Roads to Community Living

Developmental Disabilities Administration 2013-2014 Report

Roads to Community Living Staff:

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Roads to Community Living

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Executive Summary

Roads to Community Living (RCL) supports individuals with developmental disabilities who want to move from an institutional setting to the community. RCL is a demonstration project federally funded through the Money Follows the Person grant. RCL assists individuals and their families to explore and establish the services and supports that help to create a successful transition to the community. Grant funds provide individualized supports for each RCL participant, both in preparation for the move and for the first year following the move from an institutional setting. The grant began in January 2007 and was extended through 2020.

Developmental Disabilities Administration (DDA) Roads to Community Living engages and collaborates with individuals, their families, community members, paid providers, and other involved people so that individuals with developmental disabilities can:

- Make informed choices about where and how they would like to live.
- Live, work, play, and contribute in the community of their choice.
- Lead safe and healthy lives.
- Strengthen and enrich the communities where they live.

DDA believes that anyone can live safe, healthy, productive, and enjoyable lives in the community. RCL provides the supports necessary to make this a reality for RCL participants.

During 2013, 29 individuals moved to the community from an institutional setting with RCL supports. During their RCL year, four of these individuals moved back to a RHC and two individuals passed away. During 2014, 53 individuals moved to the community. There was a significant increase of individuals who moved from Skilled Nursing Facilities during 2014.

Interviews and information collected through visits and interviews with individuals who moved indicate that for the most part, individuals like where they live, are satisfied with their supports, and can make decisions about what's important to them. Many individuals indicate they want a job, more opportunities to participate in the community, and to make friends.

Many important projects, trainings, and initiatives were funded by RCL Reinvestment funds during 2013-14. These projects strengthen and improve the services provided in the community and are determined by evaluating lessons learned from individuals who continue to live successfully in the community after transitioning from an institutional setting. Some of the reinvestment projects include:

- The Family Mentor Project: The family mentor has assisted 50 families during the various stages of their family member transitioning from institutional to community living.
- RHC and Community Events: Four events were held and each brought together about 80 individuals to hear stories and discuss what makes successful transitions from individuals moving from one of the four RHCs to the community.
- Numerous workshops, consultations, conferences, and trainings were held throughout Washington communities and covered topics including, positive behavior support, supporting individuals on the Autism Spectrum Disorder, wrap around service model, supporting valued social roles in the community, reaching goals for a meaningful life, how to teach, building leadership and hope in the work place, environmental supports and housing, safe eating and swallowing, assistive technology. These learning opportunities were

conducted by national and local experts. Hundreds of people attended these learning opportunities. In addition, over 800 people attended the Community Summit held in 2013 and 2014.

- The Employment Project: Consultants work with individuals and their employment providers and local counties to develop person centered employment plans and support efforts to secure a job for the 22 RCL participants involved in this project. So far, seven have paid employment.

Please read the following report for more details about the RCL participants who moved to the community, the RCL Reinvestment Projects, what the Regions have been doing, and lessons learned.

Roads to Community Living
2013 -2014 Report

Roads to Community Living Participants

Who are the RCL individuals who participated from 2011 through 2014?

Enrolled and residing at RHC or other institutional setting	# of individuals			
	2011	2012	2013	2014
Fircrest	11	7	7	11
Rainier	9	6	14	14
Lakeland	2	0	4	3
Yakima Valley School (YVS)	0	0		4
Other (Skilled Nursing Facility, CLIP, State Hospital)			13	23
TOTAL	**22**	**13**	**38**	**55**
Left an RHC/institutional setting during the year and had a portion of their RCL year residing in the community	**# of individuals**			
	2011	**2012**	**2013**	**2014**
Fircrest	6	3	7	9
Rainier	4	6	5	8
Lakeland	0	2	3	1
YVS	4	2	4	5
Frances Haddon Morgan Center (closed 12/31/2011)	31			
CLIP		3	2	3
Skilled Nursing Facilities (SNF)		10	6	23
Eastern and Western State Hospitals		3	1	2
Other	6		1	2
TOTAL	**51**	**28**	**29**	**53**
Living in the community during the RCL demonstration year	**# of individuals ***			
	2011	**2012**	**2013**	**2014**
Region 1	5	4	10	10
Region 2	11	10	10	11
Region 3	9	35**	7	9
Total	**25**	**49**	**27**	**29**
***** Total RCL Participants**	**98**	**90**	**94**	**137**

*This is the number of RCL participants who had discharged from an institutional setting the year before but still had a portion of their RCL year in the community.

** Most of the individuals who moved from FHMC in 2011 moved to homes in Region 3 communities.

*** This number represents the total number of individuals who participated in RCL at some point during the year. This number includes individuals signed up for RCL who still live in institutional settings , individuals who transitioned from an institutional setting and moved to the community during the specified year, or individuals who moved from an institutional setting the previous year and are still in their demonstration year.

Individuals moved to the following Regions:

Where individuals moved:	Number of People	
	2013	2014
Region 1	8	13
Region 2	12	23
Region 3	9	17
TOTAL	29	53

During 2013, of the 27 RCL participants who were already living in the community:

- 5 individuals moved back to an institutional setting. 2 individuals moved back to Fircrest and one of these individuals returned to the community in 2013. 1 individual moved back to Yakima Valley School, one individual moved back to Lakeland Village, and one individual returned to Eastern State Hospital.
- 3 individuals passed away while living in the community.

During 2014, of the 29 RCL participants who were already living in the community:

- 4 individuals moved back to an institutional setting. 2 individuals were admitted to Rainier School, 1 individual was admitted to Yakima Valley School, 1 individual was admitted to the hospital
- 1 individual was disenrolled from RCL as he was admitted to a correction facility for over 30 days.
- 2 individuals passed away while living in the community.

Average length of time lived in a Residential Habilitation Center (numbers below do not include other institutional settings):

Length of Time at RHC	Number of People	
	2013	2014
Over 25 years	2	2
Between 15 and 25 years		
Between 5 and 15 years	2	2
Between 1- 5 years	5	7
Less than 1 year	10	12
TOTAL	**19**	**23**

Age when they left the institutional setting (this includes all settings):

Age	Number of People	
	2013	2014
Over 50	6	17
Between 35 - 50	7	11
Between 25 - 35	4	12
Between 20- 25	6	8
Under 20	6	5
TOTAL	**29**	**53**

Personal stories and videos

Two videos were completed in 2013. These two videos tell the story of individuals who have left an institutional setting to live in the community and their search for employment and a meaningful life.

2013 RCL videos:

- Jemal's Story showcases how he found a job in the community and the people who support him. Jemal moved from Frances Haddon Morgan Center to a home in Kent in 2011.
- Tom's Story tells how he found a job in the community. Tom also moved from Frances Haddon Morgan Center in July 2011 and moved to a home in Shoreline, WA.
- These videos can be found on the RCL website.

Stories:

- **Stephen's** story was featured in the November 2014 Community Inclusion Newsletter http://blog.satraininginstitute.org/community-inclusion/. Stephen moved back to his parent's home on Whidbey Island from Fircrest. The RCL Community Connector supports have helped Stephen to become an active participant in his community.
- **Tami** moved to a home in the Lacey community after living in both Fircrest and Rainier School for a total of 52 years. Rosemary Krueger, Family Mentor Project, supported Tami and her large family to make this move to the community. The following is Rosemary's story about Tami's move:

Kathy Thompson, Tami's sister and guardian, responded to a letter sent in June 2012, about RCL and living in the community. Kathy became inspired about Tami's possibility of moving to the community after seeing photos of people who had successfully moved and also visiting agencies and their homes in the community. At age five, Tami moved to Fircrest where she lived for 27 years, and then at Rainier for 25 years. Tami's large family was quite hesitant about her moving from Rainier. They felt she was happy at Rainier, that her staff was family to her, and that any change would be scary and upsetting. Tami has Pica and that added to their concern for her health and safety.

Eventually the family decided to make the change and after extensive planning, in June 2014 Tami moved to a lovely home in Olympia, close to her family. She adjusted easily, but was frail and underweight. Since she has moved, Tami sees her family often. She enjoys eating her choice of foods and has gained weight and strength. She loves having one on one staff attention. She has nice new clothes to match her beautiful smile.

Her guardian is now a strong advocate for families who are considering a transition. She tells them that Roads to Community Living and the Family Mentor Project hit it out of the park for Tami!

- **Sam* moved to the community after living at Rainier School for three years.**

Sam's transition from Rainier School into the community has been a long road. He was initially admitted to Rainier School following an almost fatal chocking incident. This incident was traumatic to Sam and he refused to eat. Many attempts to get him to eat were tried, but were unsuccessful. Ultimately he required a g-tube. Aside from the health concerns Sam has always had challenges with his vision and behavior, but made significant progress while at Rainier School. Through diligent efforts at Rainier School, Sam no longer required the g-tube, walked around his environment safely and engaged in other enjoyable activities. As Sam continued to make progress in both health and managing his behavior, community living seemed closer than ever. For over a year Rainier School worked closely with Sam's supported living agency to ensure that he acquired the skills he needed to succeed in the community. Because of Sam's visual impairment and ambulation difficulties, he needed a physical environment that would enhance his ability to move around and be more independent. Prior to his move, George Braddock, an accessibility home specialist from Oregon, developed a plan outlining a physical environment which would benefit Sam. Sam's supported living agency found him an apartment that fit what he was looking for.

Sam's transition to the community has been successful. He moved into a one bedroom apartment by himself. A piano was in his living room when he moved in since he is happiest when he plays the piano and likes to spend time playing for himself and others. He lives close to his mother and gets pleasure and comfort from her visits. At first, he had some difficulty getting use to his new environment, but has figured this out quite well by feeling his way around.

Even with careful planning and support there were challenges. Sam did not like to shower because the bathtub in his now home was not like the one he used at Rainier. Through support and patience of staff and Sam, he has achieved a good working knowledge of the structure of his bathroom and is becoming more successful showering by himself. Just recently, Sam was sitting at his piano and suddenly got up and felt his way to the bathroom by himself. The staff praised him and he kissed his biceps which is something he does when he's happy and proud.

To develop his communication and ability to orient himself around this home, Sam is receiving consultation from Jennifer White, a communication specialist. Sam continues to grow and develop skills that he's never shown like putting his meal dishes into a plastic bin instead of tossing them on the floor, using sign language to communicate his wants and needs, making choices about what clothes he wears for the day, and putting his shoes on after signing "shoes". He knows when it is mealtime by the sound of the processor and will make his way to his table. He also recognizes the sound of staff's voices and will seek them out to interact or to tell them what he needs. Though many of these skills may seem trivial to some these are skills that Sam has rarely or ever displayed. He continues to grow as a person and community member as he explores his new home and community.

**name was changed for privacy reasons*

Quality Assurance

Quality of Life Surveys:

The Developmental Disabilities Council (DDC) contracts with DDA to conduct the **Quality of Life surveys** as required by the federal Money Follows the Person Grant. Three surveys are completed with each RCL participant. The first survey is done two weeks before they leave the institutional setting, and then one year and two years after individuals have moved to the community.

For each interview, DDC staff is accompanied by a self-advocate who volunteers to help conduct the survey. DDC has trained 24 volunteers throughout Washington to help conduct these interviews. One former RCL participant, who received the survey, volunteers to conduct these surveys.

A sample of survey results from March 2012 – September 2013 include the following:

Question	Answer	Visit 1 Before leaving institution	Visit 2 One year after move	Visit 3 Two years after move
Do you like where you live?	Yes	69.35%	97.5%	100 %
Do you feel safe living here?	Yes	87%	97.5%	100%
Can you be by yourself?	Yes	69%	90%	100%
Can you choose the food you eat	Yes	58%	87.5%	100%
Can you talk on the phone without someone listening in?	Yes	71%	90%	100%
Do you ever go without taking your medication when you need it?	No	82%	95%	100%
Do the people who help you treat you the way you want them to?	Yes	92%	97.5%	100%
Do the people who help you listen carefully to what you ask them to do	Yes	89%	97.5%	100%
Can you see your friends and family when you want to see them?	Yes	89%	92.5%	100%
Can you get to the places you need to go, like work, shopping or the doctor's office?	Yes	92%	92.5%	100%
Are you working for pay right now?	Yes	Not asked	20%	14%
Do you want to work for pay?	Yes	Not asked	60%	57%
Are you doing volunteer work or working without pay?	Yes	Not asked	27.5%	43%
Do you go out to do fun things in your community?	Yes	90%	97.5%	93%
Would you say you are a little happy or very happy?	Very Happy	71%	75%	93%

Mover's Survey:

DDA's Mover's Survey is another process to determine how well individuals are doing after they move to the community from an institutional setting. The Mover's Survey is conducted three times within the first year after the RCL participant moves by DDA Performance and Quality Improvement staff. The first survey occurs within 30 days of the move, the second by 6 months after the move, and the 3rd by the one year move date. The Survey includes questions for both the RCL participant and the residential support staff.

A sample of survey results from January 2011 – June 2013 include the following:

Question to Client	Answer	Visit 1 30 days after move	Visit 2 4-6 months after move	Visit 3 One year after move
Are you satisfied with the services you are getting?	Yes	92%	90%	96%

Do you like where you live?	Yes	76%	74%	79%
Are staff nice and polite to you?	Yes, most staff are nice	89%	82%	96%
Do you feel safe while being supported by this provider?	Yes	94%	91%	98%
Are you satisfied with the overall quality of support given to you by this provider?	Yes	92%	80%	91%
Do you work or got to school?	Yes	26%	43%	40%
Do you want to work or go to school?	Yes	70%	77%	77%
How often do you do things outside your home each week?	Daily	53%	65%	62%
	2/3 times a week	35%	29%	31%
Do you have friends who are not staff or family?	Yes	66%	81%	86%
Do you go out to have fun?	Yes	88%	89%	96%
Are you encouraged to make your own decisions about what to do and when?	Yes	100%	100%	100%
Are you happy with your life?	Yes, happy	77%	68%	76%
Can you tell me how you like your new home?	Likes new home	85%	70%	80%

Roads to Community Living Activities and Accomplishments

RCL Reinvestment Projects that Benefit the Entire Community

To participate in the Money Follows the Person federal grant, each state must establish two components: (1) A transition program that helps Medicaid eligible people who want to move to the community from what CMS classifies as institutions, and (2) a practice of implementing rebalancing or reinvestment projects that assist state long-term support systems to be less reliant on institutional supports, allowing them to rebalance the system more toward community-based living. RCL, as a Money Follows the Person grant, undertakes dozens of these reinvestment projects each year. Examples of the 2013 -2014 RCL reinvestment projects are as follows:

Outreach and partnerships between RHCs, families, and community providers:

- ✓ **The Family Mentor Project –** The Family Mentor is a parent of an individual who moved from an institution to the community. She provides information and support to families and guardians of individuals living in institutions who are going through the process of deciding whether or not a move to the community. If the individual and their family decide to move to the community, the Family Mentor continues to provide encouragement, advice, and additional resource for support as issues arise. Highlights from 2013 -2014 include:

- Assisted 50 families at various stages in the transition process including over 600 personal interactions to provide information and/or emotional support.
- Documented personal journeys to the community by producing a project photo album.
- Established online resources for families through the Family Mentor Project website. http://www.familymentorproject.info

✓ **RHC and Community Events –** RCL convened four events focused on each of the RHCs. Each event brought together approximately 80 people including RCL participants and their families, RHC staff, community service providers, DDA Regional and RCL staff to discuss and celebrate the practices and attitudes that have created successful transitions from RHCs to community living, strengthen networks and identify opportunities to continue to improve transitions.

October 2013	Fircrest
May 2014	Rainier School
May 2014	Yakima Valley School
October 2014	Lakeland Village

John O'Brien and Connie Lyle O'Brien from Responsive Systems Associates facilitated these workshops. Each event heard and reflected on three stories of transition told by the people involved. Workshop participants worked in small groups to determine practices and attitudes that create successful transitions. (See attached report for more information.)

✓ **Mailing Information to Families -** Individuals living in RHCs and their families received information explaining the opportunities afforded by the Person-Roads to Community Living grant and the Family Mentor Project. This letter described the supports available for individuals considering a move from an institution to the community and who is available to answer questions regarding such a move.

Building community capacity for individuals who present challenges to the community support system:

✓ **Workshops and consultation related to Positive Behavior Support** were held throughout the state for a variety of audiences. The intent of this training is to improve the use of positive behavior support strategies for individuals living in the community in the areas of assessment, data collection, and analysis of behavioral supports. This has included:

- Institute for Applied Behavior Analysis (IABA) led by Dr. Gary LaVigna provided a 4 day long workshop in Renton that concentrated on Functional Assessment, Positive Behavior Support Plan development and implementation and positive responses to crisis situations.
- Dr. Peter Gerhardt provided a day long workshop about sexuality and challenges for individuals diagnosed with Autism. He also led a day long discussion with employment providers to promote ideas and possible future directions to help individuals with significant disabilities become employed.

- Dr. Travis Thompson provided a half day workshop in both Region 2 and 3 on behavioral pharmacology and some of the more recent research on pharmacology and intellectual disabilities.
- Dr. Baker Wright provided 3 introductory workshops on functional behavior and functional assessment. Dr. Wright also provided a workshop on Autism/Asperger's Disorder. Consultation was also provided at Rainier School regarding individuals enrolled in Roads to Community Living.

✓ **Mental Health Pilot**: The purpose of this pilot project is to help facilitate successful transitions for individuals who are stable and ready to move out of Western State Hospital or another acute psychiatric facility to homes in the community. Roads to Community Living has partnered with Sound Mental Health to demonstrate how appropriate proactive supports can help to minimize the need and use of crisis support services. Activities to date include:

- Sound Mental Health is evaluating this model of proactive support and training in comparison to the current support crisis team practice which requires participating individuals to receive crisis support services.
- The project currently supports six individuals residing in Region 2. The current participating individuals have lived in the community for several months and have not required the support from crisis services.
- Additional participants will be needed to create a larger sample size to determine effectiveness.

✓ **Developing best practices for supporting individuals on the Autism Spectrum Disorder (ASD)**: Many individuals with ASD have moved to the community from institutional settings on RCL. Community providers need to be prepared with skills and information to support individual's with ASD. RCL collaborated with several counties and community employment and residential providers to develop and implement the Autism Best Practices workshop series facilitated by autism experts to build statewide capacity and expertise. This included:

Date	Where	Who	Topic	# Attending
4/18/2013	Seattle	James Emmet	Employment	40
10/17/2013	Seattle	Nicolette Brigham	Overview	140 (2 sessions)
11/5/2013	Seattle	Dorothy Blubaugh	ABA – Positive Practices	100
12/12/2013	Seattle	Jennifer White	Communications Strategies and Supports	75
1/9/2014	Seattle	Nicolette Brigham	Introduction	75
4/7/2014	Yakima	Jennifer White	Communication	
4/8/2014	Spokane	Jennifer White	Communication	
4/8-9/2014	Renton	Martha Leary and Anne Donnellan	Sensory and Movement Differences and Diversity	30
4/18/2014	Seattle	Peter Gerhardt	ABA and Employment	30
9/24/2014	Renton	Nicolette Brigham and Marsha Threlkeld	Visual Supports	40
11/17/2014	Renton	Dr. Carol Schall	Autism Spectrum Disorders in Adolescence and Early Adulthood: Characteristics and Issues	100
11/18/2014	Shoreline	Dr. Carol Schall	Consultation to Shoreline	20

			School District, employment providers, and Fircrest regarding RCL participants	
11 – 12/2014 (cohort will convene monthly through 6/2015)	King and Kitsap County	Dr. Nicolette Brigham Christians and invited guest speakers	Autism Learning Cohort for supported living and employment providers in King and Kitsap counties.	32 individuals (9 employment and 7 supported living agencies each sending two staff)

- ✓ **Limiting Risk in Community Residential Programs:** This project focuses on strengthening the community residential system by reducing health and safety risks of individuals receiving supports from residential providers. A group of Supportive Living providers developed a plan and process to identify potential risks to prevent problems from occurring. This risk prevention process helps direct support staff to systematically identify, plan for and prevent dangerous events from occurring and, if the event occurs, how to learn from it. The principles established by the project are being integrated into DDA policy.

- ✓ **Wrap around services training**: Trainings were developed and facilitated for families, community providers, and CRMs regarding natural supports and the wrap around model helping to avoid institutional placement of children. In 2013, workshops were held for approximately 20 people in Vancouver, Kennewick and Spokane. In 2014 a workshop was held in Kent. A series of ten "Wrap around trainer videos" were created and distributed to partnering organizations. These were developed in collaboration with CA, BHSIAA, JR, and other community partners.

Strengthening DDA Values and Person Centered Practices:

- ✓ **Incorporating Values of the Residential and County Guidelines:** DDA engaged John O'Brien and Connie Lyle O'Brien of Responsive Systems Associates (RSA) to explore how the Administration could better incorporate long held values as outlined in the Residential and County Guidelines into all aspects of the DDA system.
    - RSA facilitated numerous planning sessions and workgroups based on **Appreciative Inquiry (AI)** as a way to learn from what is working well and how to extend that knowledge and practice to other areas within the DDA service system.
    - RSA also facilitated "***Supporting Social Roles*"** workshops throughout Washington for community providers to learn and practice ways to support individuals with developmental disabilities to have valued roles in the community such as neighbor, worker, volunteer, and community member. This workshops were held for up to 30 individuals as follows:
        - February 2013: Tukwila
        - October 2013: Shoreline
        - March 2014: Bremerton
        - March 2014: Tumwater
        - May 2014: Yakima
        - October 2014: Spokane

- ✓ **Make A Difference curriculum and workshops:** The Make a Difference process was developed by John O'Brien and Beth Mount for direct support workers to make a difference in the lives of the people they assist. This workshop guides "learning partners" (individual with developmental disabilities and his/her direct support staff) to act as full citizens who make worthwhile contributions to their community. Make a Difference workshops was developed and facilitated by Joanne Drewsen as follows:
    - Three Supported Living organizations in Region 2 participated in this workshop. Each organization identified four pairs of "learning partners" to participate in these workshops. Participants met each week for over eight months.
    - Each learning partner discovered how to engage and participate in their community by contributing their interests and building relationships with other community members.
    - Make a Difference learning partners presented their stories and experiences at the 2014 Community Summit in Wenatchee.
    - A "learning partner" team created a video of their experience which has been used to inspire others to get involved. (attach link to video)
    - During 2014, Make a Difference was expanded to include other Supported Living organizations in Region 2 and also increased the number of facilitators for these workshops.

- ✓ **Community Summit (statewide conference):** A committee representing various stakeholder groups plans the yearly Community Summit. The Community Summits bring together approximately 900 individuals including people with disabilities and their families, community providers, public employees, and other interested community members to discuss ideas and learn how to build inclusive communities. Each Summit includes national and local speakers, workshops, panels, discussion groups and opportunities for networking. Washington Initiative for Supported Employment (WiSe) carries out the logistics for these large events which have included:
    - "*The Community Summit… Let's Get Connected*" was held in Ellensburg from June 19-21, 2013 and over 800 people attended.
    - *The Community Summit….Let's Take Action* was held in Wenatchee from June 18-20, 2014 and grew to over 900 people in attendance.
    - The 2015 *Community Summit… Exceed the Possible* is currently being planned for June 16-18 in Wenatchee.

- ✓ **Community Inclusion Newsletter:** This bi-monthly newsletter was launched in August 2012 to explore and promote the values of community inclusion through personal stories. In 2013 and 2014, twelve newsletters were distributed to individuals and organizations throughout Washington. These newsletters are produced by Service Alternatives and can be obtained on the Community Inclusion Newsletter blog http://blog.satraininginstitute.org/community-inclusion/ or on the DDA website.

- ✓ **Person Centered Practices:** DDA has engaged in a process to reinforce and strengthen person centered planning and practices (PCP) that has been at the core of DDA values for over 30 years. Recent CMS published rules, which outlined expectations for person centered planning for states receiving Medicaid funding, has provided the opportunity to revisit and enhance PCP in Washington. RCL reinvestment activities include:

- John O'Brien facilitated several presentations and discussions with DDA and HCS staff regarding person centered practices and the published CMS rules regarding the expectations for PCP. John O'Brien's subsequent reports of these discussions form a template for activities to further PCP practices in Washington. Reports are included on the RCL website.
- A plan was developed with Washington PCP experts to outline a process for increasing PCP facilitation throughout Washington. This included establishing learning groups, mentors, trainings and mini grants.
- Six videos are planned to be produced for DDA CRM training regarding how PCP principles can be incorporated into service planning.
- Three PCP mini grants have been awarded to increase person centered planning facilitation opportunities for individuals and their families. A two day PCP Symposium is being planning in April 2015 to hear the experiences of these grant recipients and to make plans for furthering PCP practices.

Strengthening leadership and capacity of community providers

- ✓ **Hope at Work:** Staff turnover, low morale and productivity are some of the biggest issues that community agencies face in today's work environment, and these issues can negatively impact services to individuals. This project focuses on creating heathy work environments which brings hope to the workplace and builds strategies for improving staff performance and moral. Bruce Anderson from Community Activators facilitates large group workshops and then follows up with interested organizations to implement and hone strategies to fit the unique needs of each participating organization. During 2014:
  - Three workshops were held including one in Burien for over 100 individuals, one in Spokane over 40 individuals, and another one in Burien for an additional 30 individuals.
  - 15 organizations received follow up consultation and training.
  - The report is included on the RCL website.

- ✓ **Reaching Goals for a Meaningful Life:** This project teaches and provides consultation to community providers in how to formally teach individuals with development disabilities. *What, Where and How to Teach* is a two day workshop designed and facilitated by Teri Johnson for community residential and employment staff to learn how to teach individuals the skills they need to accomplish their goals for a meaningful life. Workshop participants can receive follow up consultation where the teaching is occurring with the individual.
  - These two day workshops were held in all three Regions. Topics of this workshop includes person centered planning to help the person identify meaningful goals (what and when) and components of Systematic Instruction (how). Systematic Instruction includes:
    - Task/Activity Design: preparing to teach by identifying and highlighting the cues within a task that will support learning and independence;
    - Task Analysis: a strategy to be an effective teacher and a way to document progress toward learning;

        - Teaching Strategies: accommodating learning style through individualized teaching approach
    - Teri provided hands on consultation and coaching to staff from **three** participating agencies and another twelve have been scheduled. Coaching occurs while staff implements these teaching techniques with individuals they support. Each consultation is customized to meet the needs of each individual and the agency that supports the person.
    - A baseline of the agency's ability to create conducive learning environments based on individual goals and learning styles was established before the consultation. During the consultation agency goals are targeted and tracked to measure learning and progress.

- ✓ **Environmental Supports and Housing :** George Braddock of Creative Housing Solutions (CHS) developed materials and provided consultations to families and community providers to customize environmental supports that some individuals may need to be successful in the community. This included:
    - The development of "***Step by Step Person Centered Environmental Planning Building Programs, Check lists and Housing Templates*****"** for community providers to use when locating homes for individuals who move to the community.
    - CHS conducted a **housing precedent study** to identify locations and environmental modifications that provide safe, desirable, and cost effective housing for individuals moving to a home in the community from an institutional setting. A survey was conducted to look at safety features, size, neighborhood quality, accessibility, layout, repairs and any concerns of the homes where people who receive supports from Supported Living agencies reside. CHS also met with ten organizations providing specialized housing for people with intellectual/developmental disabilities. Housing safety checklists were developed from this study.
    - CHS provided **consultation** regarding appropriate housing and environments for two individuals moving from institutions to homes in the community.

- ✓ **Health Care:** RCL contracted with Jamie Stevens, MS, CCC-SLP during 2013 to:

    - Review current health care documents and process at Rainier School, Fircrest School, and Yakima Valley School.
    - Develop a RCL Health Information form and process for collecting health related information during the transition and that can be used by the receiving Supported Living providers to develop health care plans.
    - Identify what's working/not working in providing quality health care for RCL participants in the community from the community providers' perspective.
    - Facilitated four Safe Eating and Swallowing workshops in Port Angeles, Vancouver, Spokane and Aberdeen.

- ✓ **Employment Project:** Employment is not typically part of someone's transition plan when they decide to move to the community from institutional setting. As a result, counties and employment providers are not involved in transition plans. Once the person moves to the community, planning efforts are often not in place to find employment. In addition, individuals who moved from institutional settings face many

struggles and barriers to find jobs suited to their strengths and interests. RCL has partnered with WiSe to develop strategies to overcome some of these barriers to employment

- A statewide steering committee of participating counties, DDA staff, employment providers, WiSe, and advocates guide this project to learn lessons, design a model, and improve systems that enhances employment opportunities for individuals leaving RHCs. This committee meets three times a year.
- During 2013, four counties (including King, Pierce, Kitsap, and Snohomish) were involved with this project. Each participating county organized and convened a local committee to collaborate, problem solve, and develop community connections that lead to community jobs for the individuals who participate in this project. These local groups include employment and residential providers, advocates, consultants, family members, DVR, DDA and county staff.
- During 2014, this project expanded to include other counties where individuals were moving. A collaborative process was designed for employment and residential providers to work together to support individuals to discover their employment interests and to find community employment. Each person has a person centered plan designed to build this collaborative support.
- 22 individuals have been involved in this project. Seven are employed.

✓ **Assistive Technology**: This project is to provide training and information regarding AT best practices.

- An Assistive Technology Steering Committee convenes twice a year to share best practices and to develop plans to promote technology. This committee includes AT experts, advocacy organizations, self-advocates, and government agencies.
- Day long Assistive Technology Conferences have been offered each year in two locations for approximately 100 attendees. This included:
  - 2013: Spokane and Tacoma
  - 2014: North Seattle Community College in Seattle and Moses Lake
  - 2015: conferences are being planned in Lacey and Everett
- iPad Cohort: Marsha Threlkeld from WiSe facilitated a group of individuals representing 17 residential and employment agencies to learn to use the iPad. This group met 5 times in 2014 to learn iPad features and apps individuals with disabilities are finding helpful, to promote independence, inclusion, productivity and communication in the community. iPad Cohort participants use what they have learned about the devices and apps with individuals they support and bring ideas and issues back to the cohort for further discussion.

✓ RCL has also provided additional **technical assistance and training to individuals and their community providers based on specific training identified for the individual to be successful during the first year of their transition. Technical assistance has included** assistive technology and communication supports, individualized employment supports, person centered planning, environmental assessments, positive behavior support, issues related to PICA and others.

RCL Program Enhancements, Updates, and Lessons

RCL Case Resource Managers:

RCL Case Resource Managers in each region facilitate transition planning for individuals who decide to move to the community from an institutional setting. Each regional case manager specializes in RCL services and enhancements that help make these transitions successful. The RCL CRM coordinates planning with RCL participants and facilitates productive communication between the person, family, RHC staff and community providers. The RCL CRM provides case management for individuals or consultation to other DDA Regional staff regarding RCL services during the first year RCL participants live in the community. Here are their 2014 reports:

Region 1: In 2014 there were 18 individuals who moved to the community within Region 1. 6 individuals moved from an RHC, 11 from a Skilled Nursing Facility and 1 from Eastern State Hospital. All of these individuals accessed RCL funding for housing support as well as medical equipment, transition funds to set up their homes, environmental modifications, behavioral support and communication enhancements.

Most of the individuals are thriving in their communities. Four individuals are either actively employed in the community or are seeking employment. Several individuals have increased their ability to communicate. Relocation to the community has also increased their engagement with others as many felt isolated in their previous environments. Overall, individual quality of life has improved according to the person and/or family members. Individuals have given positive feedback during home visits from DDA staff about their move to the community with RCL. Families and friends have given positive feedback as well.

During the past year, Region 1 has had an increase in individuals who are actively pursuing community living with RCL funding or are interested in obtaining more information about the RCL program. Most who gain information regarding community living and the supports that are offered through RCL funding pursue RCL.

Region 2: In 2014 there were 23 individuals who moved into Region 2 using RCL services. 12 individuals moved from a Skilled Nursing Facility, 8 from RHC's and 3 from CLIP placements. Three of the individuals who moved from a RHC had lived there for longer than three years. The transition planning that took place with these individuals took much collaboration, creativity, and patience.

Many of the individuals who moved utilized the RCL enhanced services to help make this transition successful. 5 individuals utilized RCL for environmental modifications which included ramps and modifying homes to accommodate wheelchairs in bathrooms, bedrooms and or hallways. One individual with autism had significant home modifications designed for her specific needs to create a safe environment and tailored to decrease stimulation. The equipment that RCL assisted individuals to purchase included typical DME like shower chairs, hospital beds, and mattresses as well as items such as swings and trampolines that were used as part of individual's Positive Behavior Support Plan. Behavioral supports were utilized through direct involvement of RCL staff writing plans, RCL consulting with agencies and contracting with behavior techs to implement programs. Four individuals benefited from the purchase of an iPad to facilitate communication and 2 additional individuals utilized expert consultants for staff training around communication.

3 individuals are actively involved in seeking employment through the RCL Employment Project. These individuals have received person centered planning to set employment goals and create collaborate teams to help them implement these goals. RCL funding helped one individual who moved to a rural community get involved in meaningful activities in his community through support from two well-connected community members. This involvement made all the difference to his successful transition back to his home community after residing at an RHC.

Region 2 has seen an increase in people who want to move from SNFs to the community and anticipates that this trend will continue as individuals living in SNFs learn about opportunities through RCL. A RLC CRM was also hired to work at Fircrest to support individuals who want to move to the community. This person has been able to improve the coordination of transition planning between these individuals, their families, Fircrest staff, Region, and community providers.

Region 3: Roads to Community Living assisted 17 people move from institutional settings to community settings in 2014. 11 of these moves were from Residential Habilitation Centers and 6 were from Skilled Nursing Facilities. One person came from California. Out of the 17 individuals, one person returned to an RHC after being in the community for less than 3 months. Three people who moved out of RHCs had lived in an institutional setting since childhood. They were able to move near their families and live in their own homes for the first time in their adult lives. They and their families have expressed much gratitude and happiness.

RCL transitions in 2014 have been rewarding. I have witnessed people having choice of where to live, new found contentment, personal growth, and the reuniting of families. Due to the volume of SNF (due to more PASRR referrals) and Short Term Stay referrals in 2014, Region 3 has reexamined the role of RCL case manager. In 2015 RCL case management will be assisting in the transition planning of all STS but will have RCL participants on her caseload through their RCL demonstration year. The RCL case manager will provide support to the assigned case managers throughout the Region.

RCL Positive Behavior Supports:

During 2013-2014, Miguel Salas, the RCL Behavior Specialist, supports the individual and their team, including family members, support staff from the institutional setting, and community providers to identify, plan for, and implement behavioral supports that will help the person transition successfully to the community. Over the last 2 years the Behavior Specialist has:

- Developed/or supported in development of individualized Positive Behavior Support Plans, Functional Assessments, and data collection systems for several RCL participants. By getting to know each person and the behavior support strategies that were successful at the institution, the Behavior Specialist has adapted these supports for the person in the new community setting. If RCL participants do not require this level of behavioral support the RCL Behavior Specialist is still available for consultation.
- Provided direct training and modeling for several supported living agency staff who provide supports to the individuals mentioned above to ensure correct implementation of their positive behavior support plan. This has included spending several days helping RCL participants settle into their new community home upon leaving the institutional setting.

- Developed and helped implement systems of monitoring for programs and staff around adaptive behaviors such as engagement in meaningful activities.
- Provided training or partnered in training around basic principles of behavior, autism, and other areas of specialty to direct care staff, families, and program staff as needed.
- Provided crisis support training and consultation for individuals identified as needing this. Training may include Therapeutic Options, development of a Cross Systems Crisis Plan, and responding to individual's homes when in crisis and support is needed.

Issues Identified and Lessons Learned:

- PASRR has provided opportunities for individuals living in SNF to know about resources to live in the community. As a result, more individuals are moving from SNF to homes in the community through RCL. Individuals who live in SNF lack knowledge about community resources and what's available for them to move. Some rural communities are not aware about supported living and other available services. **More education will need to be provided to individuals residing in SNF** and their families about the opportunity to move to the community through RCL.
- **Affordable housing and available and well trained staff** continue to be barriers for people moving. The high cost of living in cities makes it difficult for people to find good housing and also to find staff to support them.
- Many paid and non-paid guardians at RHCs are still not willing to discuss and make decisions about individuals moving to the community. The Family Mentor is a good resource for families who need support to make this decision. Several individuals who have lived in an RHC for decades have moved because of the support from the Family Mentor. We need to **explore other ways to involve family members** who have made the decision for their family member to move and to tell their story to others.
- Moving out in the community doesn't necessarily mean the individuals who have moved have a life of meaning. We need to discover a wide range of possibilities and efforts to **support people to have the lives they want.** Some question to continue to explore include: What are the qualities of a supported living agency that support individuals to have a meaningful life and how can we enhance this capacity? How can employment continue to be promoted? How can the benefits of good person centered planning and practices enhance this?
- **Trusting and committed relationships** can make all the difference for individuals to be successful in their transition. This can be particular important for individuals who have had challenges adjusting to community life after living in an institution for long periods of time. Building meaningful and trusting relationships needs to be a focus of successful transitions, including relationship building between new community providers and the individuals and their families. The **importance of building collaborations** with everyone involved in the transition process remains an ongoing lesson of a successful transition.
- **Thoughtful, well planned, and pro-active transitions** help ensure success for each person who moves to the community. Successful transitions have taken the time needed, some a few months and others over a year, as long as movement forward progresses.
- As people move to the community from an institutional setting, we need to **continue to build capacity and expertise in our communities** to support individuals, who are all very different, to be successful. This

includes crisis intervention, health care, assistive technology, employment, community inclusion, and specific strategies for people who experience autism. RCL reinvestment funds will continue to build this capacity through pilot projects and training workshops.