BRUCE DARLING: I want to start out with looking at similarities and differences between transition and diversion.

And it sort of starts out with who you're working with.

Transition is easy.

The people are in the institutional settings, we've gone through other trainings, the kinds of things that we work through in terms of transition.

I was thinking through, though, when you're working with folks there are probably two big groups of people you're potentially diverting.

People who you are actively working with in sort of a more eminent kind of diversion approach.

Sort of more of a crisis oriented kind of thing and then those who you are providing some services and supports to over time, where it's you're just maintaining their independence in the community.

So thinking through that first group, people who sort of come to the center and say, oh, my God, I'm going to be forced into an institution, or their independence is at risk.

Folks, you get these calls now, right?

Hands?

Yes, I see nodding, some hands are going up.

Okay, regularly.

So people call up.

I mean, it is not just the bad providers we have in New York that we're dealing with.

There are lots of reasons people can end up.

So what I would like to do is think through the kinds of groups of folks or situations.

We have people who have acquired a new disability or have a medical issue that results in a loss of function.

So I think we talked about so maybe someone has suddenly just, whether talk about folks having spinal cord injury, finding out, talking about them being in the rehab setting, potentially being forced into an institutional setting, trying to divert them to community based services.

Can folks think of other kind of situations or groups of people who we would be dealing with?

This is participation, I'm hoping, thank you so much, Dawn.

Brenda, thank you.

AUDIENCE MEMBER: Our state is creating a big risk of people who are now, that we're trying to help keep, to divert by changing their assessment and everybody's hours getting cut.

So we're getting a lot of people calling and saying, you know, I'm going to have to go in an institution.

So we're doing a lot of work around that.

BRUCE DARLING: I'm sure you are.

It's not like Arkansas provides an abundance.

AUDIENCE MEMBER: A big amount anyway.

I mean, eight was the basic cap for adults with physical disabilities, and people have seen a major cut, I mean in fact, it is so bad that legal aid has taken on this issue.

So they're helping us as well.

But we have had calls you know, of people saying, I can't do it without that little amount of hours.

I'm going to have to go to the nursing home.

So we've been doing a lot of that lately.

BRUCE DARLING: I think we're seeing that across the country, where the hours are being cut.

I sort of classify this as folks losing a formal support.

When the formal supports fall out.

So the home care services or whatever.

And basically, a reduction of hours is something that we see around the country.

Whether it's the state changing the waiver rules or managed care coming in.

We had an individual in New York who had basically received okay, embarrassment of riches, 24/7 services for 12 years, basically was unable to do anything for herself without assistance, needed assistance with suctioning regularly.

Okay, for the record, suctioning is not something you can put off, I will do suctioning you know three hours from now.

She was cut from basically 24/7 down to 56 hours a week.

And then they increased her to 78.

So the last decision was an increase.

The end result is the woman would either be institutionalized or die.

Which dying seemed to be the more likely case.

I know that we're seeing this across the country.

Are there other situations in terms of loss of formal services?

That's a great overall area we run into.

Just to flush that out a little bit.

So is it just cuts in hours?

AUDIENCE MEMBER: You know, I mean, if you need services, I mean, if it happened to you tomorrow, I could walk out here and trip and fall, break my head open and I'm in long-term care because I'm having seizures, I get ill.

I mean, people in this room are over 60.

I'm 61, I might need long-term care 10 years from now, or I would prefer a PA in my house than long-term care.

Anything can happen to you at any moment in time, which would give you the potential to go to long-term care or need home based services.

All of us, potentially.

BRUCE DARLING: The first group we talked about was like acquiring a disability or having sort of an, so the first group that I talked about you acquire a new disability or have a medical issue that results in a loss of function or ability.

AUDIENCE MEMBER: Accidents.

BRUCE DARLING: Right.

However it is, like loss of formal services is something not just cuts in hours, there are a couple other ways that happens.

Over here?

AUDIENCE MEMBER: What we're seeing a lot of in Illinois is that we have a long waiting list to get those supports in the first place.

Like if you're applying for home services, you have to wait at least 12 to 18 months to even get an assessment.

BRUCE DARLING: Okay, that's a great one.

So those waiting lists.

And actually, I tweeted out yesterday when Michelle talked about how services, is there a waiting list to go into the nursing facility?

No.

Is there a waiting list for community based services?

Yes, there you see the institutional bias.

I tweeted that out because I thought that was just a great example.

But the waiting list for access to community based services is something that you end up dealing with, and they have to fight to get them those services actually does, where you try to push people through that process and help them along.

Not pushing the people, but pushing the bureaucracy to respond to the people, that really is active diversion.

I thought of a couple of other things.

Thinking through sort of our nursing facility transition work, I classified it as interpersonal conflict.

I'm sure we've all dealt with the nurse who says, so and so is not appropriate for community living because he behaves badly.

There's always those kind of like the Chris Cross basically.

Maybe the home care agency isn't providing the services, they don't want to deal with that, so they say, so and so is the problem.

So that's a common thing that we see in terms of the fights for services.

I classify kind of as interpersonal, because it's then he said she said, there's this whole sort of drama thing that is going on.

I would like us to pay particular attention to that, because one of the thing that we often hear is we can't get attendants to go to so and so's house.

And listen to the conversations, cause one of the things that I've found is you know, you sort of tease into the question, well what do you mean?

Why?

Well you know, it's where he lives.

Well where does he, what's the problem?

And they'll say, you know Jefferson Avenue in Rochester is not a real safe neighborhood.

Okay.

Now we're sliding into a conversation that's generally a white nurse who is talking about people of color.

That's really what's going on here.

And it's really helpful to just turn it around and say you know, we have a lot of attendants that work for us and a lot of them work right in that neighborhood.

Are you sure you're having difficulty finding attendants?

Sort of a push back on this.

So there is really, if you look at the literature, the health disparities of people with color around traditional health care services also apply to community based services as well.

I just want us to be sensitive to that when we're looking at diversion.

If you're not seeing people of color coming in or saying they're having access issues or accessing services, you're missing a group of people who really need that service and support.

Another thing, agency closure or loss of a contract.

We're seeing a lot of that with managed care, where a long time agency has been providing services and suddenly they are wiped off the planet by a contract.

So people are going to go without services.

So loss of formal services is a big category there.

Another category can folks think of?

Or another example.

Andrea?

AUDIENCE MEMBER: Sometimes we have issues with people that are living in rural communities, like in Rochester, it's not usually an issue, because like in the city, there's bus lines and what not.

But then you have people that live in the surrounding counties and they're saying we can't find aids that are willing to go there, because it's too far.

BRUCE DARLING: So issues with formal, problems in accessing formal services and supports.

I'm trying to look through, is there another category?

Up here in front.

AUDIENCE MEMBER: The informal supports, like loss of divorce, parent passing away, loss of the informal supports, we see a lot of that.

BRUCE DARLING: That's a big one.

So like the death of a, like sometimes parents take care of their disabled child well into adulthood, meaning like 60s, and the parents die and then basically you have a sibling who is like, oh, my God, my brother has no one to take care of him or assist him.

I will point out, in a conversation with one of my folks, I hang out with people and chat sometimes, one of the things he pointed out to me is, he said you know, I was talking to John who was in this situation, his parents were getting older.

He said, he's freaking out, he's watching his parents get old and he's like, holy hell, I'm going to end up in a nursing facility.

I'm like, oh my God Kevin, you just blew my mind.

Everyone talks about the parents, no one actually talks about the individual with a disability who sees this train wreck of their independence coming.

So that is a big one, and we see that pretty commonly.

A decline in health of an informal care giver.

So it can be like an aging spouse or an adult daughter who is providing assistance.

That was actually in my own family.

It was my mother's health, her health crisis that was actually the thing that impacted my grandmother's independence more than anything.

She was the primary care giver of my grandmother who had dementia.

Or I think sometimes it is the discovery of abuse or neglect in that informal support.

Suddenly there's neglect found and that whole situation blows up.

Brenda.

AUDIENCE MEMBER: Homelessness and then hospitalizations as well.

BRUCE DARLING: Hospitalizations are a big one.

And whether it's a medical situation that results in a hospitalization or sometimes a social hospitalization where it's the lack of services.

But this is really sort of the group of folks who are sort of outside of the system.

They're not able to access the services and supports.

Oftentimes we're looking at legal problems or mental health issues that are impacting their ability to secure those services.

So that's a good example.

AUDIENCE MEMBER: I don't know if this counts, Bruce, but what about the individual who is being taken advantage of by utility companies and landlords?

Does that count?

BRUCE DARLING: Okay, so actually, it's an example on my list.

So dealing with, financial issues, shortfalls or where people are being ripped off, that is an issue where suddenly you don't have the money you need to take care of your basic needs.

So that is another one.

The only other one on my list was sometimes housing falling out from underneath you.

I was having a hard, you know, so if you had it and it sort of falls out.

It's not as common.

So it's more along the lines of basically interpersonal issues at home, where the situation where the person who needs accessible housing basically is kicked out and then they become homeless again, it's sort of in that mix.

AUDIENCE MEMBER: We've seen that, luckily it's never come to this, but when we helped someone transition into an independent living facility, they still have standards that you have to be able to maintain with respect to care.

So either you have to be able to perform for yourself or you have to have someone coming in.

So if your formal supports are impacted, that can impact your housing.

But in addition to that, if your condition declines, which I guess kind of goes under the new disability or changing nature of disability, that can take somebody who previously qualified for their subsidized housing and independent living and shift them where they are no longer able to live there.

BRUCE DARLING: I would just, I would, the issue about like your medical condition changing resulting in loss oof housing, I would pay particular attention to that in your states.

Because the HCBS rules are out there, that talk about what is community based from a federal perspective in terms of funding stream.

An individual has to have the same protections and responsibilities typically as is in the lease.

So like yesterday when we were talking about who pays the bill.

Actually it was less for me about who actually pays the rent than whose name is on the lease and is responsible.

There have been interesting interpretations about people being sort of removed from their housing because they are no longer safe or healthy for that housing and that's basically provider run housing, which should have these kind of lease rules in place.

I know New York has tried to make the case cause there's, providers want to say you know what, you're falling and not really safe here anymore.

Time to leave.

That was what we were trying to address in some of those HCBS rules.

So look at that.

There is not a lease for a nondisabled person that says, if you can't take care of yourself, we're kicking you out.

The issue is, can you take care of the apartment.

Are you infringing on the other people's use of the apartment?

So that would be something I would really sort of pay close attention to, because I think they are actually potentially violating some of the HCBS rules.

So then there's the sort of other class of folks who we're supporting whose independence is w maintained in the community.

I was thinking about where people are like these kind of situations where people are coming in and it's more, so there's the people who call up and say, oh, my God, I'm going to go into an institution.

And then there are the people who you are just supporting and they are kind of in the background and these things are there.

But is what we're doing actually diverting them or helping them avoid institutional placement?

I think that gets to be a real complex kind of question as we're trying to implement this in our centers.

So I sort of thought through this from my perspective.

I will talk about my center as sort of an example.

So for me there are the people who use the unique services provided by our center.

So there are some people who don't have the services, so if this service or support were pulled out from underneath them, would they end up in an institution?

I think a good example of that for us is our deaf-blind support service provider program.

In like in Rochester, I know Washington State has a whole program for this, Rochester, New York, largest per capita number of deaf people in the country, highest concentration.

No support for deaf people who go blind.

So there's always this sort of assumption, every Helen Keller must have you know, an Ann Sullivan who assists them.

No, not so much.

Basically Helen Kellers today if they don't have the support service providers are sitting at home or they are trapped, they don't even have access to the world.

For me, I'm thinking through the folks we're supporting in our deaf-blind support service program, which we're self-funding, that group of people without those services could end up in an institution.

Some of the services provided uniquely under the IL philosophy.

So like our consumer directed program, we work with, like I always thought we provided for folks with really significant disabilities, large numbers of hours, I thought that we actually helped them avoid institutionalization.

So we should have sent in a certain amount of hours, we knew that we were helping people, but in the back of my head, I was always kind of wondering, are we really?

Would they just sort of manage on their own if it weren't for us?

Basically about seven years ago in a political move the contract was removed from our center, because the local government didn't like us advocating, so they thought they could hurt us.

We watched in horror as individuals who had been in our program who went to these other agencies suddenly started dying, dropping out, s going into institutions, and it was because the IL philosophy that was embedded in our program of supporting people, and to a certain extent our centers attitude of bring on the people with the most significant disabilities, if you've had difficulty someplace else, come to us we will help make this work.

Other people didn't have that attitude, so folks really were at risk.

That is a group of folks that I think we are actually diverting.

And then services provided that meets the needs of an otherwise unserved population.

So like again in our consumer directed program, we had a group of folks, Spanish language, everything was in Spanish, we had Spanish speaking staff.

No other provider had that capacity in the area.

We also serve folks who were Somalian.

So you would not necessarily think that we would go into all the work to translate everything into Somalian and make sure that we had the ability to communicate, but that kind of, those kinds of unique services that we provide are part of really what we can do.

So if we're going to count these people, I personally, so Tim said the problem with miscounting is it might be in this category, it might be in that category.

At the end of the day is this something that's going to be life or death?

No.

I thought that was a good reality check yesterday.

At least for me, who sometimes stresses about this.

But the other part of this is, we should be trying to figure out how to best make the case for independent living and the fact that this service needs to be funded.

So although it isn't life and death, effective tracking, reporting and having a good explanation for where these numbers come from is really going to be important for us.

Maybe it's not going to decide whether your center continues or doesn't and it's not going to end up being a big old thing when you're reviewed, but it may be something that can help us if we do this well as a collective.

It can advance us as a group.

I'm watching my time.

I didn't see your thing where I'm at.

You can tell, this is how badly I'm at with this.

I wanted to give you an opportunity to do some small group work, because you asked for it.

You got it.

I can see some people are like, oh, thank you so much.

I won't call you out, Brenda.

All right.

So here is what I want you to do.

I will give you five minutes.

I want you to come up with a list, write it down, of the similarities between diversion and transition, and the differences between diversion and transition.

I will give you five minutes.

I have a list that took me a few hours to come up with.

So we'll see how well we do as a collective against this list.

All right.

 Five minutes.

All right, how are you all doing?

Are you socially chatting or all right.

Since we did small group stuff, you were laughing so maybe you were socially chatting.

What I'd like to do, is you've got your lists.

So pay attention to what other tables say.

We're going to bounce around the room a little bit.

If you see something on your list that someone else says, cross it out.

It's kind of like a conference room version of bingo.

We'll start in the back over here.

Can you give me one of your items in terms of a similarity?

AUDIENCE MEMBER: Similarity between transitioning and diversion?

BRUCE DARLING: Yes.

AUDIENCE MEMBER: Okay, they are both assisting someone from being somewhere that they don't want to be.

I would say that's definitely a similarity.

We discussed mostly about the differences, I would say, and in the differences within diversion itself, because with us in our CIL, we focus primarily on like installing grab bars, wheelchair ramps and keeping people from getting hurt and going into the nursing home, whereas with this whole talk about institutions and prisons and such that's a whole different ball game, that's more independent living skills, it takes it down a different route, if that makes any sense.

BRUCE DARLING: It does, but don't underestimate the importance of grab bars preventing you from, or the importance of taking out throw rugs, which are pretty, but just broken hips waiting to happen.

These are all, so just because we spent some time talking about prisons doesn't mean that other stuff is not important or shouldn't be talked about as well.

So the work, I think that, aside from the individual sort of direction, the work is very similar there.

I mean the kinds of topics, so like the providers that we're working with, the kinds of topic areas, that's all very similar.

Okay, since we did, like what's a difference that you all identified?

AUDIENCE MEMBER: Between transitioning and diversion?

Well, we didn't really establish, because we got stuck on that same topic.

I would say the difference is keeping, with diversion, I would say sometimes it will take a little bit more to make sure that they are safe in their home.

Whereas with transitioning, they are already out of it, we're just establishing like a new home.

It's going to be able to, it's going to be easier, I don't know.

People can say it's not easier.

I'm just going to stop talking.

BRUCE DARLING: Okay, we love small group work, next table.

Thank you so much.

There was actually a lot embedded in your answer, my lack of response was like, I could not nail that down to one thing.

There were like five different things in there.

AUDIENCE MEMBER: All right, so I guess a difference that we had mentioned was the location of where the individual is.

BRUCE DARLING: Okay, very good.

A similarity?

AUDIENCE MEMBER: That they both involve making a plan.

BRUCE DARLING: Yeah, actually the planning process can be pretty similar.

I think some of the umm, I was looking to see if I'm reading into it.

Where the person is actually has a significant impact, not just in, well it has an impact on the planning.

We'll keep going from there, thank you so much.

Next table up here.

AUDIENCE MEMBER: Transition is movement from one location to a location of a lesser restrictive environment.

That's transition.

Diversion is altering or changing the path or direction of something that's anticipated.

We used a couple of examples.

One of them was juvenile justice, you know, the high percentage of them wind up in prison.

And we were able to work with juvenile justice in changing the direction of those people by getting them involved in something other than the path they were going through after they got out of detention.

BRUCE DARLING: Let's boil it down.

Something a little more about implementation.

An implementation what's similar?

AUDIENCE MEMBER: They both have an outcome.

And they both require a plan, and depending on what you're dealing with and what the situation may be, whether it be juvenile justice, which is mental health, basically, or whether it be a ramp or grab bar or something of that nature, something that we're at least temporarily changing the direction of where this person is going.

BRUCE DARLING: I will build off of that, so I think the fact the outcome piece is really an important element here.

I was thinking about it.

You talked about the emotional element of the process can be very different in that if you think about it.

With transition, there is a positive change in an individual's life.

It still may be scary, but you're moving towards something.

With diversion, you're really trying to avoid a negative outcome, which is more fearful.

So the emotional element of these two things is going to be potentially very different.

Thank you so much.

 Next table.

AUDIENCE MEMBER: I'm being volun-told to do this.

So similarities, not so much.

They were also similar to some of the things you said, common goals of independence.

The CILs support their choices and is consumer driven ideally.

The differences we came up with was transition is regaining your independence, whereas diversion is maintaining your independence.

And diversion can be easier than transition, that is not what I am trying to say.

Diversion can be easier than trying to get the consumer out of an institution.

In other words, if you can divert before they get institutionalized, then.

BRUCE DARLING: Let's delve into easier.

That's up a couple of different times.

Easier is a interesting framing on it.

So when we say easier, what do we mean about diversion being easier?

AUDIENCE MEMBER: He said less obstacles and I think that, or barriers.

BRUCE DARLING: I was thinking of it in terms of scope.

Diversion is often you've got a specific thing.

It's a more limited scope in terms of what you're doing.

So that could in some ways seem easier.

Because it's this thing.

Transition you basically need to build the entire life.

Diversion, you need to clean up this one thing.

So it is, you know, I would argue though, it may not be easier, per se, because there are some complicating factors, but scope is definitely a difference.

Thank you so much.

All right, Tim, your choice, whatever direction you want to go.

AUDIENCE MEMBER: We kind of agreed with most of what has already been said, but talking about the scope of transition versus diversion and being the different mindset of the consumer and the individual you're working with I think is one of the biggest differences.

Wendy talked a little bit about the mind set of somebody who has been in a nursing home for a while yesterday and I think that's a big difference.

And then in terms of similarities, at least at our center, both cases would get a lot of core services.

They both need independent living skills and those type of services with all our staff.

BRUCE DARLING: Very cool.

So mind set, so you're talking about whether someone has been institutionalized and needing to break through that piece.

That's a great one, for the record, that was not on my list, good.

All right, next.

 Got it.

AUDIENCE MEMBER: Okay, for similarities, basic needs and resources and services need to be in place in order for both to be successful.

So that needs to be looked at, like the whole.

And then for differences, with diversion, there are still resources in place, you're not building it, like you said, from the beginning.

BRUCE DARLING: Cool, thank you.

All right, so wherever.

Here.

 Thank you, Tim.

I see the five minute sign.

Those of you who are worried, oh, my God he's going to get to me and we're not going to have anything left on our list, stress a little less.

AUDIENCE MEMBER: For similarities, we were talking about that each individual has experienced some major life situation that has got them, you know, one ended up in the institution, and one is trying to remain out of.

But each of them have experienced some major life situation.

And in differences, we're going to disagree with the resource thing, because if you have got say someone who is homeless, when you're transitioning someone out of a nursing home, you usually have that, those resources to help them get set up in a home.

Whereas someone who is homeless and just comes in, you may not have all those resources, and that can really make a difference if someone is successful when you're putting them in housing if they have everything they need.

Or whether they are in an apartment with no furniture and nothing else.

BRUCE DARLING: On my list, I was thinking generally there's less requirement for setting up a full household, but that doesn't necessarily preclude it.

So I agree, I think you're making that clear.

We can move to the next table.

But the other thing that I was thinking about related to that was, so there is a difference between when you finish the process, it is celebratory when a person transitions into the community, not so much when you avoid disaster.

You know people are always at the, even when you avoid disaster, you're always waiting for the next shoe to drop.

The other thing, in relation to that, though, is it's less heartwarming to say you're preventing an institutionalization, so you don't get as much excitement from people as well.

So when the situation where you do need to set up a household or get things together, it's less likely you're going to get people to say, that's so sweet, here, let me give you this.

It can be a little more difficult that way.

Where did we.

AUDIENCE MEMBER: All right, we're running pretty low on ideas here that haven't already been voiced.

But one of them is that in both diversion and transition, you're using your same core services that you're already performing to support the individual as well as housing as a major source of focus for both diversion and transition.

The differences, the two differences that really stood out to us were on children are more often involved in diversion, because if you've been placed in a nursing home, you probably don't still have child care responsibilities, that can vary obviously.

But in our experience, they were more encounters where people were still trying, still had legal responsibilities over the children in a diversion context.

And then there's less kind of speaking to the diversion being more limited in scope.

There's less institutional structure to fight in diversion, there's not the restrictions in place that the nursing home.

But at the same time we've also had experience where social workers in nursing homes have been very helpful in transitions, and you do not have that support available to you in a diversion setting.

BRUCE DARLING: Okay, and it may actually go.

So, like, different, I had different institutional providers are not involved.

But you may be dealing with a hospital, and it is kind of interesting.

There the social worker may not be your friend.

So their goal is to push the person out of the hospital and into the nursing facility, and you're doing everything you can to stop it.

You may find your typical allies are not in this case.

All right, so then, does anyone have a burning thing they want to share?

Seeing none, a few other things.

I will add, there's the same legal basis.

So Olmstead still applies in diversion as it does in transition.

Same expectations of confidentiality.

So all of the things that we need to think about there.

Talked a bit about the financial pressures exist are the same.

So the institution is trying to keep the person, because they want to keep the money.

Sometimes the hospitals are trying to push the person out, as I said.

The stuff that we talked about around fear of disclosure is the same in both situations.

So you're going to, although the institutional mindset is different potentially, the whole fear of disclosure is equally potentially more so in a diversion, because the person is trying to save their.

Both are stressful, we talked about them being major life experiences, so both are stressful.

Time I think though is the biggest thing with diversion.

When you've got one of those crisis calls, you are on the clock and you have to figure this out.

So it may be a smaller scope, but you have got to get it done quick, figure it out, and you need to know your resources like this, you don't have time for an extended planning process sometimes or some of that extended process.

The last similarities, family dynamics may be very similar.

So they may be, so in the case of the family may fear the person coming out because they want to keep them safe.

The family may want to be pushing the person in because they're kind of burnt out if they have been over utilized.

There's a similar need to sort of address the fact that everyone blames the individual.

Including the individual, this is all my fault.

We have to deal with that.

Probably the biggest difference though is that sometimes diversions are happening right under our nose, and we don't even realize that it's happening.

Which makes them harder to track.

I defy you to find a center where they have transitioned someone out of an institution into the community and no one noticed.

Cause I know it is basically a big freaking deal in our center when we do a transition.

So those are really highlighted.

The people who are doing the tracking actually are paying a lot of attention to that.

With this, I will turn it over to Darrel.

Thank you.

DARREL CHRISTENSON: Hey everybody, how are we doing?

Before I get started on my little piece, I want to say thanks for all your feedback from yesterday.

The Post-It notes, obviously very helpful.

Hopefully it's helpful for you to get clarification.

And again thank you for your participation.

And for being here and with that, I want to say thanks.

My part right now is to talk about how the four or five now core services, four core services really relate to diversion and transition.

And I kind of got a sense yesterday morning that a number of people in the room were feeling trepidation about this.

That it was going to be, again, that unfunded mandate, more work, more reporting, no new money, and right now I want to reassure, again, that you're already doing it.

And give yourselves credit for that.

So you're doing it through the original core services.

And as refresher, for old and new, or veteran experienced people and newbies, the information and referral, peer support, independent living skills, both individual and systems advocacy.

You're already doing this, nothing is new.

How do these services play into both diversion and transition?

Let's take, first of all the information and referral piece.

Knowledge is power.

We've heard that since we were kids in elementary school.

That the more knowledge you can gain, the more power you have, more control.

Because you're working from a fact based basis, and whether your staff know your resources for consumers or if you're a consumer going out in the community, living life like anybody else, then that knowledge gives you strength.

Learning about the disability community, the resources, services, programs, vital to both populations, both populations being transition and diversion.

So think about folks that are new to a disability and they are newly injured, maybe they're coming out of rehab or still in rehab, actually.

Learning about the resources in the disability community isn't something that the general public knows a great deal about.

They know about Chevies, and Fords, and all the basic stuff, the common things.

But as you go through life, knowing resources in the disability community are particularly applicable to people with disabilities, that's not common, main stream information.

So if you have a new disability or you have a family member, man, that's a whole new world that's opening up that you never even touched.

You think about how many kids that are growing up with limited, not more, but limited access to interacting with someone with a disability.

So to know about the resources?

No.

So the whole idea that maybe you have a spinal cord injury or traumatic brain injury or such, and all of a sudden on Monday you're fine, and Tuesday afternoon you go down the highway, get into a car accident and, boom, life changes.

Man, that's turning your world upside down.

And all these new acronyms and all these new services and all this new information, just being avalanched upon you, that's overwhelming stuff.

Right?

That's overwhelming, because you never even had a basis to work from prior to Monday's accident.

So when you look at that and think about it, if you're an individual, man, that's turning your world upside down.

And what happens now?

You hear a lot about people being depressed and suicidal because life has changed on its ear.

And I don't know if studies actually back this up, but I would say for men, where much of their identity is based on physical proudness, I'm a man, I'm strong, I can lift a truck, you know.

And all of a sudden, a spinal cord injury changes that.

Man, you know?

People are saying I'd rather be dead than deal with this stuff.

And so as a family member, that changes the whole dynamics.

I remember when I did my graduate internship in Wisconsin, there was a gentleman in a hospital bed in their living room, and to use theater terms, the spotlight was center stage on him and the two of us that came in from the center, a spotlight right on him in his hospital bed in the living room.

Off in the kitchen was his wife.

Off in the wings, off stage.

Like a stage manager.

And even though initially we were spending all our time with him, I realized what was going on, and I just quietly came over, and said, this is a big adjustment for you too, isn't it?

And she wept and she said, yeah.

My relationship with my husband is so different now.

It's not an equal partnership.

But I'm going to have to be his care giver for much of this, and my relationship as a mother, because we have two young daughters, has changed.

And so off in the wings, she was grieving a loss as well.

So when we came in and we worked with both of them and programs, that's powerful stuff.

But again, put yourself in their shoes.

That's not a basis from which you had a working knowledge at all prior to Monday's accident.

You were there to provide information and whether you can provide the service in your center or if it's in the community, I don't care.

But your piece is to provide that information.

So it's both services internally to keep people in the community and moving people back to the community.

Referrals to the community partners also achieve both objectives.

Again, keep in mind that an empowerment piece, you can give them the information and the phone numbers, but don't make those calls for them.

Because that's empowerment.

You can tell them what kind of questions to be asking.

And support them that way, but they need to take that ownership.

That's where they learn.

And CILs need to be knowledgeable to assist consumers.

As far as peer counseling, that's a no-brainer as well.

I'm preaching to the choir here.

Who else is better able to assist than peer mentors?

When we had a peer mentor come into that gentleman's house, he also had a similar injury, young man in his late 20s.

He came in later and mentored him.

That's powerful stuff.

I tell people, I tell anybody that will listen, my credibility in working with consumers does not come because I put a suit jacket on.

My credibility with consumers doesn't come because I have a master's degree hanging on the wall with counseling.

My credibility with consumers comes from a lifetime experience as a person with a visible disability, that's where the credibility comes.

That's where the peer mentoring happens.

Centers are represented, obviously, by a majority of people with disabilities, that's a built in base.

Both populations learn from folks that have been there, done that.

Especially, like I said yesterday, if you can get to people in the rehab setting those first three weeks, get it to them early so that they don't get that information that life is over.

Give them the message that life has changed, but it's not over.

It's different.

Share your experiences and stories are powerful ways to go grow and learn confidence.

Volunteer peer mentors are useful extensions of staff.

So to recruit and train them to assist.

I worked at a couple of different centers now.

One who paid their peer mentors for their time.

And when I worked for another center, where it was strictly on a volunteer basis, that was an adjustment in my brain to figure that out, why this was even better.

It was different certainly, but the dynamics are so much better if they are on a volunteer basis.

Because otherwise you come into the home and you're just another paid professional to be here, and that peer mentoring as a paid position is being viewed differently.

People view it differently.

You're just another paid professional as a peer mentor.

But if you volunteer that's a whole different game in people's minds.

Independent living skills training, and that as we know includes financial management, cooking, goal setting, transportation, sexuality, social skills, et cetera, the whole nine yards.

Financial management, that's our number one.

I don't care if you are getting 733 from Social Security Disability or if you are that millionaire on a private pay basis.

Managing money is important.

And everybody in this room, if we had our financial manager come in, everybody in this room would benefit, right?

Yeah.

Sexuality, you know, oh, my God, the person with a disability thinks about sex?

They have sex?

And they enjoy it?

Yeah.

But it may be different, but you can still enjoy it.

Teaching the IL skills reduces reliance on others, such as parents, attendants and other paid professionals.

Again, if you can be more independent in your life, whether it is cooking or doing whatever, then you have less reliance on attendant care and other, you know, spouses and such.

Increasing skills and abilities for one's self, increases the confidence, self-esteem.

I talked yesterday about the pompoms and the cheerleader and being the rah-rah person.

I hope you didn't get the wrong impression that in doing so, I'm thinking I'm just looking at life through rose-colored glasses, and if you got that impression from me yesterday, I'm sorry.

Because that's not my intent.

But you got to look at things realistically, but use it from a strength base rather than focusing on just the disability and what you can't do or need help with.

So independent living skills gains confidence, self-esteem, also with safety and independence.

Okay, somebody was talking about falls and falls prevention.

I'm on the Arizona Falls, our agency is on the Arizona Falls Prevention Committee, and I don't remember the numbers offhand, but the amount of money that's spent for hospitalizations, ERs, and nursing homes caused by falls, astronomical.

So if we can reduce the likelihood of falling, no matter what the disability or situation is, we're going to save them a lot.

You hear the old joke that 90% of all accidents happen within two miles of your home.

That's why people move three miles away.

Okay, cheap joke.

But you're awake, thank you.

Bruce?

 Okay, we're good.

BRUCE DARLING: I was laughing.

DARREL CHRISTENSON: Good, Bruce was laughing, thank you.

But and in talking about the throw rugs, I mean, Aunt Mable made the throw rug for us, we love Aunt Mable, great memory.

Hang it on the wall.

It's a great decoration on the wall, rather than a fall waiting to happen.

More and more my staff are working with people that are hoarders.

Oh, my gosh.

I mean, even put a number of these families on the hoarding show right, where you are barely able to squeeze through one little pathway because of all these piles of magazines or whatever.

And if you can graciously suggest that you move some things out or rearrange furniture, this is a way of doing low tech home modification.

It is, right?

If you can rearrange furniture or get rid of a couple of those piles, you've done some home mod, and it didn't cost the county anything.

So individual advocacy, of course we're by nature an advocate organization, this assists both populations by speaking up for one's needs or desires, stay out of or move out of an institution.

Learning how to advocate and know that your needs are valid.

That's a big one.

How many times have we all heard, I don't want to rock the boat for just little old me.

I don't want to make a big fuss.

That might get somebody's job in jeopardy.

So I won't say anything, it will be fine, I will get by.

We teach self-advocacy skills and we advocate with, and not for the consumer.

It would be so much easier, hey, I know Bruce over at the center, I will give him a call for you.

Hey Bruce old buddy, can you help me out over here, I have got this consumer, no.

It may be more efficient and quicker, and may get some good results, because we know each other and we're going to help each other out with a consumer.

But are you really doing the consumer any good?

Are you really benefiting, giving benefits to that consumer?

We would say not.

I had a co-worker who used to get on me because I wasn't doing so much of that like she was.

I'm like, really?

 No.

I'm doing more for the consumer because I'm giving them information and they're making the calls rather than you doing all this hand holding for them.

Where does that get them?

That doesn't teach anything.

So do it with them, not for them.

And expressing empowerment and confidence.

Systems advocacy, making communities more accessible and inclusive so individuals can make use of the information, resources and skills that they acquire through the independent living services.

So it's individual advocacy and systems advocacy.

So bottom line people, is embrace diversion and transition.

If you have concerns about your CIL providing these services, as you can see, even without additional funding, you're already doing it.

You're already doing it! Through the original core services.

Until yesterday, you probably didn't realize it.

And consider the role of the ancillary programs that you have, such as the home care, the rehab visits, employment and benefits to work, empowering youth, socialization through recreation.

Boy, that's an easy draw for consumers to come to your center.

It's easy for them to come to a social event, dip their little toe in the water of independent living, and they'll find out that this place is okay, I might come back.

It's not intimidating, but it's a great entrance to other services.

Home modifications, the ADA technical assistance, all these ancillary programs that many of us are doing, and many of you have these, and others to assist in achieving these goals and objectives.

So think about that as you look at diversion and transition.

And with that, I think I'm on time.