WELCOME TO

Advocacy Training for Community Integration, Personal Assistance Services & Employment Issues

Dallas, Texas - December 2 - 4, 1998

Advocacy Training

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Advocacy Training for Community Integration
Personal Assistance Services & Employment Issues

December 2 - 4, 1998 • Dallas, Texas

AGENDA

Day 1 - WEDNESDAY, December 2, 1998 1:00p - 5:30p

Reception - Networking & Door Prizes 6:00p - 9:00p

1:00p - 1:30p *Welcome - Phil Stinebuck, Organizational Consultant*
University of Arkansas, Regional Rehabilitation
Continuing Education Center

1:30p - 3:00p *NATIONAL OVERVIEW OF PERSONAL ASSISTANT SERVICES (PAS) AND EMPLOYMENT*

PERSONAL ASSISTANT SERVICES

Bob Kafka, National Organizer
ADAPT
Austin, Texas

Mike Oxford, Executive Director
Topeka Independent Living Resource Center
Topeka, Kansas

Stephen F. Gold
Attorney, Civil Rights Specialty
Philadelphia, Pennsylvania

EMPLOYMENT

Katherine Carol, President
Tango Consulting
Denver, Colorado

3:00p - 3:30p *Break*

3:30p - 5:30p *TRACK 1*
PAS in "Most Integrated Setting"
Bob Kafka
Steve Gold
Mike Oxford

TRACK 2
"Four Jobs and a Career"
Katherine Carol

6:00p - 9:00p *Reception - Networking & Door Prizes*

Day 2 - THURSDAY, December 3, 1998 9:00a - 5:00p

9:00a - 12:00p (Breaks TBA) *TRACK 1 (continue)*
PAS in "Most Integrated Setting"

TRACK 2 (continue)
"Four Jobs and a Career"

12:00- 1:30p *Lunch (on your own)*

1:30p - 3:00p *TRACK 1 (repeat)*
(Participants switch tracks)

TRACK 2 (repeat)
(Participants switch tracks)

3:00p - 3:30p *Break*

3:30p - 5:00p *TRACK 1 (continue)*

TRACK 2 (continue)

Day 3 - FRIDAY, December 4, 1998 9:00a - 2:00p

9:00a - 11:00p (Breaks TBA) *TRACK 1 (conclusion)*

TRACK 2 (conclusion)

11:00p - 12:00p *Bring It All Together/Sharing Ideas - Bob Kafka & Katherine Carol*

12:00p - 12:15 *Break*

12:15p - 2:00p *General Session & Closing Luncheon -*

"An Employer's Perspective"
John Daw, General Manager
Albuquerque Marriott
Albuquerque, New Mexico

"Advocacy: The Key to Independent Living and Civil Rights"
Ralph Rouse, Regional Director
Office of Civil Rights
US Department of Health & Human Services
Dallas, Texas

Meeting Rooms

Wednesday, December 2, 1998
1:00 – 3:00 p.m.
Ballroom – Platinum - Gold

3:30 – 5:00 p.m.
PAS in "Most Integrated Setting"
Bob Kafka
Platinum Room

Employment "Four Jobs and a Career"
Katherine Carol
Gold Room

Reception 6:30 p.m. – 9:00 p.m.
Gold Room

Thursday, December 3, 1998
9:00 a.m. – 5:00 p.m.
PAS in "Most Integrated Setting"
Platinum Room

Employment "Four Jobs and a Career"
Gold Room

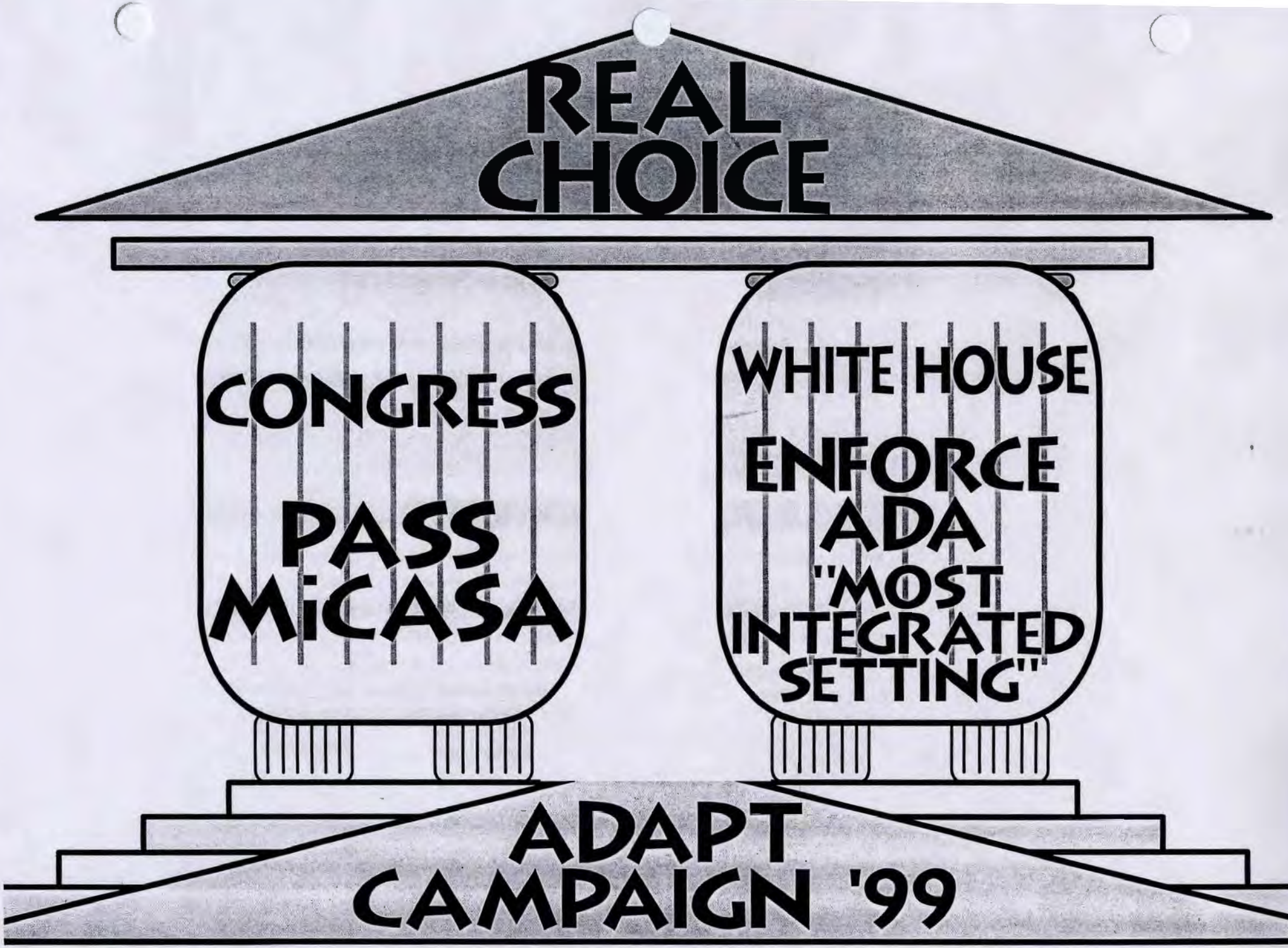
Friday, December 4, 1998
9:00 a.m. – 11:00 a.m.
PAS in "Most Integrated Setting"
Platinum Room

Employment "Four Jobs and a Career"
Gold Room

11:00 a.m. – 12:00 p.m.
General Session
Ballroom Platinum – Gold

12:15 p.m. – 2:00 p.m.
General Session & Closing Luncheon
Ballroom Silver


CAMPAIGN FOR REAL CHOICE • CAMPAIGN FOR REAL CHOICE •
FREE OUR PEOPLE
ADAPT
MiCASA HR2020


REAL CHOICE
CONGRESS
PASS MiCASA
WHITE HOUSE
ENFORCE ADA "MOST INTEGRATED SETTING"
ADAPT CAMPAIGN '99

MiCASA

MEDICAID COMMUNITY ATTENDANT SERVICES ACT OF 1997 H.R. 2020

W. does H.R. 2020 (CASA) do? It gives people real choice in long term care. MiCASA:

1) Amends Title XIX of the Social Security Act-Medicaid and creates a new Medicaid service called "Qualified Community-Based Attendant Services".

2) Allows the choice by any individual eligible for Nursing Facility Services (NF) or Intermediate Care Facility Services for the Mentally Retarded (ICF-MR) to use these dollars for "Qualified Community-Based Attendant Services." THE MONEY FOLLOWS THE NDIVIDUAL!

3) Requires services be provided in THE MOST NTEGRATED SETTING APPROPRIATE to the needs of he individual.

4) Provides $2 billion dollars over six years to help states transition from institutional to community-based services. This $2 billion dollars are in addition to the Medicaid dollars the state would spend on people eligible for nursing homes and ICF-MR.

5) ovides qualified community-based attendant ervices.

a) based on an assessment of functional need;
b) in a home or community-based setting to include a school, workplace, recreation or religious facility;
c) with various delivery options including vouchers, direct cash payments, fiscal agents and agency providers;
d) selected, managed and controlled by the consumer of the services;
e) with backup and emergency attendant services;
f) including voluntary training on how to select, manage and dismiss attendants;
g) and according to a service plan agreed to by the person receiving services.

) Allows health-related tasks to be assigned to, elegated to, or performed by unlicensed personal ttendants.

) Covers costs of transitioning from a nursing facility ICF-MR to a home setting are "qualified community- as attendant services." This might include rent and i. deposits, bedding, basic kitchen supplies and her necessities required for the transition

8) Covers individuals with incomes above the current institutional income limitation if a state chooses to waive this limitation because the potential for employment would be enhanced by providing these services.

STATES' TRANSITION PLANS

Each state shall develop a long term care services transition plan, with major participation by the Sate Independent Living Council, the State Developmental Disabilities Council and Councils on Ageing.

This plan must have specific action steps and timetables to increase the proportion of home and community based services provided in the State.

DUTIES OF THE SECRETARY

The Secretary of Health and Human Services shall:

1) develop regulations that will maximize consumers' independence and control for the non-agency provider models;

2) review existing Title XIX regulations as they related to home health and home and community-based settings and submit a report to Congress on how excessive use of medical services can be reduced;

3) develop a functional needs assessment instrument, and

4) establish a task force to examine financing of long term care services.

SUPPORT CASA NOW!

What does ADAPT mean by "most integrated setting?"

That people with disabilities receive services exactly where nondisabled people receive them. *Even services that are aimed at people with disabilities* should be provided "in the most integrated setting" possible.

The Americans with Disabilities Act (ADA) "integration" mandate requires that:

"A public entity shall administer services, programs, and activities in *the* most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 CFR §35.130(d). Failure to provide services "in the most integrated setting" is discrimination against people with disabilities.

- For example, people with disabilities who need personal attendant services and medical care are often put in nursing homes, instead of receiving attendant care and medical services in their own homes and communities. The Helen L. v. DiDario lawsuit says that to put people in nursing homes when they could live in their own homes with the same money is illegal.

- Another example are intermediate care facilities (ICFs). These house from six to hundreds of people with disabilities. In ICFs, people with disabilities may receive a variety of services – all of which could be provided in the community. Often, a state pays for ICFs instead of using the same public funds for people with disabilities to live in their own communities. This is unnecessary segregation and violates the ADA.

- Another example is medical care. People with disabilities should have access to the same doctors and dentists as nondisabled people. Yet, many doctors' and dentists' offices are still inaccessible. This means that people with disabilities do not have the same choices at the same locations as nondisabled people. It is segregation when a person with a disability cannot gain access equal to nondisabled people .

- Another example is sheltered workshops. It is segregation when a state provides employment or employment training in workshops only with and for people with disabilities. There is nothing to prevent such employment or training to be integrated.

If you suspect segregation:

- Ask where nondisabled people receive similar services; where a public entity would provide similar services to nondisabled.

- Ask if the service could be provided without the stigma of being segregated i.e., could the service be provided so that the person with a disability could live in the community with his/her family and friends, while receiving the service.

- Ask why the service looks like, smells like and sounds like the public entity is providing a service, while keeping the person with a disability away from nondisabled people.

ADAPT
Real Choice

Our long term service system must change. It was created over thirty years ago as a health care program, funded by Medicare and Medicaid dollars. These medical dollars were never intended to meet the long term care needs of people. It is time for this antiquated policy to be updated. We need a system that empowers people and allows REAL choices.

- ☆ The money should follow the individual not the facility or provider.
- ☆ A national long term service policy should not favor any one setting over the other, as it currently favors institutions. It should be neutral and let the users choose where services should be delivered. The current system is not neutral.
- ☆ Over 80 percent of our Medicaid dollars ($40 billion) going to long term care is spent in institutions, leaving less than 20 percent ($10 billion) for all community services.
- ☆ The current system is expensive, and we must establish more cost-effective alternatives. Community based services are less expensive and better liked than institutions.

Demographics of the United States are changing.

- ☆ Greater numbers of people are living longer every year, and a much higher percentage of older people are in need of long term care.
- ☆ Medical technology is keeping young children, and adults alive who would not have survived just a few years ago.

All people want services in the community.

- ☆ People with disabilities both old and young, including those with severe mental and/or physical disabilities want services in their own homes.

- ☆ The federal government needs to work in partnership with states to create flexible delivery systems that gives people REAL choice.

-More-

People with disabilities and their families want REAL choice:

- ☆ equitable funding for services outside institutions.
- ☆ no program or rule disincentives to community services
- ☆ Empowerment. Service delivery options must include agency, vouchers, and fiscal intermediaries.

Family values---Keeping families together.

- ☆ Children could grow up at home with their parents, not in institutions.
- ☆ Our grandparents need not work their whole lives just to see a nursing home strip them of their home and life's savings.
- ☆ It's so much easier for adults with disabilities to be gainfully employed living in the community, than in a nursing home. This allows people to become TAXPAYERS instead of TAX USERS.

Funding must follow the individual.

- ☆ When program funding is attached to individuals, rather than beds, it eliminated costly and burdensome rules and regulations by government regulators.

Eliminate fragmentation and create a seamless system.

- ☆ A system based on functional need instead of medical diagnosis will end fragmented service delivery and eliminate gaps in service.

There are some long term providers of service and families who believe REAL choice would threaten what they have. In fact, REAL choice will only increase the services and options that families and individuals have. We cannot continue the system as it is today. It is expensive, fragmented, over-medicalized and disliked by almost everyone.

THERE'S NO PLACE LIKE HOME!!!

ADAPT
Free Our People

ADAPT
Nursing Home Watch

The following individual/family is in imminent risk of going into, or is currently in, a nursing home because of the lack of appropriate home and community services. They want to stay in the community or have an opportunity to move back into the community.

Name_____ **Age** _____

Address _____ **Sex** _____

City _____ **State** _____ **Zip** _____

Phone _____ **Fax** _____ **e-mail** _____

Please describe your situation with as much specific information about your need for home and community services:

_____

_____

_____

_____

Can we share this information? _____ **Yes** _____**No**

Add my name to the "Campaign for Real Choice" _____ **Yes** _____ **No**

CAMPAIGN for REAL CHOICE
"MOST INTEGRATED SETTING"
CHECKLIST

1. ____ Identify Medicaid Designated Agency and Medicaid Director (Head of Designated Medicaid State Agency and Medicaid Director may not be the same.)

2. ____ Develop and send letter asking for the State's self evaluation of their programs, services and activities. Specificly ask for the portion of the self-evaluation that addresses nursing homes, ICF-MR facilities and home and community-based services. Demand response in 10 days.
Send letter to the head of the Designated Medicaid State Agency with a copy to the Medicaid Director.

3. ____ Identify people in nursing homes or other institutions that would benefit if "most integrated setting" was followed by the State. This makes the complaint stronger, though you can file the complaint based on stories you have heard.

4. ____ Review self-evaluation for "most integrated setting".
If you need assistance in reviewing the plan call ADAPT.

5. ____ If self-evaluation not sent in ten days go to office of Medicaid Designated Agency. Demand self-evaluation!

6. ____ Write a letter of complaint saying that your State is violating the"most integrated setting" mandate of the ADA by not providing long term care services in the "most integrated setting" and you want them to review the State to assess if they are complying with the ADA.
Send it to:

    ____ Regional OCR office of HHS
    ____ John Wodatch, Dept of Justice
    ____ Secretary Donna Shalala, HHS

John Wodatch
US Department of Justice
P.O. Box 66738
Washington, D.C. 20035-6738

Donna Shalala, Secretary
US Dept of HHS
200 Independence Ave, SW 615F
Washington, D.C. 20201

7. ____ Send copies of all letters sent and received to ADAPT.

ADAPT
CAMPAIGN for REAL CHOICE
"MOST INTEGRATED SETTING"
STATE STRATEGY
PHASE II

In Phase I you requested a copy of the Self-Evaluation, if received reviewed for "most integrated setting" language and filed an ADA Title II complaint. Phase II includes specific actions your State can take to implement "most integrated setting" so that people with disabilities in your State have a "Real Choice" in long term services and supports.

_____ **Have your State create a "Most Integrated Setting" committee to . . . update the State's Self-Evaluation.**

_____ **Have your State create a "Community First" policy that would include:**

- ____ **Notification of all people applying for institutional services of all home and community service options;**
- ____ **Notification by letter of all people in institutional settings of their options for home and community services;**
- _____ **Contract with consumer groups throughout your State to go into institutions and inform people of their home and community service options;**
- _____ **Work with HCFA Regional office for development/expansion/consolidation of Medicaid waivers;**

_____ **Identify and keep a list of all individual who are IN or at "IMMINENT RISK" of going into an institution.**

"Most Integrated Setting"

ADAPT demands the following:

1) **A copy of the most current self-evaluation;**

2) **A written commitment that no person with a disability will ever be forced into an institution because of lack of funding for community services;**

3) **Write a letter with ADAPT informing ALL folks in nursing homes, ICF-MR facilities and other institutions about their options for community services and consumer community organizations that can give them information;**

4) **Fund a training designed by ADAPT for consumer community organizations who can assist people getting people out of nursing homes, ICF-MR facilities and other institutions.**

U.S. Department of Justice

Civil Rights Division

Disability Rights Section
P.O. Box 66738
Washington, DC 20035-6738

JUL - 6 1998

Mr. Michael Auberger
ADAPT
Post Office Box 9598
Denver, Colorado 80209

Mr. Bob Kafka
ADAPT of Texas
1339 Lamar Square Drive
Suite 101
Austin, Texas 78704

Dear Mr. Mike Auberger and Mr. Bob Kafka:

Thank you for your letter seeking clarification of the Americans with Disabilities Act's (ADA) self-evaluation requirements as they relate to the "integration mandate" of title II.

The ADA requires every public entity to conduct a self-evaluation of its "current services, policies, and practices, and the effects thereof, that do not meet the requirements of [the title II regulations] . . . ." 28 C.F.R. 35.105(a). One of the fundamental requirements of the title II regulations is that public entities "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. 35.130(d).

This integration requirement applies to all State activities, including the provision of nursing home, institutional, and community-based services to people with disabilities. L.C. v. Olmstead, No. 97-8358 (11th Cir. April 8, 1998); Helen L. v. DiDario, 46 F.3d 325 (3d Cir. 1995). Therefore, a State must review, as part of its self-evaluation, its policies and practices regarding the provision of nursing home, institutional, and community-based services to ensure that individuals with disabilities receive services in the most integrated setting appropriate to their needs.

If a State has failed to address the ADA's integration requirement in its self-evaluation, then its self-evaluation is incomplete. In these circumstances it would be appropriate for State officials to address the integration issue. As provided in the Department's implementing regulation at 28 C.F.R. 35.105(b), interested persons, including individuals with disabilities or organizations representing individuals with disabilities, must be given an opportunity to participate in the self-evaluation process.

Sincerely,

John L. Wodatch
Chief
Disability Rights Section

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

JUL 29 1998

Dear State Medicaid Director

In the Americans with Disabilities Act (ADA), Congress provided that "the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals." 42 U.S.C. § 12101(a)(8) Title II of the ADA further provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs or activities of a public entity, or be the subject of discrimination by any such entity." 42 U.S.C. § 12132. Department of Justice regulations implementing this provision require that "a public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d).

We have summarized below three Medicaid cases related to the ADA to make you aware of recent trends involving Medicaid and the ADA.

In L.C. & E.W. v. Olmstead, patients in a State psychiatric hospital in Georgia challenged their placement in an institutional setting rather than in a community-based treatment program. The United States Court of Appeals for the Eleventh Circuit held that placement in an institutional setting appeared to violate the ADA because it constituted a segregated setting, and remanded the case for a determination of whether community placements could be made without fundamentally altering the State's programs. The court emphasized that a community placement could be required as a "reasonable accommodation" to the needs of disabled individuals, and that denial of community placements could not be justified simply by the State's fiscal concerns. However, the court recognized that the ADA does not necessarily require a State to serve everyone in the community but that decisions regarding services and where they are to be provided must be made based on whether community-based placement is appropriate for a particular individual in addition to whether such placement would fundamentally alter the program.

In Helen L. v. DiDario, a Medicaid nursing home resident who was paralyzed from the waist down sought services from a State-funded attendant care program which would allow her to receive services in her own home where she could reside with her children. The United States Court of Appeals for the Third Circuit held that the State's failure to provide services in the "most integrated setting appropriate" to this individual who was paralyzed from the waist down violated the ADA, and found that provision of attendant care would not fundamentally alter any State program because it was already within the scope of an existing State program. The Supreme Court declined to hear an appeal in this matter; thus, the Court of Appeals decision is final.

In Easley v Snider, a lawsuit, filed by representatives of persons with disabilities deemed to be incapable of controlling their own legal and financial affairs, challenged a requirement that beneficiaries of their State's attendant care program must be mentally alert. The Third Circuit found that, because the essential nature of the program was to foster independence for individuals limited only by physical disabilities, inclusion of individuals incapable of controlling their own legal and financial affairs in the program would constitute a fundamental alteration of the program and was not required by the ADA. This is a final decision.

While these decisions are only binding in the affected circuits, the Attorney General has indicated that under the ADA States have an obligation to provide services to people with disabilities in the most integrated setting appropriate to their needs. Reasonable steps should be taken if the treating professional determines that an individual living in a facility could live in the community with the right mix of support services to enable them to do so. The Department of Justice recently reiterated that ADA's "most integrated setting" standard applies to States, including State Medicaid programs.

States were required to do a self-evaluation to ensure that their policies, practices and procedures promote, rather than hinder integration. This self-evaluation should have included consideration of the ADA's integration requirement. To the extent that any State Medicaid program has not fully completed its self-evaluation process, it should do so now, in conjunction with the disability community and its representatives to ensure that policies, practices and procedures meet the requirements of the ADA. We recognize that ADA issues are being clarified through administrative and judicial interpretations on a continual basis. We will provide you with additional guidance concerning ADA compliance as it becomes available.

I urge you also, in recognition of the anniversary of the ADA, to strive to meet its objectives by continuing to develop home and community-based service options for persons with disabilities to live in integrated settings.

If you have any questions concerning this letter or require technical assistance, please contact Mary Jean Duckett at (410) 786-3294.

Sincerely,

Sally K. Richardson
Director

cc All HCFA Regional Administrators

All HCFA Associate Regional Administrators
for Medicaid and State Operations

ADAPT
Free Our People

Secretary of Welfare
1234 Market Street
City

Dear Secretary _____,

ADAPT of {Name of Your State} requests a copy of the self-evaluation that the Medicaid Designated Agency had to develop to meet the requirements of Title II of the Americans with Disabilities Act, (28 CFR 35.105(a)), with regards (1) nursing facilities and (2) intermediate care facilities - mental retardation.

According to the July 29, 1998 letter from Sally K. Richardson, Director, HCFA, to [name of your state]'s Medicaid Director, a copy of which I am enclosing for your convenience,

> "States were required to do a self-evaluation to ensure that their policies, practices and procedures promote, rather than hinder integration. This self-evaluation should have included consideration of the ADA's integration requirement. To the extent that any State Medicaid program has not fully completed its self-evaluation process, it should do so now, in conjunction with the disability community and its representatives to ensure that policies, practices and procedures meet the requirements of the ADA."

According to a July 6, 1998 letter from the Department of Justice, Civil Rights Division, a copy of which I am also enclosing for your convenience,

> "[A] State must review, as part of its self-evaluation, its policies and practices regarding the provision of nursing home, institutional, and community-based services to ensure that individuals receive services in the most integrated setting appropriate to their needs. If a State has failed to address the ADA's integration requirement in its elf-evaluation, then its self-evaluation is incomplete."

Specifically, ADAPT of [your state] wants a copy the ADA-required self-evaluations written by [your state's] Medical Assistance program with regards to people who are in Title XIX-Medical Assistance funded nursing homes and intermediate care facilities - mental retardation.

Please respond with a copy of the self-evaluation by [10 days]. If you do not have a copy of the self-evaluation, please write so stating with [10 days]. We will pay for any copying costs to receive this document.

For an Institution Free [name of your state]

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cc: John L. Wodatch, U.S. Department of Justice
_____, Region , Office of Civil Rights, hHHS
{your local commissioners – if you know who they are.}

Model letter of Complaint to use for September 10th action

John Wodatch
US Department of Justice
P.O. Box 66738
Washington, D.C. 20035-6738

September 10, 1998

Dear Mr. Wodatch:

Please regard this letter as a formal complaint against the state of _____ for violation of Title II of the Americans with Disabilities Act.

Specifically, our complaint states that the State of _____ when they did their self-evaluation of nursing home, institutional, and community-based services did not ensure that individuals with disabilities received services in the most integrated setting appropriate to their needs and have taken inadequate steps to address this issue. This violates the ADA regulations for self-evaluation and integration.

Because of the national significance of this problem we ask the Department of Justice to investigate this complaint directly.

Thank you

cc: Donna Shalala, Secretary
US Dept of HHS
200 Independence Ave SW 615F
Washington, DC 20201

REGIONAL MANAGERS

REGION I — **STATES**

Caroline Chang - CT, ME, MA
Regional Manager NH, RI, VT
Dept. of Health & Human Services
Office for Civil Rights/Govt. Ctr.
JFK Federal Bldg.-Rm 1875
Boston, MA 02203
91-617/565-1340 Fax 565-3809
TDD 617/565-1343

REGION II

Michael Carter -NJ, NY, PR*, VI*
Acting Regional Manager
Dept. of Health & Human Services
Office for Civil Rights
Jacob Javits Federal Bldg.
New York, NY 10278
91-212/264-3313 Fax 264-3039
TDD 212-264-8900

REGION III

Paul Cushing - DE, DC, MD, PA,
Regional Manager VA, WV
Dept. of Health & Human Services
Office for Civil Rights
535 Market Street - Rm. 6300
Philadelphia, PA 19101
91-215/596-1262 Fax 596-4704
TDD 215-596/5195

REGION IV

Marie Chretien - AL, FL, GA, KY,
Regional Manager MS, NC, SC, TN
Dept. of Health & Human Services
Office for Civil Rights/Fed. Ctr.
61 Forsyth street, S.W.
Atlanta, GA 30323
91-404\331-2779 Fax 730-9693
TDD 404\841-2867

REGION V

Charlotte Irons - IL, IN, MI,
Regional Manager MN, OH, WI
Dept. of Health & Human Services
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105 West Adams - 16th Floor
Chicago, IL 60603
91-312/886-2359 / FAX 312 886 2301
TDD 312/353-5693

REGION VI — **STATES**

Ralph Rouse - AR, LA, NM
Regional Manager OK, TX
Dept. of Health & Human Services
Office for Civil Rights
1301 Young Street Suite 1169
Dallas, TX 75202
91-214/767-4056 Fax 767-0432
TDD 214-767-8940

REGION VII

John Halverson - IA, KS, MO, NB
Regional Manager
Dept. of Health & Human Services
Office for Civil Rights
601 East 12th Street - Rm. 248
Kansas City, MO 64106
91-426/7278 Fax 426-3686
TDD 816-426/7065

REGION VIII

Vada Kyle-Holmes - CO, MT, ND
Regional Manager SD, UT, WY
Dept. of Health & Human Services
Office for Civil Rights
1961 Stout Street - Rm. 1426
Denver, CO 80294
91-303/844-2024 Fax 844-6665
TDD 303/844-3439

REGION IX

Ira Pollack, Actg. - AZ, CA, HI, NV
Regional Manager GU*, PS*, AS*
Dept. of Health & Human Services
Office for Civil Rights
50 United Nations Plaza
San Francisco, CA 94103
91-415/437-8310 Fax 437-8329
TDD 415\437-8311

REGION X

Carmen P. Rockwell - AK, ID, OR, W
Regional Manager
Dept. of Health & Human Services
Office for Civil Rights
2201-Sixth Ave., - Suite 900
Seattle, WA 98121
91-206/615-2287 Fax 615-2297
TDD 206/615-2293

HDQRS. FAX # - ES 619-3818, DO 619-3437 & OPO 260-0550
*REGION II - PUERTO RICO & VIRGIN ISLANDS
*REGION IX- GUAM, PACIFIC ISLANDS AND AMERICAN SAMOA
REGIONS 800 NUMBER 1-800/368-1019 (VOICE) & TDD 900/537-7697

2-12-98

EMPOWERING SERVICE DELIVERY

Putting Independent Living Principles in the Delivery System

****

Ongoing Debate in Independent Living Movement

Role of Independent Living Centers

Service versus Advocacy

Getting Beyond the Debate!

WHAT IS EMPOWERING SERVICE DELIVERY?

1. Taking Control of the Service Delivery System

2. Putting the Independent Living Principles into the Delivery System

3. Changing the paternalistic/medical model way of delivering services

Benefits

1. Direct contact with individuals who need the services

2. Ability to organize around need for more and better services

3. Resources from delivery of services can be used for other advocacy activities

4. Learn how the delivery system works

POTENTIAL PROBLEMS

1. Get co-opted by fear of losing contract(s)

2. Consumers not satisfied with your services - you become the problem

3. Litigation

Long-time activist Bob Kafka calls for "the next evolution of the independent living movement"

Empowering Service Delivery

by Bob Kafka

Since the start of the independent living movement 20 years ago, we've been debating the role independent living centers should take in delivering services. What is the role of a "true advocate?" we've asked. "Should we become part of the system, or should we stay outside?" These debates have occupied many hours of conference time over the years.

We must get beyond this debate!

Purists have argued that "pure" advocacy would be co-opted by the economic pressures of a service delivery role. Instead of being a strong voice for the interests of a disabled person, they've said, a Center that delivered services (and saw itself as part of the service delivery system) would become more interested in the bottom line, or in keeping a contract with a state agency. These purists have insisted that only by being outside the system can one truly advocate for the things necessary to change the system.

This argument, though, is becoming more and more difficult to sustain. While Nero fiddles, Rome is burning. People with disabilities are demanding more than rights: they are demanding services. Almost two million people with disabilities, young and old, are locked away in nursing homes and other institutions, unable to use the rights promised them by passage of the Americans with Disabilities Act. While the disability community has this intellectual argument, services vs. advocacy, our brothers and sisters lie in bed waiting for real alternatives to institutionalization.

The healthcare system in this country is drastically changing the way acute medical services and long-term support and services are delivered. This change is occurring at a rapid pace. The disability community must be at the forefront of these changes or be relegated to a minor role. People with disabilities, including those of us with long-term care needs, have been fighting to be excluded from the managed care juggernaut based on the belief that the cost of our services, rather than our service needs, will be the incentive that motivates the managed care organization.

But while we fight, pilot programs around the country are already testing how best to serve people with disabilities using managed care concepts, both for acute and long-term care services. Managed-care providers are already talking about "carve-ins" or "carve- outs" of specific disabilities; talking about integrating acute and long-term care needs; debating whether entrance into the managed care system should be voluntary or mandatory.

The economic imperatives that fuel the managed-care train today are too powerful to stop. Even if managed care changes its look, a "managed care" (read: "save money") approach will soon subsume the whole health care delivery

Bob Kafka is an organizer with ADAPT.

The economic imperatives that fuel the managed-care train today are too powerful to stop. Unless we people with disabilities are at the table telling managed care corporations what concepts we want in a delivery system, we will find that we will continue to be at the mercy of providers who understand little about our functional needs and even less about the independent living philosophy.

system. The disability community must deal with this issue directly and not stick its head in the sand and hope it will go away. The question isn't "if managed care..." but what managed care will look like as we move into the 21st century.

So: what role does the disability community want to play in this managed-care delivery system that's upon us? What role will the disability-rights and independent-living community play in the long-term care/personal attendant service delivery system when people with disabilities start being absorbed into managed care programs around the country?

Unless we people with disabilities are at the table telling managed care corporations what concepts we want in a health care delivery system; unless we ourselves start the process of becoming what I call "empowered service deliverers" ourselves, we will find that we will continue to be at the mercy of health care providers who understand little about our functional support needs, and even less about the independent living philosophy.

"Empowering Service Delivery" is my name for an old concept. Since the beginning of the independent living movement, the challenge has been to put independent living philosophy concepts into the larger systems — and only provide services on an interim basis till the larger system has changed. ESD is an interim step I propose we take till the larger long-term care/personal attendant service system embraces independent living concepts.

This approach to changing the current service delivery system would have independent living centers become service providers -- and put the independent living concepts of choice and control into operation through a delivery system: independent living centers as deliverers of long-term care/personal attendant services.

Although there's been a lot said and written about how people with disabilities can individually become more empowered, there's been very little said about how the delivery system itself can become empowering for people with disabilities.

The disability movement has often — and for good reason — cast the delivery system of nursing home, "home health" and ICF-MR providers as the "medical-model" enemy of disabled people. Though this is true, changing that "medical model" from outside has been a slow process. "Empowering Service Delivery" would allow us to expand our strategy to advocate for changes in the larger system from the perspective of a progressive insider.

The disability community needs to take a lesson from other minority groups who have effected change by taking economic control of their neighborhoods. We, people with disabilities need to take economic control of our "neighborhoods," too.

To racial minorities, "taking control of the neighborhood" meant taking economic control of the system that delivered goods and services to their own communities; by doing this, they gained control over what happened in their communities, and also brought their own cultural perspective to the community. Since people with disabilities all don't live in one neighborhood (unless you consider nursing home and other institutions "neighborhoods"), our "taking control" must take another form.

The analogy works like this: people with disabilities should take over the pieces of the health care delivery system that for years have controlled our lives. Independent living centers should become deliverers of personal attendant services.

If a person with a disability calls up an independent living center today and wants to get out of an institution, what can the majority of them offer? Classes? Information and referral? Peer counseling?

To begin the process of becoming independent, that person first needs to be able to get out of the institution. Being able to get someone out of an institution -- or keep

Continued

someone out — is truly what the independent living movement is about.

If we don't provide ESD ourselves, consider what "providers" we have to battle: The American Health Care Association— the nursing home providers. The National Association of Home Care — the "home health" service providers. Other professionally-driven health care providers: Occupational therapists. Physical therapists. Social workers. Psychologists. And on and on.

Disabled people are always on the outside — we're the "crop" for a lucrative, profit-driven health care system that harvests billions of dollars from us (or our Medicare, Medicaid or insurance companies) — based on their definitions of our needs. ESD allows us to directly confront the paternalism in the existing system and make changes from the inside. It also puts some of that money back into our organizations, money which can then be used for advocacy efforts such as enforcement of the ADA, affordable and accessible housing and community organizing activities.

The traditional disability rights movement's response has been simply to shun the "medical model": make believe it doesn't exist and attempt to totally bypass the delivery system. An agency model, even one that might be progressive, has been shunned. The model promoted was one where individuals would hire their own attendants and, in essence, run their own "service delivery system" by being in charge of one — or more — attendants, managing their funds, reimbursement and all the rest.

The Topeka Independent Living Center, the Atlantis Community in Denver and Liberty Resources in Philadelphia have been providing cost-effective personal attendant services for many years — and also have a reputation of doing aggressive advocacy work — showing that services and advocacy can go hand in hand.

This traditional independent-living movement approach to how personal attendant services should be delivered may work for some individuals who have the desire and skills to run things on their own. But for the vast numbers of people who have disabilities, it's just not working. Sticking to this one approach to personal attendant services delivery will not meet the diverse needs and skill levels of the disability community. Independent living centers need to develop a complete service delivery system for personal attendant services.

Let me give you an example of why we need a delivery system in place: The U.S. delivered tons of food to the docks in Somalia to help feed starving people — but at that point it wasn't real "food" to the people of Somalia. Until it got to the people, it might as well have been cardboard. There had to be trucks found to move the food into the villages where people lived. Somebody had to load the trucks. Somebody had to drive them. Gasoline had to be found to fuel the trucks. Somebody had to decide what food went to which villages. Once there, somebody had to unload the trucks. All of this is a "delivery system." Only after a "delivery system" was working did the food reach the people. There had to be a delivery system.

It's no different with delivering attendant services.

Right now, the vast majority of attendant services are provided by home "health" agencies. The disability community doesn't like that; we're not in control, and we view the agencies as coming out of the evil "medical model." The bottom line, though, is that without an alterna-

FREEDOM WATCH

HCFA, DOJ and the ADA

"Freedom is now within our reach" say ADAPT activists. Both the Department of Justice and the Health Care Financing Administration (HCFA) have issued letters insisting states' Medicaid programs comply with the Americans with Disabilities Act. Recent ADA lawsuits have showed this means funds must be used to let people live in their homes rather than nursing homes.

A July 6 letter from DOJ Civil Rights Division Chief John Wodatch to ADAPT organizers Mike Auberger and Bob Kafka says a "fundamental requirement" of the ADA is that states "administer services...in the most integrated setting...." On Aug. 3, HCFA Director Sally K. Richardson issued a letter to state Medicaid directors reminding them of HCFA's "commitment to and responsibility for ensuring compliance with" the ADA, adding that "if necessary, HCFA will refer matters to the.. Department of Justice for legal action." The letter's online at http://hcfa.gov/medicaid/smd8398.htm

Readers wanting specifics on using the documents' strong words to get folks out of nursing homes can call the Topeka Center for Independent Living for how-to

tive delivery system in place, people with disabilities are at the mercy of the home health industry. In some states, a few disabled people manage their own attendants and avoid this; they participate in tiny programs that use vouchers, "fiscal agents" or "direct pay" programs.

But although these can be effective ways to have control over the services, it's been shown they don't work for the vast numbers of us who need some sort of a delivery system to deliver attendant services.

Many people with disabilities use the traditional "medical-model" delivery systems already in place because there are no alternatives available. An ESD alternative would give many people with disabilities the alternative they have been looking for —a program run by and for people with disabilities instead of "business as usual" the home-health agency way.

Delivering personal attendant services in an empowering way means interjecting independent living principles into the delivery system. Under such a system, disabled people would be able to select, manage and dismiss their own attendants. If independent living principles were at the basis of the delivery system, the "health" services that often go along with delivery of attendant services wouldn't have to be delivered by a doctor or nurse as has traditionally been done; they could be delegated or "assigned" by a nurse or doctor to a qualified but unlicensed person. Services would be designed to enhance the person's ability to function in the community, rather than to "fix" or "cure" the person.

If the independent living movement were to take over the delivery of personal attendant services, we wouldn't have to be "just like the current system," as people fear. We'd bring the disability communityÕs unique perspective of choice and control to the hands-on delivery of services.

Through the concept of "empowering service delivery," the disability-rights and independent-living communities could change the way attendant services are delivered. We wouldn't be traditional "home health agencies"; we could change our names and call ourselves Home and Community-based Support Service Agencies — or HCSSAs. Our philosophy would shape the service delivery system.

HCSSAs would be consumer-driven. They'd be as non-medical as possible. They'd work with people with disabilities instead of against them. People who wanted total control over their attendants would be able to use the HCSSA as a "flow-through" for the money they paid their attendant so the HCSSA would be able to provide a consistent system for accountability to the funding source. Our concepts of choice and control would permeate the traditional system. Our presence could assist advocates working to change the larger home health industry.

Yes, it's true that HCSSAs could succumb to the same pressures that home health agencies say they're up against. Sometimes the consumer of services might get angry at us, too. The truth is that it's difficult to deliver any service competently all the time — including personal attendant service. Yes, we'd make mistakes. But having the agency based on the independent living/consumer-driven philosophy would be some protection against our becoming co-opted by economic and political pressures in the traditional sense.

Though HCSSAs may not be the total answer to changing our traditional delivery system, if the independent living movement moved in this direction many people who are in nursing homes and other institu-

Continued

Disabled people are always on the outside — the "crop" for a lucrative, profit-driven health care system that harvests billions of dollars from us.

Somalia

Let me give you an example of why we need a delivery system in place: The U.S. delivered tons of food to the docks in Somalia to help feed starving people — but at that point it wasn't real "food" to the people of Somalia. Until it got to the people, it might as well have been cardboard. There had to be trucks found to move the food into the villages where people lived. Somebody had to load the trucks. Somebody had to drive them. Gasoline had to be found to fuel the trucks. Somebody had to decide what food went to which villages. Once there, somebody had to unload the trucks. All of this is a "delivery system." Only after a "delivery system" was working did the food reach the people. There had to be a delivery system.

It's no different with delivering attendant services.

tions would finally be able to live in the community. This is real independent living.

As "empowered service deliverers," HCSSAs could be there to provide community-based personal attendant services when a person is coming out of a hospital or rehabilitation facility as well as the other services provided by the independent living enter.

Managed care entities are grappling today with how to move people from "acute" environments — hospitals, rehab facilities — into the community. Independent living centers have the answer to this problem: they can — as they've traditionally been supposed to do — not only provide the personal attendant services, but also locate accessible and affordable housing, information on assistive technology and offer a range of other services which most of our centers provide today anyway.

An "empowered service deliverer," armed with the ability to deliver actual services, would provide the individual the ability to truly become independent and a way to become active in the community.

Delivering services in this way can be efficient and cost-effective. Filtering out the over-medicalization of services has been a goal of the independent living movement for years. Independent living centers as "empowering service deliverers" can prove to managed care organizations, through their effective use of a non-medical and more efficient model, that the medical model is costly and doesn't work nearly as well as the independent living model.

The Topeka Independent Living Center, the Atlantis Community in Denver and Liberty Resources in Philadelphia have been providing cost-effective personal attendant services for many years. These centers show that ESD can work. These centers also have a reputation of doing aggressive advocacy work. They show that services and advocacy can go hand in hand.

Unnecessary case management, and too many professionals in our lives, are also areas where cost savings wouldn't be a dirty word. Many of our Medicaid waivers are based on the idea that we are "broken" and that professional services can "fix" us. With ESD, independent living principles, rather than "medical model" concepts, would form the basis for evaluating whether a particular service would be of "benefit" to a client. Rather than seeing a client as someone to be "fixed," it would see a client as someone who needed services to function in the community. The measure of a service's success would not be a medical professional's evaluation; the measure of success would be in how well the clients are able to go about their lives in the community.

Infiltrating the health care delivery system from within, as well as pushing for change from the outside (as we've traditionally advocated) are not strategies that need be mutually exclusive. The independent living philosophy that spawned the independent living centers of today needs to progress to the next stage nd truly "empower" the delivery system itself. This is the next evolution of the independent living movement.

House Guest
(For Nonnie)

This morning I thought of you in that instant
I bent to load the dishes and arose,
holding breath and counter top in crippling
embrace. Greedy for writing time, I logged
Sunday's fire with the mastodon of the pile
who bit me then, leaving the long tooth
to pierce again at 3:00 a.m.
Thirty years ago I watched my cousin
carry you down the steep river path
carved in the bluff for surefooted fishermen
carrying only rods and creels.
Through medical school and family practice,
family deaths and his escape, you carried
him, three children, your parents, childlike
in divorce, dropping them only at journey's
end accompanied always by the silent
one you didn't choose, nor introduce, nor
ever lose. For three days I've favored my
companion, hoping he'll grow bored with me
and have no wish to linger like an old
fish forgotten in the fridge, too rank
to touch or to remove. Too long I've watched
him, love struck, your incubus, remain
to watch Troy burn again in your pain.

— Frances Downing Hunter

COMPONENTS OF AGENCY-DELIVERED, CONSUMER-DIRECTED SERVICES

1. Maximum control by the consumer to select, manage, and dismiss the attendant, regardless of who the employer is.

2. Flexibility of services. After number of hours are assessed, the consumer has the responsibility to determine when and how these services are delivered.

3. Services are community based/noninstitutional.

4. Services are available based on functional and health-related needs, regardless of disability and/or age.

5. Services are as nonmedical as possible and allow for unlicensed people to perform health-related tasks through delegation or assignment.

6. Agency can provide a pool of attendants for the consumer to select.

7. System has a backup and emergency system that is designed by both the consumer and the agency; this could include the consumer or the agency arranging for backup.

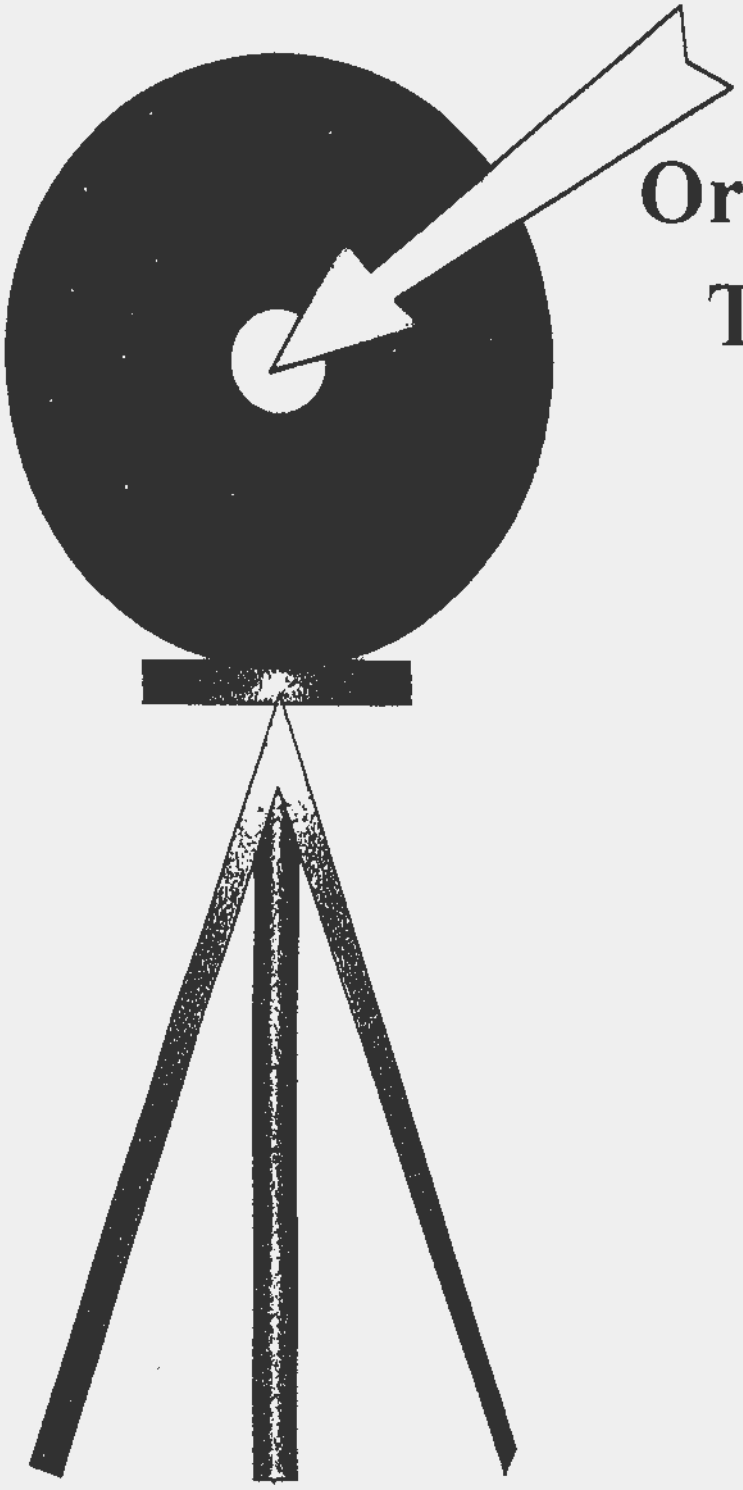
8. Services are provided where the client needs them (including home, work, school, church or other locations).

9. Services are available 24 hours a day, 7 days a week.

10. The agency can be the fiscal agent for employment responsibilities, or these responsibilities can be taken on by the consumer.

11. Voluntary training is available on attendant management and employment responsibilities.

12. Financial responsibility includes a copay or sliding fee scale for people of higher income. ■

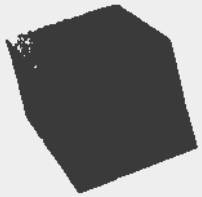


Organizing in Local Communities: Targets, Tactics & Techniques

ABC's of Strong Organizing

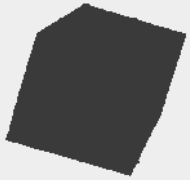
Action

- Involving, participatory, inclusive



Buy-in

- Makes sense to the membership



Commitment

- Valued roles
- Taps and strengthens leadership potential of all members
- Nothing succeeds like success

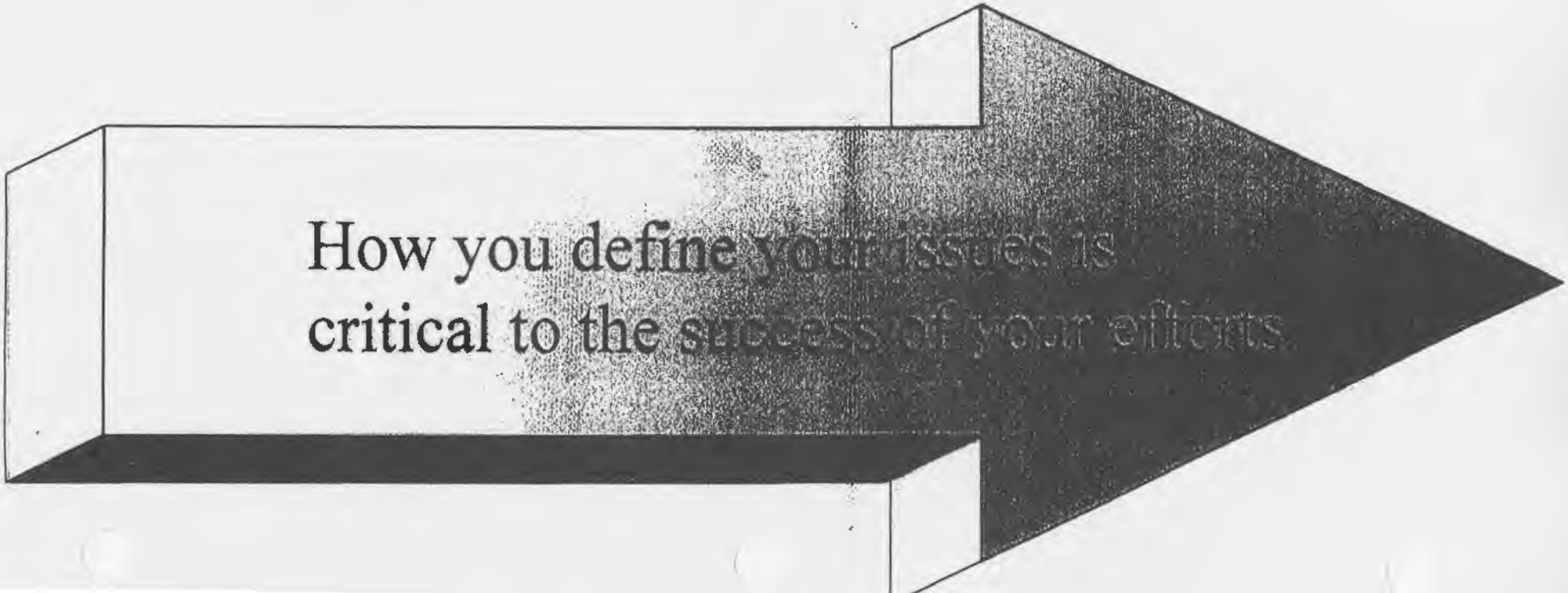
We want **Action and Commitment**

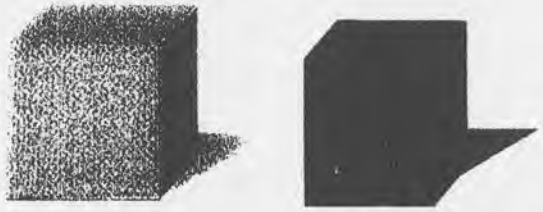
In community organizing an issue is

NOT a personal problem.

It should be shared

by a number of people you are working with.





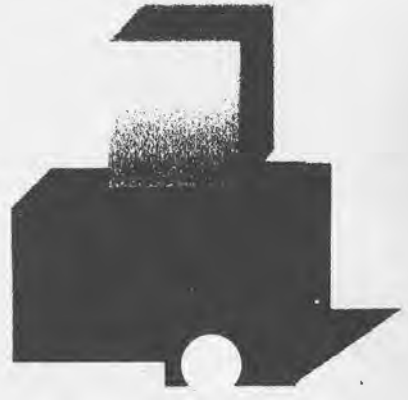
Issues are the building blocks of organizing and people power activism.

An issue is a problem broken down into specific parts.

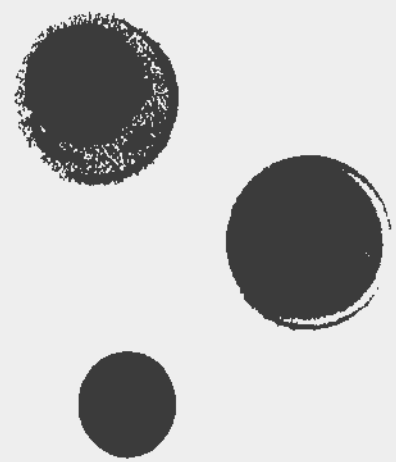
Our task as leaders and organizers is:

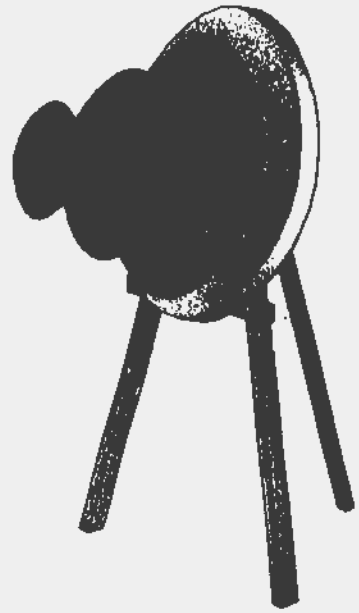
- to move our folks to make something happen
- to take it from concerns to issues.

You can start with a concern, but must shift focus to an issue right away.



Concerns	Vs.	Issues
▪ General, vague ▪ Interesting discussion ▪ Too big to deal with ▪ Drugs and gangs ▪ No access ▪ No risk		▪ Focused, aimed call for action ▪ Says commit/reject ▪ Able to be solved ▪ Crack house on 1201 N. Main ▪ IHOP has no braille, no ramp ▪ Webster: "a culminating point leading to a decision"

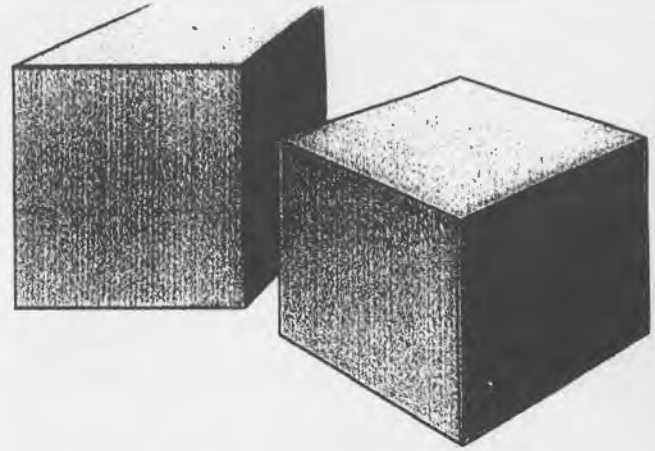




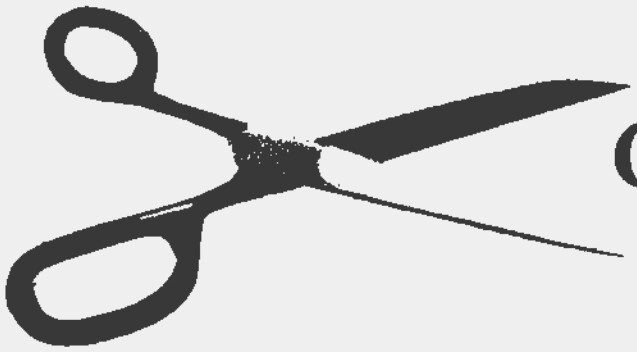
Making an Issue of It!

- Issues are not concerns.
- Issues are not personal problems.
- Issues are problems broken down into specific parts that require targeted action to change.

People Don't Act From Logic . . .

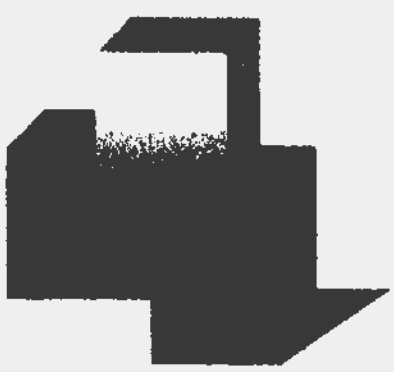


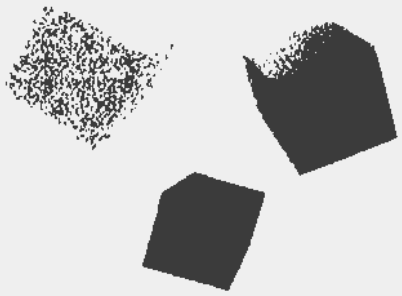
But From Emotion.



Cutting the Issue:

1. Use flag words - - emotional, scary
2. Show effect on me/my family in heavy way
3. Show how it attacks my dignity, self worth
4. Tie it to my pocketbook
5. Make it personal, how it affects me, self-interest
6. Make it personal in identifying the enemy, someone not a group





Strategies -- The Routes to Change

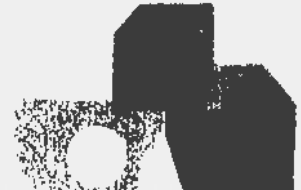
A strategy's aim is to change the balance of power:
to force the enemy to deal with you.

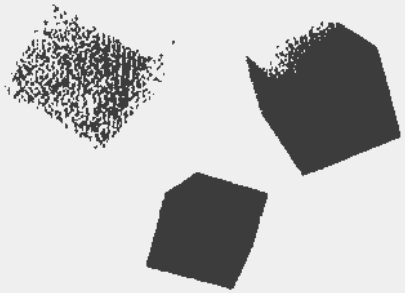
Remember!

You want something they don't want to give you.

We can be liked and not get what we want.
Or we can gain respect by demanding what we want.

Be direct -- don't be afraid to ask.

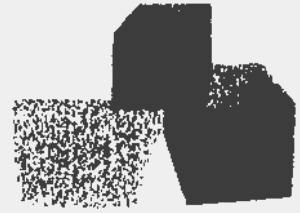




Strategies should engage your people and have two goals:

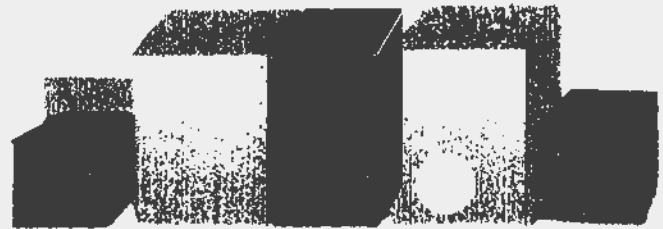
1. Win a victory, a change for the better

2. Empower your people, change how they think and feel about themselves for the better.

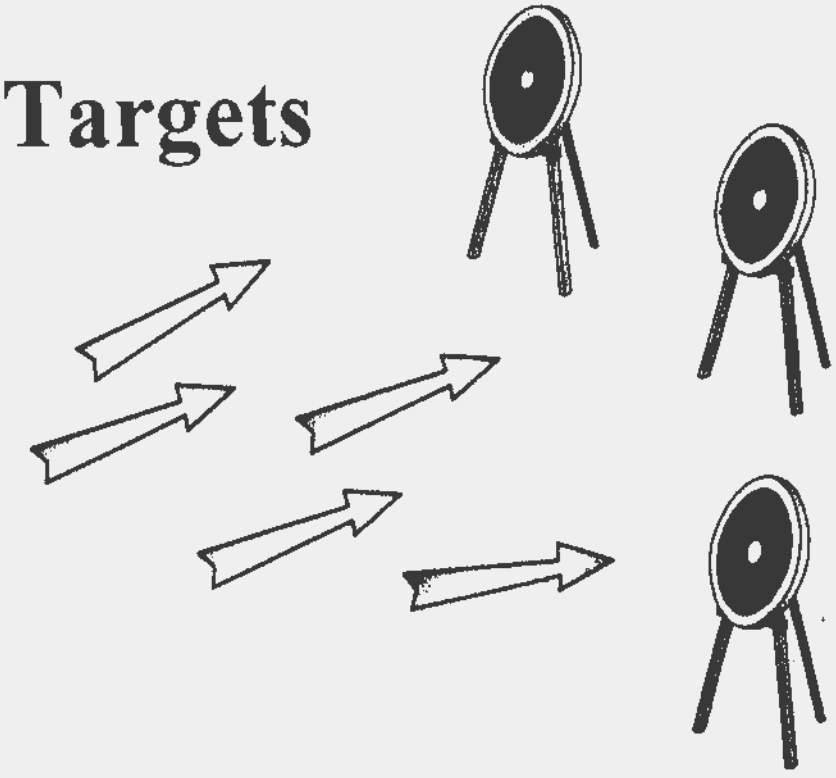


A Winning Strategy

1. Be logical and acceptable to the people
2. Be outside the experience of the enemy
3. Attack the weakest point of your enemy
4. Attract other power bases to your side
5. Be varied, so enemy doesn't adjust to it
6. Be fun
7. Embarrass the enemy, or make them look foolish

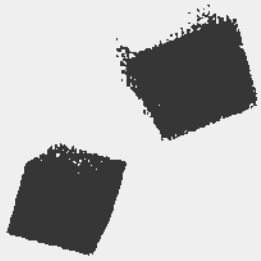


A Few Words about Targets



- Who has the power?
  1.
  2.
  3.

- What is their self-interest
- Your power over the target --
  voter, constituent, taxpayer
- The trouble with faceless, nameless enemies



The enemy determines the level of conflict.
They can stop the conflict at any level . . .
by coming to the table.

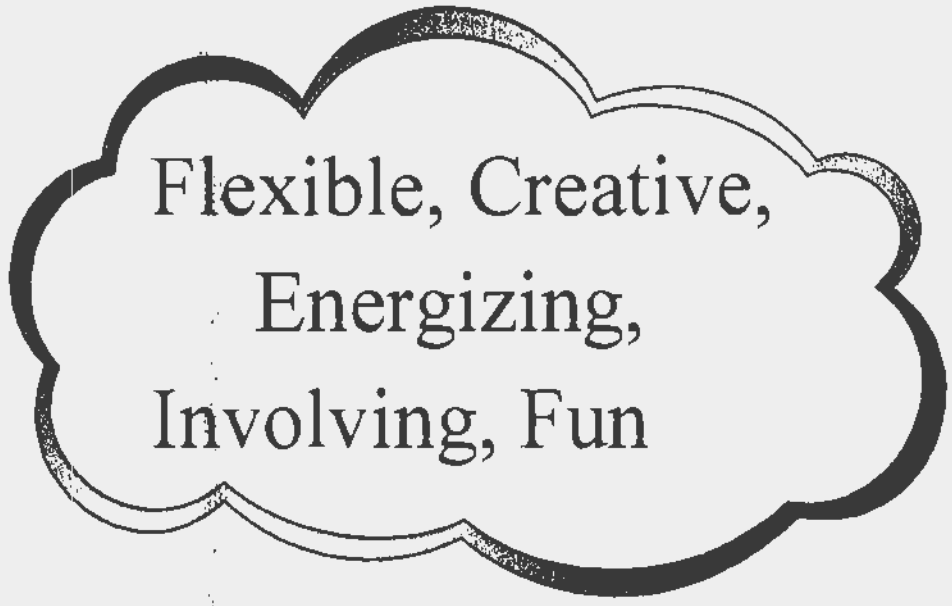
The purpose is to get us the the negotiation table.

The Way You Do the Things You Do

Tactics

Actions in Context

- Specific
- Measurable
- Time-Limited
- Winnable



Tactical Maneuvers

Actions, Theater

Confrontations

Public Hearings, Meetings

Strikes, Sit-ins

Lawsuits

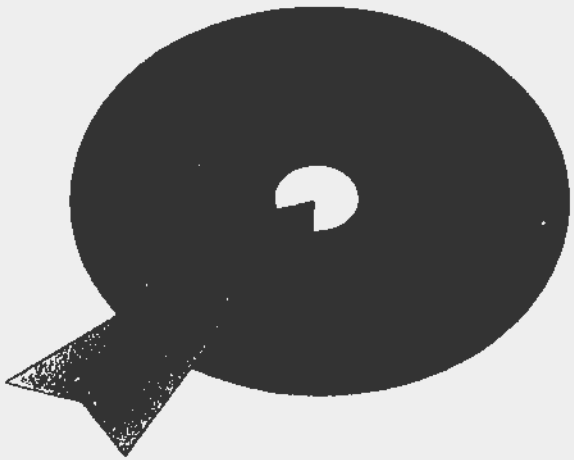
Press Conferences, Media Events

Rallies, Marches

Petitions, Call-ins

Etc., etc., etc.

Etc., etc., etc.



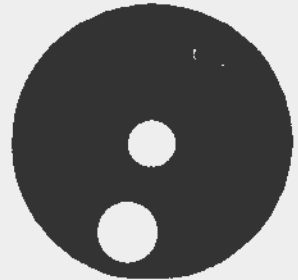
Developing an Action Plan

I. Define the Issue! What is it you want to **Change**

II. What will you do to bring about this **Change**?

A. Brainstorm possible actions / goals and objectives

B. List all Alternatives

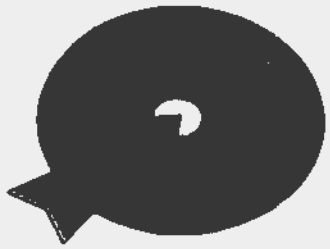


III. Assess your resources
   A. People
   B. Money
   C. Time
   D. Skills

IV. Select the Leadership Team!

V. Select things that you can do!

   A. Specific
   B. Measureable
   C. Time-limited
   D. Winnable
   E. Energizing



Write up the plan!

A. What are you going to do? Outline steps of plan!

B. Who is going to do what? Involve lots of people!

C. When are they going to be done? Be specific!

D. What will they need to get it done?

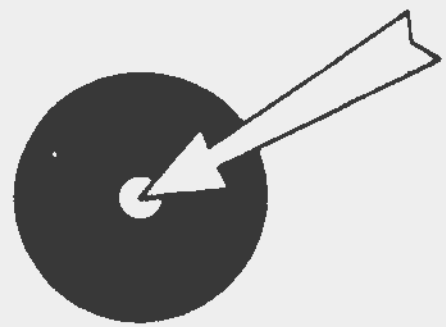
Remember

Keep everyone informed about what's going on!

A. Get feedback from everyone!
B. Deal with problems -- Don't avoid them!
C. Give encouragement!

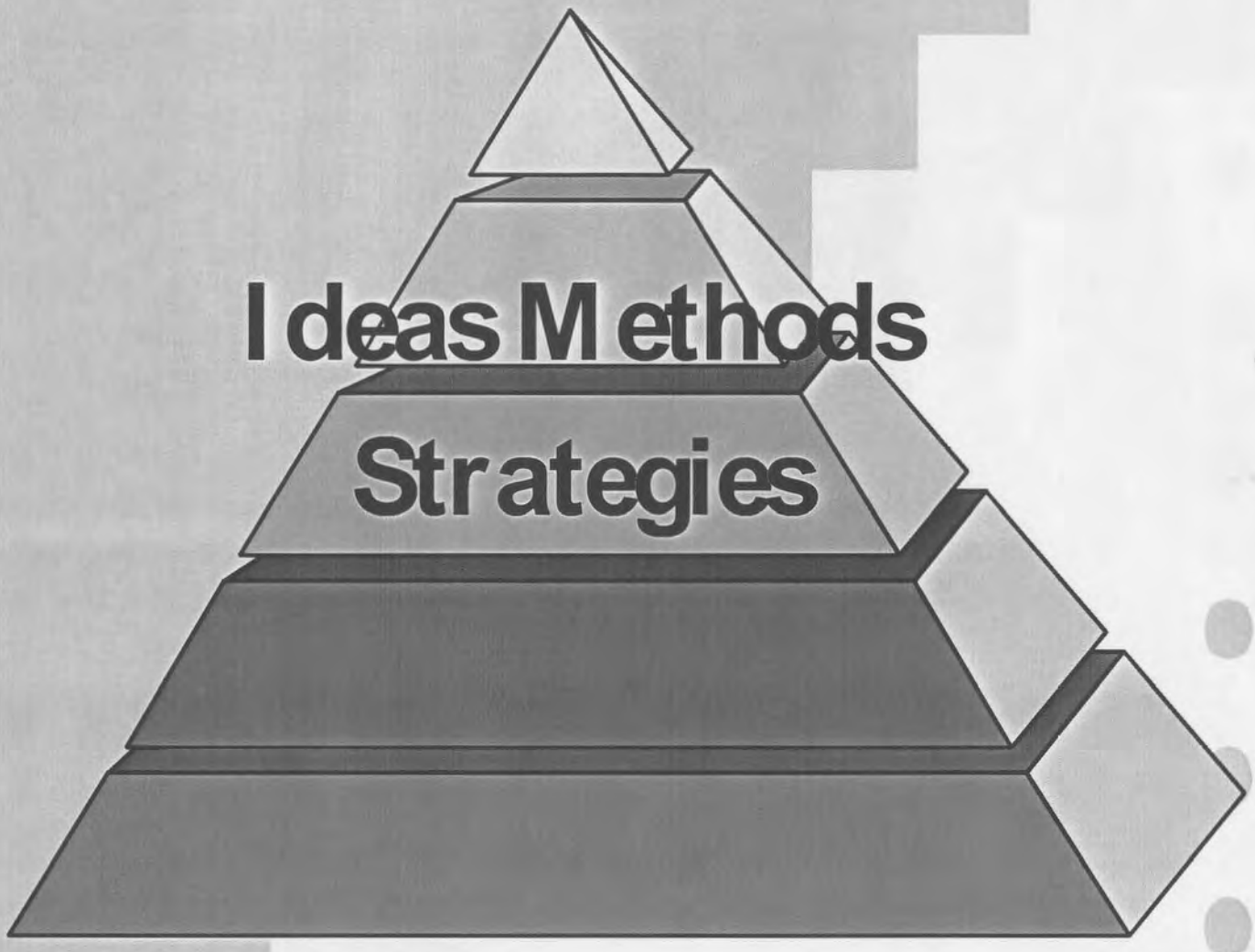
Evaluate your work!

A. Do it / Fix it!
B. What did we do right? What did we do wrong?
C. Have Fun! Celebrate Victory!



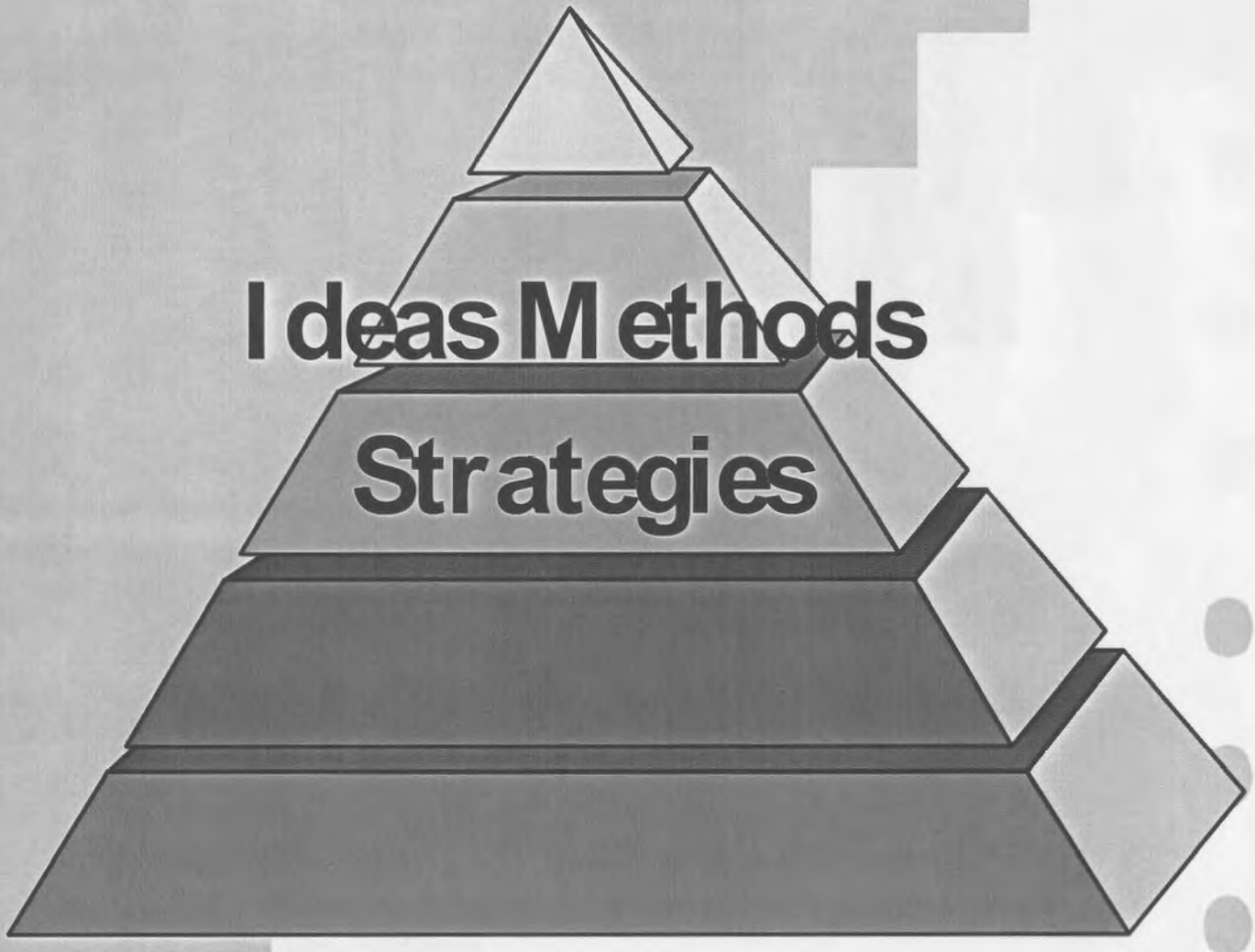
SECTION 2

Getting Great Jobs



An Introduction to Supported Employment

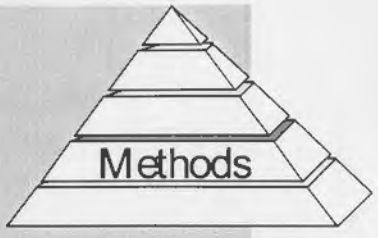
Job Development



Building Relationships with Employers

Values that Guide

- **Zero Exclusion**
- **Partial Participation**
- **Zero Instructional Inference**
- **Mutuality**
- **Interdependence**
- **Positive Presence**



Visit

Target Job

Observe

Learn It

Do It

Consider Teaching Strategies

Write T. A.

Get Approval

Match??

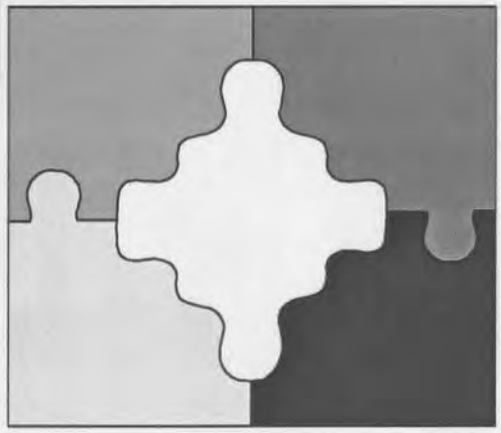
Job Analysis

Employment Myths

- **The community is not accepting**
- **My applicant is under-qualified**
- **My applicant's skills limit their opportunities**
- **The best qualified gets the job**

What You Need To Be Successful !!

- Be involved with your community
- Use your connections
- Be successful yourself
- Don't be shy
- Ask for leads everywhere you go
- Know the applicant



Service You Can Offer...

- Pre-screened applicants
- Situational Assessments
- Job analysis
- ADA consultation
- Employment consultation
- Assistance in Training
- Follow up support

What benefits the employer?

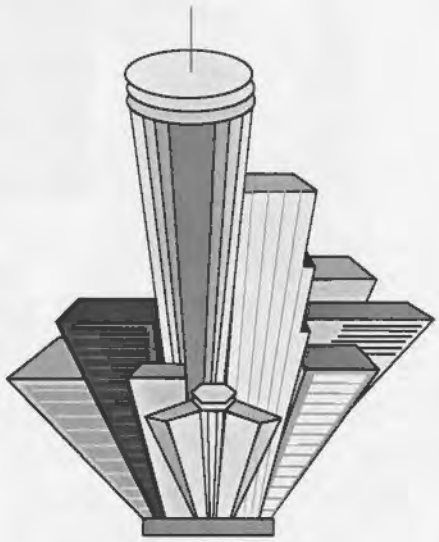
- **Need:**
  - A problem/issue that needs a solution
- **Feature:**
  - What your product or service is and does
- **Benefit:**
  - The gain or advantage resulting from a feature

Steps to Employer Development

- Recognize the potential
- Investigate the opportunities
- Solve the employer's problem
- Evaluate
- Continue to build rapport/relationships

Opportunities to Meet Employers

- Civic Clubs
- Letters
- Phone Calls
- Personal Visits
- Everywhere You Go
- Appointments
  - Cold Calls
  - Peer Marketing
  - Leave Behinds



Next!!

- Research employers
- Learn about potential jobs, observe
- Develop fact sheet
- Leave behind portfolio
- Possibly, Arrange for a Situational Assessment

What is Next?

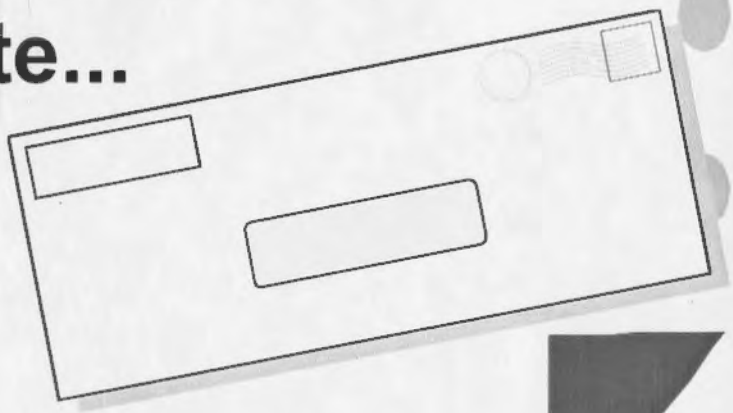
- Make a list of potential employers
- Learn industry lingo"business talk"
- Who knows them
  - staff
  - friends
  - community contacts
  - peers
  - you

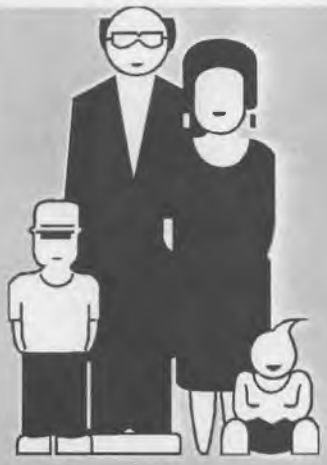
Community Mapping

- Start with where the applicant lives
- Applicant's dream job
- Look at manufacturing (light and heavy)
- Service Industry
- Public Education
- Government
- Construction
- Resource Based (agriculture, forestry, fishing)

Remember To:

- Be On Time
- Follow Up
- Send A Thank You Note...





Remember to...

- Talk with Families/Residential Supports-Involve them
- Ask their concerns, opinions, and needs
- Utilize their connections
- Know the company culture
- Connect with others (friends,co-workers,family) for ongoing support

Remember to...

- Talk with Families/Residential Supports-Involve them
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Situational Assessment

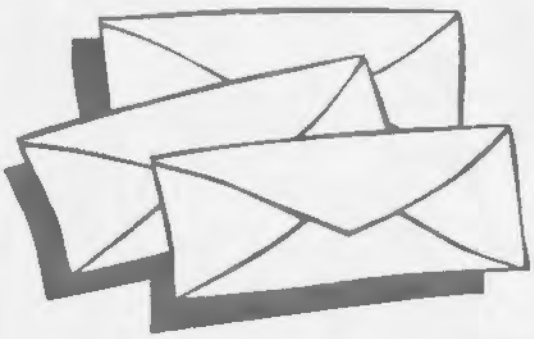
Section One

- **Consumer Job Preferences**
- **Targeted Jobs Available in the Community**
- **Specific Businesse Identified**
- **Employer Contacts Made**

Situational Assessment

Section One

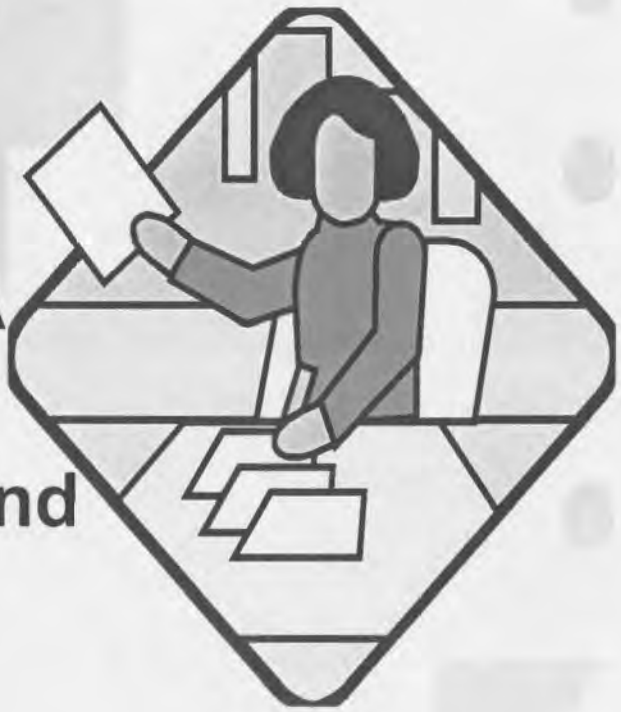
- **Observation Dates**
- **Sample Jobs Targeted** **(include Task Analysis)**
- Job Descriptions and Procedures Obtained?
- Assessment Scheduled
- Copy of Schedule Sent to Everyone Concerned
- Thank You's Sent



Situational Assessment

Section Two

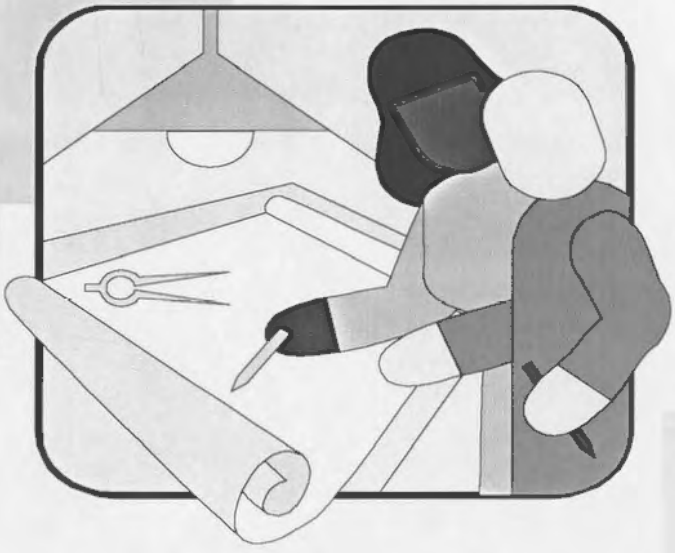
- **Consumer Shows Preference**
- **Consumer Works Efficiently at Various Times of the Day**
- **How Long Does Consumer Work Before Needing A Break**
- **Does S/he Respond Negatively or Positively to Environment**



Situational Assessment

Section Two

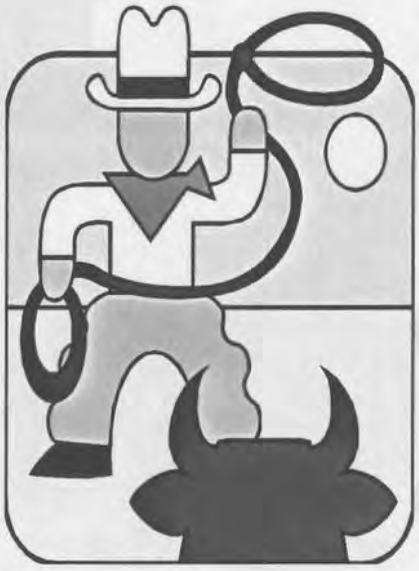
- **List The Prompts Available in the Environment and Frequency**



Situational Assessment

Section Three

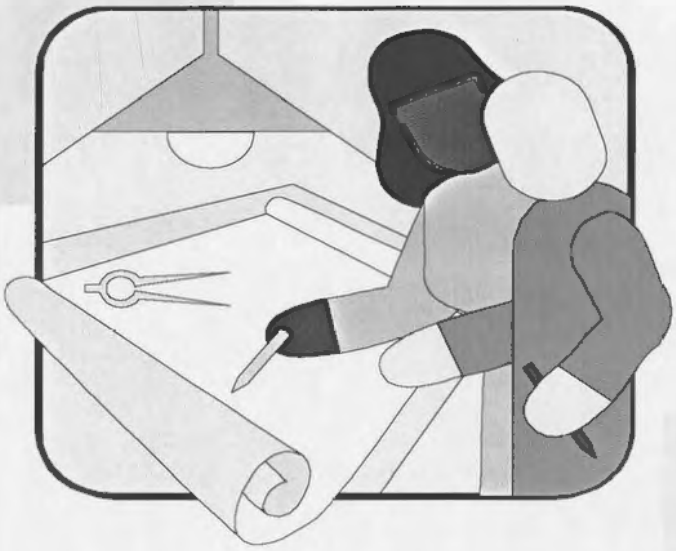
- **At What Speed or Rate of Performance Did The Consumer Work?**
- **How Long Does S/he focus on Their Work?**
- **Level of Initiative to Perform The Tasks?**
- **How Fast Does S/he Learn New Tasks?**



Situational Assessment

Section Three

- **How Flexible/Adaptable Is S/he to Environment, People and Demands?**



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CONFERENCE EVALUATION

Advocacy Training for Community Integration

"Personal Assistance Services & Employment Issues"

December 2 - 4, 1998, Dallas, Texas

Mark in boxes, as applicable.

A. Did this conference meet your expectations?

- ☐ Exceeded Expectation
- ☐ Satisfactorily Met
- ☐ Somewhat Met
- ☐ Not Met

B. Was this conference:

- ☐ Too Advanced
- ☐ About Right
- ☐ Too Elementary

C. Overall...

	Excellent - *Poor* ⑤ ④ ③ ② ①
The management of the conference was	☐ ☐ ☐ ☐ ☐
The objectives of the conference were	☐ ☐ ☐ ☐ ☐
The work of the presenters was	☐ ☐ ☐ ☐ ☐
The ideas and activities were	☐ ☐ ☐ ☐ ☐
The scope was	☐ ☐ ☐ ☐ ☐
Overall, I consider this conference	☐ ☐ ☐ ☐ ☐

D. Please rate the program/individual sessions based upon:

Name of Session	*Usefulness of Content* Excellent - Poor ⑤④③②①	*Quality of Presentation* Excellent - Poor ⑤④③②①
PAS, Session 1	☐☐☐☐☐	☐☐☐☐☐
PAS, Session 2	☐☐☐☐☐	☐☐☐☐☐
Employment, Session 1	☐☐☐☐☐	☐☐☐☐☐
Employment, Session 2	☐☐☐☐☐	☐☐☐☐☐
John Daw	☐☐☐☐☐	☐☐☐☐☐
Ralph Rouse	☐☐☐☐☐	☐☐☐☐☐

E. I'm glad you included the part(s) on:

_____

_____

_____

F. I wish you had not included the part(s) on:

_____

_____

_____

G. Has your knowledge of employment outcomes for individuals with disabilities increased as a result of your attending this conference?

☐ Yes ☐ No ☐ Undecided

H. Will your job performance change in any way as a result of this experience?

☐ Yes ☐ No ☐ Undecided

I. Topics I would like included in future conferences or in training programs:

_____

_____

_____

Additional Comments: _____

_____

_____

_____

Thank You!