

A.1 Case Studies

Introduction

The following hypothetical case studies reference the Preference Interview Tool. The interview process helps residents examine from their own perspective, their ability to successfully move into the community with the services necessary to be as independent as possible.

Administered twice to residents, three weeks apart, the Preference Interview Tool provides information about the feasibility of transitioning in individual situations. The first survey gives inpatient facility residents and/or their surrogate decision makers (proxies) an opportunity to consider and discuss the idea of transitioning to the community as well as explore their needs and existing support services.

A second interview, performed three weeks after the initial interview, allows residents and their surrogate decision maker time to reflect on the important decisions they'll need to make to transition and to consider whether available support systems can serve their needs.

Lead organizations and transition teams are integral partners with DHCS in California Community Transitions. Lead organizations will execute an agreement with DHCS and organize one or more regional transition teams. These interdisciplinary teams will include at least one transition coordinator. Team members will conduct preference interviews to determine residents' preferences to transition from an inpatient facility. Together, the resident, family members or surrogate decision makers, transition coordinator, team members, and facility staff will work with residents to design their personal comprehensive service plan that details the health, social, and supportive services they will need to successfully transition to a community living arrangement.

A.1.a Case Study: Mrs. Sara Brown

Background Information

Mrs. Sara Brown is a 65 year old widowed female with no children and no living family members. Her husband suffered a cardiac arrest and died approximately three years ago. Her only income is Social Security Disability Insurance (SSDI) for \$1,200, which made her eligible for the Medi-Cal program. She is also a Medicare beneficiary.

In February 2007 she fell in her one-bedroom publicly subsidized apartment and broke her pelvis. She couldn't reach the telephone but, luckily, her neighbor who visited Mrs. Brown daily discovered her within one-half hour of the fall lying on her kitchen floor and immediately called 911. The paramedics took Mrs. Brown by ambulance to Patients Hospital where she was admitted approximately five hours after arriving in the emergency department. While she was being treated in the emergency department, Mrs. Brown reported that just before she fell, she had felt a severe pain in her chest. Subsequent tests concluded that she had experienced a mild heart attack.

Mrs. Brown's recovery was delayed due to her chronic health conditions including cardiomyopathy, high blood pressure, hypertension, neuropathy, osteoporosis, and a bout of pneumonia. After nearly three months in the acute care hospital, Mrs. Brown's doctor recommended she transfer to Residents Health & Rehabilitation Facility for physical therapy and rehabilitation. Since she had no family support and didn't want a personal attendant, she agreed. Actually she was relieved because she was afraid to go home alone.

When she was awake and alert (she had been sleeping more than she ever had) she enjoyed the hustle and bustle at Residents Health & Rehabilitation. Mrs. Brown had always been active in her church, but since her admission to the hospital and subsequently, to the nursing facility, she was not able to personally attend services. Occasionally her friends from church visited her, but as the visits became less frequent, she found some comfort in watching televised nondenominational services on weekends and game shows during the week.

Due to her lengthy inpatient stays, Mrs. Brown had no choice but to give up her apartment. Somewhat sadly, she asked her closest friend from church to collect some of her small personal belongings, and donate her furniture and usable household supplies to a needy family, because she didn't think she would ever be able, or want, to live independently again.

Current Situation

During the months she lived at Residents Health & Rehabilitation, Mrs. Brown was able to regularly participate in physical therapy sessions, but her progress was slow due to the ongoing pain she felt whenever she walked. She enjoyed the sessions and became known as "Over the Moon Sara." After eight weeks of therapy, she finally met her goal of being able to move around her room slowly with the assistance of a walker and provide for her own basic needs. At that point, her activities of daily living needs were as follows:

- Dressing – Could choose appropriate items and slowly get dressed.
- Hygiene – Could take a shower using a shower chair and hand-held shower head.
- Mobility – Could walk around her room and the facility using her walker, with an occasional stop to rest due to continuing pain and shortness of breath; could not navigate stairs.
- Eating – Could eat without assistance and was able to heat prepared food and/or beverages in microwave during therapy sessions.
- Continence – Was continent of bowel or bladder.
- Toileting – Was able to use a raised toilet using the grab bars.

After Mrs. Brown had lived at Residents Health & Rehabilitation for nearly three months, she was asked to serve on the resident council. She happily agreed to help choose speakers and plan special meal menus and community activities for the residents. Mrs. Brown's friends from church continued to intermittently visit and kept her updated on their activities and encouraged her to make use of the church van program so she could attend services when she was feeling well. After much coaxing,

she tried it. She found that by using a wheelchair with assistance to get from the van to the building, she was able to use her walker to get around inside. Mrs. Brown made every effort to be as independent as possible.

After four more successful trips to Sunday services, Mrs. Brown told one of her friends from church that she missed playing occasional hostess for their weekly cribbage games. When she returned to Residents Health and saw John, her nursing assistant, she told him the same thing. He told her he didn't want her to leave because she was one of the nicest residents in the facility and that he would miss her terribly.

Learning about Community Options

Later that week, at the resident council meeting, Cliff, a volunteer from the Long-Term Care Ombudsman's office gave a presentation about California Community Transitions. Mrs. Brown, who believed in Kismet, requested more information about how to receive services and supports so she could "return home." She gave Cliff permission to give her name to the lead organization.

The lead organization contacted Marilou, a social worker, who telephoned Mrs. Brown. Marilou introduced herself as the transition coordinator and made an appointment to meet with Mrs. Brown to discuss the possibility of moving home. Marilou met with Mrs. Brown that following Friday and during the meeting, conducted a Preference Interview and then discussed what services would be available through the demonstration. Marilou noted that Mrs. Brown expressed a high level of interest and before leaving, asked Mrs. Brown to put more thought to it; maybe even discuss her options with her friends from church. Mrs. Brown agreed, and also arranged to meet with Marilou again when she came back about two weeks later.

Two weeks later, Marilou returned and conducted a second Preference Interview, and noted that Mrs. Brown seemed somewhat hesitant about leaving. Cliff, the volunteer Ombudsman, had been visiting other residents that day, so with Mrs. Brown's permission, he sat with them to talk about what Mrs. Brown could expect during the transition process. She listened intently as Marilou read each statement on the *California Community Transitions Participant Information Form* (Appendix IV), then engaged in a discussion about the services she might need to sustain her in an independent setting and what would happen at the end of the 12 months when her demonstration period would end. Mrs. Brown expressed relief when she learned that as long as she was still eligible for the Medi-Cal program, she would continue to receive health care and other necessary supportive services when the demonstration ended.

At that point, while Mrs. Brown felt all her questions had been answered, she also felt reluctant to leave the facility. Both Cliff and Marilou heard the ambivalence in her voice as she began to talk fondly of her friends at Residents Health, particularly Carmelita and John, the nursing assistants who regularly attended to her. As she signed the *Participant Information Form*, she reminisced about some of the fun times she had experienced since living at Residents Health, and she felt grateful to Cliff and Marilou for spending another 15 minutes with her after the paperwork had been completed. Cliff reassured Mrs. Brown that her choice of living arrangement was hers

alone, that she did not have to rush to make a decision, and that he would visit her in a few weeks.

In the meantime, now that Marilou had permission to discuss Mrs. Brown's potential health care, social and supportive service needs, she met with the social services designee at Residents Health, and subsequently, the transition team. The transition team included Marilou, Cliff, and representatives from the area agency on aging, independent living center, and Rebuilding Together. The group all recognized that Mrs. Brown's most immediate need was to locate accessible, affordable housing. They continued working together to design a comprehensive service plan, which would be the basis for ongoing services after discharge.

Determining Eligibility for Demonstration Participation

Marilou had contacted the county social services agency to inquire about Mrs. Brown's Medi-Cal eligibility status, and to inform the county of her interest in moving out of Residents Health. The Medi-Cal eligibility worker, Tanya, confirmed that Mrs. Brown had been receiving Medi-Cal benefits for the past two years, and that her eligibility remained current.

Assessment for of Health Care and other Service Needs for Transition

While Mrs. Brown had lived independently before she fell, she recognized that she now had limited mobility, and so total independence would not be possible. She acknowledged needing personal care assistance, and agreed to apply for In-Home Supportive Services (IHSS) for help with some meal preparation, home cleaning, shopping, and possibly transportation to health care appointments. She learned from the independent living center housing specialist on the transition team that there was a section 811 subsidized housing project with a short wait for a studio apartment located near to where Mrs. Brown attended church. Mrs. Brown preferred to have a larger apartment but nonetheless, she was enthusiastic about moving.

At this point, Marilou had Mrs. Brown complete an IHSS program application so that a member of the transition team could follow-up with Tanya to request an IHSS evaluation; she learned she'd also need to complete other applications to be considered for:

1. An apartment in the housing project.
2. Enrollment into a home and community-based services waiver.

During the first meeting with Mrs. Brown, Marilou had gotten written consent to contact Dr. Green's office, the physician Mrs. Brown saw before she was admitted to Residents Health & Rehabilitation. He agreed to resume oversight over Mrs. Brown's medical care after discharge, and to prescribe her medications, physical therapy visits, durable medical equipment, and other necessary medical care orders.

Marilou consulted with the CCT project nurse regarding Mrs. Brown's waiver eligibility upon discharge. After reviewing the waiver criteria and contacting the waiver intake staff, the CCT project nurse informed Marilou that Mrs. Brown appeared to meet the clinical eligibility requirements for the Assisted Living Waiver Pilot Project (ALWPP)

in her area. The section 811 subsidized housing project had a current lend-lease agreement with a home health agency to provide ALWPP services (section B.9 contains additional information). The CCT project nurse informed Marilou that she wouldn't need to help Mrs. Brown complete the application for housing after all because it was already part of the ALWPP. Additionally, Mrs. Brown would not be able to receive IHSS because she would receive assisted services through the ALWPP.

The next day, Marilou had an appointment with another resident at Residents Health to conduct a Preference Interview. While she was there, she found Mrs. Brown leaving the activity area in high spirits and asked her if she had some time to talk. They headed to the large, attractive lobby, and as they sat, Mrs. Brown gushed about the impressive entrance and how happy she felt that she lived in such a beautiful facility. Marilou agreed and attempted to discuss the attributes of the ALWPP, but Mrs. Brown declined and asked Marilou to come back another day.

Fortunately for Marilou, she met Cliff on her way out and, as the two transition team members who knew Mrs. Brown best, both agreed that she may not be ready to leave Residents Health at this time. It was decided that both would stay in touch with her, but that they would wait for a time when Mrs. Brown instigated a conversation about transitioning.

That time came four weeks later, when after church one Sunday, Mrs. Brown asked John to call Marilou and ask if she would come and talk to her about the ALWPP. She told John that she had made up her mind while she visited with friends and other members of the congregation after services. That following Friday, Marilou submitted Mrs. Brown's application to the ALWPP unit within DHCS.

Comprehensive Service Plan

Transition team members had already discussed through a HIPAA-compliant interdisciplinary process, to present the following information to Mrs. Brown to assist her in the development of her comprehensive service plan:

- Document name of physician for ongoing medical care services.
- Enroll in the ALWPP to receive care and supervision, medication reminders.
- Provide "Nursing Facility Transition Care Coordination" service (the lead organization may claim reimbursement after Mrs. Brown is successfully transitioned, provided services are rendered in the timeframe not to exceed 180 consecutive days prior to transition).
- Arrange for the following state plan services: physical and occupational therapy services twice weekly; pharmacy services for physician-prescribed medications; personal attendant to help Mrs. Brown with cooking, home cleaning, shopping, and transportation to healthcare appointments.
- Arrange for meals five days per week through the area agency on aging (Older Americans Act funding).
- Attend the adult day services program twice per week at the local senior center for social activities (funded through the city and private donations).
- Obtain a Personal Emergency Response System (PERS) to allow her to summon help in emergency situation (reimbursed from demonstration funds).

- Purchase a shower chair (durable medical equipment through Medi-Cal).
- Apply to Medicare for mobility aids (walker, wheelchair and/or scooter)
- Apply for assistance with bill-paying with a financial agency (one-third of Mrs. Brown's income will go for rent for her studio apartment).
- Assess the studio apartment for safety features and needed assistive devices (grab bar in the bath tub and near the toilet; floor coverings secured in all areas).
- Arrange for home set-up and supplies (reimbursed through waiver and demonstration funding, if necessary).
- The comprehensive service plan will be reviewed on an ongoing basis by the transition coordinator and the case manager to ensure that needed services are included. The program nurse will be a resource person to them for the duration of the demonstration.

Service Coordination

Marilou, also a care coordinator for the ALWPP, made a follow-up appointment with Mrs. Brown to complete the assessment for enrollment into the waiver. By this time, both Mrs. Brown and Marilou had become well acquainted with each other, and while Mrs. Brown lamented the amount of paperwork to be completed, she enjoyed seeing Marilou; and the more time Marilou spent with Mrs. Brown, the more she was able to suggest relevant services when the move took place. Therefore, while awaiting DHCS' approval to enroll into the ALWPP, the transition team continued the ongoing work on the comprehensive service and discharge plans to ensure services were being set up.

At the next interdisciplinary transition team meeting, the gerontologist from the area agency on aging completed applications to Medicare for a scooter, and to change Mrs. Brown's aid codes for SSDI and Medi-Cal information. In addition, she arranged to meet with the friend who had stored Mrs. Brown's personal belongings and inventoried the items in storage. They discussed what furniture, household equipment and remaining home modifications would be needed prior to Mrs. Brown moving into her new home. This information was taken back to the team and documented in her comprehensive service plan.

Transition

Mrs. Brown learned that with funding through the ALWPP, the team was able to purchase a new bed, basic furnishings, dishware and supplies. Transition team members representing Rebuilding Together had taken pictures of the inside of the studio apartment so that Mrs. Brown could give direction as to where she wanted the furniture placed. Mrs. Brown's church friends had previously volunteered to assemble a "move-in crew" and her close friends brought and arranged her personal items.

The week before discharge, Mrs. Brown slowly boxed up her belongings. Cliff conducted the Quality of Life Survey per demonstration requirements so that national evaluation contractor could compare baseline data with Mrs. Brown's responses to follow-up surveys administered at 11 and 24 months after discharge. Marilou reviewed

the comprehensive service plan one last time to ensure all services were in place the day of discharge.

On the day of discharge, Mrs. Brown had packed all her belongings, received her discharge instructions from the social services designee, and was ready to go when two of her church friends had arrived to take her to her new home. The “move-in crew” had placed the furniture per Mrs. Brown’s instructions and had also purchased groceries so food was available. In addition, church members had brought several hot dishes they knew Mrs. Brown had enjoyed during past potlucks.

Post Transition

As part of Mrs. Brown’s comprehensive service plan, the area agency on aging had arranged for a volunteer from the telephone reassurance program to call her every day; and also arranged for a transition team member to visit her weekly during the first month to ensure Mrs. Brown was receiving services as planned and to address any issues that had arisen. She was receiving physical and occupational therapy services twice weekly through the home health agency. The local information and assistance service helped her find a local pharmacy, and linked her with the Paratransit service to help her get to healthcare appointments and the social adult day program at the local senior center. She learned how to use her personal emergency response system and was grateful to have the security of knowing she could summon help in emergency situations. She also kept the phone numbers of the lead organization under a magnet on her refrigerator in the event she had any questions about her services.

Additionally, through the ALWPP, the home health agency provided or coordinated: oversight from 24-hour awake staff to meet Mrs. Brown’s scheduled and unscheduled needs; provision and oversight of personal and supportive services; assistance with medication self-administration or administration by a licensed nurse; provision of three meals and snacks, housekeeping, and laundry assistance. Additionally, Marilou, who was also the ALWPP care coordinator, visited Mrs. Brown to discuss the appropriateness of ongoing services.

Mrs. Brown met many friends in her new housing community. Her mobility improved and she was happy to receive needed services while living in her own home.

End of Demonstration

At the twelfth month after discharge, the lead organization arranged for a social worker to meet with Mrs. Brown to conduct the second Quality of Life Survey. The social worker explained to Mrs. Brown that she would not notice when the demonstration period ended, because her services and supports would continue without interruption. At the end of their meeting, the social worker reminded Mrs. Brown that she would need to complete one last Quality of Life Survey next year.

1.A.b. Case Study: Robert Jones

Background Information

Robert Jones is a 43 year old male who resided at Green Valley Health Center for the past 12 months. Robert had been a computer service technician and owned his own computer service business for about ten years when he had a skiing accident, in which he sustained a spinal cord injury that left him with paralysis in the lower extremities, and with minimal function left in his arms. His therapists and physician have been unable to identify any further therapy that would restore function beyond current levels. Robert has exhausted any rehabilitation benefit under Medi-Cal and was not yet eligible for Medicare.

Prior to the accident, Robert had lived in an apartment, but two months after the accident, he could no longer pay the rent. His furniture and household items have been in storage ever since.

At the most recent monthly facility care conference, the Green Valley Health Center staff discussed future plans for Robert. He had no job, no financial resources, no housing, and no prospects to obtain and pay around-the-clock personal care assistance to help him with bathing, dressing and preparing meals. He became frustrated and angry at himself for needing help, has been uncooperative, and frequently lashes out at the staff.

As there are no further rehabilitation goals to be set for Robert, the facility discharge coordinator talked to Robert about his future plans. Robert expressed his desire to leave the Green Valley Health Center, but he didn't know how he could move out and continue to live and function with his need for round-the-clock personal assistance.

Learning about Community Options

On one of his wheelchair trips around the facility halls, Robert saw the brochure about California Community Transitions and other community-based living options. He was skeptical about the reality of the service, but asked a visitor near the information display to hand him a copy of the brochure. When he returned to his room, the brochure went into his drawer, where it stayed for several weeks.

One day Steven, a certified nursing assistant, noticed the brochure in the drawer when he retrieved some supplies for Robert's personal care. Steven asked Robert if he would consider moving out of the facility. Robert stated he wished that was possible, but knew that with his care requirements he couldn't move anywhere. Steven brought this information to the attention of the charge nurse, who in turn told Nancy, the facility social worker. Several days later, Nancy stopped Robert in the hallway and asked him if he had heard about some of the community-based living options available in this area. Robert said, "No, but they probably wouldn't be helpful anyway."

Four weeks later, Nancy told Robert that there would be a presentation in the activity room that afternoon about community-based living options. She told him the speaker was someone who used a wheelchair and had personal assistance needs

similar to Robert's needs, and suggested him go and listen. Robert was again skeptical, but since he had nothing better to do, he agreed to go. After listening to the talk from Joe, the speaker, Robert was still not sure what was in it for him, but just to satisfy his curiosity, he asked Joe a few questions. "Who helps you?" "How can I get the same kind of help?" Joe asked Robert if he would like to have an independent living center (ILC) staff member come and speak with him about available options. Though he continued to be skeptical, Robert agreed to a meeting the following week, but asked Joe not to tell the staff.

Over the next week, while awaiting the meeting, the facility staff noticed Robert appeared more preoccupied than usual. On the day of the meeting, staff noticed he was on time for breakfast and seemed to be watching the clock.

Robert listened to the presentation from Valley ILC staff and asked a few questions about the center's programs. He read the California Community Transitions brochure and said he might be interested in learning more, that he'd sure like to pursue moving to his own place, but he had a hard time visualizing how it could happen. It would mean not just meeting his day-to-day care needs, but also finding a new way to make a living and earn an income. Several days after the meeting, Robert took the brochure to Nancy and requested more information.

Nancy, who had good rapport with the independent living center staff, requested someone come out to conduct a Preference Interview with Robert. She knew he wanted to pursue a different lifestyle and the interview would give him an opportunity to talk about his supportive service needs outside Green Valley. His decision would impact many aspects of his life—his desire to get employment training, pursue a job, acquire new housing, and manage his own financial, personal and spiritual independence. Robert agreed to meet with a "transition coordinator."

Jim, the transition coordinator and LCSW, interviewed Robert and confirmed that he wanted to pursue the feasibility of transitioning. Through the interview Robert listened and found Jim credible and knowledgeable about the new services. He gave Jim permission to engage his personal physician and the facility staff regarding his needs and abilities. Jim advised Robert that with his permission, he and a team of professionals would help him make some decisions about housing, Medi-Cal eligibility, IHSS, and other independent living supportive services. He advised that much would depend on where Robert wanted to live, or if he wanted to work and/or attend school. Then Jim discussed housing and service options with Robert.

Determining Eligibility for Demonstration Participation

Jim explained to Robert the California Community Transitions services again and made arrangements to enroll Robert in the demonstration, as that was his decision. Robert signed the *Participant Information Form* stating he understood the terms and conditions of the demonstration, and gave permission for the transition coordinator to meet with nursing facility staff and resource personnel to gather information and coordinate transition plans (see *Participant Information Form* in Appendix IV). They discussed what happens during the demonstration and at the end of 12 months when he is no longer in the demonstration. Robert was told he would still be able to receive

health care services when the demonstration ends, providing he continues to be eligible for Medi-Cal and his care and support needs still meet the required level of care.

Assessment Healthcare/Service Needs for Transition

Robert met with the transition coordinator, a housing resource specialist from the ILC (a transition team member), and the facility staff to discuss his current needs. From this discussion, a comprehensive service plan was designed to cover the next 6-12 months, which was the basis for ongoing services after Robert was discharged. In addition, Robert and Jim continued to meet to discuss available service options.

The housing specialist located a local independent group home for four residents who have disabilities. Besides functioning as a half-way home for new people transitioning to the community, they have monthly support meetings to discuss ongoing concerns and issues with living in the community. The housing specialist assisted Robert with the application to the group home.

After Jim spoke with the physician Robert had prior to his injury, an agreement was reached for Dr. Snow to oversee Robert's medical care on discharge. Dr. Snow was familiar with the NF/AH waiver and the group home. He agreed to write Robert's medication prescriptions, and any durable medical equipment or other orders needed for his care.

The transition team used Robert's current needs and requested services to design a comprehensive service plan. Dr. Snow advised Jim of the targeted discharge date so Jim could add it to the plan. In addition, Jim consulted with the CCT project nurse regarding enrollment into an appropriate HCBS waiver. After reviewing the assessment criteria and contacting the waiver staff, the project nurse advised that Robert met the clinical eligibility requirements of the Nursing Facility/Acute Hospital (NF/AH) waiver. With assistance from a transition team member, Robert completed the waiver application, and Jim submitted it to the project nurse for processing.

Comprehensive Service Plan

The transition relocation coordinator told Robert that this process was designed to support him through the transition; however, Robert would make all the decisions. He was presented with a transition assessment and services that included the following:

- Document name of physician for ongoing medical care services.
- Enroll in the Nursing Facility Acute Hospital (NF/AH) waiver.
- Arrange for home health agency to manage medications
- Arrange for personal care services to provide 24/7 assisted daily living care
- Obtain the following durable medical equipment:
 - Hospital bed with bedside rails, over-bed trapeze, over-bed table, and alternating pressure mattress
 - Electric wheelchair
 - Shower chair
 - Hoyer lift
- Arrange for counseling support with local ILC

- Arrange for rehabilitation training with the Department of Rehabilitation.
- Apply for In-Home Supportive Services (IHSS) Advance Pay option through the California Department of Social Services
- Arrange for an adaptive vehicle for transportation with the Department of Rehabilitation
- Apply for assistive technology, a voice activated computer under environmental services
- Obtain personal emergency response system (PERS) under supportive services
- Arrange for home adaptation services
- Arrange for home modification services such as: ramp at entrance, floor access to shower, etc.
- Arrange for transportation services to healthcare appointments, physical and occupational therapy appointments
- Obtain rent deposit for apartment and utilities
- Arrange for home set-up and supplies.
- The comprehensive service plan will be reviewed on an ongoing basis by the transition coordinator and the case manager to ensure that needed services are included. The program nurse will be a resource person to them for the duration of the demonstration.

Service Coordination

Robert's service plan focused on self-directed options, e.g., Advance Pay, so that he could direct the scheduling, hiring and firing of personal care attendants under the In-Home Supportive Services (IHSS) program. Independent living specialists, transition coordinators, or advocates were involved to support other aspects of the plan.

Transition

Robert received notification of acceptance to live in the local group home. Jim explained that Robert had to sign a lease agreement with the independent group home owner. Robert agreed to the terms and conditions and signed a 12-month lease. As other people with similar disabilities shared the same living situation, no new home modifications were required.

Post Transition

The day Robert was discharged he went home with the services and supports he needed to manage his life outside of Green Valley Health Center—Jim had ensured that most all of the durable medical equipment detailed in Robert's comprehensive service plan were in place, including the home adaptations he required. The home health agency had ensured that Robert's personal care attendant reported to work at the same time Robert arrived at the group home. The remaining equipment arrived shortly afterwards including his new electric wheel chair and shower chair. Robert was looking forward to starting the counseling support sessions with the independent living skills staff at Valley ILC and the rehabilitation training with the Department of Rehabilitation. Soon he would receive a voice activated computer for his work so he could pursue online college courses to complete his degree in computer programming.

In the weeks that followed, a transition team member phoned intermittently during the demonstration period to check on Robert's well-being. Jim also visited with Robert to ensure he was adjusting to his new living arrangement and that the services authorized in his comprehensive service plan were being delivered.

End of Demonstration

Approximately a year after discharge, Robert completed the demonstration period uneventfully and his services through the NF/AH waiver were not affected. Jim arranged to meet with Robert again to conduct the second Quality of Life Survey and Robert again expressed his appreciation for the help in moving him to the community. Jim informed Robert that he would need to complete one more Quality of Life Survey in another year, but he wasn't sure who would conduct it.

Robert had been receiving his services and supports without interruption; and at the 24 month Quality of Life Survey meeting, the following information was received about Robert's progress. He had graduated with a degree in Computer Programming and secured a job with a small computer software company as a writer of computer help programs. The company did not offer health benefits, but Robert learned that he could still work full or part-time and still receive Medi-Cal benefits through the Medi-Cal Working Disabled Program. Under this program he would be allowed to earn up to \$52,092 per year, or more, with a share of cost premium based on countable earned income (additional information can be found at: www.chiip.org). With Robert's permission, a counselor at Valley ILC contacted a representative at the county social services department and verified that Robert maintained full-scope Medi-Cal eligibility status which allowed him to continue receiving waiver services.

Robert also now spends his free time with residents at Green Valley Health Center as a peer mentor.