August 2025 Webinar_The Living Well Project_FINAL Recording

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SPEAKERS

Kaitlin McNamara, Dr. Jennifer Johnson, Alixe Bonardi, Dr. Seb Prohn, Val Bradley, Sally Flaschberger, Kate Brady, Mikey Wilson

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K **Kate Brady** 00:00

Welcome folks, glad that you are joining us! This is the Grassroots Project webinar. The Grassroots Project is administered by the Human Services Research Institute (HSRI), with funding from the Administration for Community Living (ACL). My name is Kate Brady. I co-direct the Grassroots Project with my colleague, Alixe Bonardi, who will introduce herself when she joins us. I am joining you in a light-blue shirt, with light-pink glasses. I'm a middle-aged white woman using a wheelchair, with short, brown, curly hair, and behind me is some art made by my father. Today's webinar is titled "The Living Well Project: Looking Back and Forging Ahead." I wanted to share with you some webinar logistics, so you will feel fully prepared to participate. All participants are currently muted, and we invite you to use the Q&A feature to ask questions so that you can communicate with panelists, and we will get to those questions either at the end, or in the communication after the webinar. If you are having difficulty with an urgent issue, you can direct those to our colleague, Amie Lulinski. Her email is on the screen. It is alulinski@hsri.org, and she'll do her best to resolve those concerns. But please, in the meantime, and for most things, use the Q&A. We are live-captioning, and providing both ASL and Spanish interpretation. So you'll see an interpreter on-screen. If you would like to hear this webinar in Spanish, we invite you to click the interpretation button at the bottom of the screen in Zoom, it looks like a world icon. And you can then choose the Spanish channel, and then you'll want to silence the original audio. And I'll say that in imperfect Spanish, so that if you are a Spanish speaker, you can understand the directions. Se puede hacer dar a la interpretacion en Espanol in vivo haciendo, click en el button interpretacion, en la parte inferior de la pantalla de Zoom, icon del mundo, uno vais en el canal Espanol por favor silencio el audio original. Another note related to Zoom, is that we have been in communication with them, and have learned that full accessibility, including ASL interpretation, may not be available if you are joining with a mobile device. It seems that ASL interpretation and the slides cannot be viewed at the same time on a phone or tablet. So if you need to, you'll be required to swipe on your mobile device so that you can find the ASL interpreter. We have asked Zoom to make changes to their platform, but those [changes] have not yet happened. We will be doing some polls and evaluation questions. So, we would love if you could be prepared to interact during the polling times. Alright, so our agenda for today: intros and welcomes. We've already talked about logistics, and then we're going to have wonderful presentations from our panelists. First [we will hear] from Dr. Jennifer Johnson, Acting Commissioner of the Administration on Disabilities. We'll hear from Val Bradley, President-Emerita of HSRI. We'll hear from Mikey Wilson, Project Coordinator for the DSP and Training Assessment Program at UGA. We'll hear from Seb Prohn, Assistant Director of Research and Evaluation at VCU's Partnership for People with Disabilities. And we'll hear from Katelyn McNamara at the Living Well Project in Wisconsin's BPDD. She is also Executive Director of the Sibling Leadership Network. And Sally Flaschberger is joining us from the Living Well Project, as Project Manager in Wisconsin, as well. At the end, we hope to have a facilitated conversation hosted by the Grassroots Project co-director, Alex Bonardi. On screen here is our team, including the fabulous Laura Bernas, who is our Project Manager and has been hosting in the background, this webinar. We'd love to have your feedback. We won't be monitoring the grassroots@hsri.org email during the webinar, but again, [we] invite you to email Amie for urgent matters. But we would love any follow-up questions or feedback that you have, to be sent to that email. We're not officially approved for CEUs, however, we do provide confirmation of attendance. If you need that, please get in touch. And you will receive a link to the webinar when it concludes, it will include the recording and other materials, such as slides and a plain language guide that will be available after the webinar. Some of these materials will be archived on our project website, which is on the screen, and we'll also make that available to you electronically. We'd love to get a sense of who is here with us today, and [we] are putting a poll up on the screen. Polls in Zoom do require some scrolling downward. So the first question asks you, in what way do you primarily identify with the disability community? And you can check any of those categories that apply to you. I'm already seeing responses come in, and appreciate that. If you'll scroll down, the next question asks you, which of the following leadership roles do you play in? You can check any of those that apply. I'm seeing we have coalition leaders, community elders here, board of director members, peer supporters, great variety of folks. And many of us here—I've bumped myself above that category already—but would love to know your age range. If you keep scrolling, that's the third question. Next question is, are you Hispanic or Latino? If you'll continue to scroll down, we ask, what is your race? Again, you can check all that apply. At number six, we are asking if you belong to any of these national organizations, or are otherwise connected to them—you can be liberal in your response. That is the last question in that poll. So we can give it just another minute, and then we'll go ahead and share those results. About half of you have participated so far. What we can do is go ahead—I think it's time to—yes, you've shared those results. Thanks so much! So you can see we have a variety of ways people are identifying here, and a variety of roles. Age range is between about 35 and 64, a variety of racial and ethnic identities, although majority are white. And some folks from APRIL have joined, as well as NASILC and NCIL, glad to have you here. Thank you. All right, we are going to keep going. Much appreciate your participation in the poll. Alright, so I'd like to give you a quick overview of the Grassroots Project. Our project, as I mentioned, is funded by the Administration for Community Living (ACL). It was launched in 2023 to support national, state, and local disability advocates in building networks to stay informed about policies that affect people with disabilities. We are also supporting disability advocates to work together, to ensure that their perspectives, priorities, and preferences are reflected in disability policies and service systems. Now on the right-hand side of the slide, you'll see a concentric circle image, laying out for you the structure of our project: individuals with disabilities [are] at the center, and then State and Local Advocacy and Action Coalitions that we have funded and are partnering with to do local work, and then our phenomenal National Advocacy and Action Coalition—as well as a State Agency Partnership Group that supports a volume of national work and also provides advice. We have two basic approaches in this project. One, to develop structures, processes, and relationships that support the development of a next generation of cross-disability, cross-generational, and culturally diverse leaders within the advocacy movement. We are also working to grow and strengthen networks of grassroots advocacy coalitions around the country, with the aim that they be supported to connect with one another, and grow skills and knowledge to support their advocacy for improvements in community living. And you'll see on the left, a restatement of our key partners. This is an advocacy project, but we want to be clear that in this context, we are doing the work under what we call "little-a." So on the right, in the blue, you'll see we can do things like education, information dissemination, and supporting people in getting connected to one another and organizing, as well as preparing for their advocacy. We are not involved, nor would we be, in direct action or lobbying. Alrght, so, transitioning to today's webinar. This is the fifth webinar hosted by the Grassroots Project, and we are bringing together experts from the state and national level who worked on the ACL Living Well Project, so that we can discuss successes and challenges of creating and participating in the program, and consider what is still going on and how we might engage further. The Living Well Project worked to impact the current state of community integration and living for people with IDD. You'll hear more about the project, and we are hopeful that you will gain a better understanding of how grassroots advocates can use the lessons learned and the ongoing work of Living Well Project leaders around the country to further your advocacy goals. So, it is my pleasure to introduce Dr. Jennifer Johnson, Acting Commissioner for the Administration on Disability. And I'll pass it to you, Jennifer, thanks for being here.

Dr. Jennifer Johnson 13:42

Thank you, Kate, for that introduction, and thank you for having me here today. I'm really delighted to be here and provide you [with] a little bit of information about the Living Well Project. I also want to thank you all for joining today's webinar and taking the time to learn more about this project. To give you a visual description, I am a middle-aged white woman, with salt-and-pepper gray hair. My hair is pulled back in a ponytail, and I have a white, collared shirt on and necklaces, and my background shows my desk behind me that has some papers and pictures on it. And, I think that kind of does it for my visual description. So again, really glad that I'm able to join you today and share a little bit more about our project. So, wanted to start by providing background on the Living Well grants. The full name for the projects were "Living Well: Model Approaches for Enhancing the Quality, Effectiveness and Monitoring of Home and Community-Based Services for Individuals with Developmental Disabilities." So, with that long name, I think you can appreciate why we called the the projects "Living Well" for short. Next slide, please. The focus for the project came from multiple areas of interest, and also with knowledge about where the field is—and was—at the time when we funded these projects. And a lot of it was around knowing that there has been a significant shift in where people with IDD are living, and that many, many more—there's been a growing trend, as I'm sure all of you know, of more people living in the community, and that people living in the community really achieve positive outcomes as a result of being in the community. And we've really seen multiple drivers for these shifts over the years. Some of that is due to federal disability law—like the DD Act, and the Rehab Act, and the Individuals with Disabilities Education Act, as well as the Americans with Disabilities Act—but we also know that people really want to be living in the community, and people with disabilities want to have control over their lives, and they want to work and they want to be connected. So there's a real desire on their part to be actively participating and living in the community, as well as families [who] want to keep their family together, and have their child with a disability living with them, and a part of their community. So families have really had an interest in this, as well. And it has taken a lot of hard work and perseverance of both disabled people and family members, and other advocates, to see the changes that have occurred over time. And that has really led not only the federal government, but [also] state policy makers, to make decisions based not only on that advocacy, but also looking at things like, the benefits to people when they live in the community, and cost savings, as well. And so, we've also seen a lot of people at the local level developing common-sense solutions, and more effective policies that have really helped to support more people to live in the community. Next slide, please. I think, over time of these changes—they haven't necessarily happened in an orderly way or a strategic way, and there is wide variation in the accessibility of quality home and community-based services across the country. And that's to be expected. It's a huge shift that is being made and has been occurring over the years, to have so many people living in the community. And again, that's going to happen at different paces, at different times, and in different ways in different communities. So, it isn't going to be a uniform process across the board. But because of that, and the various ways in which we have pockets of quality in home and community-based services, it's also created concerns about health and safety in home and community-based settings. And some of those concerns are not necessarily unique to people living in the community, and we know people can experience abuse and neglect in any kind of setting. But again, with more and more people living in the community, there has been an increasing interest on our part in looking at, and understanding, health and safety in home and community-based settings. We know for individuals, [people] can feel social isolation in various settings, depending on their circumstances of where they're living. Many people, regardless of where they are living, may have a fear of reporting that they've been abused or neglected, or they're living in an unsafe environment. They may not know how to report, or where to report. They may not even understand that they're being abused or neglected. So there's a lot of individual issues around health and safety, but there's also system challenges related to health and safety, in terms of the size of a system and the scope of services, and other factors. And like I said, we have had an interest in better understanding how to monitor for health and safety in home and community-based services, because it is complex when you start to think about, how do you do that well? And how do you monitor for for health and safety? So, about 10 years ago, we started looking into this. We started thinking about, what does community-based monitoring look like? And so, we did fund a very small project, just looking at safe transitions into the community. It was around this time that we were starting to do this work, that in early 2018, we—along with the Department of Health and Human Services Office of Inspector General, and the HHS Office of Civil Rights—issued a joint report that was called "Ensuring Beneficiary Health and Safety in Group Homes." And this was really a collaboration that resulted from audits that the Office of the Inspector General (OIG) was doing, that really put a spotlight on systems failures, that found significant gaps and weaknesses in reporting of critical incidences in group home settings. And that joint report that was published back in 2018, included model practices that states could use to improve health and safety outcomes in home and community-based settings. So that definitely raised more awareness, and put more of a spotlight on issues related to health and safety, and again, how we go about doing monitoring in the community for people with intellectual and developmental disabilities.

Dr. Jennifer Johnson 21:58

Sorry, I was having a hard time. I thought I had lost my Zoom, but there it is. Sorry for that pause! So, if we can go to the next slide, please. So, again, that's sort of the background as to why we funded these projects. We started funding these projects in 2017, really to look at how we can test model approaches and strategies for having more comprehensive systems to support people with IDD to live well in the community. So again, what does that look like, and how can we make it happen? And the grant had two core components. One [was] around this idea of community-based monitoring, and then the other [was] around community capacity building. So, if we're identifying incidences in the community where there's abuse or neglect happening, how can we use that information to then build capacity to mitigate those incidences from happening? Next slide, please. So we awarded a grant—starting in 2017—with the first cohort of grants in Georgia, Virginia, and New Hampshire. And then in 2018, we awarded grants in Alaska, Idaho, Indiana, Missouri, and Wisconsin, for eight grants overall. Next slide, please. One of the things that we did, in addition to funding these grants, was to fund a cross-site evaluation. And I'm going to very briefly go over high-level findings of what came out of those evaluations, of what came out of the projects. Next slide, please. So, in terms of what we found from the projects—we found that they actually really made a difference. They helped to strengthen the workforce, they created practical tools, and really sparked lasting change in systems. In terms of workforce development—a lot of the projects did focus on strengthening the workforce in terms of training to DSPs and other service providers, to strengthen their skills and knowledge so they could really do their jobs well. We also had projects that were developing different types of tools and resources—like toolkits—and creating evidence-based models that were developed [by grantees], that could then be applied in other states for use. They also did a lot around systems change to really help shape broader changes in HCBS systems, and set the stage for efforts to be repeated and sustained after the grant ended. Next slide, please. Some of the more specific things that came out of the projects was, we saw improved health and safety, but also inclusion of people with IDD. And grantees were using person-centered approaches that really boosted quality of life and safety and independence for people with IDD. We also saw better tools and systems for community monitoring that really did help to prevent abuse, neglect, and exploitation, and we also saw stronger partnerships between self-advocates, families, state agencies, and providers to really work together to carry out solutions together. Next slide. So really, what we want to be able to do with this information —it was great that we funded this project, but as you all know, it's great only if it can be used by others and scaled up. So, not only were these projects able to sustain some of their efforts, but what we want to be able to do is make sure that others can use this information and learn from the projects, and take those lessons learned and apply them in their community or in their state. And that's a lot of what this Grassroots Project is about, sharing information about what's worked, and what then can be applied and used in other states. We really want you to be able to use the ideas, strategies, and lessons learned from these projects, so you can turn them into real change that helps to make your community healthier and safer, and more inclusive. So in addition to this webinar, we encourage you to visit the website, but also reach out and connect. I hope you find the information today useful, and information that you can use in your state and in your advocacy efforts. And now I'm going to turn it over to our next speaker, and that is Valerie. Thank you so much.

V Val Bradley 26:48

Thanks very much, Jennifer, that was great background information. My name is Val Bradley. I am the President-Emerita of the Human Services Research Institute (HSRI), but still very much a part of the Institute. I should also mention that Alixe Bonardi and I were very much involved in the Living Well Projects, and had the privilege of being able to provide some technical assistance to the grantees during the course of those projects. I am a white, older woman with red, curly hair. I'm wearing an orange and yellow Hawaiian-type shirt, and in the background you can see major beams that are supporting my ceiling, and some art over to my right. Next slide, please. So as Jennifer mentioned, the impetus for the Living Well grants really came from the Office of the Inspector General's overview of state Incident Management Systems. And they basically found them to be not transparent, not really utilizing data, not being responsive quickly enough to various incidents—and made some very comprehensive recommendations about changes to state Incident Management Systems, many of which had not been reformed or revised for many years, especially in light of what Jennifer just said about the explosion of community services around the country. So each project coalition—and they were all based on coalitions—chose different strategies, or combinations of strategies, to respond to the issues in the OIG report, and they were very much dependent on the state context. Was it a centralized state? Was it a very dispersed state? Or was it county-based, like in Wisconsin? So, each state tailored its approach to its own policy, organizational, and geographic context. And in terms of capacity building, which Jennifer mentioned, partnerships were key. Also, meaningful engagement with people who use services, and the people who support them—their families—are key to any capacity building, since their first line of defense are direct support professionals and other HCBS providers. Data collection and dissemination and monitoring, are also very important strategies in this whole process. Without data, and the ability to use data to bring about systems change, you really aren't going to move the ball forward. Finally, implementation and evaluation strategies that will sustain the kinds of systems change that these projects aim to create. Next slide, please. So a little bit more about partnerships. Clearly, in taking on the whole system of incident management, and prevention of abuse and neglect, it's important to hear all voices in the community. For many years, Incident Management Systems were a bit of a black box. There was no information coming out of them. They were not transparent, in terms of how information was used. Some of the information was used for the HCBS assurances, but the public really was not brought up-to-date on how these systems worked, and how they could use the information in their own communities. So, reaching out to all stakeholders—and certainly people with disabilities, their families, providers, case managers—any aspect of the system, or any voice, that would have some information and insight into the issue. Then, obviously meaningful engagement with people with disabilities and their family members, who are, again, right there—sometimes as victims, but certainly as people who understand what self-advocates and families need to arm themselves to make sure they are able to report and recognize abuse and neglect. Evidence-based practices—certainly improving access and quality of community services—finding ways to mitigate, prevent, and reduce the eventual abuse and neglect statistics, and also, giving people with disabilities and their family members the information and the power they need to recognize abuse and to do something about it. Again, as I mentioned, many of these projects worked directly with direct support professionals and other HCBS providers. Again, as I said, DSPs are the backbone of the system. They are there on the front lines. They need to understand the risks that the people they're supporting may be subject to, how to recognize abuse, and how to prevent it in their own organization. And then, community monitoring, as Jennifer mentioned, [is] very important. Again, community monitoring isn't any good unless people have the information they need to help improve system. Addressing health and safety with data tools—including National Core Indicators and other indicia of quality and outcomes. Program and outcome evaluation—making sure that once systems are built, systems are improved, and that there's an ongoing way of making sure that those systems are achieving the desired outcome. And finally, sustainability. How does all the work of these projects really build ongoing sustainability of improved monitoring, improved use of data, improved transparency, improved prevention of abuse and neglect? Next slide, please. So, partnerships—you're going to hear a good deal about the kinds of partnerships that these states had pulled together from our next three providers. Wisconsin, in particular, was able to build on existing coalitions that included representatives of many voices from around the state, and they were able to use those partnerships to really bring pressure on the state to reform and update its Incident Management Systems, which were highly decentralized at the county level. Data was not really being aggregated to be used for system improvement. And so, because there was a big coalition and many voices were heard, they were able to really bring some pressure on the state to improve those systems.

Meaningful engagement, and active engagement, with people with disabilities—certainly, Virginia took that to heart, by not only having self-advocates as part of advisory groups, but also having self-advocates as co-trainers working with direct support professionals, so that direct support professionals understood the perspective of the self-advocate regarding abuse and neglect, the fears they had, how they were to report information, and so forth. Alaska also heavily used self-advocates, as people who inform them about the needs of the system in that state. Evidence-based practices—again, we mentioned the importance of using data to identify people at risk. Jennifer mentioned that Missouri used their National Core Indicators data to identify indicia of risks—like people who really don't have friends, people who don't have mobility, people who haven't gotten out into the community, people who aren't members of groups. They also used standards of practice to make sure that everybody who touched a person with a disability, whether it was a DSP, a service provider, or a case manager, all understood the necessary standards of practice in order to prevent any kind of abuse and neglect. So finally, getting back to my hobby horse—many of these projects directed their energies towards helping direct support professionals receive the training that they need in order to better support people, and to protect the people that they support from any abuse and neglect. You're going to hear from our friends from Georgia, who will tell you about a very ambitious project that they undertook to build a network of providers, and to give them the ability to dial into important curricula from the College of Direct Support. I should mention, also, as a general matter, that many of these projects started right before the pandemic, and the pandemic really threw a bit of a wrench into what everybody had hoped could be accomplished. I think they all deserve a round of applause for really plowing through some very difficult challenges during the pandemic, moving all of their meetings to Zoom, and making the accommodations they needed to continue to meet the mission of these very important projects. So I invite you to listen to the firsthand knowledge and reports of these people who were directly involved in these projects. I'm going to turn it to Mikey Wilson. Mikey's from Georgia, and she's in charge of the the DSP training initiative. Go ahead, Mikey.

M Mikey Wilson 37:36

Thanks, Val. Good afternoon, everybody! My name is Michaelyn Wilson, I do just go by Mikey. I am with the University of Georgia. My pronouns are she/her. I'm a Caucasian female with blonde hair, and I'm wearing a black shirt. So, I've worked on the Living Well Georgia Project since its inception. I worked very closely with Dr. Carol Laws, she was unable to be here today. So, I will be going over with you our accomplishments, our challenges, and the insights that we gained during our time with the Living Well Georgia Project. Next slide, please. The goal of our project was to develop a model that demonstrates how innovative interventions at the DSP level, would improve the quality of supports and outcomes for those who are being supported. So the interventions that we used—first, was Therap Services. This is a platform that captures service documentation. It's for tracking, reporting, and record-keeping, and all of that is done in a web-based system. Then we utilized the College of Direct Support, specifically DirectCourse, and this is an online learning management system. Then we did our "in-person" trainings, which are in quotations because as Val had mentioned, COVID happened right in the middle of our project. So we really had to transition our trainings to that virtual platform. So the trainings that we did, were "Supporting Informed Decision-Making," "Supporting Social Roles," and the NADSP Code of Ethics. We also partnered with five provider organizations across the state of Georgia. They offered various services, but they mostly did day and residential services. Each of our partners were offered an NADSP membership, and part of that included attending the annual conference, specifically for DSPs, which I'll talk a little bit more about later. Next slide, please. Alright, so one of our anticipated outcomes was a Quality Enhancement Advisory

Council would be developed and supported. Our accomplishments here—we were able to get MOUs with DBHDD, GAO, GCDD, etc, etc, support coordination, and of course, our five provider partners. We held quarterly meetings online. We also did an annual retreat, in-person pre-COVID, and then we eventually had to switch those to the online format. We did add two self-advocates from Uniting for Change in 2021, and DBHDD consulted with the PI on our project—which is Dr. Laws—for a proposal for ARPA funding, which I will talk about at the end. Some of the challenges that we really faced here—we had a lot of position changes that happened with our parent mentors, and then out of our five provider partners, we had four executive directors change, so that kind of threw a wrench in. We were able to work through it, but that's a big challenge, when you have these partners working on a pilot with you. Also, People-First dissolution happened during COVID, but we were able to absorb members in Uniting for Change. Next slide, please. Our next anticipated outcome—providers will demonstrate increased ability to retain and develop their staff. So, some of our accomplishments here—we did develop staff surveys, and our provider partners completed these annually. We were able to see in real time, every year, how many DSPs did you lose, how many new DSPs did you hire? So we had a clear understanding of what was really happening there. We also created a CDS and DBHDD crosswalk. So we took the content—the courses within the College of Direct Support—and we compared them to the DBHDD training requirements for DSPs. So we made sure that everything aligned, and we also developed career paths with this. In this box, you can see that by utilizing the College of Direct Support, with our five providers, we were able to see how many DSPs they had enrolled, the total number of lessons that have been assigned, and how many of those lessons were actually completed. And from this, we were able to see a completion rate. And you could see from provider one and provider five—we're excited, we're almost at 90%, what are you doing that's working? And then we could go to provider two and four and say, what's not working? Are the interventions not working? How do we need to adjust them so that we can get more DSPs completing these lessons? Next slide, please. Some of our challenges that we had here—of course, COVID, it forced closures of day programs. In response to this, we did develop a COVID and Health Module within the College of Direct Support, and that was available to all of our provider partners. Staff access to unemployment typically required separation, so we did see even more people leaving the field at this time. Those vacancy rates were still high in 2021. We still saw them in 2022 and into 2023 of the project. A lot of our DSPs have limited access to technology, and that internet stability from home was an issue for participation, as well. And then, that NADSP conference that I had mentioned earlier—a lot of our DSPs that went, for some of them it was their first time leaving the state or being on an on a plane. It was a huge experience for them, and we had fantastic feedback, but unfortunately, due to COVID, that got moved to that virtual format, and then that really started to limit their participation in that conference. Next slide, please. Okay, our next anticipated outcome was that staff within our organizations would gain knowledge and skill in supporting informed decision-making and supporting social roles. So some of the accomplishments here—we did develop procedures for recruiting and supporting and training co-trainers. Myself and Dr. Rackensperger would go out, and we would do these trainings with DSPs, and we would also have co-trainers with disabilities. And so we recruited, we supported them, and we provided training. We did have to redesign our in-person trainings to that Zoom training in 2020, which we had to continue on for pretty much the entirety of the the pilot. But, we did offer 26 trainings to 309 DSPs across the state of Georgia. Some of the challenges here were, our co-trainers often needed in-home support to really participate virtually. If they were unable to attend, we did have them record presentations, so their voice could still be heard with our DSPs. This wasn't ideal, and not what we wanted, but we kind of had to work through it with what we had at the time. Those high staff vacancy rates did lead to a lot of training cancellations in 2021 and 2022, and we did see that continue mildly into 2023. Next slide, please. Okay, so our next anticipated outcome was that our providers would report an increased ability to understand and respond to trends and incident reports. So some of the accomplishments here—we did utilize the Therap Business Intelligence tools, specifically general event reporting. This is aggregated data regarding incidents, and it helps alert to trends, and our providers were then able to respond to those trends. So, if there's an incident, they could see the time, the location, and the staff involved, and they were able to provide just-in-time training as needed. So if they can see from these reports that falls are happening more at 3pm, but we see it's the staff—oh, that's shift change. Now I know exactly what I need to go in and train my staff for. Some COVID-specific accomplishments—our providers and the DSPS were able to attend the NADSP webinars during this time. We developed an asynchronous pandemics and DSP training that all of our DSPs had access to. And then we assisted with a COVID vaccination event with three of our provider organizations. 250 people with disabilities, and their staff, were vaccinated at this event. Some of the challenges we had here was mostly around data literacy. We have Therap, and these reports are coming from Therap, but sometimes they were difficult for staff to understand. So we did provide TA about running and analyzing the reports. Next slide, please. Okay, our next anticipated outcome was that people with IDD receiving supports would demonstrate increased achievement of their personal goals. So some of our accomplishments here—we collaboratively developed data-driven outcome dashboards in Therap. So, basically what we did here with our provider partners, was map ISP goals and progress notes to very specific, aggregated domains. Think of an umbrella, and you've got all these domains underneath. Collectively, we decided that choice, meaningful activities, person-centered practices, social connectedness and relationships, and lastly, safety, health, and well-being, would be those aggregated domains. We then went a step further, and we were looking at these goals, and we really realized you could say goals were important to, or important for, a person. And then also, was the goal achieved? Is it in-progress, or is it not achieved? This really allowed staff to see the progress and meaning in the documentation, and realize they could have a voice in outcomes and goal attainment for people they were supporting. It also did lead to awareness of pretty poorly-written ISP goals across the state. Next slide, please. Some more accomplishments here—we were able to do staff comparisons using this DDO within Therap. So if you look at the first box, you can see staff number one. This staff did not receive any of the interventions that we had with Living Well. And you can see those achieved goals never go higher than 12.29%. But if you look at the staff person below, in the bottom box, staff number two—they started receiving our interventions at the end of 2020. They attended 63 modules within the College of Direct Support, and they attended our Supporting Informed Decision-Making training. And we watched—you can see from 2020, it went up from goals only being achieved a little above 5%, to 62.5%. So we got to see how impactful our interventions were, as it related to those being supported achieving their goals. Next slide, please. Some of the challenges here—those DDO reports were managed by mid-level management. There's a lot of time constraints on that staff and a lot of turnover, so we were constantly having to retrain how to utilize Therap—those data literacy limitations I had previously mentioned. We also learned that most of the goals that are written are important for the person, and most of the goals that were being achieved were important for the person, so those goals that were important to them weren't really being achieved as often as important for. Next slide, please. So some of the insights that we gained—provider leadership has to be bought in and supportive of their staffs' time. If they are not bought in to professional development and these initiatives, it's not going to have a very big impact for the staff. Also, virtual meetings and trainings can be more accessible and preferred, if that technology and support is put into place. And then lastly, high vacancy rates are barriers to professional development initiatives, if they're offered while staff are on the clock. Because when staff are on the clock, we saw that professional development went out the window, and they were being assigned to a million different places, and it really took a back burner. So we saw a lot of pauses when those vacancy rates kept getting higher. So, some impactful outcomes—we were able to reach 570 direct support professional learners across the state, and there were 7,358 College of Direct Support lessons that were completed among DSPs in Georgia. You can go to the next slide. So, some exciting new projects did come out of our work with Living Well. First is Georgia Uplift, they seek to reduce turnover, strengthen IDD organizations, and create a more sustainable workforce. Also, the Georgia Direct Support Professional Advisory Council—the next two are tongue twisters—but they're collaborating with supporters and allies to influence social and policy change that enhances the DSP profession across Georgia. And then lastly, the Direct Support Professional Training and Assessment Program, we call it DSP TAP—this is what Dr. Laws and I are currently working on. This is an online credentialing program for DSPs, it includes a 50-hour curriculum through the College of Direct Support. Once that curriculum is completed, DSPs then go and take a remote, proctored credentialing exam. It is designed for potential DSPs because we want to bring more in, but it's also recognizing the competency of DSPs who are currently working in the field. We can go to the next slide, this just gives a little bit more information. So for example, those 50 hours that they're taking, it is self-paced. And of course, we're a university, so we love working on a university schedule. So, think of a semester model, but they have basically a semester to go through and take those courses at their leisure. I have some that finished in 30 days, and I have some that finished the day it's due. You can go to the next slide, thank you. So, this is the last one. We're pretty excited about the progress that we've made. As it stands, we have 426 DSPs that have passed the DSP One exam, and we have offered that on two separate occasions. And then, we went on and we developed the DSP Two exam, and we had 260 DSPs pass as well. When we first were floating around this idea, we had some kickback that, you know, DSPs wouldn't be able to take a credentialed exam. And Dr. Laws and I didn't accept that. If we set the bar here, that's where they're going to meet us. So we feel we should set the bar higher. And guess what, they're all meeting us there. They're doing fantastic, and we're really excited to continue this work that has stemmed off of Living Well Georgia. Thank you so much, guys. I know I talked a little quick, and I'd be happy to answer any questions you might have. I will go ahead and pass it on to Seb with Living Well Virginia.

D

Dr. Seb Prohn 52:33

Okay, thank you! Thank you, Mikey. I'm Seb Prohn from Virginia Commonwealth University, at the Partnership for People with Disabilities. I'm wearing a black shirt, and I'm a white male with silver and black hair, and a silver and black beard. Let's go to the next slide, please. Just a quick overview of what I hope to accomplish in the next few minutes, is to give you an overview of Project Living Well Virginia, and then talk about some of the ongoing ways that this project has been sustained—including information access, abuse prevention, and data-driven decision-making through our regional quality councils here in Virginia. Next slide. Okay, so what is Project Living Well Virginia? From about 2016 to 2023, Project Living Well, which was coordinated by the Partnership for People with Disabilities at VCU, we really worked to strengthen Virginia's developmental disability system. Our goal was to build a more aligned, and better functioning system, that could improve the quality of life and outcomes for people with intellectual and developmental disabilities. We really wanted to get after DD system leaders' perspectives on the state and the functioning of Virginia's DD system throughout the life of the grant. Some of the partners are listed here on this slide, but include the Medicaid agencies, the Virginia Board for People with Disabilities, the Protection and Advocacy agency, the Arc of Virginia, Centers for Independent Living, and others. And we had a lot of great opportunities to learn what areas of the system that they felt were healthy, and then areas where there might be priorities for improvement—and to address some of the areas of improvement, as described by these leaders, but also by families. You know, we really wanted to hear from these leaders and families and self-advocates. And basically, I just wanted to point out that there was a focus on capacity building efforts, including strategies for employment, abuse prevention, health advocacy, positive behavior supports, person-centered practices, family support, and inclusive housing. We also used data to monitor and improve health, safety, and outcomes. So, supporting our P&A, we reviewed thousands of critical incident and Adult Protective Services reports to identify risks and gaps. And then also, annually, we collected and analyzed National Core Indicators data to track trends in mental health, behavior, hospitalizations, and other quality measures. So that's an overview of the project, but now we can go to the next slide. And this is really an overview of our systems change framework. You know, we really encourage staff and partners in the Virginia DD system to think of the system as a living network of organizations, and rules, and people, and resources that all interact. So changes in one part of that system, whether it's new leadership, or a shift in funding, or like Val was saying, a public health crisis like COVID—you know, those ripple across the entire system. And our approach to systems thinking was guided by foster Fishman and Watson's able change framework on for guiding systemic change efforts. And the basic premise of this is that we have a better chance of impacting complex systemic problems and promoting systemic change when there's a framework in place to to address some of these changes. And so the ABLE framework breaks down systemic change into some basic rules and strategies, and that gave us a way to frame our efforts. And in particular, we focused on some of these areas you see here on the slide, which include these interconnected elements of mindsets, program components, connections and regulations. So first, mindsets, these are kind of the beliefs and values and priorities that drive how system leaders act and how they're willing to collaborate to make change. And so we did a lot of in depth interviews with a lot of diverse stakeholders, and what came from this was that they were really five shared priorities, developing and supporting direct support professionals, promoting community inclusion, shifting to Person Centered thinking, recognizing people with IDD as contributors, and improving systems of communication. So these commonalities allowed us to create a shared agenda, and it also revealed where maybe misalignment was slowing down some progress in the process. And so to address this, we really focused on some of those small wins, you know, targeted feasible projects that could build trust and momentum across the system. We also focused on program components, and these are I mentioned earlier. These are kind of those concrete trainings and initiatives to strengthen system capacity. Our team developed an expanded evidence based program, such as the LEAP abuse, abuse prevention training, person centered training, health advocacy training, etc. And collectively, these programs address systemic barriers like safety, quality of life and access to independent living. And again, we had to design these for accessibility, but also during covid 19, we had to change a lot of this to virtual delivery. A third connections, the strength of our system, and all systems, I believe, kind of depends on the quality of relationships between the different nodes or different parts within that system. And so we mapped the DD system to understand how different agencies and organizations were connected, and we identified some highly connected partners that could you know that that could really form a hub in some way for spreading information and ideas. So we partnered with the Virginia Board for People with disabilities to lead statewide information access initiatives. We'll talk about I'll talk more about that here in a bit. And we worked with dbhds to engage regional quality councils, and I'm going to talk more about that. About that as well. Finally, regulations. All of this work takes place within a regulatory environment that sort of shapes what's possible. And in Virginia, there was an ongoing Department of Justice settlement. You know, that was kind of a defining factor. For for Project Living Will you know, compliance had driven critical improvements, but also meant that there was a big focus on procedural requirements and didn't give a lot of room for a whole lot of innovation or large scale transformation. And we really had to find ways to advance change within those contexts. So by weaving together all of these elements, I think we were able to make to build, you know, opportunities for more ongoing collaboration and systemic change well beyond, beyond the life of the grant. And that's what I want to quickly describe right now, is what's been happening since project living well, sort of wrapped up, and we can just keep on going to the next slide. Okay, so information, access. I talked about this a little bit before, but it was one priority that emerged during project living well, and it's, you know, obviously a frequent challenge for people with IDD and their families as they're navigating services. And so while we began collaboratively planning around these issues during project living wells, Project Living Well, excuse me, one of our key partners, the Virginia Board for People with Disabilities, really took a strong leadership role in taking it to the next level and promoting systemic change in 2022 the board completed an information access assessment, highlighting issues like fragmented sources and technical language, lack of accessible formats, inconsistent updates and gaps in consumer respect or follow through. So recommendations were all grouped to share some of that, and you can access that document through the QR code on this slide, they also developed an RFP, which led to an information ecology assessment, and that was really neat for expanding the user experience and how providers manage and share information. So working with the Virginia Board and other partners, Project living rail really started this opportunity to advance access and made it a strategic priority in Virginia. Next slide, please.

Dr. Seb Prohn 1:02:12

Sorry about that. We'll just do a little bit of click through. A few click throughs here.

Dr. Seb Prohn 1:02:19

Here we go. Okay, so leap that stands for Leadership, for empowerment and abuse prevention. It was strongly supported by project living well as a capacity building effort, and it equips adults with intellectual and developmental disabilities to recognize healthier relationships and to prevent abuse through on through an engaging and accessible approach. It's an interactive four session training that's led by CO trainers with and without IDD. And during project living well, 538 people were trained in leap. But since Virginia's living well project sort of wrapped up, a little bit, leap has continued to grow and expand, and this has led to a lot of partnerships, and including specifically adapted versions of leap to address the needs of teens and then autistic adults. It's received ongoing financial support from a crucial state agency and also through the Family and Children's Trust of Virginia. So leap continues to build off of the systems change model that I described by reinforcing capacity building and person centered learning and even peer especially peer leadership here, and you can use this QR code if you want to learn more about the LEAP training and some of its ongoing impacts throughout Virginia Next slide, please. Okay, across Virginia, we have regional quality councils, which are just teams that are dedicated to making sure that services for people with IDD are the best that they can be, and they're made up of a mix of voices, including people who receive services, family members, providers, employers, case managers and others. And what makes this work powerful is that they really turn use collaboration to turn information into action, and with guidance from the statewide improvement committee, their local solutions stay connected for to Virginia's bigger pictures for quality care and assurances. Let's just go to the next slide that shows a timeline through Project Living Well, we are able to support the development of modules and train new regional quality council members. But we were also able to kind of organize several years of regional quality Council summits, and you can see all these different data workshops here, but they change really changed over time. We started with the basics on what is data and how do we understand data in different contexts? Then we transitioned to providing regional specific data in our workshops and having rqcs learn about their region and make plans based on benchmarking to Virginia and to other regions. And that was sort of a common goal as we moved but as we moved beyond the project, living well years the RQ sees have grown and changed with their comfort with data, and so we got more and more complex in the process, really moving towards inferential statistics and launch looks at longitudinal data for quality improvement initiatives. Let's go to the next slide. So speaking of quality improvement initiatives, you know, these continue to take many shapes and forms and have become more complex. One of these ones that's on the slide is pretty neat, and it's built off some presentations and papers that we wrote a partnership for people with disabilities, including some machine learning work to understand the factors that strongly determine whether or not service users were prescribed medication for mental health conditions. And specifically, in this Qi, they wanted to learn more about who and under what conditions people were without mental health conditions were prescribed and taking mental health medications. And so through this process, they've been able to examine a wide range of data to be able to address this a little bit more, I'm going to have to, it looks like I'm going to have to just leap forward a little bit. So these are just some quotes, again, showing some of the nuanced understanding that we're able to be accessed through data. For example, there was our QC members were really able to tune into the link between communication and how people have opportunities to make choices in their everyday lives. And so they started to create goals about how, you know, making sure that people who use nonverbal forms of communication were giving ample support and opportunity to be in control of the choices in their lives. Next slide. And then just finally, this is just to show that, you know, a lot of people who are participating in these rqc summits or on the regional quality councils are showing that this has been really beneficial in taking data and transforming it into action to improve regional systems and and the DD system across Virginia. Okay, so the last slide is just some contact information. If you want to learn more about Project living well Virginia or the ongoing impacts, please don't hesitate to reach out to me. My email address. Is there? S, M, P, R, O, H n@vcu.edu, thank you so much, and I think that Katelyn and Sally are up next.

K

Kaitlin McNamara 1:07:56

Thank you so much. Sub My name is Kaitlin McNamara. I am a white woman with long, dark brown hair and bangs, and I'm wearing a pink sweater, and Sally, I'll turn it over to you to introduce yourself, since you're on screen as well, sure

S

Sally Flaschberger 1:08:13

I'm Sally Flaschberger. I am. Use the pronouns she her, and I am a white woman with blonde hair, wearing glasses, and I have a striped shirt on, and I'll turn it back to Caitlin to get us going.

K

Kaitlin McNamara 1:08:29

Thanks. Sally. Sally and I both worked for the Wisconsin Board for People With Developmental Disabilities on the living wild project, and we're going to talk through this afternoon some of the highlights and the impacts that we have seen as a result of the work we were able to do. I will focus a lot on our self advocate leaders, as you can see them featured here in our first slide. Go ahead and go to the next slide, please. The impact of living well in Wisconsin was fairly profound. In our experience, we really saw that this project created a shift in the way in which we approached safety and capacity building within the state, we prioritized the with lived experience in changing the way that we approach self direction. Across the many years of our project, we were able to see hundreds of individuals experience learning about their rights and advocacy and how to speak up for themselves, we also see a large shift in the provider agencies that we worked with in how they train staff and responded to concerns not only. In those who joined our project in an attempt to transform their services and grow but those who joined our project in a mentoring role originally also saw a large shift in the way that they also approached their work. Saw families become more informed, not only support one's rights and goals, but also in transforming the quality of the services and lives that they were supporting their loved one to live, but certainly that I will focus on my part of the president is our self advocate Leadership Network. They were the cornerstone, the beating heart of our project. They were involved in as leaders in every step of the work that we did, from the tools that we created, the trainings, the meetings, the consortium that we built and the messages that we shared were all informed and formed by our self advocate Leadership Network. Next slide please, as a result of the information that we learned from this project and the partnerships that we were able to build, we have seen a continuation of that leadership and engagement from self advocates across the state at our own organization, we've been committed to sustaining and expanding on the work that the self leadership network established. We do this in partnership and collaboration with our self advocate organization, people, first Wisconsin, who continue to employ and find new opportunities for self advocate leaders to continue the work that they started. We have focused at bpbd a lot on the idea of peer mentorship, which I will go into further, as a service that continues to be offered by living well providers and with self advocates and people with lived experience. Our efforts, like I said, involve training new peer mentors, having our self advocates continue to work with our Department of Health Services offer their insights and important information to forming our HCBS waivers and continuing to build provider capacity with self advocate leadership included, they continue to share in our policy, work, conduct trainings and be important voices in their communities. Some of them serve on boards that they didn't serve on before. Many of them have jobs they did not have before, and they continue to help grow a new generation of self advocate leaders in our state. Next slide please. Across our project, we partnered with a lot of organizations in Wisconsin, but the most important one to our self advocate Leadership Network was our our people, first, Wisconsin, which is, I said, is our self advocate led network. We identified so 10 self advocate leaders. All of these are individuals with lived experience. They were geographically located across Wisconsin, so they came from a wide range of geographic areas and experiences, and these leaders came together in person, online throughout the pandemic and all different kinds of formats to help us create the materials, the conversations, the trainings, the webinars, anything that we did to both providers to family members, to other self advocates, they were always at the table with us, and they were co facilitating our peer to peer education, which Sally will mention a little bit in her part of the presentation, as well, and partnered with provider agencies, many of whom continue to go back to those same self advocate leaders to employ them to help peer education efforts in an ongoing capacity. They also were our first group of peer mentors, and they continue to show up to train new peer and bring about a sustainable model of peer mentorship in Wisconsin as part of their leadership. Next slide, please. So I wanted to just mention why, why it was important to us to focus on a peer to peer. Model and what we saw as an experience with our peer to peer education efforts. We knew that people responded better when they were hearing from other people with disabilities, those who had lives that looked more like theirs, and that they learned from each other when they were sharing in a group, we also saw an increased rate of disclosures regarding incidents in their lives that they were unhappy with, whether that was as extreme or as serious, as a disclosure around abuse and neglect or just a feeling of unhappiness with their service provision things that they wanted to see changed. There was a higher rate of that kind of conversation happening when the education involved appear in a leadership role. It also helps us build more peer mentors and leaders by providing education and examples of leadership, because we all learn best when we see someone like us walking in the shoes that we want to see for ourselves. Next slide, please, the lasting impact of the self advocate leadership network goes far beyond just peer mentoring, but I wanted to specifically describe the ongoing peer mentoring program that is being developed in Wisconsin as a result of living well. The purpose of this was to provide adults with intellectual disabilities the opportunity to become and support and assist other people with disabilities in an actual career trajectory. This helps both ends, the community inclusion of those seeking to be employed in this field, as well as helping those who are mentees, receiving the information and guidance from a person with the lived experience, the mentors offer their own experience, personal experience and encouragement and support to help another generation of self advocates advocate for the life that they want and for improving the system that exists here in Wisconsin and cross country. Next slide please. In creating our model, we looked at several different states, as well as different programs that existed already in Wisconsin. We had a close partnership with Michigan and their model of peer mentorship to train our first round of self advocates, and developed our program based largely around their model. So this just kind of gives you an overview of some of the work with that went into developing that peer mentor model. Next slide please.

K

Kaitlin McNamara 1:17:50

In the end, we worked with two of our provider agencies in living well, two of our managed care organizations, and 510 self advocate leaders to start our peer mentoring program here, all of those five self advocate leaders went on to do an internship with one of those providers. They were becoming certified peer mentors, and now have a slate of mentees that are being served, and we have trained more individuals. We held our first training with six individuals and then trained an additional six. So we are also working to build a sustainable model of peer mentors across the state and sustainable funding method as well. Next slide please. Like I said, we trained an additional six individuals to be peer mentors after that, so we now have over 20 individuals who have been trained, and more than a dozen in their internship phase or have graduated to be a certified peer mentor the pilot the pilot agencies have gone on to find additional grant funding to continue that work, and we have received some additional funding to continue with the technical assistance and training, and we continue to work with our Department of Health Services and our self advocate leadership network to find a sustainable waiver based trajectory for the funding of peer mentors. Next slide, all right, I'll pass it over to Sally. Then,

S

Sally Flaschberger 1:19:28

great. Thank you. I'm going to talk a little bit about our Living Well blueprint you can go to the next slide. So some of the impacts, as Katelyn talks about, we talked about peer mentoring. We definitely saw, you know that we really made some change in our disability service system. We know that people with disabilities were safer, more informed and more empowered. Families also were better equipped. We really captured all of the all of the. Work that we did in our grant, in what we call the living well blueprint. And our blueprint really has it has ready to use tools, templates. It talks about evaluation, data, reflection, guides. Not only do we have a paper paper blueprint, but we also have a website that you can find all the information on. So I'm going to go into that a little bit so you understand what the blueprint is, so you'll be able to look for it next slide. So these were some of our impacts of the overall grant, and I'm just going to leave this slide so I can get right to the blueprint, but it gives you a real good idea of really the reach that we had in all of the work with that we did. So next slide please.

S Sally Flaschberger 1:20:59

All right, so our Blueprint is where you can find all of the different interventions, promising practices, best practices, that we really used in Wisconsin. We also look to other states to see what they were doing, so that we could include that. And our blueprint focuses on those, quality improvement, our self advocate leadership and engagement, family engagement, improving abuse and neglect responses and building those community relationships. And I'm going to talk through a little bit about how you can navigate the blueprint to find the information that will be most important to you if you're an individual, if you're a provider, or if you're at the state level. So that's just the cover of our our blueprint Next slide. So again, as we talked about our structure was very clear into these five elements, and so in the blueprint, you'll be able to look at each element and find your area. You'll also be able to search on our website by element. So if you're looking for family engagement, you can just go to that family engagement tab and really learn all about what we did around family engagement. Next slide. So within the blueprint, we broke it into three. We have the element, but then we have who would that pertain to? So if you're a self advocate or a family member, you may be looking in the individual section. If you are a service provider, you're going to want to look in that section. And then again, if you're part of a state agency looking how to implement some of these different best and promising practices, you're going to look there. So each section starts with the why it goes on to the how we did it. It gives you the tools, and then it gives you a set of reflection to see, is this happening? Are these services available in my state? What does that look like for me? Questions that you can ask if you're an individual, you can ask your provider, if you're a provider, you might say, Am I doing these best practices? So it's all about an interactive tool that you can be using Next slide. So that's kind of our blueprint. What I wanted to talk about was three of our educational materials that we developed for education for people with disabilities, their family members that providers can use. So first, we developed what was called the safe and free series, and we adapted this from materials from Green Mountain self advocates. It was meant to be a co led so by a provider and a self advocate leader that they would be facilitating these conversations using what we call the safe and free facilitator guide in small groups. We originally intended to do that in person. We did a lot virtually, but people eventually, once they came back, did do many sessions in person, and we really evaluated what people were learning, how we could scale this within a provider. And again, most importantly, we included our self advocate leaders to help us make these plain language this plain language series, and really it focused on areas of self advocacy, abuse and neglect rights, kind of an introductory to to advocacy for individuals, problem solving relationships. And so this facilitator guide is available. For anyone to use next slide, our second toolkit is our health, healthy and safe, connected toolkit that was really meant to be. It originally started as a covid tool where we had sections on being healthy, being safe and being connected. What we then did was we recreated that into an overall healthy, safe and connected toolkit. And again, like all of our other resources, there are, there's information, there's tools, there's action plans, all of those things are being used. And again, co created with our self advocate leaders. We did pilot this with our pilot agencies, and then also our managed care organizations to see how it would work for individuals to use it as a working tool. Next slide. And then finally, we had our let's talk about rights guides and videos. And so this was three different versions. We had a guide for providers to be working with their staff, a guide for self advocates and a guide for families. And again, our self advocate guide was co created with our self advocate leaders. Education for people with disabilities was done in small groups, we conducted focus sessions to gather feedback on the guides, and then we created a very a 17 video series about each right, and so you're able to access that all through the blueprint Next slide. So this is the link to our full Blueprint, and you'll find all of these resources in there many, many more, any links to the video, videos you can find on our website. Next slide. And so this is the link to the website where you can really search. And you can search for all the resources. You can look as a as you're an individual, all of that. And that's really, you know, we hope that you'll go out and take a look at that. And we do have, we did do a presentation, so we do have a link to our full presentation on the blueprint, also at that website,

Sally Flaschberger 1:27:18

next slide.

Sally Flaschberger 1:27:21

And this is just our contact information, and I will turn it back over to our great hosts.

Alixe Bonardi 1:27:31

Thank you, Sally and Katelyn. This is Alex Bonardi. I am a white woman with shoulder length blonde ish hair and dark glasses in my office with a blue wall behind me, I want to thank each of our speakers today who joined us from Georgia, Virginia and Wisconsin, from the state teams, and then also Jennifer Johnson and Valerie Bradley, who set this up and to my Code the co director of the grassroots project, Kate Brady, who opened up this project, this conversation today, this has been such an exciting session to be able to bring forward some of the work from the Living Well projects, as Jennifer mentioned, These got started in 2017 has been and so with Administration for Community Living funding at that time getting rolling, you can see some of the longer term effects, where the catalyst of bringing coalitions together starting to do capacity building, it takes time we understand, and we know that there's been some tremendous resources that Come along the way. So with all of that, very excited to be able to sell to share your resources with the grassroots project members. And we look forward to continuing to being in touch as we build on this the grassroots project we do continue to learn from people, and we have a brief web survey that will be bringing up very shortly. There it is, and we're very interested in hearing from you, all of our everybody who's participated here about their experience with this this webinar, please stay tuned. Stay we'll be in touch, and we will be sharing upcoming opportunities to learn and share with each other. Thank you again. Thanks to the grassroots project team who were working behind the scenes to make this webinar all come together, and I look forward to being in touch with with many of you in the future. Thanks again, everyone, and we'll hope to see you soon.