SODC IMPLEMENTATION OUTLINE & KEY FEATURES
PLAN ELABORATION

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ILLINOIS DEPARTMENT OF HUMAN SERVICES
DIVISION ON DEVELOPMENTAL DISABILITIES

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I. **Scope of Service**

Utilizing an Independent Person-Centered approach is critical to securing critical information for planning for the transition of care of the individual into the community; securing critical clinical information and various additional assessments; develop and coordinate individuals' transition plans to alternative services; in ensuring successful transitions to new community residential settings; supporting the families/guardians involvement through this stressful and major life change placement; and formal resident follow up/monitoring of the transition of care.

Among the numerous challenges faced in this process is the need to do simultaneous service and support design and implementation necessary to enable transition on a person-specific basis. At the same time it is necessary to correct and/or mitigate identified deficiencies within the overall transition/service system and developing services and supports which will be necessary for long-term success and which do not currently exist in many locations. **The goals are not limited to simply the number of people transitioned.**

Rather, the goals include the improved quality of lives for the people transitioned, the improved quality and capacity of the community, and creating a culture shift that manifests in both the clinical and supports realm, but also in the attitudes and behaviors of those providing those supports and services. We believe that when people actively embrace the community, such as demonstrated in the 5 Star Quality Model (see Appendix 1), the above not only **can** happen, but **will** happen.

Person-Centered Approach Responsibilities

1. Conduct Independent Person-Centered Assessment and Planning Process for each SODC resident to secure critical information for planning for the transition of care of the individual into the community.

Secure Critical Clinical Information & Additional Assessments

2. Gather clinical information from SODC staff & prepare Clinical Transition Plan
    a. Electronic entering into Clinical Transition Plan
    b. Clinical data entered into database

3. Arrange & secure additional necessary independent assessments as part of the Resident Needs Evaluation
    a. Medical, Dental, Psycho-pharmacologic, and Psychiatric Assessments
    b. Psycho-Social Assessment
    c. Communication Assessment
    d. Physical Therapy Assessment
    e. Occupational Therapy Assessment
    f. Sensory Integration Assessment
    g. Other as determined necessary

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Develop and Coordinate Individuals' Transition Plans

4. Gather critical resident independent evaluation information for planning and preparing Transition Plans.
   a. Person-centered descriptions from Person-Centered Assessment and Planning Process
   b. Clinical Transition Plan
   c. Various needs assessments

5. Draft Transition Plans for transition of care

Ensuring Successful Transitions to New Residential Settings

6. Collaborate with the Illinois Association of Microboards and Cooperatives in supporting Resident/Families/Guardian interest in forming a Microboard that assists the resident in exerting greater control over their day-to-day lives. This is done with the recognition that this is difficult to do fast but is a necessary element for some individuals to experience the success that is desired for them.

7. Collaborate with affordable housing options to maximize the ability of providers to separate services from supports whenever possible.

8. Referral/Shopping – Establish and initiate RFI/RFA process with providers of multiple types to determine their interest in meeting the needs of the individuals who will be transitioning, their capacity to do so, and their willingness to meet the transition process criteria.

9. Review formal proposals to serve SODC resident from interested providers
   a. Work with specific interested providers to establish potential service and support plans as individuals and/or their families/guardians express interest.
   a. Upon selection by an individual transitioning, negotiate person-specific proposed service and support plan.
   b. Compare proposed services and supports to person-centered description and corresponding plan.
   c. Verify proposed services are acceptable to the individual and/or families/guardian.
   d. Compare proposed costs with needs and what is budgeted and negotiate a proposed support financial structure/rate and submit to DHS for approval.

Extended information regarding the proposed process and criteria is available in Appendix 4

10. Acceptance of proposed service – facilitate agreement between the individual/family and the provider and the state.

11. Facilitate implementation of individual Transition Plans and SODC resident transition of care.

Family Liaison to Provide Family-to-Family Support

12. Community Resource Associates (CRA) is aware of the extensive efforts of the advocacy community in Illinois, including those of the Arc of Illinois. It is CRA's intention to fully collaborate with these organizations in their current efforts and to build off of the foundations they have laid to achieve the best possible outcomes for the individuals and their families.

13. Listen to, and document, the Guardian/Family concerns about community living for their relative in public and private meetings. We believe that Families and Guardians are an integral part of the project and must be included and listened to from the very beginning. We will work closely with Families/Guardians and others to ensure the highest degree and involvement at every step of the process.

14. Attempt to address these concerns in the process of developing the transition and long-term Person-Centered support plan. This will be incorporated into a "running list" and can be used to help with the quality/monitoring follow- up for each person (i.e., were we able to clearly address and mitigate the family's concern).

15. Whenever possible work with other stakeholders and identified family transition support experts within Illinois to facilitate appropriate supports for the family/guardian. This will be especially important as CRA attempts to manage concerns of "moving too fast", etc.

16. Actively seek the involvement of other stakeholders, including but not limited to: ARC, Family Support Network, The Institute on Public Policy, IARF, Don Moss, and Independent Living Council and others to obtain feedback guidance, and support at every step of the way.

17. Share information about the kinds of services that are available outside the SODC. This will be done both in discussions as well as via electronic media, such as the Illinois Life Span Project.

18. Arrange for Guardian/Family and, as possible, the individual, to be accompanied on a preliminary visit to see what a functioning Community Integrated Living Arrangement (CILA) is like and how it can be customized to meet the needs of the individuals living there.

Formal Follow Up/ Monitoring

19. Participate in weekly face-to-face visits for the first 8 weeks and monthly face-to-face visits after the first 8 weeks for the first year.

20. Encourage and facilitate, as is possible, monthly contacts with guardian/family members for the first year after transfer.

II. General Services:

CRA will conduct assessments for the purpose of making determinations of service needs of the individuals to be transitioned. CRA will also evaluate potential sub-contractors/service providers.

CRA is expected to contract with the most competent individuals who embrace the values and goals of this project, available for the services and supports they are to provide under this agreement. While there is a clear preference to use individuals from Illinois when they meet the above standard whenever possible, CRA is free to contract with and/or employ whomever they believe is most appropriate for their needs in keeping with the goals of this project.

At every step of the way, a major criteria for contracting and/or for recommendation of specific provider, is the adherence to the stated values outlined by the Governor and embraced by CRA in this proposal.

CRA will actively collaborate with the SODC Transition Work Groups as is determined appropriate by Mr. Casey, Mr. Doyle, and Mr. Turner to the fullest extent possible.

Further, CRA will attempt to identify those state employees that are considered excellent that CRA would like to have involved on a more regular basis. State personnel will make every effort to facilitate this process to the benefit of the employee and the project.

III. Developing Person Centered Plans

CRA accepts and supports the decision of the State of Illinois to use several different approaches to develop person-center plans and the related transition plans that will be developed for individuals.

Families and consumers will be given the greatest degree of control possible over how their planning is completed (able to select an approach they want, etc.). CRA will be responsible for coordinating the availability and utilization of these approaches. CRA will immediately work to develop and maintain a website with the capacity to have information related to each approved/endorsed person-centered planning (PCP) format.

CRA intends to initiate the implementation of the PCP process throughout the course of this initiative. It is CRA's intention to address the training needs directly and immediately associated with the SODC Transition of Care Initiative at the local level. If requested, and sufficient funds are available, CRA is willing to expand these plans to offer Person-Centered Planning training to a wider audience.

More detailed information about Person Centered Approach approaches endorsed in this process is provided in Appendix 2.

CRA will recommend levels of support needed based on data/assessments, suggested providers, and rates etc., but the final decision will be made by DHS in order make sure that there is not a conflict of interest or perceived collusion or favoritism toward any provider(s). CRA will make every effort to provide objective data to validate the recommended levels of support.

CRA and DHS agree that time is of the essence regarding providers selected, establishing budgets and rates for services, initiating supports that have been determined as necessary and appropriate, and related issues. Consequently, within 72 hours of receiving a proposed plan, CRA Senior Partner Mike Mayer, has agreed to personally review every plan before it is submitted to Kevin Casey to be certain that nothing that is needed to address the needs of the individual is missed. All parties agree that we will make every effort to expedite this process and prevent actions which hinder this process.

Please see Appendix 3 for information related to the operational principles and values associated with the implementation of this process.

Further, every single person supported will have a final review by Kevin Casey or his designee before a final provider is selected or rates for service are determined for each individual person. Again, every attempt will be made to complete this review within 72 hours of having received it from Mike Mayer.

This effort is to make every reasonable effort to assure that at least two people have the overall perspective of what is being designed for each person – with the hope that we can minimize any chance of missing some significant issues, which could have major negative consequences in a timely manner.

IV. Providers/Service

CRA will ask interested providers to engage in an RFI/RFA type process following several presentations regarding what is needed/expected for RFA, etc. across the state (it will be recorded and placed on our YouTube channel via our new website as well). This will also give the providers a chance to ask important questions that can be addressed prior to their submission of their RFI/RFA response.

The responses to the RFI initially will be via paper/email response but eventually via a web-based submission. This will allow CRA to have a database of willing and able providers, etc. that agree to meet the criteria that we have established for acceptable providers, including working with CRA to implement the Person-Centered Plan. Additionally, providers will be expected to agree to embrace the "5 Star Quality Model" for community engagement for the individuals to be served.

The RFI/RFA process will also provide an initial assessment of the capacity of interested providers to meet the needs of the identified individuals. We can use this information to

complete a "gaps analysis" to determine which types of services/providers will be needed to foster/develop/recruit to meet the remaining need. This must be developed and implemented at the earliest possible opportunity.

Each PCP will specifically include efforts to help establish unpaid and desired linkages into the community.

People who have IDD who want to live in their own homes ("homes" shall always be inclusive of apartments, townhomes, and similar locations when used within this document), with up to two additional individuals who have disabilities should not be required to have licensure for their home.

CRA will not transition individuals into community settings greater than four persons, with a clear preference for a maximum of 2. When an individual or guardian will not approve community placement and the move is required by the State, the State will attempt to identify an individual from the receiving facility who would like to move into the community in that person's place. CRA will not be responsible for transitions to another SODC, but will coordinate and consider its responsibility to transition the individual who is now slated for community placement.

Further, every effort will be made to collaborate with Home First Illinois and other affordable housing options to help make it clear that services and supports separated from housing is the clearly preferred option. Providers who adopt this principle will be given preference over others.

CRA will make every effort to find providers willing to support individuals being transitioned in non-congregate day services/workshops, with a clear preference for paid supported employment, or other inclusive options as the first and preferred option in all cases.

Service Coordination and related Social Work services must be active and ongoing and must be willing to work with all due speed to facilitate the movement of individuals. The State will clearly communicate this expectation to the providers of Service Coordination and related Social Work services and will facilitate expedited engagement and dispositions to the full extent that they are expected.

V. Assessments

It is critical that all assessments must meet two primary criteria:

1. Assessments are independently completed by competent professionals, and;
2. Assessments must be functional in nature – ***"What do we need to do to help them be successful in the community?"*** is the question to be answered.

To achieve the above criteria, CRA will manage the format and providers through selection and/or direct contract. All providers of assessments will agree to the functional nature and presume the need for success in the community. Likewise, CRA will decide which assessments are required as virtually no one should need all of them. CRA will also create an internal "checks and balance" system to assure that no need that should be caught gets missed in this process.

CRA understands that in some situations there will be a need to arrange for contract clinicians with specialized expertise, especially for those who have challenging health and/or behavioral health concerns.

It is CRA's intention to develop web-based clinical assessment reporting capabilities and a related clinical database. This information should then be used with the web-based clinical transition plan process. Further, CRA intends to create and use a new "transition plans database" to assure all needs are addressed in the assessment and planning process.

VI. Community Service Development

Availability of acute and chronic/ongoing services for those who need them is undetermined but historically considered low outside of major metro areas and requires:

1. Clinical services for people with significant health issues clinical support for people with challenging behaviors/mental illness
2. Availability of competent psychiatric services in areas of SODCs

CRA will need to work closely with DHS, in addition to the licensed practitioners, providers, community, et al to create all above.

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Appendix 1

Abbreviated From:
Five-Star Quality™
Measures and Outcomes Defined

Revised 2010
www.cra.cc

Introduction

In the Five-Star Quality Model™ there are several key elements that must be clearly understood in order to accurately describe the degree of quality that exists. Accurately (and objectively) describing a human service agency's quality level, provides the necessary understanding of what quality level the organization currently is delivering and thus provides the direction for what must be done to move to the next higher level.

Additionally, we hope to provide further information on the measures that will help the reader to more objectively identify the level of quality by the outcomes evident. There are many ways to accomplish the different levels of quality so it is not possible or necessary to describe every way that these things can be done. It is far more important that we have a clear understanding of what the outcomes are for each level.

At the same time, it is not our intent to come up with a chart that details percentages, logarithms, or can be scientifically proven. Thus, Five-Star Quality™ is a system that is not about "paper compliance" or abstract policies and procedures, but rather something that we will be able to define by "*what we see when we see it*".

Five-Star Quality: The Concept

The Five-Star Quality Model concept can be described as a continuum of five stages in which two things occur. First, the individual is transformed from *client* to *citizen*. Second, programs and initiatives undergo a transformation from being agency developed, led and "*owned*"; to being led, implemented and "*owned"* by the community. Each level can be described by a set of key measures and outcomes related to these two ideas. We will outline these later in more detail.

In our model (Fig. 1), quality levels One through Three describe initiatives that deliver experiences to the person that are confined within what we call the "Disability Bubble" – meaning that in these first three stages, programs are developed and operated by agencies for people who have disabilities – effectively both the person and the program are *confined* within the system and are not *members in* or *of* the community. Hence they remain in the *protective* Disability Bubble.

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Between quality levels Three and Four is what can be described as the "Quality Transformation Threshold". This is the key line of demarcation that needs to be described and evaluated. Below this line, programs and initiatives are agency owned and led, and clients remain within the disability system. Above this line, programs begin to be community led and implemented, while clients begin to transform into citizens and to become *members in* and *of* the community.

This fundamental distinction between initiatives and the resulting outcomes, and whether they are above or below this Quality Transformation Threshold, is the most crucial idea to understand in terms of defining the quality level of agency or program.

Three-Star Quality is Still Good

Having said that, we want to emphasize that Three-Star Quality is very good – it is the best of what traditional service systems have available. In comparison to much of what we currently see in operation after 60 years of community services – within the *Disability Bubble,* only Three-Star Quality could be considered great quality.

Most typical accreditation services would consider this level of service to be worthy of their highest evaluation. Three-Star Quality means that an agency has at least crossed the point of no longer seeing that all supports for people with disabilities need to be self-contained – meaning that they understand that not all services and supports must be provided within the walls of the agency, by agency employees or volunteers. Most importantly, it means that the agency helps people enrolled in their services to not just *"be"* in the community, but helps them truly become participating members of their community.

 This frankly contrasts with most Two-Star Quality situations we see that are still incredibly prevalent in human service agencies today. Any type of sheltered employment, group home, or other operation they can be distinguished as self-contained, is clearly Two-Star Quality. These operations may meet all of the licensure requirements, have great health and safety records, hold multiple accreditations, and have community outings on a regular basis, but they are still only a Two-Star Quality program in the Five-Star Quality Model.

From Client–centric Service to Community-centric Support

… the agency becomes a support for building community competency – so that the community can help people who have disabilities become functioning citizens – with the least amount of specialized support from the human services agency as is possible.

This mindset obviously requires a significant transformation of the organization if it is to embrace this clear redefinition of success. Success is no longer measured by the number of employees, the size of the budget, the number of programs it operates, awards, accreditation, or how well it is known in the community.

Quite to the contrary, the organization moves to the background and the community and the people who receive support move to the foreground. The new identification for the person who receives support now becomes that of an employee, member of the (*non-disability*) community organization, or team-member of the event, or a full citizen participant of the community opportunity, rather than being identified as a "client" of the disability agency.

An Incremental Step to Four-Star Quality

For the immediate future, Four-Star Quality can be defined as when the organization begins a project, such as a supported employment project within a factory, but then turns it over to the management of the factory. The organization then provides support to the various departments of the factory so that they are able to meet the needs of the individual employees with disabilities.

Another example could be the dance that was always sponsored by the disability organization and that others in the community were invited to attend. To reach Four- Star Quality status, the agency turns over the dance planning and execution to the local Elks Club and the agency's name now is only identified under the heading "with support from", and thus joining others on the list such as the local radio station that promoted it, the grocery store that provided food and decorations at cost, etc. The agency's role now is to be invisible support as trainers, consultants, greeters, clean-up staff, etc. but not as "obvious staff".

Five-Star Quality Measures and Outcomes

So far we have discussed Five-Star Quality from a conceptual perspective. But just how is one objectively to determine program and agency quality? In other words, what measures and what outcomes can we use to evaluate "*what we see when we see it*". Fortunately there is a set of key measures and outcomes that one can use as a starting point to provide insight into the quality level of the program or agency we are trying to assess.

We have developed a basic framework of criteria as a starting point for evaluation… However, there are additional general qualitative factors that can be used as measures within the Five-Star Quality framework....

As we have outlined earlier, some of these measures include:

- Program/Initiative Leadership. Who develops or leads the program or initiative? Is it solely the agency or is there community involvement or leadership?
- Program/Initiative Location. Where is the program held? Is it at a sheltered workshop or is it within a community venue?
- Program/Initiative Focus. Who is the program designed for – solely for the person with disabilities, or also the general community? Who can participate – only those served by the agency or does it permit participation by the community and interaction between attendee groups?

- <u>Program/Initiative Responsibility.</u> Is the agency funding, directing and managing the initiative, or is the community in charge? In other words, who is the "owner", who has the final say…

Once these questions are answered, we need to be rigorous in our evaluation of the outcomes they produce for the individual. The overriding issue is how *and where* we view the person – are they client or citizen? We need to ask ourselves what the result of the initiative is for the person.

- Is the person *absent* from the community, are they *in* the community, or are they a *participant with* the community? (*One, Two and Three-Star*)
- Is the person a *member of* the community or are they *of* the community? (*Four and Five- Star*)

Quality Levels Illustrated

By using the dance example, we can describe each level of quality and its outcome.

<u>One-Star</u>: A dance for people with disabilities that is sponsored by the human services/disability organization and held at the sheltered workshop. (The person is "***absent from***" the community).

<u>Two-Star</u>: A dance for people with disabilities is held at the local YMCA that is sponsored by the human services/disability organization. People with disabilities are "the audience" even though some people who do not have disabilities may attend. (The person is ***"in"*** the community)

<u>Three-Star</u>: A dance for the general community is held at the local YMCA that is sponsored by the human services/disability organization *in partnership with* the YMCA and other organizations. People with disabilities from that agency and possibly others are in attendance. (The person is a ***"participant with"*** the community)

<u>Four-Star</u>: A dance for the community is held at the local YMCA and sponsored by the YMCA and other community groups. The human services/disability organization provides "invisible" (*i.e., not publicly-recognized*) support to the YMCA and the rest of the community to enable people with disabilities to *fully participate* as anyone else would. People with disabilities from throughout the community are clearly welcomed and may or may not have paid supporters assisting them. (The person is a "***member"*** of their community).

<u>Five-Star</u>: A dance for the community is held at the local YMCA and sponsored by the YMCA and other community groups. People with disabilities from throughout the community are clearly welcomed and may or may not have paid supporters assisting them.

The human services/disability organization is not obviously a part of the dance planning, coordination, etc., but rather acts as consultants and trainers to the sponsoring organizations to help them have the capacity to support people with disabilities and to fully to participate as anyone else would. The human services/disability

agency personnel are "invisible" but remain "on-call" for the sponsoring organizations. (The person is *"of"* their community – meaning the community has the ability to meet any immediate needs of the individuals who have disabilities).

Final Thoughts

We know that for some agencies it will be a bridge too far. For others it is a chance to move from *client-hood* to *citizenship*. We believe that people with disabilities deserve the promise provided by full, Five-Star Quality lives, filled with the richness of experiences as the result of (*with apologies to Abraham Lincoln*) enlightened programs and collective efforts, *of the community, by the community and for the community.*

Derrick Dufresne

Mike Mayer

Community Resource Alliance

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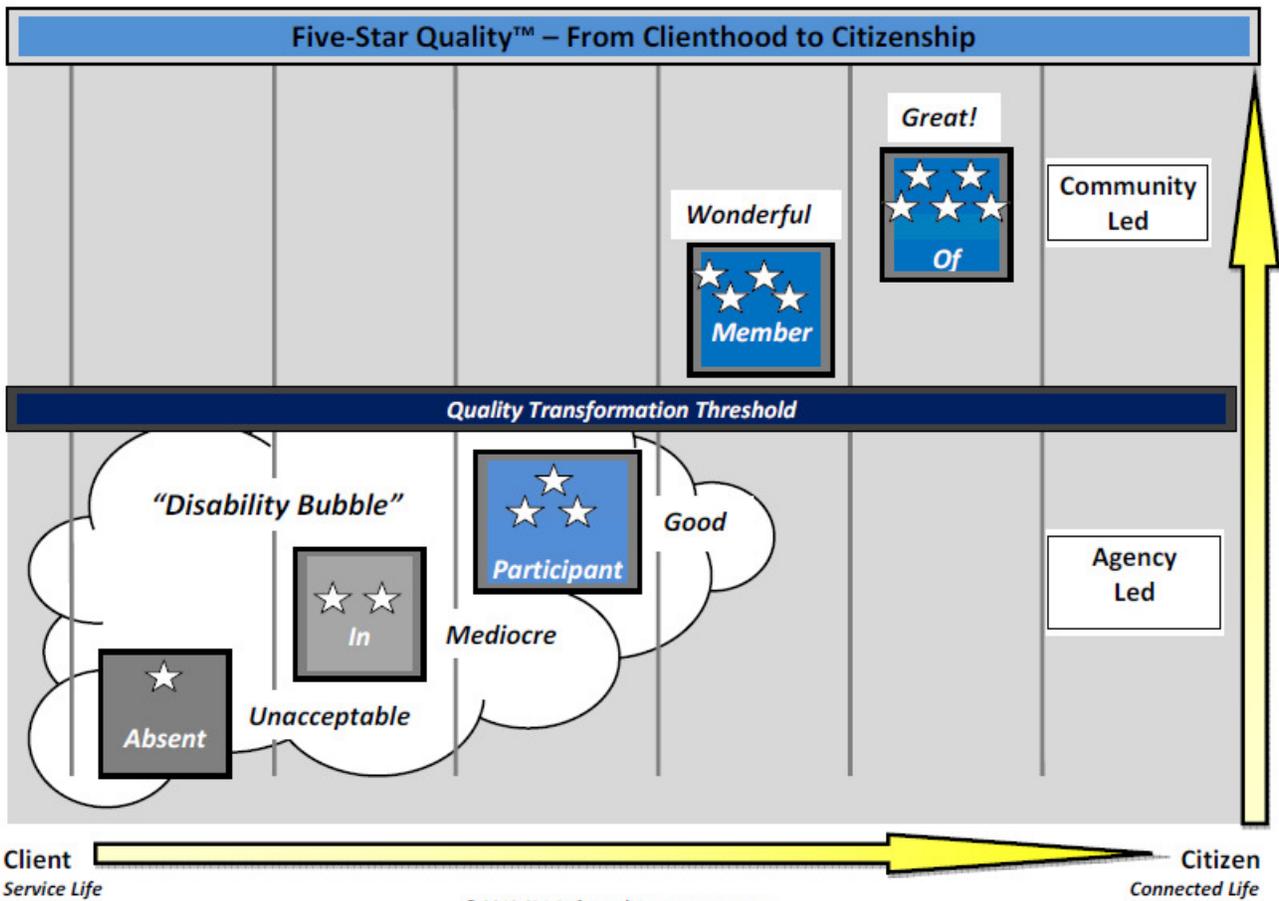
Figure 1

IMPROVING QUALITY USING 5 STAR PRINCIPLES AND STANDARDS

Five Questions We Can Ask Ourselves

1. How can we assist people have more choice and control in their lives?
2. How can we assist people make valuable, contributions to their communities?
3. How can we increase a person's presence in their neighborhood and community?
4. How can we assist people make and maintain friendships?
5. How can we assist people to develop their abilities?

Some Things To Do...

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1. Facilitate positive engagement with others who are not paid, especially the development and maintenance of friendships
2. Promote good citizenship through work, reciprocity, and positive private and public contributions
3. Promote decision-making and problem-solving that end clienthood and encourage citizenship
4. Based supports on being able to demonstrate and develop known interests and talents – outside of the disability bubble
5. Do not require compliance with rules based on a prejudicial group mindset and encourages positive options to manage for dynamic tension and resistance
6. Include a plan to prevent and manage behavioral and other crises minimizing any restrictions of citizenship
7. Support the individual to learn from their mistakes
8. Challenge the status quo and stereotyped expectations of the institutional mindset and disability bubble
9. Staffs are expected to model positive social engagement and learning is focused on the natural environment and not disability focused and controlled settings.
10. Maintain a consistent application of core values and has obvious integrity to the vision and mission of the organization (the core promise to the individual receiving services).
11. All staff are aware of the goals and desires of the individual's Person Centered Plan/MyPlan/PATH
12. Staff are encouraged and rewarded to take reasoned risks, take initiative, and demonstrate the desired skills which support the core values, etc.
13. Celebrations of accomplishments, efforts, success, etc. are a common occurrence.

Selection of learning focus is guided by three primary considerations:

1. Learner's informed choices
   - Learner chooses to learn
   - Learner is presently attempting this task

2. Learner's needs based upon demands of environment
   - Learner would use this skill in present and future environments of home, community, leisure and/or work

   - Learner would frequently use this skill

3. Choice of content which grants release from custody (more freedom)

- Someone else must now perform this task
- The person would require less supervision if they master this task

Procedures for developing learner's preference & encouraging choice

1. Provide choices about how to achieve a goal
2. Provide choices from observed likes and dislikes
3. Provide choices from real alternatives
4. Provide open-ended choices
5. Provide for examination of why choices are made – including likely consequences of making and not making a certain choice
6. Provide information and choices to consumer about their rights and responsibilities
7. Respect choices made

Helping the person to identify their individual needs and desires

1. Discuss his/her short and long-term goals and desires with the learner

2. Observe the learner in the environment

3. Interview natural supports and others who care about the person and an advocate, family, or caregiver considers this a critical skill

4. Consider the skill sets of peers without obvious disabilities

- Age relevant skill because it is performed by peers without obvious significant disabilities

Selecting content to reduce custody

1. Apply goals of independence in daily living skills

- It will increase the self-concept and or social acceptance of the learner
  - Reduce hopeless feelings and increase self-worth
  - Reduce stigma and increase normalization
  - Reduce isolation and increase community membership and social integration
  - Reduce social burden and increase social contribution

- Reduce custody and increase skills for self-sufficiency

2. Minimize intrusiveness in their life

- Psychologically safe skill to teach because the intrusiveness and/or embarrassment associated with instruction will be

  acceptable to the individual

3. Physically safe

- It will increase the learner's personal safety
- It is safe to perform even when done inappropriately or without supervision

4. Prioritize what is to be taught

Some questions to ask

- How much assistance does the person *really* need? (physical assistance, medication, supervision, personal care, understanding communication, being interested in someone else, not overeating, etc.)

- Under what circumstances does the person need help?

- Who provides this assistance now?

- Could someone from the community provide the necessary assistance?

- How could someone be trained or supported to provide the necessary assistance?

- What are the implications for the person's participation in various community activities?

Some things to watch out for…

- Thinking that person-centered, community focused services that emphasizes natural supports will cost more money or require more staff (it will require professionals to work differently, and smarter, but not necessarily harder)

- Requiring community people to be volunteers rather than "just friends" or "just neighbors" or "just family", etc. Friends don't document their relationships on a service note (they use a scrapbook, a blog, or diary)

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- Using behavior, skills, deficits, mental health, etc. of the person as an excuse for not doing what should be done
- Using "liability" as a justification for not supporting individuals in having as integrated and independent a life as possible
- Using "risk-taking" or "trusting" as a justification for carelessness, thoughtlessness, or inadequate planning
- Trying to "over-program" and "formalize" all activities
- Compromising on ethics and agreed upon standards of professional behavior

Some suggestions to promote positive outcomes for people with disabilities:

- Examine the major priorities of life and redirect energy and resources to those priorities
- Start conversations about the importance of developing community based and natural support focused solutions
- Prioritize supporting people in the life of their choice, helping people learn how to make choices, supporting community membership, etc. This includes helping people establish friendships
- Examine creative uses of time
- Promote natural supports over formal and volunteer roles
- Encourage creativity regarding the solutions and collaboration
- Trust the natural capacity of the community, and provide sufficient support for that capacity to be realized
- Recognize that small changes can make a big difference
- Recognize that overall change takes a long time

Some things to minimize:

- Random stressors
- Aversive stimuli
- Unnecessary exposure to overt opportunities for problems
- Destabilizing factors
- Extensive negative role model exposure

Some things to maximize:

- Work skills

- Physical activity
- Physical wellness

Necessary Ingredients:

- Comprehensive staff training
- Consistent staff interactions (behavior plans for staff)
- Quality "clinical supervision" for staff
- Interdependence of development and relational advantages and clinical imperatives is maximized

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Appendix 2

Person Centered Planning Approaches

1. Authentic Person Centered Planning
2. Essential Lifestyles
3. MyPlan/WRAP
4. Support Circles

1. **Authentic Person Centered Planning: Key Factors And Success Indicators In Person-Centered Supports**
   The Council on Quality and Leadership

This approach to Person Centered Planning is already utilized by approximately 17 agencies In Illinois that receive accreditation through the Council on Quality and Leadership (CQL). This nationally recognized organization looks at the outcomes of services in people's lives rather than a specific process.

By beginning with outcome measures, it is then possible to see what is most important to the person and to then devise strategies, supports and people that will develop individualized supports.

As a result, a series of factors are looked at on an individual basis by the person and allies that are most important to he/she. These factors include:

FACTOR 1 Person-centered Assessment and Discovery
Indicators:
   1a People feel welcomed and heard
   1b People have authority to plan and pursue their own vision
   1c Assessment of needs is fair and accurate
   1d Assessment and discovery identify personally defined quality of life

FACTOR 2 Person-centered Planning
Indicators:
   2a Planning is person-centered
   2b The plan identifies and integrates natural supports and paid services
   2c Informal community resources are used
   2d Planning is responsive to changing priorities, opportunities and needs
   2e Planning and funding are connected to outcomes and supports, not programs

FACTOR 3 Supports and Services

Indicators:

       3a People have authority to direct supports and services

       3b Supports are flexible

       3c Support options are accessible

       3d People manage supports and providers

       3e Supports are available in an emergency or a crisis

       3f People can identify personal champions

FACTOR 4 Community Connection

Indicators:

       4a Community membership facilitates personal opportunities, resources and relationships

       4b Peer support / mentoring is available

       4c People receive information and training

FACTOR 5 Workforce

Indicators:

       5a The workforce is stable and qualified

       5b Practices are culturally competent

       5c Personnel have the flexibility and autonomy to support people

       5d Support for cultural / organizational change is provided

       5e Advocacy efforts promote fair and affordable provider rates and responsive payment systems

FACTOR 6 Governance

Indicators:

       6a Organization mission, vision and values address person-centered supports

       6b Organizational practices are both person-centered and system-linked

       6c People and families play meaningful leadership roles

FACTOR 7 Quality and Accountability

Indicators:

       7a Quality management systems are integrated

       7b Quality of supports is measured

       7c Participants, families and advocates evaluate supports and providers

       7d The public is kept informed

       7e Personal information remains confidential

FACTOR 8 Emerging Practices in Individual Budgets

Indicators:

8a People control their budget allocations

8b Individual budgets are both fair and ample

8c Budget, money and services / supports are portable

2. An Overview of Essential Lifestyle Planning (ELP)

Essential Lifestyle Planning holds the basic belief that there are core elements in day to day living that reflect essential basic quality of life components that matter deeply to any one of us. ELP is a process through which these essential elements can be explored, understood and integrated into the work that is conducted with and on behalf of people with disabilities.

ELP is a guided process for learning how someone wants to live and for developing a plan to help make it happen.

It's also:

A snapshot of how someone wants to live today, serving as a blueprint for how to support someone tomorrow;

A way of organizing and communicating what is important to an individual;

A flexible process that can be used in combination with other person centered techniques;

A way of making sure that the person is heard, regardless of the severity of disability.

Essential Lifestyles Plans are developed through a process of asking and listening. The best essential lifestyle plans reflect the balance between competing desires, needs, choice and safety.

The "Learning Wheel" was developed to graphically reflect an on-going commitment on behalf of the planners to seek to understand what is very important and meaningful in matters pertaining to everyday life for the person who is the focus of the planning effort. It requires that careful attention be given to the stories and the reflections of the person and of the people who know and care about the individual.

The Learning Wheel is represented through a series of interconnected arrows beginning at the top of the "wheel" with arrows connecting listening and understanding in a circular fashion. This listening continues until the listener(s) have a clear sense of direction as provided by the person who is the focus of the planning effort. When the understanding becomes clear enough for taking action an offshoot arrow connects what has been heard and understood to the development of a plan. The plan is simply the synthesis or organization of the information that has been heard and understood. When the plan has been drafted and approved by the focus

person an offshoot arrow connects the planning to the doing or implementation of the plan.

This is the "try it" stage of the plan. During the implementation phase another arrow connects this stage to the "assessment" stage of the planning process. This stage looks at how the plan is working in the context of what the focus person identified and continues to identify within the ongoing process of listening and understanding. Thus, the final arrow, completing the "wheel" connects the assessment stage back to the inner exploratory loop of listening and understanding.

From listening and understanding you can:

> Plan (organize/synthesize) using the information that the planner has gathered from the stories that have been told, from the identification of critical themes woven throughout the dialogues, and from the surfacing of what is most important in quality of life issues as understood from the perspective of the individual and from their family members and friends.

> Implement (try it) the plan by mobilizing resources and creating the structures and opportunities that honor what have been heard.

> Assess (see how it's working) the plan against the interests and preferences of the person with whom the planning is being done. Look for ways to use what is being learned to keep the momentum of the plan moving forward. Questions that are helpful guides in this process are "What have we tried? What have we learned?" "Given what we have learned, what do we need to try next?"

Michael Smull's Learning Wheel
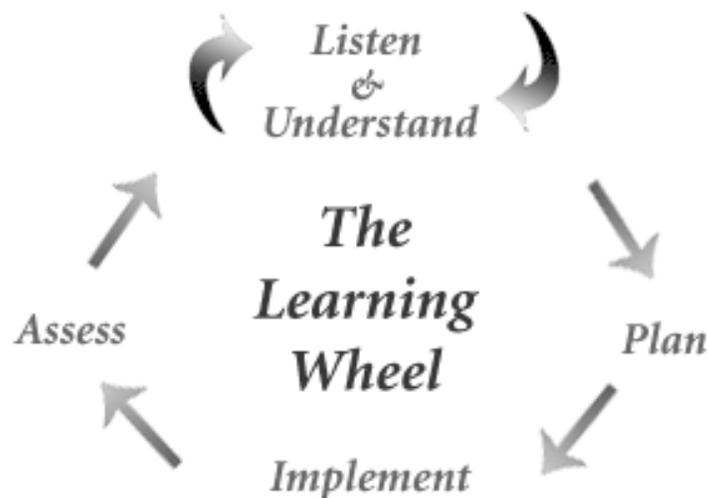
Developing Essential Lifestyle Plans require:

- The perspectives of those who know and care about the person;
- Their stories about good days and bad; and
- What they like and admire about the person

Each of us wants lives where we are supported by & contribute to our communities

- At the base of our wants is the desire to stay healthy and safe (our own terms)
- Then we need to have what/who is important to us in everyday-life; people to be with; things to do, places to be
- Have opportunities to meet new people; try new things; change jobs; change who we live with & where we live
- Finally at the top is have our own dreams & our own journeys

Most of all, it is critically important to remember that a plan is not an outcome. Plans need to be written in draft form and used as a tool for exploration and recording what is being learned. Plans should not exist as an end product but serve as a means to an end. It bears repeating: A plan is not an outcome.

3. MyPlan and WRAP - Twin approaches to Recovery and Wellness

For a very long time in the field of intellectual and developmental disabilities (IDD), there has been a denial of the mental health needs of individuals who have IDD. The focus has been on "changing the person's behavior" rather than treating the mental illness that a person may have. This created a situation where professionals prescribed treatment/behavior plans, medication, structure, and occasionally activities for the individual that was meant to "cure" the behavior.

It is important to note that the focus was on "treatment". The individual was not so much a partner in this experience as much as they were the object of the efforts of professionals. They were typically seen as fragile, often unpredictable, individuals who needed therapy directed by those same professionals to be able to comply with the expectations of those professionals in the environments controlled by those, and other, professionals.

In recent years, this approach has been challenged by the emergence of a new concepts and approaches associated with the outcomes of Recovery and Wellness within the mental health field. One of the most hailed approaches to support these goals is called WRAP (Wellness Recovery Action Planning).

As Stated in the article "*Culture of Recovery*":

> *It's a program that was developed in Vermont in 1997 by Mary Ellen Copeland and a group*
> *of friends who were all experienced with the mental health system. WRAP is now recognized*

as an exemplary practice and has been widely implemented throughout 50 states, England and New Zealand.

The WRAP program involves an educational and planning process that is grounded in mental health recovery concepts such as hope, education, empowerment, self- advocacy, and interpersonal support in connection. Within a group setting, individuals explore self-help tools (e.g. peer counseling, focusing exercises, relaxation and stress reduction techniques) and resources for keeping themselves well and for helping themselves feel better in difficult times.

Copeland states: "For a person who's been on the system a long time, WRAP is often a person's first introduction to the idea that their own ideas and views have value, and that they can make their own decisions and move on with the recovery. It can be the initial step in the recovery process."

WRAP not only involves the individual in their search for wellness, it promotes and endorses the idea that people must *own* their own recovery and direct it as well. There is a presumption of both competency and strength in this approach. Every individual is seen as capable and having the potential to recover from their illness and to seek the treatment and the services that are needed and desired - in a manner, shape, and form that is unique and best suited to the individual as requested by them.

WRAP is much more than a one-time event. It is an ongoing series of life experiences, planning, mini-experiments, trials of various approaches, and documentation that allows individuals to customize their own plan for recovery and wellness – and actively re-engage in their own life with the belief that they will be well again and can remain well over time through these efforts, personal responsibility, and the support of others – including professionals.

Needless to say this approach is very challenging to many professionals, especially those identified as being in the clinical community. At times there is a lack of understanding or appreciation regarding the role of the individual in his or her plan. Professionals sometimes mistakenly think that individuals utilizing a WRAP are incapable of making the necessary decisions to help control and direct their own recovery, and thus, should have no active role other than to report progress. They also mistakenly believe that somehow WRAP automatically excludes the use of medication, counseling, or other therapeutic supports. This is especially true within the IDD system, where professionals frequently question the competence of the individual to be able to make informed decisions about what matters most in their lives.

This is complicated by often complex relationships and the absence of non-clinical supports. The key is to getting the information needed directly from the individual that can help others to support their personal journey. One of the first steps is to find out what their ultimate dreams are for their life in the future. It is also important to

accurately capture where things are today so that we understand how the individual, and those who care about them, see their current situation. This is important so that the team can find some things that are ***positive and possible*** that can be worked on – in ways that support the WRAP intentions – that can start as of the day that the overall plan is completed.

Finally, it is important that these desires are translated into specific and immediate action steps that individuals on the team commit themselves to, with the individual who desires recovery and wellness as the pilot of this process and the team of supporters they select (professionals and non-professionals alike) as navigators.

This is called the MyPlan process.

MyPlan is a tool to help people plan and achieve their life goals. The MyPlan process involves people who are invested in the success of a single person working as a team to graphically record a colorful and creative process for the participant. This process serves as a guide to help the participant identify his or her most important life goals[1] and what can be done – starting today - to begin the process to reaching those goals.

The MyPlan process developed by Mayer and Dufresne, is efficient and effective-so that the actual team meeting as a group is between 2 and 3 hours. Much work is done with the individual in advance of the team meeting, often including the completion of the Assessment of Essential Motivation, Tension, and Resistance.

Utilizing the MyPlan process, the individual and their chosen allies come together to envision and plan a different future. The realities and issues of the day are discussed and evaluated to ensure the plan is grounded in reality so that it is possible to establish a firm commitment to building a better future so that we do not need to keep repeating the cycles of the past.

A key feature of the MyPlan process is the use of co-facilitators if possible. One facilitator is seated near the person, to create an atmosphere of trust and a safe environment. The other facilitator draws simple pictures that capture the essence of what the person is telling us. This multiple approaches respects and enhances various learning styles and becomes the property of the person at the end of the session.

 By establishing specific tasks within a brief overall action plan it is possible to build positive momentum and facilitate the move forward to a desirable future.

The intention is that MyPlan will identify critical elements that will help support the recovery and wellness of the individual and "jump-start" the implementation of overt efforts to reach those outcomes that were identified as positive and possible and getting the person that much closer to their ideal life. It also begins to help identify the types of things that can be considered for inclusion in their WRAP plan that might have been otherwise overlooked.

It is important to note that MyPlan not intended to replace the WRAP, just as WRAP is not intended to replace good support planning. These two techniques truly are twin approaches that can be highly successful when used in conjunction with each other for people who have complicated support needs to address their behavioral/mental/emotional health and related problematic behaviors so that they can be successful in the community.

Conclusion

For each of us, there must be at least one compelling reason to get out of bed in the morning – and to take care of ourselves once we are out of bed. Our need to find meaning in our actions, relationships, work and communities is critical to our emotional and physical health is critical to developing the compelling reason or reasons.

For too long individuals who have IDD, especially those also experiencing mental illness, have been guests at their own table. For these people, all too often the services they receive have been viewed by the person as something they must endure and, often passively, comply with in order to get through the day.

Unfortunately, this often results in a distinct lack of ownership and personal commitment to their planning, behavior change, and wellness process. In many cases it also diminishes the sense of personal responsibility and accountability for decisions that are made by the individual – because they perceive themselves as simply pawns in the game of services and treatment - so if bad things happen it is because others didn't do their job. These two approaches reverse that thinking.

WRAP is an active engagement of the person to take control of their treatment and wellness. By self-directing their plans, they own the process and the result - with dramatically increased personal responsibility and accountability. This also provides hope, meaning, and direction and encourages social reciprocation and community contribution, which are the hallmarks of good citizenship. MyPlan then provides a specific road map on how to get there.

The two approaches –MyPlan and WRAP offer the opportunity for all citizens experiencing IDD and mental illness to take charge of their life and build a better future one day at a time with the support of their allies – both professional and non-professionals.

Derrick Dufresne & Mike Mayer

CRA Inc.

www.cra.cc

(1) Definition of New Mexico Department of Developmental Disabilities

(2) Person-Centered Planning: Maps and Paths to the Future

4. Support Circles – Neighbours Inc.

Neighbours depends on finding out what people hope for their future and what they will need to help them to move in that direction.

There is no one way of planning with people. Sometimes we facilitate planning processes such as **MAPS** and **PATH**. Often we gather information through meeting with the people we support, their family and **support circle**. We LISTEN!

Neighbours facilitates the development of a plan that reflects the person's vision and dreams, and details what they will need to work towards them. The plan becomes a guide. It can remind people of what they said they wanted to do and help them to stay on course.

The plan also is the guide for the **individual budget**.

Neighbours believes that relationships and friendships are key to a full rich life. We all have people that we need, people who help us get through life. All of us can identify people we need for love, for friendship, for inspiration, for support, for work, for money. We all rely on other people, and if we are truly fortunate, they rely on us. We are really inter-dependent.

If we think about it, some of those people are very close to us, family, lovers, best friends, and some are not as close, acquaintances, co-workers, members of clubs we belong to, etc.. There are even people that we pay to support us.

The point of it all is --- none of us do life alone!

Most of us have an informal "support circle". Many of the people in our support circles may never even meet each other. They come from different parts of our lives --- family, work, school ...

But people with disabilities have historically faced challenges than many of us have not. By design, people have been left out or excluded from opportunities to be part of community life. Their rights of citizenship have not always been upheld.

Circles are groups of people who intentionally come together around a person they know, like and care about. Their common thread is a commitment to the person and his or her right to live a full life.

Support Circles are groups of people who know, like, and care about someone, and come together as a group to make sure that the person they care about is supported to be a part of community life. Support Circles intentionally come together to overcome the barriers that they face.

Advisors help to make it possible for support circles to come together. They facilitate meetings so that circle members can have conversations about:

What is important to the person?

What is happening in their life now?

What is the vision?

What gets in the way?

What do we need?

How can we get it?

Who can help us?

...and much more.

The Circle generates a lot of the content for the **Person Centered Plans** that are created.

A meaningful and effective circle is a key component of self-directed supports.

Appendix 3

PRINCIPLES AND VALUES

Supporting Individualized Transitions to the Community

1. We understand the urgency of the situation. We know we must act quickly and yet deliberately and effectively. We also believe that people deserve a life – not just a "placement". We will do everything possible to help them achieve that goal as fast as we possibly can.

2. We will look at people and supports - not facilities and slots. We will commit to develop supports for one person at a time. An intensive, person-centered, community-based individual support plan must be developed for each person. We must be good stewards of public resources.

3. We believe that people deserve to be healthy and safe. We also believe that behavior is communication and we need to listen to what people are telling us. We must listen carefully. We acknowledge that people with significant and complex behaviors create issues both for the individual with difficult behavior and the group with which he/she lives. Each plan must include a provision for ongoing best-practice crisis supports – including prevention, medical and related healthcare, and other supports anticipated as being needed for the plan to succeed.

4. Settings are likely to be 1-2 persons and never more than four persons. If there is a roommate, it will be a person who is compatible, not based on diagnosis or some other artificial criteria. All individuals will have his/her own room if he/she has a housemate.

5. We acknowledge best-practice trends to separate housing and services. The first option explored should be assisting the individual or family directly renting or owning the housing. As settings are small, they are more available than larger settings. The community support provider should concentrate on facilitating and providing the supports. A separate housing provider is preferable and desired.

6. As a part of the support planning, we presume no set manner for service and support delivery – except that we will facilitate and provide what is recognized as best-practice to the fullest extent of our collective ability. This includes preferring supported employment over traditional day programs and not presuming the need for 24/7/365 shift-staffing. In many cases, people with significant and complex behaviors need and want the stability of relationship that comes with live-in staff, or a family setting. This option will be offered utilizing creative approaches and supportive adjuncts that are fiscally sustainable.

7. We will seek providers who subscribe to these principles and values. The individual will have maximum control over the selection of the provider to the extent possible. Providers must agree to work to their fullest extent possible with the transition project team to prevent any re-institutionalization.

8. There will be an individual support budget developed that is based on the assessed individual need and the plan to meet that need. In all cases, every budget will be individualized, and flexible to respond to the situation, as is necessary to provide for the success desired and to prevent any re-institutionalization.

SODC Implementation Outline & Key Features

Plan Elaboration

Appendix 4

The RFI/RFA Process and Forms

Abbreviated

Overview:

There are two forms providers will be asked to submit. The **RFI** (Request for Information) is simply to collect information about their current services and capacity.

The second form, the Request for Application or **RFA** which is optional, is to be submitted with the RFI if the provider is interested in expanding their services to help meet the needs of individuals who are transitioning their services and supports from the SODC to the community.

The Process

In order to determine the capacity of the current provider community, including licensed practitioners, and what supports and services will be necessary to assist current providers and also the overall goals of this effort, it is been decided to establish a Request for Information (RFI) process that is directly tied to a Request for Application (RFA) process.

This process, which will engage many types of providers, will determine their interest in meeting the needs of the individuals who will be transitioning, their capacity to do so, and their willingness to meet the transition process criteria.

There are several presentations planned to be held across the state regarding what is needed/expected for a response to the RFI/RFA. At least one of these will be recorded and placed on a YouTube channel via the new Transitions website. These sessions will not only

present information regarding the process, they will give providers a chance to ask important questions that need to be addressed prior to their submission of their RFI/RFA response.

Following these presentations providers will be asked to submit responses on forms they will be able to download from the web or obtain via email. Eventually these responses will be via a web-based submission. The content for these forms is being finalized as of this writing but should be available, at least in draft form, in the very near future.

This process will provide an initial assessment of the capacity of interested providers to meet the needs of the identified individuals.

The intention is to develop a database of providers that agree to meet the criteria that has been established for acceptable providers, including agreeing to embrace the values and principles for this project, that are

interested in supporting individuals in the transition process. There is no "closing" date for submissions, as the database will be constantly updated. However, providers who wish to be considered in the earlier selection periods should respond immediately.

This database will allow individuals, families, and guardians to know which providers are potentially willing and able to meet their needs. CRA will then work those providers to establish potential service and support plans as individuals and/or their families/guardians express interest.

In general, this means that when a provider is selected by an individual transitioning (and/or their family/guardian), CRA will work with the new "team" to develop/negotiate a person-specific proposed service and support plan that corresponds to the completed person-centered description and corresponding plan.

Then CRA will verify that the proposed services and supports are acceptable to the individual and/or families/guardian. Assuming that they are acceptable, CRA will work with the provider to create a person-specific budget. CRA will then propose this financial structure/rate to DHS for approval.

Once there is an acceptance of proposed service and financial structure/rate by DHS, CRA will facilitate the working agreement between the individual/family, the provider, and the state.

CRA will then work with the team to facilitate the implementation of individual Independent Person-Specific Transition Plan and the official SODC resident transition of care.

Following the transition, CRA will provide technical assistance and training supports to providers to assure the long-term success of both the individual and the provider. CRA will also participate in weekly face-to-face visits for the first 8 weeks and monthly face-to-face visits after the first 8 weeks for the first year.

This will be ongoing process that transitions the care of 194 individuals within the first 10 months of operations and a total of 600 individuals through FY14, averaging approximately 20 individuals per month. So, providers are needed immediately, and will be needed for several years to make this happen, so even if a provider is not ready to participate now, there may be opportunities for a provider to become engaged at a later date.

The RFI and RFA

The RFI is simply a series of questions that the provider submits answers to. This does not obligate the provider to any services, further processes, etc. but rather serves as a baseline of what services currently exist.

The RFA is a second element of the document, again with questions that providers respond to, that indicates that they are interested or not interested in developing and/or providing certain services under the specific conditions of this project. This is an "application for consideration" – first by those involved in the development of system capacity as a viable candidate for engagement and later by

individuals/families/guardians as potential providers of the community services and supports that will be needed for that specific person.

…It is important to note the following:

1. Individuals will not be placed into congregate settings of greater than four persons.
2. Residential providers will be expected to collaborate with CRA and Home First Illinois and other affordable housing options to separate housing from services and supports whenever possible.
3. CRA has committed to the state that every effort will be made to find providers willing to support individuals being transitioned in non-congregate day services/workshops, with a clear preference for paid supported employment as the first and preferred option.

RFI and RFA DRAFT forms follow.

Illinois Transition Project Request for Information and Request for Application

Working Draft

Request for Information

TheRequestforApplicationfollowsthissection.

Date Submitted: Please Check One ☐ Original   ☐ Revision

Agency Name:	
Address:	
Contact Person for RFI Responses:	
Contact Office Number:	
Contact Cell Number:	
Contact email Address:	
Other Contact Info:	
Agency Website:	
Counties Currently Served:	

Current Services	#
Total number of people served	
Number who have Intellectual and Other Developmental Disabilities	
Number of people not included above that have an Autism Spectrum Disorder	

Estimated number of above individuals who would be described as having:	#
Borderline intellectual disability	
Mild or minimal disabilities - Needs intermittent supports	
Moderate disabilities - Needs limited supports	
Severe disabilities - Needs extensive supports	
Profound disabilities - Needs pervasive supports	

Estimated number of people who also have: (numbers can be duplicated)	#
Mental illness	
Severe behavioral challenges	
Significant medical problems	
Mobility challenges	
Significant communication problems	
Toileting needs	
Feeding needs	
Aggression	
Self-injury	

Sexuality related issues	
Forensic issues (criminal charges, history of illegal behavior)	

Estimated number of people served residentially in:	#
Shared Living situations (two-three people sharing a home)	
Supported living arrangements (their own home or apartment)	
Settings of 4 or fewer people (not included above)	
Settings of 5 or more people	

Estimated number of people served vocationally in:	#
Traditional pre-vocational congregate settings	
Traditional workshop settings (not included above)	
Enclave settings	
Mobile work crews	
Supported employment	
Competitive employment	
Micro-enterprises (not included above)	
Not engaged in day services (not included above)	

On a scale of 1 to 5, with 1 being very limited competency or experience and 5 being high level of competency or experience please rate your organization's experience/competency with the following items/skills:

Positive Behavior Supports	
Dual Diagnosis (MI/IDD)	
Providing housing services/developing housing (not providing the services)	
Providing residential support services but not providing the housing	
Providing the following types of assessments:	
Medical	
Dental	
Psycho-pharmacologic	
Psychiatric	
Psychological	
Psycho-Social	
Communication	
Physical Therapy	
Occupational Therapy	
Sensory Integration	
Functional Behavioral Assessments	
Providing the following types of services:	
Medical	
Dental	
Psycho-pharmacologic	
Psychiatric	
Psychological	
Psycho-Social	

Communication	
Physical Therapy	
Occupational Therapy	

On a scale of 1 to 5, with 1 being very limited competency or experience and 5 being high level of competency or experience please rate your organization's experience/competency with the following items/skills:

Providing the following types of services:	
Sensory Integration	
Positive Behavior Supports	
Facility-Based Crisis Services	
Mobile Crisis Services	
Crisis Respite	
Collaboration with community organizations	
Supporting Self-Advocacy	
Working with Micro-Boards	

For many reasons, some agencies, by policy or practice, do not typically work with people have certain behaviors or diagnoses. Please indicate below with an X in the box, any behaviors or diagnoses that your agency typically does <u>not</u> work with.

Borderline intellectual disability	
Mild or minimal disabilities - Needs intermittent supports	
Moderate disabilities - Needs limited supports	
Severe disabilities - Needs extensive supports	
Profound disabilities - Needs pervasive supports	
Mental illness	
Severe behavioral challenges	
Significant medical problems	
Mobility challenges	
Significant communication problems	
Toileting needs	
Feeding needs	
Aggression	
Self-injury	
Sexuality related issues	
Forensic issues (criminal charges, history of illegal behavior)	

On a scale of 1 to 5, with 1 being very poor and 5 being very positive,

please rate your <u>access</u> to the following services.

Medical, including hospitals and General Practitioners/Primary Care providers	
Dental	
Psycho-pharmacologic	

Psychiatric	
Psychological	
Psycho-Social	
Communication	
Physical Therapy	
Occupational Therapy	
Sensory Integration	
Positive Behavior Supports	

Please estimate the number of people your organization has assisted to transition from SODC's to services you provide in the past 5 years.	
Please estimate the number of the people identified above that have been successful in their transition.	

Please provide the top three reasons you believe people have <u>not</u> been successful with their transition to your services in the community from SODCs

Please provide the top three reasons you believe people <u>were</u> successful with their transition to your services in the community from SODCs

Please estimate the <u>total</u> number of the people that your organization has <u>sent</u> to an SODC in the past 5 years.	

Please provide the top three reasons you believe people needed to go to an SODC for services.

| |
| |

Additional comments are welcome.

If submitting electronically, please add comments to the last page of this form.

| |
| |
| |
| |

Request for Application

This form should be submitted as an attachment to your completed Request for Information.

Agency Name:	
Address:	
Contact Person for RFA Responses:	
Contact Office Number:	
Contact Cell Number:	
Contact email Address:	
Counties We Would Consider Expanding To:	

The responses that follow will serve as an indication of your organization's interest and perceived competence at addressing specific issues associated with transition, including specific disabilities, staff skills, organizational values and practices, and community engagement.	
Assuming that you are provided sufficient resources to expand services appropriately, on a per person basis, please estimate the number of additional people you believe you can support within the next year.>>	

Of the people you have said you could serve with expansion support above, people who have which of the following types of disability are you able and willing to assist? Please check all that apply.	
Autism Spectrum Disorders	
Borderline intellectual disability	
Mild or minimal disabilities - Needs intermittent supports	
Moderate disabilities - Needs limited supports	
Severe disabilities - Needs extensive supports	
Profound disabilities - Needs pervasive supports	
Mental illness	
Severe behavioral challenges	
Significant medical problems	
Mobility challenges	
Significant communication problems	
Toileting needs	

Feeding needs	
Aggression	
Self-injury	
Sexuality related issues	
Forensic issues (criminal charges, history of illegal behavior)	
For the people you said above that you could serve with expansion support, which of the following types of service are you able and willing to develop (with appropriate assistance)? Please check all that apply.	
Shared Living situations (two-three people sharing a home)	
Supported living arrangements (their own home or apartment)	
Settings of 4 or fewer people	
Supported employment	
Competitive employment	
Micro-enterprises (not included above)	
Individualized non-work/community-based day services	
Positive Behavior Supports	
Dual Diagnosis (MI/IDD)	
Providing housing services/developing housing (not providing the services)	
Providing residential support services but not providing the housing	
Providing the following types of assessments:	
Medical	
Dental	
Psycho-pharmacologic	
Psychiatric	
Psychological	
Psycho-Social	
Communication	
Physical Therapy	
Occupational Therapy	
Sensory Integration	
Functional Behavioral Assessments	
Providing the following types of services:	
Medical	
Dental	
Psycho-pharmacologic	
Psychiatric	
Psychological	
Psycho-Social	
Communication	
Physical Therapy	

Occupational Therapy	
Sensory Integration	
Positive Behavior Supports	
Facility-Based Crisis Services	
Mobile Crisis Services	
Crisis Respite	
Collaboration with community organizations	
Supporting Self-Advocacy	
Working with Micro-Boards	

Following are philosophical/values statements that are directly related to the implementation of

the Transition Project.

On a scale of 1 to 5, with 1 being very low and 5 being very high, please rate your

We believe that people deserve a life – not just a "placement".	
We do everything possible to help people achieve their desired goals as fast as we possibly can.	
We look at people and the supports they need - not facilities and slots.	
We are willing to develop supports for one person at a time.	
We believe that good person-centered plans must be developed for each person and adhered to.	
We also believe that behavior is communication and we need to listen to what people are telling us. We must listen carefully.	
Each plan must include a provision for ongoing best-practice crisis supports – including prevention.	
People typically do better in smaller residential settings.	
Roommates/housemates should be compatible with each other - not on the basis of diagnosis or need.	
We embrace best-practice trends to separate housing and services.	
The first option explored should be assisting the individual or family to directly rent or own their housing.	
We believe in developing and supporting innovative and creative services and supports.	
As a part of the support planning there should be no set manner for service and support delivery.	
We will facilitate and provide what is recognized as best-practice to our fullest ability.	

The individual should have maximum control over their life to the greatest extent possible. It is our responsibility to assist them to achieve this goal.	
Providers must work to their fullest extent possible to prevent any re-institutionalization.	
Individual budgets should be based on assessed need and the services and supports necessary to implement a person-centered plan.	
Supports should be flexible to meet changing needs and interests.	
We believe that we should do everything we can to maximize the participation of people in their community.	
We believe that community membership facilitates personal opportunities, resources, and relationships and we embrace working with the community.	
We consider ourselves to be a progressive agency.	
We consider ourselves to be a flexible organization - doing what is needed to help people not just what we have always done.	
Our workforce is relatively stable.	
Our workforce is well trained for the people we serve.	
Our workforce is culturally competent.	
Our workforce is comfortable working in the community.	
Our personnel have the flexibility and autonomy to support people	
Our preferred model for person-centered planning is (fill in the name below)	