whatever, then maybe they were discharged to a nursing home, then with our other program, then we'll work to get them out of the nursing home and back into the community using the same -- many of the same tools that we have with this program, you know, the peer mentors, IL skills, those types of things. So it's two different pieces to the same puzzle, and it's like do you do the PASO DOBLE or the salsa. It's a different dance but you still want to get out into the community.

 >> TIM FUCHS: Good dance analogy, Darrel.

 Doris, I want to clarify, too, this is Tim, that we were really impressed by Darrel and Don's program at Ability360, but we didn't mean for this to be a solution to the whole conversation on diversion, and we're going to be doing a number of trainings over the next year, certainly some webinar discussions, maybe an on-site training, just about that, about the diversion people, and keeping people out of nursing homes, closing the front door, so to speak. So this is just one piece of that and a beginning to the conversation, if you will.

 Okay. We have another caller on the phone. So we'll go there now and open up their line. Caller, you can go ahead.

 >> CALLER: My name is Gretchen. I'm with the fort Benson Center for Independent Living, and you had used the phrase to create some kind of discharge, and I didn't write the word down, but it struck me as very positive expression. Do you remember what you said, creating a something discharge.

 >> DARREL CHRISTENSON: Might have been a positive discharge.

 >> CALLER: It might have been. I don't know. That's what we have to do. We have to -- we have to see it in a positive light before we can even establish it, you know, to them. So I appreciated that comment.

 >> DON PRICE: Especially -- it might have been the word community as well because we -- that's the whole point of the diversion, is to keep people in the community and to allow them to go back to the best, most appropriate setting for them.

 >> CALLER: Thank you.

 >> DARREL CHRISTENSON: Thank you pup.

 >> DON PRICE: Thank you.

 >> TIM FUCHS: Great. Thanks. Let's see. Next question comes from expwroan and Joan is wondering if we're going to be talking about funding options for staff to support these types of activities.

 >> DON PRICE: We'll talk about it in a bit, however, I can just say from the funding piece we started off the program where, again, we saw the need in the community and went after funding to make it happen rather than the funding chasing the tail. And so we were fortunate for a number of years with United Way funding, and United Way saw this as a viable piece of making folks more independent community and more active and employable and whatnot, and so we had a fair amount of funding for the position, for Don's position, for a number of years, and then recently they've kind of changed direction and their focus, and we lost that funding, and so fortunately then we have our home care program, or our personal attendant program, and through those additional funds the kretion air ea funds are now continuing to support the position. So be entrepreneurial and start a home care or attendant care program in your Center and you, too, can help to pay for some of these ancillary programs and broaden your base and -- because the other funding sources across the country are shrinking. So we encourage as a side note for centers to get involved with home care programming to fund these types of ancillary programs.

 >> TIM FUCHS: Great. And this is not a fee for service program, is that right, Darrel?

 >> DARREL CHRISTENSON: Right. Good point, Tim. It is not a fee for service program, and the expenses are Don's salary and then some administrative parts as well of a couple different staff, myself included, but primarily it's for Don's full-time staff. Many.

 >> DON PRICE: Additionally a I get mileage because I do put on quite a few miles around the Valley of the Sun here, as you can imagine, the rehabs are spread out from one side of the community to the other. So I do put a few miles on my vehicle.

 >> DARREL CHRISTENSON: And looking forward, I should add that we are going to be looking to some of the facilities to help maybe kick in some dollars because, again, we're helping them meet their mandates of transitioning folks to the community, and that's part of healthcare that they -- they get bonus points or they get points for moving folks into the community. So since we're a resource in the communities that help them do that we're going to start to in the future here ask them to kick in for part of the expense of the program, too.

 >> TIM FUCHS: Okay.

 >> DARREL CHRISTENSON: We'll keep you posted and keep your fingers crossed.

 >> TIM FUCHS: Good. All right. We're going to take -- there are two more questions I have and then we'll continue to make sure we have time for the presentation. Next question comes from Donna. Dawn you is is wondering if you can talk more about how you teach IL skills as part of the outreach and transition effort, and are you talking about teaching those scims while the individual is still in or out of the rehab facility?

 >> DON PRICE: This is Don. I would like to address that. Donna, really, the IL skills is not something that I would do in this program. It would be more of a referral to our staff that do those specific jobs. It's just -- there's not enough time -- when I do a visit, it's just to talk about our programs, let them know about our IL skills training and our other programs as well, but I myself would not do that training. Now, I can obviously as a mentor give them some tips and tricks on how I do things and answer their questions that way. So there is some organic IL training, I guess, but specifically it would be referring them to our programs. I hope that answers it.

 >> TIM FUCHS: Okay. Great. We did a training a few years ago just on IL skills training for transition, what's important to teach folks as they're planning to move out. That's posted on ILRU's website. If anybody is interested, you can write to me and I'll send you the direct link after the call.

 This final question comes from someone who is frustrated with some of the calls that they get, similar to what you all mentioned. You mentioned that you have facilities staff that often calls you when they want to discharge someone right away. How have you discharged that? Is there something you can offer -- I'm always hearing from people that we have this person. They need to be out tomorrow. And if you don't do something to help them, et cetera. Nints later when they can't get subsidized housing they still want to know how long it's going to take that pit seems very hard to explain there are serious housing issues, no matter how many times I explain it to them. Any tips there for discouraging that kind of behavior with rehab facilities?

 >> DON PRICE: He wow, do I feel your pain. We definitely can relate to that type of question. The sort of guilt trip that they'll sometimes lay on you. Any tips -- I just -- just to let them know that we don't have any kind of magic bullet. We are there to help them but we don't have -- we don't have our own housing available. We don't have any kind of emergency funds for people, and that really -- again, this is -- goes back to the reputation and maybe the comparisons to other rehabs. If they're not doing their job, they're not going to get positive discharges and have positive outcomes. So, you know, we do -- one of the things that we do offer is we have a house that was donated to us by a gentleman named Robert Mast. So we call it the Mast House and we use it for transitional living, up to eight weeks people can use it -- say they're being discharged, their home is not quite ready for them, they can rent this house for up to eight weeks, but that has such a great demand that it's almost never available. So I think sometimes they'll call to see if that's an option, but, no, it's really -- it's really a tough situation when we get those calls. Our I&R person, information and referral person, is wonderful. She will give them as much resources as she can, housing lists and resources in the community, but we just don't have a magic answer. Darrel, do you have anything you want to add?

 >> DARREL CHRISTENSON: I think nationally, whether you're in a smaller rural community or a large metropolitan area across this country, accessible, affordable housing is really huge issue. Boy, yeah, I think -- one of the things that can help to make a dent in moving back to your home he is if you have a home modification program yourself at your center or if you know of other programs in the community, Habitat for Humanity or area agency on aging. You he know, different programs that might have home modification programs that can help to make some improvements in their own home so they don't have to move to an apartment or sell their house or go to a nursing home. That's -- that can be a small piece of it, but like Don said, man, if you have that answer, you've got the world on a string because that's such a tough one.

 >> DON PRICE: If I can just jump back in, along those lines, one of the things I try to encourage when that I meet with people early on, I try to encourage them to start thinking about those things. If they're working with a case manager or social worker at the rehab, that is their job. If they're not already engaged in looking for those options, they really need to be thinking about that. So that's part of the my job as well, is to make sure people are looking ahead, not just concentrating on getting through that day, but to think ahead on the housing, employment, transportation, all of those things. So I try to encourage them to think that proactively.

 >> TIM FUCHS: Don, speaking of which, I want to think rl Darrel Jones for catcherring this, in Donna's question a few minutes ago, I miss add keyword, and that was not giving them the IL skills training, of course, in the facility, but the referral. So are you actively making referrals to IL skills training and other services for rehab patients while they're in the facility?

 >> Within the agency, yeah. Right, Don?

 >> DON PRICE: That's correct.

 >> DARREL CHRISTENSON: So, I think -- to that point, Tim, you know, and, Darrel, really using your resources that you have internally and use them together, the information and referral about howing waiting lists, the Independent Living training, the peer mentoring that happens right away in rehab, the home modification, the home care service. If you have those services in house, then by all means, don't work in a silo. That gets nobody anywhere.

 >> TIM FUCHS: Right. Okay. Thanks.

 I want to go ahead to slide 20 and turn it back over to Don to make sure we have time for the rest of the presentation. We will take more questions before the call concludes.

 >> DON PRICE: Thank you and great questions.

 So we're kind of getting more into the nuts and bolts of my visits here. When I go out, I never make a visit without the consumer's knowledge and consent. I don't just pop into somebody's room and say, hello, here I am. That would be a good way to get a phone thrown at my head or something like that. I make most of my visits in the afternoon, which is when they're usually finished with their therapies. The referrals themselves can be made by family members, rehab staff, case managers or the consumer themselves if they're proactive and looking for resources. And I would say of those, the most common is the rehab staff, somebody working with that patient will call and ask them, you know, is it okay if I bring in somebody from Ability360 to talk to you? And they will give them consent and then I'll go visit them. But all the aabove have been common referrals.

 When I go in and talk to people, often it's the family member or family members that have the most questions. Typically the patient is just trying to survive the day because rehab is pretty grueling. So it's typically the family. And a lot of times this is where those referrals that you were just talking about come in. I'll mention our programs. I'll say if this is you would be interested in after you're out of rehab, this is what's available to you, and tell them about our IL skills. Again, typically the patient is not thinking that far ahead. They're dealing with pain or stress or medications. So it's the family members that really take the information and, I think, encourage that person after rehab.

 And I feel as part of my job it's important for me to stay on top of resources and be knowledgeable about community services and resources, because I'm that first point of contact, and so, you know, it's part of my job to stay on top of things and to know what's out there in the community so that I can offer that information to them. So if I can go on to the next slide, please.

 Whenever possible I collect contact information from the consumer for those follow-ups we talked about, and then that will get down to the measurables in a bit. It's important to understand and recognize the stages of grieving. And so that you understand that you can come into somebody's room and they can be having a really bad day and might be angry and might not want to talk to you peafn after they've given their consent. That particular day they just might be having a hard time. So I'm always mindful that the patients can be tired, they can be medicated, they can be emotionally drained. So I say, be sensitive to their fatigue and be aware of nonverbal cues. If somebody is yawning repeatedly or looking away or distracted, I take it as a cue they're not really engaged and might not be ready for me that day. I don't take it personally. I've actually never had anybody get angry or throw me out of their room in all these years. So I guess -- I guess that's a good sign, that I've managed to read their body language or their cues pretty well. Sometimes they'll say, I'm really tired, can you come back another day. So just something to be aware of. The job is really rewarding, to be honest with you. When you are talking to somebody and you see that light go on that, hey, you know, I can get through this, that I can do all these things that I never thought were possible again, when that light comes on, as you know again, preamping to the choir, it's really an amazing thing. But it also can be a frustrating job, too, because, as we just talked about, sometimes the resources aren't there for them, housing or transportation or whatever it is. So something to keep in mind.

 If we could go to the next slide, please, talking about measuring outcomes.

 We talk about knowledge of consumers to be involved in the rehab planning and therapy outcomes. Again, this is a hard one to quantify, but this gets to that point of we want to engage them in thinking about their outcome and thinking about the future, what's going to happen after they leave the hospital. Then we also want to encourage them to be actively involved in focusing on their future. We track individuals returning to residential settings. So we try to keep numbers on how many people went back to the -- their own home or how many people ended up in nursing homes. And then another one -- an outcome is just by observation see how people are proactive in their self-advocacy skills.Le these are all, and I keep re feeing this, hard to qualify and very subjective but, again, we don't have a control group but we can observe and hear from them by self-reporting that this program is effective and helpful to them. Sometimes it can be a period of a year or two where they'll come back and say, you know, that visit you gave to me, when you gave me that information, or seeing you out there doing your thing meant a lot to me. And so it's -- how do you keep numbers like that? But we do know from the self-reporting that it works.

 Next slide, please. Darrel, if you want to jump in at all.

 >> DARREL CHRISTENSON: Methods to gather and collate measurable results. Well, we have regularly scheduled visits to rehab units and we meet with rehab staff for referrals and newly disabled individuals and their families. And we do on one meetings with newly disabled individuals and their families. Often weekly visits while they are in rehab. This is a very good goal, and we always aim high, but it's also very difficult. As we mentioned earlier, it's a highly dynamic situation. Patients can have setbacks, be moved out of rehab back into maybe ICU or their insurance company will suddenly cut them off and could be moved to a SNF -- SNF -- oh, skilled nursing facility. Sorry. There's a lot wrong with that acronym. Sorry. Or nursing homes. So doing a weekly visit is often very difficult, but we aim for that if at all possible.

 If we can go to the next slide, please. So we also have regularly scheduled discussions with rehab staff to review and assess our intervention and to identify specific issues that need to be addressed. The staffs at rehab units view our activity as an important adjunct, and again this goes back to their standards that they want to compare against other rehab facilities. They have numbers they want to meet, positive discharge to communities. They want to keep up their rehabs -- their certifications and their reputation within the community. They're like any other agency. They want to have a high reputation and they take a great pride in being ranked in the top whatever, top 10 rehabs in the country or top 10 rehabs in the state. So they really want to keep their quality high, and that's why we can market to them as an important piece of that puzzle.

 We facilitate focused discussions on particular aspects of Independent Living philosophy and support group meetings. For example, yesterday I had -- I was invited to a support group at one of the rehabs, and we talked a great deal about some physical issues, like bowel and bladder care, and I was happy to give them my experience with those issues, and then we also just gave an overview of our programs and they were very welcoming and thankful for that.

 And then we conduct follow-up surveys at regular intervals. I try to do it after a month, and then after three months, and if possible, farther down the road I do, but it's really hard to track people after three months. And a lot of times we'll just see them at our programs somewhere down the line.

 >> DON PRICE: If I can jump in, you know, the last three slides here are talking about the outcomes. Just as a little insider secret, these outcomes come directly off our grant proposal. So you can put in the numbers that you want, and you're well on your way towards a grant for funding.

 I think another point, too, to be made, that over the years the program has changed, that, you know -- and, Don, you'll back this up, that years ago we were able to go in and they would just give us a list of the patients on rehab and names, room numbers, you know, background, the whole nine years, and now with the HIPAA guidelines they don't even put names on the doors anymore. They just have numbers and room numbers, and the confidentiality piece is so much tighter than I think if we weren't such a known commodity up there and a trusted partner, I think we would have a much tougher time to have access to some of the patient information, but that's been developed over the 17 years, and they know that we're still a partner of high quality, because, you know, you get other solicitors in there saying that they're peer mentors or they're from Joe Blow Agency or whatnot, and they need to be careful and understandably so. I don't know, do you want to talk about some of the changes like that that you have seen, Don, or examples?

 >> DON PRICE: Yeah. It's a good point, Darrel. For one thing, the rehab stays are much, much shorter than they were in the past. When I was injured, again, 34 years ago, I did two months of acute care and five months of rehab. Today a typical stay for someone with that same injury level would be maybe 10 weeks, you know. So we're looking at weeks instead of months. And so it's even more so important to get that information to them before they're discharged, and so we want to try and catch as many people as we can while they're still in the rehab hospital. Yeah, it has changed quite a bit. And because of liability issues, they are somewhat more reluctant than in the past to give us referrals to their patients unless they know for sure it's going to be a good fit.

 >> DARREL CHRISTENSON: So I guess if we can move on to the next slide, please. The program uses a three-pronged collaborative partner approach. Number one, the program is completely integrated with Ability360s other Independent Living programs. So obviously the referrals that we're talking about. Number two, the program collaborates with medical rehab facilities. These relationships are mutually beneficial as staff refer individuals to Ability360. Again, that's a repeat. And then number three, the program collaborates with other disability-related and community organizations. And diversion from institution to the community is always the bottom line goal.

 And then if we can go on to the next slide, please. I know everybody likes examples and stories. So we included this one about a consumer of ours named Steve. I met Steve in the rehab hospital after he had sustained a stroke, and I met with him and talked with him and gave him our information, and he was so impressed he started sharing it with other patients in the hospital while I was not there. He he took it upon himself to become a mentor while he was still in the rehab himself. After he was discharged he became involved with a number of our programs, including attending the living well with disability classes that we offer. He went through our peer mentor training. He attends a men's support group that I facilitate. He became involved in our sports and fitness center. And he went through our IL skills training. Basically wherever you look Steve is involved here at our facility.

 If you can go to the next slide. To the point where he -- he was a chef before his stroke. Obviously he's still a chef. He has taken it upon himself to create an accessible kitchen here at our facility. He wants to open up sort of a cafeteria that is staffed by people with disabilities, and then use that as a training and -- a training facility for people to learn cooking skills. And so he's just exemplified Independent Living philosophy. It's an amazing thing to see. And that all was born out an early intervention visit and he just -- maybe -- it's not a typical story. Just the extent of his involvement. But it is a great story that shows the power of making that initial connection.

 >> DARREL CHRISTENSON: I think as far as another case example or example of meeting needs and such, from a management standpoint, I was just -- I'm still blown away by the work that Don does because he had seen that -- the demographics as we showed earlier were that 70% of the are folks he sees are men, and so he, Don, took it upon himself to start up a men's support group and getting the word out to folks in rehab and those that were recently discharged, and the numbers that are now attending are just through the roof, and to talk about real personal issues that guys need to talk about after acquiring a new disability, everything from relationships to sexuality to -- you name it. But Don as a staff member took it upon himself to really reach out and meet the needs and I think I was smart enough to give him the green light go if it was a good idea. By all means go for it. And sometimes hearing the comments or the discussion after Thursday night's groups you know you're making a difference in the community, and, Don, what were some of the other -- another example of somebody that really had an ah-ha moment in one of your recent groups?

 >> DON PRICE: Well, yeah, there's a lot of mentoring that just happens in these groups. And so somebody was talking about having the blues and being down and depressed, and the other group members just chimed in and just started to talk about their experiences as well, and he realized that he was not alone in this situation, and then what we did is we arranged to have somebody come in from an agency and speak on that topic the next month. So -- we addressed the topic and made sure that he knew that we were thinking about him and caring about him. So he felt really welcome by community and it made a big difference for him.

 So I know we are tight on time so we're going to go ahead and move forward. I think we only three or four more slides left.

 So some things to consider. We've already talked that funding is an issue, and early on we were funded by the United Way. Currently the program receives revenue from discretionary unrestricted dollars from our home care program. You'll have to find staffing for the program, somebody that sort of fits the -- I don't know --

 >> DON PRICE: Qualifications. And anybody listening on the line, no, Don is not available to relocate from the Phoenix area to start your new program.

 Obviously you'll need rehab facilities in your service area. Then there's also some rehab reluctance that we mentioned earlier regarding confidentiality issues, HIPAA and liability. So those are some of the things that you'll have to consider and barriers that can be overcome.

 If we can go on to the next slide, please. I just talk briefly here about the most common concerns of consumers when I meet with them. Probably the main one is the housing issue. Second to that would be quality of life issues. You know, what am I going to be able to do? Can I go back to work? Will I be able to parent? A real common one as well is sexuality and relationship concerns. And then after that I mentioned daily functionality questions, again, getting to things like how am I going to get around my house? Will I be able to get into my bathroom and those type of questions. A lot of times I also get medical questions. I can move this much. Am I going to be able to regain more function? And those are questions obviously that I stay away from. I offer my best hope for them. I never squash their hope but I also don't offer any medical advice. Same with recommendations, if they're asking me, you know, do you know of a good doctor or a good lawyer or -- anything like that, those are things I have to avoid as well. I can offer them information, like brochures or lists maybe of people to contact, but, of course, I never make those recommendations directly myself. So this all comes down to choice and control of the consumers. We give them the information, and what they do with it is really their business.

 If we can move on to the next slide, please. Just a few pointers here that I included that the coordinator should be positive and living proof that there's life after disability. However, I said, it's important to be honest and realistic, not go into cheerleader mode. They can see right away if you're just blowing sunshine, that you're phony, because everybody knows you're going to have good and bad days. And so I include that whenever I talk to them. I let them know, hey, you know, I'm living a productive happy life out there, but I do have bad days when things just go wrong. My wheelchair will break down. My catheter will leak. I'll get stuck somewhere. These are all things that I face. But the balance of my life is not dealing with those things, an that it's very positive. So I just wanted to include that. I think people are really comforted in knowing they're not alone. And so we talk about, in quotes, disability community and disability culture as well, and we let them know that we're out there and we're there to support them, and that really, a lot of times, makes a huge difference, especially with family members, just knowing that there are people out there that care and that they're not going to be alone. We let them know, hey, if you have questions or you get out of the rehab hospital and you get home, suddenly who are you going to call? You have this issue to face? Call us. Here's our number. We're here to help you. That makes a big difference. Then finally I said, technology helps reduce but not eliminate the isolation of rural areas. So we know a lot of people go home to a rural community and are not able to get here to our facility to participate in a support group or a class. Whenever possible we try to provide a call-s in oash webinars or anything we can to accommodate them, but we do know it doesn't completely end the problem of isolation. So that's something we're mindful of and we always are seeking solutions to better overcome that.

 I think, bottom line is, when I go in and talk to somebody, I know there's no magic words I can say. I give them information. I let them know they can have a productive and happy life and let them know of the resources that will help them. I give them the dance steps, if you will. And then I watch them hopefully dance and keep out of going into that cycle of depression or just a downward cycle when they get home.

 Bottom line, there it is, we want to give consumers and their families tools they can use after rehab to avoid becoming depressed, lost or isolated. We want to prevent the downward spiral of depression, drug use and isolation. So that's our idea of the transition and diversion dance. So hopefully this has been informational for you and you can find ways to utilize that in your communities.

 >> DARREL CHRISTENSON: And so, yeah, that kind of puts a wrap on our presentation here on slide 32. You'll see we're open for another 10 minutes of questions. Tim is asking also that you complete the evaluation and feel free to give us a holler if you have questions of us as well. So, Tim?

 >> TIM FUCHS: Let's open it up. \*# if you're on the phone. And while we're waiting for those, I'm going to start with the questions that have come in on the chat in the meantime.

 So, Don, I got a question here, I wondered if you can talk more about working with people with brain injuries and how that differs from working with people with spinal cord injuries, including how you might successfully communicate with people who have communication difficulties in rehab.

 >> DON PRICE: Okay. Excellent question. I actually -- I have to say I don't work with a lot of people that have traumatic brain injuries, but I do get some referrals he. We are lucky that we're here in the same facility as the traumatic -- the brain injury alliance of Arizona. So I'm able to a lot of times bring in somebody that from staff that can talk about their programs and bring in their resources. If they're somebody that has difficulty communicating, I rely on family members typically or rehab staff that may have developed a communication style with that person. There are some times when it can be difficult and challenging, but we typically find a way to do it. Additionally, it reminds me of another issue that we face in that I do speak Spanish, and we do have quite a few people here who only speak Spanish. So I rely, when that is the case, I rely on either peer mentors that speak Spanish that I can bring along or sometimes there are staff members at the rehab that will do the translation for me. So again it's an issue that we do face sometimes, and we always try and find a way around it just so that we can be sure to get them the information that they need.

 Did that address the question?

 >> TIM FUCHS: I think so. Thanks.

 Another question for you, Darrel: How many total staff you have to providing services? And can you explain what you mean by your home care program?

 >> DARREL CHRISTENSON: Right. I think overall Ability360 has about 135 staff. We're very fortunate to have a home care program which other term would be a personal care attendant, PCAs. So that's going throolt Medicaid, and ours, right now, I think we employ about 2300 attendants to provide services to about 2,000 consumers, and so again, those dollars, we have some excess money that from program that we are able to use discretionarily to the ancillary programs like this. Owe 135 in house and 2300 out in the community.

 >> TIM FUCHS: Okay. Great. Fantastic.

 A similar question: How many of the participants from this program, from Don's program, end up using those PCA services?

 >> DON PRICE: Good question. I don't know that we've -- I don't know, Don.

 >> DON PRICE:, that's something that I don't think we've ever tracked really. I wouldn't even have a guess. We could maybe work on trying to get some numbers.

 >> DARREL CHRISTENSON: Like Don has been saying, to do the follow-up sir vases that's been so tough because we don't always have that information where they're going post discharge, and so to try and figure out who is using our home care service, boy, that would be great information, but I don't think we have it available right now.

 >> TIM FUCHS: That's okay.

 >> DARREL CHRISTENSON: Because there's different choices that people have in who they want as their provider. So we can't just direct them from our early intervention program straight to our home care. We can't market that way. So that kind of puts a hamper on it, too.

 >> TIM FUCHS: Got it.

 >> DARREL CHRISTENSON: Whoever asked that stumped presenters.

 >> TIM FUCHS: Well, that's the end of the questions that I see. I'm going to start to wrap up here, and then if there are any other questions I'll make sure to take them.

 As Darrel mentioned here on slide 32, this is the live link to the evaluation form. So please do fill that out. It was also in the confirmation email.

 I know a couple of you -- a few of you are participating in small groups, and that's great, we love that, but please do fill out the evaluation as an individual. I want to know what each of you thought of today's call, what you liked, what we could maybe do better.

 And so before we close, though, I obviously want to thank Darrel and Don so much. You all really have put together an excellent presentation, an overview of this rehab outreach program that's been so powerful in the Phoenix area, and it's a great model, and I really sincerely thank you all for putting this together for us and for the other centers. Of course, I want to thank all of you, too, from around the country for taking the time to join us today. I really appreciate it. With that, I don't see any other questions, and I think we're going to close the call.

 Darrel and Don, thanks again. Everyone have a wonderful afternoon. Bye-bye.

 >> DON PRICE: Thank you.

 >> DARREL CHRISTENSON: Thank you.

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