Individual Support Plan Training

EHR DSP CORE Training Individual Support Plan Training

☐ Each individual receiving services through DES/DDD has an individualized plan, Individual Support Plan (ISP), or an Individualized Family Service Plan (IFSP), used for children 0-3 years of age and their families. They may also have a Person Centered Plan (PCP).

☐ The support plan provides important information you need to do your job.

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Individual Support Plan Training

All Support Plans:

- Are individualized.

- Are developed with the person and, when appropriate, his/her family.

- Documents the individual's strengths, needs, and resources.

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Individual Support Plan Training

INDIVIDUAL SUPPORT PLANS

The Support Plan describes the person's goals and plans and what works for the person. This can include:

- Likes and dislikes.
- Abilities and special needs of the person in areas like daily living skills

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- Medical issues, communication and movement issues.

- Social and family supports.

- Medication assistance needs, potential health and safety risks.

- Services and supports a person will receive.

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The purpose of support planning is to ensure that everyone is working together to achieve the goals identified by the individual being supported. The planning document becomes the roadmap for how services and supports are delivered.

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- The support plan is reviewed through quarterly and annual team meetings, and will receive ongoing monitoring by the Support Coordinator.

- Ongoing monitoring includes progress reports, reviewing attendant monitoring, and incident reports.

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ROLES AND RESPONSIBILITIES OF TEAM MEMBERS

Individual

The individual receiving support is central in the development of the plan. The person is there to talk about choices, hopes, dreams, and any potential barriers. Regardless of any potential participation barriers, including age, cognitive development, and communication ability, this meeting is for the person. The plan is for and belongs to the individual. Teams may need to be creative to accommodate the person's needs and preferences.

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Individual Support Plan Training

People important to the individual include:

Family

Depending on the needs of the individual, the family may play a very large role in the planning process. In fact, if the plan is an IFSP, the planning process focuses on the entire family, not just on the individual. For other plans, family involvement will vary from person to person. If family members are legally responsible, they must be a part of the planning team.

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Support Coordinator

In addition to providing on-going coordination and monitoring of the plan itself, the individual's DDD Support Coordinator (Case Manager) is typically the one that will facilitate team meetings unless the individual or responsible person prefers otherwise.

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Funded Team Members

At the annual ISP there must be a representative from each provider entity that the Division funds.

These team members contribute in ways that reflect the best interests of the person being supported. This could include sharing assessment information, advocating, making recommendations and determining the specific supports and services that will help the person achieve their goals.

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Direct Support Professional (DSP)

DSPs support people with developmental disabilities to work toward their goals and help to meet their daily needs. The support plan is the person's map directing you to where the person wants to go and the steps needed to get there.
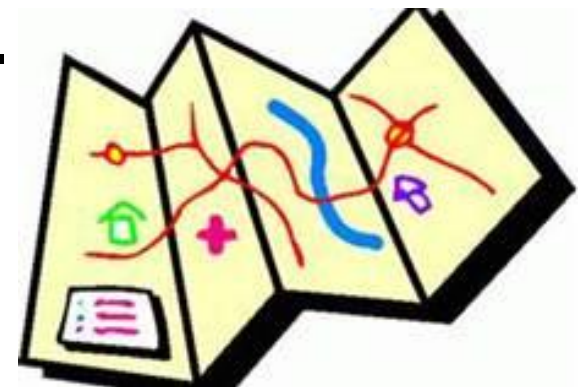
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Before the meeting:

☐ Get to know the person and develop a respectful relationship.

☐ Help the person think about what he/she wants to express at the meeting.

☐ If need be, think of ways to help the person participate in the meeting.

☐ Prepare to discuss progress, challenges, and changes since the last team meeting.

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During the meeting:

☐ Be professional.

☐ Be a positive, active participant.

☐ Speak up and share what you have learned about the person.

☐ Support the person's participation.

☐ Focus on the person's desires, capabilities and talents.

☐ Be an advocate.

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After the meeting

☐ Implement the supports outlined in the plan.

☐ Carry out the actions you are responsible for.

☐ Communicate with other team members.

☐ Complete required documentation.

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The responsible person or the individual served, if they are an adult and legally responsible for themselves are the ones who choose who else can attend. Participants in the support planning process could include:

☐ Significant Others/Spouse

☐ Friends

☐ Other Advocates

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GOAL PLANNING

Support planning is a process that we use to help identify the things that a person wants to achieve, the skills that need to be learned, and the barriers that need to be overcome to achieve that dream, all this through a step-by-step plan to help get them there. It's not really different than the type of goal setting that we all do for ourselves!

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Long-term goals

- A long-term goal is anything that you want to accomplish in your life. Make it specific, (i.e. buy a house, get a degree, lose 25 pounds, etc.)

To truly help you understand this process, please apply it to yourself through the questions we pose:

- What are YOUR personal long-term goals?

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First steps

- First steps are the things that you can do today, or in the very near future, to reach your milestones (short-term goals), and eventually your long-term goal, i.e. open a bank account or get a gym membership.

- What would be your first steps towards YOUR long-term goal?

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Barriers

- Barriers are anything that may slow you down, or prevent you from reaching your Goals (i.e. poor health, lack of budgeting skills, etc.)

- Can you think of any real or possible barriers that would stop you from reaching your personal goals?

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Here is an example of another's goal planning:

Long-term goal:
• Buy a new car

Short-term goals:
• Good credit
• Savings
• Driver's license

First steps:
• Pay bills on time
• Put $25.00 per paycheck in the bank
• Study for drivers test 10 minutes each day

Barriers:
• Overspending on fast food and entertainment / Create a budget
• Habit of paying bills late / Write due dates on calendar
• Lack of time to study for drivers test / schedule 10 minutes each day during lunch for studying

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This individual's long-term goal, in the previous example, is to buy a car. Short-term goals that will need to be accomplished to reach this long-term goal, in this case are having good credit, having some money saved, and having a driver's license. To reach these short-term goals, and ultimately the long-term goal, there are first steps" that will need to be done initially, then on a regular basis and skills that need to be acquired. For example, pay bills on time to improve credit score, put money in the bank each week to save toward the car payment, and study for the driving test to get a driver's license.

These first steps are the equivalent of the outcomes / objectives that will be discussed later

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Barriers were identified: choosing to spend money on other things, poor bill paying habits or lack of time to study for the driving test. There was also a "plan" for each identified barrier: creating a budget, writing the due dates for each bill on their calendar and carving out a specified, 10 minute timeframe to study each day.

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You have just completed a process that is very similar to the ISP process. The purpose of the ISP is to identify the individual's goals, the steps that will be necessary, any barriers or obstacles they may face, and how the individual and the team will address those obstacles.

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During this meeting, one or more long-term goals will be identified that are important to the person and his or her family. Services, supports, team agreements and assignments, specific outcomes and other action items will then be identified based on this long-term goal.

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Individual Support Plan Training

The following pages contain the ISP packet.

ISP Cover Sheet

The first page, the ISP Cover Sheet contains information that is typically not discussed during the teaming itself as it will seldom change. It is merely a document that will accompany additional pages that captured the team's discussion. It will have useful information for you, the DSP in the event of an emergency (I.e. important contacts, medical insurance information, etc.). This page will also indicate who attended the individual's ISP teaming.

This is the ISP coversheet. The top half of the form will have important identifying information about your client.

Third Party liability (TPL) is additional healthcare insurance that you need to be aware of if you take your client somewhere to receive medical care.

DD-214-FF (6-12)
P/P Ch.800
(DDD-1472A packet)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

INDIVIDUAL SUPPORT PLAN (ISP) – COVER SHEET

NAME (Last, First, M.I.)	DATE OF BIRTH	ASSISTS NO.	DATE

ADDRESS (No., Street, City, State, ZIP)	PHONE NO.

RESPONSIBLE PERSON (Guardian)	PHONE NO.

ADDRESS (No., Street, City, State, ZIP)

CURRENT RESIDENTIAL SETTING	WORK, SCHOOL OR DAY PROGRAM

INCOME
☐ SSI ☐ SSA ☐ Other ☐ DD Only

TARGETED ELIGIBLE (TITLE 19) ☐ Yes ☐ No

TARGETED CONTACT TYPE ☐ Phone ☐ In Person ☐ Letter

TARGETED FREQUENCY ☐ 90 Days ☐ 180 Days ☐ 365 Days ☐ Other:

ALTCS ELIGIBLE ☐ Yes ☐ No | AHCCCS ID. NO. | FOSTER CARE ☐ Yes ☐ No | EXTENDED FOSTER CARE ☐ Yes ☐ No

AHCCCS HEALTH PLAN | PRIMARY CARE PHYSICIAN'S NAME | PRIMARY CARE PHYSICIAN'S PHONE NO.

THIRD PARTY LIABILITY ☐ Yes ☐ No | THIRD PARTY LIABILITY COMPANY NAME | POLICY NO.

DENTAL COVERAGE ☐ Yes ☐ No | DENTAL POLICY CARRIER | DENTAL PHONE NO. | BEHAVIORAL HEALTH RECEIVED BY ☐ RBHA ☐ ALTCS PCP ☐ N/A

SUPPORT COORDINATOR'S NAME | ID NO. | PHONE NO.

LOCATION OF MEETING | REASON FOR TEAM MEETING ☐ Annual Review ☐ 90 Day Review ☐ 180 Day Review ☐ Spec. Staffing ☐ Other (Specify)

COMMITMENTS AND SIGNATURES

Support Coordinator: I understand all team members must have the ISP mailed to them within 15 working days.

Responsible Person: I understand that I may choose the Support Coordinator, subject to availability.

All Team Members: I understand that my signature indicates participation in the development of this plan, and that I will carry out all responsibilities I have agreed to undertake in this plan. I understand that service decisions may require further approval, subject to ALTCS requirements or state funding. I understand a service provider may review the Division's case files for any historical and behavioral information per A.R.S. 36-557(M). **The grievance and appeal procedures have been explained to me.** If I am not satisfied with this plan and want to request an Administrative Review, I understand that I must make the request within 35 days of the date of this plan by contacting DES/DDD Office of Administrative Review, S/C 016F, 3443 N. Central Ave., 6th Floor, Ste. 606, Phoenix, AZ 85012.

TEAM MEMBER'S NAME (Print)	RELATIONSHIP TO PERSON	TEAM MEMBER'S SIGNATURE	DATE

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at 602-542-0419; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Disponible en español en línea o en su oficina local.

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Individual Support Plan Training

Acknowledgement of publications /
Information

Everyone served through the Division of Developmental Disabilities have rights that govern the type and amount of services and supports that they receive. The next page, Acknowledgement of publications / Information ensures that the person you serve was made aware of those rights.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

ACKNOWLEDGMENT OF PUBLICATIONS / INFORMATION

INDIVIDUAL / RESPONSIBLE PERSON'S NAME *(Print or type)*	DATE

The Individual/Responsible Person will acknowledge receipt of the publication/information by placing his/her initials next to the applicable statements.

_____ I was informed of the opportunity to choose my Support Coordinator. I understand that my choice will be honored to the best of the ability of the District. *(Required annually for all individuals)*

_____ The Statement of Rights (PAD-195) booklet was given or offered to me. I may also go to www.azdes.gov/ddd/ to obtain a copy. *(Required annually for all individuals)*

_____ The ALTCS Member Handbook (PAD-465) was given or offered to me. I may also go to www.azdes.gov/ddd/ to obtain a copy. I understand services offered through the ALTCS program are described in this publication. *(Required annually for all ALTCS individuals)*

_____ The DDD/ALTCS Member Survey was given or offered to me. I may also go to www.azdes.gov/ddd/ to obtain a copy. *(Required annually for all ALTCS individuals)*

_____ The Notice of Privacy Practices (DDD-1314A) was given or offered to me. I may also go to www.azdes.gov/ddd/ to obtain a copy. *(Required annually for all individuals)*

_____ The Decisions About Your Healthcare (PAD-588) pamphlet was given or offered to me. I may also go to www.azdes.gov/ddd/ to obtain a copy. *(Required annually for all individuals age 18 or older)*

_____ The Voter Registration information was given or offered to me. I may also go to www.azsos.gov/election/VoterRegistration.htm to obtain a copy. *(Required for individuals who do not have a legal guardian, and who are or will be 18 by the next general election)*

_____ I was informed of my requirement to register with the Selective Service. *(Required for males at age 18)*

_____ I was informed of the provision that my or my child's Social Security number is not required. *(The family must be informed of this at intake.)*

_____
Individual / Responsible Person's Signature

_____
Date

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Individual Support Plan Training

Team Assessment Summary

- The <u>team assessment summary</u> provides the Direct Care Worker with an overview of the individual's strengths and support needs in areas of health, learning, communication, social skills, self-care, family, etc.

- Support Information, includes medication, adaptive equipment, and behavioral health needs. Information in this section changes rapidly, so be sure to check for updates.

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Division of Developmental Disabilities

TEAM ASSESSMENT SUMMARY

INDIVIDUAL'S NAME *(Last, First, M.I.)*	DATE

Use as many pages as needed to describe the person's capacities, resources, challenges and supports needed. Areas to address must include, but are not limited to:

- **Daily routine** (What does a typical day look like? What are the best parts of the day? What are the most challenging?)
  - Communication
  - Health
  - Daily living skills (level of independence)
  - Places where the person spends time *(school, work, community)* or would like to spend time
- **Health**, including behavioral health and acute care services.
- Friends, family and other important people (unpaid) and amount of time spent together
- Paid supports (through Division or others, such as school) and amount of time spent together
- Things the person does that may gain respect/lose respect
- What things do other people do that cause loss of respect for the person?
- Accomplishments / Progress on outcomes
- How does the person make major life decisions? Who helps with major life decisions?
- Risks (As risks are discussed, complete a *Risk Assessment*, DDD-1309A)

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ISP – Vision of the Future

Once the individual as well as their team accomplish the team assessment, it is important to understand what the individual wants for their future, how they'd like their life to look five years from now and in the shorter term, what they'd like to have happen for themselves in the coming year. The team should help the individual explore all aspects of their home life, their vocational path as well as how and when the person would like to access their community.

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Division of Developmental Disabilities

ISP - VISION OF THE FUTURE

INDIVIDUAL'S NAME (Last, First, M.I.)	DATE

Use this space to record the person's Vision of the Future. Consider ways to improve quality of life at home, work/school, and in the community.

1. Things I want for my future include:

2. What I would like my life to look like five years from now:

3. Things I would like to have happen in the coming year:

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EHR DSP CORE Training Individual Support Plan Training

ISP – Priorities for the Upcoming Year

Based on the individual's 'Vision of the future' as previously discussed, the team will then identify the top priorities of the individual for the upcoming year. They will consider:

1. What the individual's top priorities are

2. What is currently happening regarding those priorities

3. What else is needed to get there. (The team needs to explore natural or community supports to assist the person with this step)

4. Lastly, once all natural or community supports have been exhausted, the team will need to identify if the person will need additional support.

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ISP - PRIORITIES FOR THE UPCOMING YEAR

INDIVIDUAL'S NAME (Last, First, M.I.)	DATE

Based on the *Vision of the Future* (DD-218), identify the top priorities of the individual for the upcoming year.

What are <u>MY</u> top priorities?	What is currently happening?	What else is needed to get there? What natural or community supports are available or what else is needed?	Check if support is needed beyond natural or community supports.*
			☐
			☐
			☐
			☐
			☐
			☐

* If checked:
• Complete the *Service Evaluation*, DDD-1517A or B, as appropriate, to assess for Attendant Care and/or Habilitation.
• Complete the *Justification and Additional Services Outcomes*, DDD-1581A for all other services.

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Service Evaluation

What type and how much support beyond natural or community supports will be based on assessed need. Once your Supervisor gives you a copy of your individual's annual ISP you will find this 10 page document that explores what and how much assistance/learning the individual will need to accomplish personal care tasks, etc.

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Justification and Additional Service

Outcomes

This is additional space within the document to help the team justify funding the needs that have been identified.

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JUSTIFICATION AND ADDITIONAL SERVICE OUTCOMES

A. INDIVIDUAL'S NAME *(Last, First, M.I.)*	B. ASSESSMENT DATE

C. JUSTIFICATION FOR PAID SERVICES *(Include any changes in the individual's life)*

D. ADDITIONAL SERVICE OUTCOMES (Teaching / Learning)	E. SERVICE

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Service Plan

Once the Service Evaluation has been completed, the team now needs to identify what the individual's service plan looks like. There may have been progress so not as many services are required for the upcoming year. This could result in the reduction, suspension or termination of a particular service. A new life challenging event could have occurred (I.e. a broken hip, a new communication device procured, etc.) or a new need could have been identified resulting in a new or increased service.

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Division of Developmental Disabilities
SERVICE PLAN

INDIVIDUAL'S NAME						DATE

Service and Provider	Service Frequency In Place Prior to This Assessment	Service Frequency Currently Assessed	Service Change			Authorization Start / End Date	Individual / Responsible Person
			☐ None ☐ Reduce	☐ New ☐ Terminate	☐ Increase ☐ Suspend		☐ Agree ☐ Disagree
			☐ None ☐ Reduce	☐ New ☐ Terminate	☐ Increase ☐ Suspend		☐ Agree ☐ Disagree
			☐ None ☐ Reduce	☐ New ☐ Terminate	☐ Increase ☐ Suspend		☐ Agree ☐ Disagree
			☐ None ☐ Reduce	☐ New ☐ Terminate	☐ Increase ☐ Suspend		☐ Agree ☐ Disagree
			☐ None ☐ Reduce	☐ New ☐ Terminate	☐ Increase ☐ Suspend		☐ Agree ☐ Disagree
			☐ None ☐ Reduce	☐ New ☐ Terminate	☐ Increase ☐ Suspend		☐ Agree ☐ Disagree
			☐ None ☐ Reduce	☐ New ☐ Terminate	☐ Increase ☐ Suspend		☐ Agree ☐ Disagree
			☐ None ☐ Reduce	☐ New ☐ Terminate	☐ Increase ☐ Suspend		☐ Agree ☐ Disagree
			☐ None ☐ Reduce	☐ New ☐ Terminate	☐ Increase ☐ Suspend		☐ Agree ☐ Disagree

COMMENTS

Service Plan Acknowledgement for ALTCS individuals. My service plan has been reviewed with me by my Support Coordinator. I know what services I will be getting and how often. All changes in the services I was getting have been explained to me. I have marked my agreement and/or disagreement with each service above. I know that any reductions, terminations or suspensions *(stopping for a set time frame)* of my current services will begin no earlier than 10 days from the date of this plan. I know that I can ask for this to be sooner.

If I do not agree with some or all of the services that have been authorized in this plan, I have noted that above. I know that my Support Coordinator will send me a letter that tells me why the service(s) I asked for was denied, reduced, suspended or terminated. That letter will tell me how to appeal the decision that has been made about my services. The letter will also tell me how I can receive continued services.

My Support Coordinator has told me how the appeal process works. I know how I can appeal service changes I do not agree with. I know that I can change my mind later about services I agree with today. I know that if I change my mind before the changes go into effect, I will get a letter that tells me the reason my services changed. The letter will also tell me about my appeal rights, including how to receive continued services.

I know that if I need more or other services than I am getting, I can contact my Support Coordinator at _____ to talk about this. My Support Coordinator will contact me within 3 working days. Once I have talked with my Support Coordinator, s/he will give me a decision about that request within 14 days. If the Support Coordinator is not able to make a decision about my request within 14 days, s/he will send me a letter to let me know more time is needed to make a decision.

INDIVIDUAL/RESPONSIBLE PERSON'S SIGNATURE	DATE

SUPPORT COORDINATOR'S SIGNATURE	DATE

Routing: Original – File; Copy – Individual/Responsible Person

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Individual Support Plan Training

ISP – Support Information

There may be critical key supports that foster success for the individual such as medication, behavioral health services or adaptive devices, etc. It is important that you, the DSP is aware of these things and understand your responsibility with each. All will be made clear in your orientation to the person.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
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ISP - SUPPORT INFORMATION

INDIVIDUAL'S NAME	DATE

DDD ELIGIBLE DIAGNOSIS	BY WHOM

DDD ELIGIBLE DIAGNOSIS	BY WHOM

DOES THE INDIVIDUAL HAVE AN ADVANCE DIRECTIVE?
☐ Yes ☐ No   If yes, is there a copy in the file? ☐ Yes ☐ No

DOES THE INDIVIDUAL HAVE A BURIAL PLAN?
☐ Burial ☐ Cremation ☐ No preference ☐ No plan

INSTRUCTIONS REGARDING RELIGIOUS SERVICES (if any)

ADAPTIVE EQUIPMENT

Equipment	Purpose for Use / Instructions	If not meeting needs is an action item needed?

BEHAVIORAL HEALTH

BEHAVIORAL HEALTH AGENCY / CLINIC	
ADDRESS (No., Street, City, State, ZIP)	PHONE NO. (Include area code)
PSYCHIATRIST	PHONE NO. (Include area code)

QUALIFIED BEHAVIORAL HEALTH PROFESSIONAL (QBHP) / CLINICAL LIAISON'S NAME AND TITLE

PHONE NO. (Include area code)	FREQUENCY OF MEDICATION REVIEWS

BEHAVIORAL HEALTH DIAGNOSIS

BEHAVIORAL HEALTH PRESENTING PROBLEMS

DATE OF LAST PROGRAM REVIEW (If applicable)*

Behavior Plan ☐ Yes ☐ No

*A Program Review Committee approved behavior plan is required when:
- Individuals who take psychotropic medication live in a DDD funded/licensed setting.
- A behavior plan/paid provider proposes to restrict a person's rights, use force, or use protective devices to prevent self-injury.

Behavioral Health Treatment Plan ☐ Yes ☐ No *If yes, attach a copy to ISP*

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INDIVIDUAL'S NAME			DATE

MEDICATIONS

Assistance needed for medication self-administration: ☐ None ☐ Needs reminder ☐ Total assistance

Name of Medication	Dosage	Reason for Medication	Precautions/ Major Side Effects

Special Instructions:

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Risk Assessment

The risk assessment is used to identify risks that could compromise the individual's quality of life. The assessment should include what could be done differently to minimize or eliminate the risk. If needed, when developing Part II – Prevention of Risks, the team should consider normal and unusual risks for the individual in various areas of the person's life. The team should also discuss and document preventative measures. Some examples include history of seizures, self-injurious behavior, dietary needs, choking, etc.

RISK ASSESSMENT

INDIVIDUAL'S NAME *(Last, First, M.I.)*	DATE

PART I – ASSESSMENT OF RISKS

CRITICAL DOCUMENTATION:

The Risk Assessment is used to identify risks that could compromise the individual's quality of life. It should identify what could be done differently to minimize or eliminate the risk. Any Risk Assessment document should be simple, straightforward, visible and readily available to the staff working directly with the individual. The third page may assist in determining whether Part II of the Risk Assessment is required.

- <u>Every</u> individual must be assessed for risk.
- If risks are determined, then Part II - Prevention of Risks must be developed.
- Consider normal and unusual risks for the individual in various areas of the person's life and discuss preventative measures.
- If additional risks are identified, use an additional form.

Is the person ALTCS eligible and receiving Attendant Care, Habilitation Independent (HAI), Housekeeping or Respite in a Non-Licensed setting? ☐ Yes *(If yes, complete a Back-Up Plan (DDD-1309B)* ☐ No

The signature below indicates the team has assessed and determined that a Part II – Prevention of Risks is <u>NOT</u> necessary.

INDIVIDUAL/RESPONSIBLE PERSON'S SIGNATURE	DATE	SUPPORT COORDINATOR'S SIGNATURE	DATE

PART II – PREVENTION OF RISKS

WHAT IS THE IDENTIFIED RISK?	DATE RISK IDENTIFIED

WHAT IS CURRENTLY WORKING TO PREVENT THE RISK?

Action Item Needed?   ☐ Yes ☐ No

WHAT IS THE IDENTIFIED RISK?	DATE RISK IDENTIFIED

WHAT IS CURRENTLY WORKING TO PREVENT THE RISK?

Action Item Needed?   ☐ Yes ☐ No

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INDIVIDUAL'S NAME (Last, First, M.I.)	DATE

WHAT IS THE IDENTIFIED RISK?	DATE RISK IDENTIFIED

WHAT IS CURRENTLY WORKING TO PREVENT THE RISK?

Action Item Needed?   ☐ Yes ☐ No

WHAT IS THE IDENTIFIED RISK?	DATE RISK IDENTIFIED

WHAT IS CURRENTLY WORKING TO PREVENT THE RISK?

Action Item Needed?   ☐ Yes ☐ No

WHAT IS THE IDENTIFIED RISK?	DATE RISK IDENTIFIED

WHAT IS CURRENTLY WORKING TO PREVENT THE RISK?

Action Item Needed?   ☐ Yes ☐ No

WHAT IS THE IDENTIFIED RISK?	DATE RISK IDENTIFIED

WHAT IS CURRENTLY WORKING TO PREVENT THE RISK?

Action Item Needed?   ☐ Yes ☐ No

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INDIVIDUAL'S NAME (Last, First, M.I.)	DATE

What is the Identified Risk?

☐ **None**

Life Threatening Behavior
☐ Alcohol Use/Abuse
☐ Illegal drug use
☐ Individual attempted suicide
☐ Person has ingested foreign objects
☐ Other _____

Medical Issues
Please list specific risks related to the diagnosis listed below

☐ Allergies (Environmental, Food and/or Medications)

☐ Asthma/Breathing Problems
☐ Bowel Problems
☐ Brittle Bones
☐ Bronchitis
☐ Catheter
☐ Cerebral Palsy
☐ Diabetes
☐ Dietary
☐ Feeding Tube
☐ Hearing/Vision Impairment
☐ Heart Problems
☐ High Blood Pressure
☐ History of Aspiration and Pneumonia
☐ Infection
☐ Other Medical Equipment
☐ Respiratory/Lung Problems
☐ Seizures
☐ Skin Break Down
☐ Ventilator Dependent
☐ Other _____

Behavioral Issues
☐ Depression/Mood disorders or any mental illness
☐ Difficulty understanding consequences
☐ Invades personal space
☐ Pica
☐ Property destruction
☐ Runaway risk
   (Continued in next column)

Behavioral Issues (continued)
☐ Self-Abusive
☐ Suicidal thoughts
☐ Verbal/Physical aggression
☐ Other _____

Safety/Self-Help
☐ Chokes easily
☐ History of ambulation concerns/falls
☐ Inability to evacuate home in an emergency situation
☐ Lack of judgment
☐ Lacks community safety
☐ Lacks fire safety skills
☐ Lacks Stranger Danger skills
☐ Memory loss
☐ Past or potential for police involvement
☐ Risk of exploitation
☐ Other _____

Risks associated when a provider does not show up
☐ Cannot self-medicate
☐ Cannot use the telephone
☐ Difficulty with communication
☐ Difficulty with reading comprehension
☐ Does not recognize signs of an illness
☐ Food handling and storage
☐ Managing own finances
☐ Relying on an untrained caregiver
☐ Unable to complete independently; dressing, cooking, feeding, bathing or using the bathroom
☐ Other _____

Life Events
☐ Aging
☐ Change in Household Composition
☐ Change of residence
☐ Does not adjust well to change
☐ Family member dies
☐ Family move or abandonment of support system
☐ New health diagnosis/disabling condition
☐ Other _____

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EHR DSP CORE Training
Individual Support Plan Training

ISP – Action Plan

   - Action items are an agreement or an assignment that could be assigned to any ISP team member that will ensure the individual's continued success such as who will monitor a skin integrity issue or who will research a newly discovered condition, etc.

   - In the section below there is a space that is designed to capture any other action required such as unique training that the individual's DSP will require (I.e. special protocol training, etc.)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

ISP – ACTION PLAN

INDIVIDUAL'S NAME (Last, First, M.I.)	DATE

ACTION ITEMS

HCBS Provider Training - Document specific training needed (if any) in the section below.

If skin integrity is an issue, the team must identify a person responsible for monitoring and document any follow-up needed as an Action Item.

Action Items	Person Responsible	Due Date	Date Completed

COMMENTS

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EHR DSP CORE Training
Individual Support Plan Training

Back-up Plan

The back-up plan is the result of a law suit that compels the Division to notify all of its clients of their right to receive "critical" long term care services such as bathing, toileting, dressing, feeding, etc. It is EHR's responsibility to ensure all of our clients receive these critical services without delay.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities
AHCCCS / ALTCS / DDD MEMBER CONTINGENCY / BACK-UP PLAN

DATE OF PLAN

MEMBER'S NAME	AHCCCS ID NO.	ASSIST ID NO.

In-Home Services Provided by ALTCS / DDD	Frequency	Provider
1)		
2)		
3)		

MEMBER SERVICE PREFERENCE LEVEL – based on member's choice for how quickly a replacement caregiver will be needed if the scheduled caregiver becomes unavailable. Members must be informed that they have the right to a back up caregiver within 2 hours if they choose. *(Check member's choice)*

☐ Needs services within 2 hours ☐ Needs services today ☐ Needs services within 48 hours ☐ Can wait until next scheduled visit by provider

Member has been advised that he/she may change the Member Service Preference Level and also his/her back-up plan, as indicated below, at any time, including at the time of a gap.*	Support Coordinator (Initials) (Date)

If my ALTCS / DDD caregiver does not show up to provide services as scheduled, my back-up plan is as follows: *(Check all that apply)*

Back-Up Plan	Name	Phone Number
☐ **I WILL CONTACT AHCCCS**		1-800-218-7509
☐ I will contact my provider agency		
☐ I will contact my support coordinator		
☐ I prefer to have family or friends provide my care instead of another AHCCCS/ALTCS /DDD provider / caregiver.	1	
	2	
	3	
	4	

☐ I can wait until the next scheduled visit from my provider agency to receive authorized care.

☐ Other:

*A gap in critical services is defined as the difference between the number of hours of critical service scheduled in each individual's care plan and the hours of the scheduled type of critical service that are actually delivered to the individual. The following situations are <u>NOT</u> considered gaps:

- The member is not available to receive the service when the caregiver arrives at the member's home as scheduled.
- The member refuses the caregiver when he/she arrives, unless the caregiver is not able to do the assigned duties.
- The member refuses services.
- The member's home is seen as unsafe by the agency/caregiver, so the caregiver refuses to go there.

See reverse for EOE/ADA/LEP disclosures

AHCCCS / ALTCS/ DDD MEMBER CONTINGENCY / BACK-UP PLAN (continued)

MEMBER'S NAME	AHCCCS ID NO.	ASSIST ID NO.

I understand that I have the right to receive all the services in my care plan to help me with bathing, toileting, dressing, feeding, transferring to or from my bed and wheelchair and other similar daily activities as needed. These services (Attendant Care, Personal Care, Homemaker and Respite) are called "critical services." I understand that the Division must make sure that I receive these critical services without delays. I understand that if I do not receive my critical services on time I can call AHCCCS to report the problem so they can assist in replacing my caregiver as soon as possible. I may also call my provider agency or case manager for help. If there is a delay and I do not receive these services on time, the Division must provide a back-up caregiver within 2 hours of the time they are notified of the gap, unless I specify otherwise at the time of the gap. I understand I also have the right to file a written complaint about the failure to provide such services as scheduled.

I understand that in order to receive services I must be available and willing to accept the scheduled services. If I choose not to accept the services I understand I must tell my support coordinator. This plan has been reviewed with me and I agree with it. I will keep a copy of this plan.

Please have member/representative sign here at time of initial/annual plan development

MEMBER / REPRESENTATIVE'S SIGNATURE	RELATIONSHIP TO MEMBER	DATE

Quarterly Visit

This plan was reviewed with me by the support coordinator during my quarterly service review. My signature below indicates I still agree with this plan and no changes are needed. I understand that I may change my Member Service Preference Level at any time, including at the time a gap may occur. My support coordinator and I will fill out a new Contingency Plan form if I have changes to my plan, but at least once a year.

Please have member/representative sign here to indicate continued agreement with the plan at the time of each 90 day service assessment. If the member/representative wishes to make changes to the information in this plan, a new plan must be written. A new plan is required at least once a year.

DATE OF REVIEW	MEMBER / REPRESENTATIVE'S SIGNATURE
DATE OF REVIEW	MEMBER / REPRESENTATIVE'S SIGNATURE
DATE OF REVIEW	MEMBER / REPRESENTATIVE'S SIGNATURE

Copy to: Member/Representative – Provider – Case file

EHR DSP CORE Training
Individual Support Plan Training

It is CRITICAL that you, the DSP is on-time and provide the entire authorized amount of service unless specifically told not to do so by the individual/responsible person or your supervisor.

EHR DSP CORE Training
Individual Support Plan Training

If you are more than fifteen (15) minutes late or leave fifteen minutes or more early, OR you alter the day a particular service is supposed to occur according to the individual's service provision schedule *for any reason*, (to include individual/family's request) you MUST report this **EVERY time** to your supervisor!

EHR DSP CORE Training
Individual Support Plan Training

For those we serve through our residential or day treatment programs, there is more information pertinent to those types of settings that we also need to document. The following pages cover the forms that are needed in addition to the forms previously discussed.

EHR DSP CORE Training
Individual Support Plan Training

ISP – Summary of Professional Evaluations

This section of the individual's ISP covers all of the professional/specialty evaluations a person could receive. The first page covers all of the typical evaluations one should seek each year. The second page is dedicated to the evaluations that cover unique needs that not everyone may have.

The team will document any follow-up or action items necessary due to these evaluations and they will become the responsibility of the DSPs assigned to accomplish unless specified otherwise.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

ISP - SUMMARY OF PROFESSIONAL EVALUATIONS

INDIVIDUAL'S NAME *(Last, First, M.I.)*	DATE

This form is required for people who live in a licensed residential setting. Use additional pages to summarize specialty evaluations that are required due to the unique medical needs of the person. Include: gynecology, cardiology, neurology, orthopedics, nutrition, psychiatry, nursing, etc. Additional categories may include: hospitalizations, emergency room visits, immunizations (received or needed) since the last ISP. If follow-up is needed, identify action(s) needed and person(s) responsible. It will be the responsibility of the licensed residential provider to follow-up on recommendations and agreements within the timeframes specified, unless otherwise noted.

Report and Dates	Results and Recommendations/Agreements
Physical Exam Evaluator Date	
Family History ☐ Diabetes ☐ Liver Disease ☐ Heart Disease ☐ Cancer ☐ Kidney Disease ☐ Other: If any of the above are checked, has the appropriate referral for screening been made by the PCP? ☐ Yes ☐ No	
Pelvic Exam Evaluator Date	
Mammogram Evaluator Date	
Testicular Exam Evaluator Date	
Prostate Exam Evaluator Date	
Audiology Exam Evaluator Date	
Vision Exam Evaluator Date	
Dental Exam Evaluator Date	

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INDIVIDUAL'S NAME *(Last, First, M.I.)*	DATE

Report and Dates	Results and Recommendations/Agreements
Psychological Evaluation Evaluator Date	
Speech Therapy Evaluator Date	
Occupational Therapy Evaluator Date	
Physical Therapy Evaluator Date	
Type Evaluator Date	
Type Evaluator Date	
Type Evaluator Date	
Type Evaluator Date	
Type Evaluator Date	
Type Evaluator Date	

EHR DSP CORE Training
Individual Support Plan Training

ISP – Rights, Health and Safeguards

This document is mandatory for anyone living in a residential setting or attending our Day Program. However, if the individual has risks of any sort, it would be wise for the ISP team to use this document in any setting.

This document explores levels of supervision (I.e. alone time criteria, proximity to water without staff, etc.), types of monitoring/support (I.e. special transportation needs or gender of staff providing personal care, etc.) and safeguarding of items that could compromise a person's safety or health (I.e. storage of medication or toxic substances, etc.)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

ISP - RIGHTS, HEALTH AND SAFEGUARDS

INDIVIDUAL'S NAME (Last, First, M.I.)	DATE

This form is required for persons residing in a licensed residential settings (e.g. group homes, CDH's, ADH's), and is optional for Individual Support Plan Teams to use in other settings.

1. May the person have access to bodies of water (e.g., swimming pools, irrigation ditches, fish ponds) without constant staff supervision?

   ☐ Yes   Please describe restrictions/safeguards, if any _____

   ☐ No   If no, why _____

2. Does the person of legal drinking age wish to drink alcoholic beverages and have guardian consent (if one has been appointed)?

   ☐ Yes   Please describe restrictions/safeguards, if any _____

   ☐ No   If no, why not _____

   ☐ NA

3. Does the person of legal age wish to use tobacco and have guardian consent (if one has been appointed)?

   ☐ Yes   Please describe restrictions/safeguards, if any _____

   ☐ No   If no, why not _____

4. Does the person have any special transportation needs or requirements (e.g., medical, safety, behavioral)?

   ☐ Yes   Please describe (medical and behavioral concerns require a Risk Assessment, DDD-1309A)

   ☐ No   _____

   ☐ NA   _____

5. Does the person require assistance with personal care (e.g., dressing, bathing, toileting, menses care)?
   If so, indicate the responsible person's choice regarding the gender of staff to provide such assistance [check only one].

   ☐ Female staff only   ☐ Male staff only   ☐ No preference   ☐ N/A

6. If the person lives in a licensed residential setting, does the person have a skin integrity concern?

   ☐ Yes   If, yes, a Nursing Assessment is required with the plan of care completed for the provider.

   ☐ No

7. Does the person have access to unlocked toxic substances (e.g., cleaning supplies, pesticides)?

   ☐ Yes   Comments _____

   ☐ No   If no, why not _____

8. Does the person have access to unlocked medication (e.g., prescribed, over-the-counter)?

   ☐ Yes   Comments _____

   ☐ No   If no, why not _____

9. Are there any reasons preventing this person from sharing a bedroom (e.g., age, medical concerns, behaviors)?

   ☐ Yes   Describe reasons _____

   ☐ No

10. Does the person have limits to the amount of money he/she can carry?

   ☐ Yes   How much? _____   Reasons for restriction _____

   ☐ No

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INDIVIDUAL'S NAME *(Last, First, M.I.)*	DATE

11. Does this person have unsupervised time in the community?

☐ Yes   Duration _____   Conditions _____

☐ No   If no, why not? _____

12. Does the person have unsupervised time within their residence?

☐ Yes   Duration _____   Conditions _____

☐ No   If no, why not? _____

13. Does the person have:

a. A history of threatening behavior within the past three years *(e.g., ingesting foreign objects, assaultive behavior)*?

☐ Yes   ☐ No

b. A medical or behavioral issue that could jeopardize quality of life *(e.g. frequent falls resulting in fractures, seizure disorder)*?

☐ Yes   ☐ No

c. One or more serious Incident Report(s) in one year? *(The nature of the serious incident and need for a Risk Assessment will be determined by the Team.)*

☐ Yes   ☐ No

d. Other life events (e.g., death of close relative, diagnosis, diabetes)? *[The nature of the serious incident and need for a Risk Assessment will be determined by the Team.]*

☐ Yes   ☐ No

e. Residence in a Licensed Residential Setting?

☐ Yes   ☐ No

A *Risk Assessment* (DDD-1309A) is required to address EACH risk identified.

ADDITIONAL COMMENTS:

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EHR DSP CORE Training
Individual Support Plan Training

ISP – Spending Plan

This form must be completed for anyone for whom DES/DDD is the representative payee (they receive Social Security funds on behalf of the person served) and/or for individuals living in a licensed residential setting or attending the Day Program. This document will consider sources of income, the individual's assets as well as their monthly/annual expenses. No money should be spent on behalf of the individual that requires this unless it is documented on this form.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

ISP – SPENDING PLAN

INDIVIDUAL'S NAME	DATE

The Spending Plan must be completed for individuals for whom DES/DDD is the representative payee and/or for individuals living in licensed residential settings. If follow-up is needed, identify action(s) needed and person(s) responsible on the *Action Plan* (DD-219-FF).

SOURCES OF INCOME

Source	Amount	Frequency	Payee
☐ SSI Note: Do not list Social Security Number	$		
☐ SSA Note: Do not list Social Security Number	$		
☐ Earnings	$		
☐ Other:	$		
☐ Other:	$		

ASSETS

Fund or Property	Value/Balance	As of/Date	Custodian
☐ DES Account	$		
☐ Group Home Account	$		
☐ Personal Bank Account	$		
☐ Other:	$		
☐ Other:	$		

EXPENSES

Type of Expense	Amount	Frequency	Comments
☐ Rent/Room & Board	$		
☐ Personal Spending Money	$		
Clothing	$		
Special Occasions	$		
Medical/Dental	$		
☐ Other:	$		
☐ Other:	$		
☐ Other:	$		
☐ Other:	$		
☐ Other:	$		
☐ Other:	$		
☐ Other:	$		

Is the person responsible for his/her own money?   ☐ Yes   ☐ No

Does the guardian or payee want to receive a copy of the person's financial ledger or receipts?   ☐ Yes   ☐ No

If yes, how often?

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EHR DSP CORE Training
Individual Support Plan Training

Changes in the ISP

All individuals served by the Division are required to have an annual ISP teaming but there are reviews/teamings that have to happen in between such as quarterly (4 times a year) reviews as well as teamings to address newly identified special needs such as a change in condition. If any action item in the annual ISP is altered such as services, outcome statements, agreements/assignments, etc. then that change must be captured on a "Changes in the ISP" form.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities
INDIVIDUAL SUPPORT PLAN (ISP)
CHANGES IN THE ISP

INDIVIDUAL'S NAME *(Last, First, M.I.)*	DATE

Use this form to describe and document changes in the annual ISP.

TYPE OF CHANGE(S)

☐ New objective/Outcome   ☐ Discontinue objective/outcome

☐ Revised objective/outcome   ☐ Change Team Agreement/Assignment

☐ Other *(Specify):* _____

DESCRIPTION OF CHANGE(S)

Use the space below to describe the specific change(s) being made, e.g., list new objective or team agreement.

REASON FOR CHANGE(S)

PRINT NAME OF PERSON SUBMITTING CHANGE	SIGNATURE OF PERSON SUBMITTING CHANGE		DATE
PRINT NAME OF SUPPORT COORDINATOR	SUPPORT COORDINATOR'S SIGNATURE	PHONE NO.	DATE

The Support Coordinator has explained the change(s) to me. I understand that if I disagree with the change(s) and wish to request an Administrative Review, I must request one within 35 days of the date of this change notice.

☐ Agree   ☐ Disagree   ☐ Request team meeting before change

☐ Disagree and I will request an Administrative Review.

To request an Administrative Review as checked above, this form is being submitted to my Support Coordinator, or I will mail, call, fax or deliver in person to:

Division of Developmental Disabilities Compliance and Review Unit 1789 W. Jefferson St., 791A, 4th Floor PO Box 6123 Phoenix, AZ 85005	**OR**	Telephone (602) 542-6859	**OR**	Fax (602) 364-2850

It is your responsibility to obtain any needed assistance and to submit your request within the time specified. If you have any questions, please contact your Support Coordinator.

PRINT NAME OF CONSUMER/RESPONSIBLE PERSON	SIGNATURE OF CONSUMER/RESPONSIBLE PERSON	DATE

Routing: **Copy** - Support Coordinator File, **Copy** – Consumer/Responsible Person, **Copy** – Provider

EHR DSP CORE Training
Individual Support Plan Training

- Individuals are in charge of their ISP and entitled to make decisions and choices about their lives, with the least amount of assistance necessary from family, guardians and support systems.

- Not all supports need to be written in formal support plans. The team should also discuss informal supports for the person to participate actively and in a meaningful way each day.

EHR DSP CORE Training
Individual Support Plan Training

Informal supports can be wide and varied. It may be access to a cell phone, so a person can be alone in the community or stay in touch with people important to them. It may include faith communities, natural supports, social groups, online supports, etc. The support planning teams should be creative and flexible in identifying the best ways to help a person be successful!

Skill Building Training

EHR DSP CORE Training
Skill Building Training

Habilitation Skill Building

In an individual's ISP, it might be identified that there are tasks/activities that the individual needs to learn to do for themselves. You the DSP will be the one that will help them to achieve those skills. What you'll formerly teach the individual will be developed in their ISP teaming and will be called an outcome or objective. There should be a direct correlation between what they are learning and what the long term vision of their future is via their short term goals.

EHR DSP CORE Training
Skill Building Training

Given that you will be the one to teach the individual those identified skills, you MUST develop a relationship that has a foundation of trust and mutual respect.

How you as the DSP gets there is through your every day communication with the person.
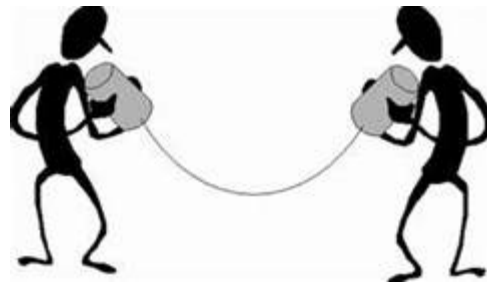
EHR DSP CORE Training
Skill Building Training

Building Relationships Through Communication

The individuals we work with/for not only need to learn new skills (how to brush their teeth, plan a nutritional meal, wash their cloths, etc.) but also need to develop *more positive attitudes towards themselves* and towards the people around them. They must learn to like themselves, *develop a feeling of self-confidence*. They need to *know that someone likes and cares about them*.

EHR DSP CORE Training
Skill Building Training

They must feel successful and be able to say, "Hey, look what I did!" If they do not feel good about themselves, then teaching them new skills will seem to be nearly impossible.

The responsibility for helping the individuals we work with/for develop good feelings about themselves lies with the people who support them.
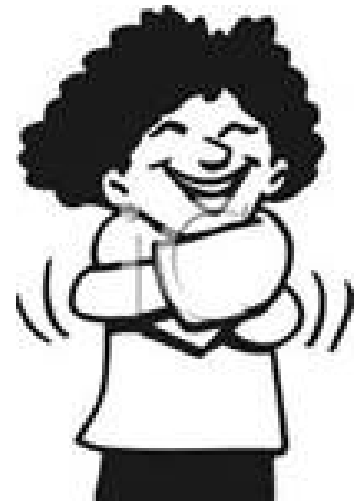
EHR DSP CORE Training
Skill Building Training

As a person who provides direct support, you can accomplish this responsibility by developing a positive relationship with the individual. To do this, you must say to the individual by your words and actions, "I like you", "You are a worthwhile person", I know you can do it!"

EHR DSP CORE Training
Skill Building Training

We need to RESPECT and VALUE the individuals we work with/for, they have likes/dislikes, needs, wants, etc. just like everyone else. In order to identify these and help that person learn to fill them we must develop a relationship with that individual. Remember – We are here to help each person develop their potential as an individual. We do NOT build products. We build relationships and relationships build people!

EHR DSP CORE Training
Skill Building Training

Some of the tools we can use to do this are:

1. Concentrate on the Individual's Strengths:

a. When you are with the individual, talk about what they can do, don't dwell on what they can not do.

b. What are their positive points?

c. What can you and the individual do to further develop these positive points?

EHR DSP CORE Training
Skill Building Training

2. Praise the Individual

Praise the individual for the good things they do. Do not assume they know what they're doing is correct. Praise builds self-confidence. The more things they know they can do, the more they will try. Don't forget to praise attempts even if they are not successful – you are praising the fact that they tried.

EHR DSP CORE Training
Skill Building Training

Use the individual's name when you are praising him/her. Let them know it is they, as individuals, you are praising. When you praise someone base it on his/her likes. Likes are things a person chooses to do to have, that they are willing to work for and will get obvious pleasure from (places, events, people, objects, etc.)

EHR DSP CORE Training
Skill Building Training

3. Be aware of your Verbal and Non-verbal Actions

Some of the strongest communication we give is through our non-verbal actions (I.e. eye contact, gestures, body language, facial expressions, etc.) People will pick up on these things and will act accordingly.

EHR DSP CORE Training
Skill Building Training

- Are you warm, friendly and interesting?
- Do you yell at the individual?
- Do you look angry?
- Are you afraid of the person?
- Do you look bored or do your actions suggest such (eye rolling, sighing, checking your watch, etc.)?

EHR DSP CORE Training
Skill Building Training

4. Treat the Person as a Person

a. How many times do you find yourself "giving orders" saying things like, "Do this" or "Do that" or maybe more frequently, "Don't do that!" Each time you do this you are really telling someone they can not do anything for themselves and you are taking that person's control from them. No one can learn independence or self-confidence or trust if someone continually orders them around. It also takes away the opportunity to build relationships with people.

EHR DSP CORE Training
Skill Building Training

b. Try saying, "Could you help me with this? I think this is a good idea, how about you?"

c. Give choices whenever possible. *Don't we all like to have some control over our own lives?*

EHR DSP CORE Training
Skill Building Training

5. NEVER talk about an individual in front of him/her as if he/she were not there. If you must discuss a person, involve him/her in the conversation with you.

Take a moment and think about how this could be done in a planning meeting (ISP teaming).

EHR DSP CORE Training
Skill Building Training

6. NEVER talk about an individual's problems or shortcomings in front of other individual's present. Reserve any discussion for a time when others are not around or when the person can be involved in the discussion (problem solving).

7. NEVER talk about an individual's problems or shortcomings you work with/for to any person who is not professionally involved with that person. MAKE SURE they have a need to know!

EHR DSP CORE Training
Skill Building Training

Potential Barriers to Teaching

1. Colors should not be bland, boring or too busy.

2. Textures should have variety

3. Furniture may be inappropriate (wrong size or height) or inadequate (not enough support or run-down).

4. Inappropriate temperatures (too hot or cold) may affect alertness and agility.

5. Strong odors are a problem in any environment.

EHR DSP CORE Training
Skill Building Training

6. Cramped areas, clutter and poor arrangement may limit activity.

7. Too bright or too dim light may interfere with an activity.

8. Confusing, complex, insufficient or large layouts are a problem.

9. Noise can interfere with hearing or concentration.

10. Other – general ugliness, dirt, etc.

EHR DSP CORE Training
Skill Building Training

How Do Your Values Impact Others?

We all place our judgments onto others. Therefore, a person's maladaptive behavior may be getting them what it is they need or want in the only way they know how to get it.

We then judge them as inappropriate or appropriate.

EHR DSP CORE Training
Skill Building Training

Your judgments are based on:

1. Your personal values.

2. Your limited knowledge of the situation.

3. Your emotional state.

EHR DSP CORE Training
Skill Building Training

In order to work more effectively with another person, you need to put your own personal values and judgments aside.

EHR DSP CORE Training
Skill Building Training

Inappropriate or maladaptive behaviors are those behaviors which:

1. Are not safe for the persons involved.

2. Violate the rights of others.

3. Limit the person's ability to live a full, self-directed life as a member of society.

EHR DSP CORE Training
Skill Building Training

Understanding *WHY* a person behaves like they do is the key to helping them find a better way to meet their own need.

EHR DSP CORE Training
Skill Building Training

How do you prevent inappropriate or maladaptive behaviors?

1. Get to know the person you serve WELL!

2. Build a professional, respectful relationship with that person.

3. Learn to recognize what is upsetting them (antecedent) and what the warning signs are that they're getting upset (pre-cursor behavior)

4. Know the order that the individual likes to do things through out their day (routine) and where what you're trying to get done fits in best with what's already going on.

EHR DSP CORE Training
Skill Building Training

5. Use positive reinforcement for behavior that is desirable.

6. Know the person well enough to know how you can divert them away from an undesirable behavior to one that would be appropriate (redirection). This will help to avoid confrontations that may just make that person even more upset.

7. **BE CONSISENT!** If you are not, then they will always have to check to see "What's it going to be" today!

EHR DSP CORE Training
Skill Building Training

8. Use appropriate communication. Sometimes just validating what they're trying to say in a way *they* get **YOU** GET what they're trying to say (active listening) helps.

9. Teach alternative skills and behaviors. A person displays maladaptive behavior for a reason! Again, find out *why* and teach them a more socially acceptable way to meet their own need.

EHR DSP CORE Training
Skill Building Training

10. Evaluate the environment and make needed changes in terms of:

    a. Privacy

    b. Noise or activity level

    c. Furniture placement

    d. Congestion

    e. Dress and attire

EHR DSP CORE Training
Skill Building Training

11. Provide opportunities for choice and decision making on the part of the individual you are serving.

12. Provide Active Treatment - aggressive, *consistent* implementation of a program of specialized and generic training, treatment and health services as identified in the individual's ISP.

EHR DSP CORE Training
Skill Building Training

Measurable outcomes are written by the ISP team when habilitation services are documented as a need in the ISP. Any time habilitation services are authorized (24/7 in a licensed group home), Measurable Outcomes are a must!

EHR DSP CORE Training
Skill Building Training

Why Do We Need Them?

Measurable Outcomes are a statement describing:

- A desired change in behavior and/or mastery of a skill for an individual

- That is wanted by the individual and/or the family.

- That is relevant to the person's life circumstances

- That clearly describes the situation when it will occur, and

- How success will be measured, and

- By when

EHR DSP CORE Training
Skill Building Training

Measurable Outcomes are determined by the ISP Team.

They give us a "target" to shoot for and a way to measure how close to the mark we are.
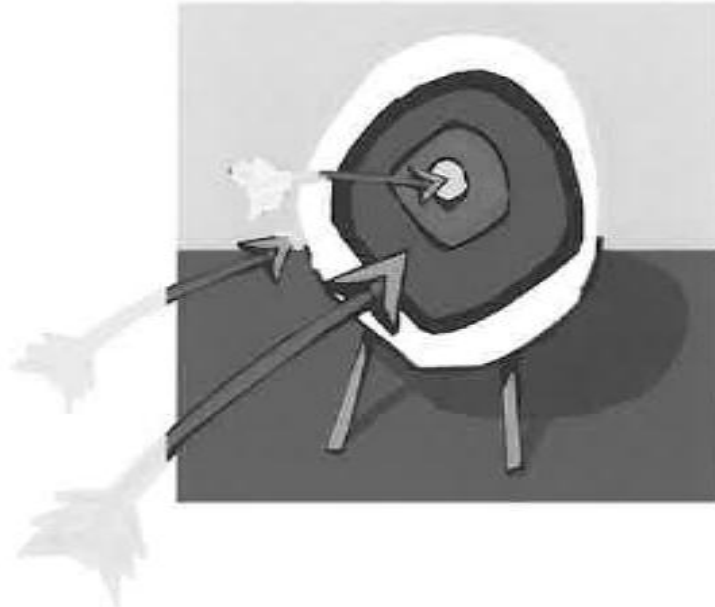
EHR DSP CORE Training
Skill Building Training

Selecting Meaningful Measurable Outcomes

As the ISP team is determining what learning objectives are the best and most meaningful *with* an individual, the following questions should be considered:

- Is it a priority for the individual and/or his/her family? Is it important?

- Will improve his/her ability to function more independently?

EHR DSP CORE Training
Skill Building Training

- Will it enhance the person's dignity? Will it help the person to be seen as more valued?

- Will it enhance his/her relationships with others? Help the person to make and keep friends? To be accepted by others?

- Will it promote development and growth?

- Does it help the person to achieve his/her visions and dreams for themselves?

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- Are there other ways to achieve the same objective that are simpler ad easier such as changing the environment?

- Are other skills needed first? Has the person mastered these? Or will we just be frustrating them?

- Is this achievable this year?

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What is a teaching strategy and why do I need one?

A teaching strategy is a written plan for how a skill will be taught. A teaching strategy is a plan for someone else's learning which includes the following:

- Step by step instructions for how the skill will be taught

- Indication when the outcome should be implemented.

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- Data collection procedures

- Identification of who is responsible for implementation

- And what will happen if the person achieves the outcome sooner than expected or doesn't progress at all (phase changes)

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A teaching strategy is necessary to ensure that the skill is taught the same way by everyone who is responsible for teaching the person the skill. This provides a consistent way for the skill to be taught, no matter who is working with them.

Habilitation Outcome Teaching Strategy

Person Served: [   ]   Annual ISP Date: [   ] / [   ] / [   ]

Date Goal Implemented or Revised: [   ]   Goal #: [   ]

Person Responsible for implementing the goal: [   ]

Recording Cycle: [   ]   **The recording cycle will indicate how often an outcome is to be implemented**

Outcome Statement: (from ISP documents): [   ]

Current performance: (what is the individual currently able to do for themselves in regards to this skill or what are they currently not doing that prevents them from performing this skill independently for themselves.): [   ]

What is currently happening regarding the skill or task

Personalized Information:
(What will motivate the individual to attempt to accomplish this outcome, what approach should the DSP take specifically for this outcome, what the DSP should avoid doing specifically for this outcome, etc.): [   ]

Information that could help you motivate or keep you from shutting down the person attempting to learn the new skill

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Required Conditions or Materials: [   ]   **You want to know all the required materials you'll need so that you can gather all of them up BEFORE you engage the individual.**

Strategy Steps (one measurable behavior per step):
[   ]

There should be one instruction or behavior per step so that if the individual does not progress as planned, the team can identify which step is the stopper

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Scoring:

The provider will record a "+" if:

The provider will record a "—" if:

The provider will record an "R" if:

The provider will record a "B" if: there are barriers to implementing this outcome (ensure explanation is dated and annotated on the back of the data collection tool.)

This is your scoring legend. This will indicate to you what to put on your data collection tool based on the individual's performance regarding this outcome.

Criteria for Success: 100% of all opportunities for [ ] entire month(s).

Criteria for success indicates how many times the individual will need to demonstrate the skill as written in the outcome statement for the team to consider the skill achieved.

Phase Change Criteria:

If no progress was made for three consecutive months: [ ]

If Individual Served achieved this outcome prior to the goal date: [ ]

Phase change criteria indicates what to do if the person achieved the desire skill prior to their goal date or if they do not progress at all.

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- The teaching strategy is a plan like all other plans and failure to implement the strategy as written is considered programmatic abuse.

- If the teaching strategy is not effective, **TELL YOUR SUPERVISOR IMMEDIATELY** so that it can be revised.

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Habilitation Data Collection Tool-HCBS

For DSPs working in the individual/family's home, you will receive two data collection tools per month, one to turn in with each pay period's timesheet. Your HAH (habilitation hourly) timesheet will not be processed in the absence of your tool.

This is the HCBS HAH Data Collection tool that all DSPs will use that provide in-home supports

Habilitation Hourly (HAH) Data Collection Tool

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Individual Served: [ ]   Month/Year: [ ]

	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Outcome #1:																
The provider will chart a "+" if:																
The provider will chart a " − " if:																
The provider will chart an "R" if the individual refuses to engage in this outcome at all																
The provider will chart a "B" if there is a barrier to implementation (Chart the date, outcome number and reason for barrier on the back of this data collection tool)																
Staff Initials																
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Outcome #2:																
The provider will chart a "+" if:																
The provider will chart a " − " if:																
The provider will chart an "R" if the individual refuses to engage in this outcome at all																
The provider will chart a "B" if there is a barrier to implementation (Chart the date, outcome number and reason for barrier on the back of this data collection tool)																
Staff Initials																
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Outcome #3:																
The provider will chart a "+" if:																
The provider will chart a " − " if:																
The provider will chart an "R" if the individual refuses to engage in this outcome at all																
The provider will chart a "B" if there is a barrier to implementation (Chart the date, outcome number and reason for barrier on the back of this data collection tool)																
Staff Initials																

Staff Printed Name	Staff Signature	Staff Initials	Staff Printed Name	Staff Signature	Staff Initials

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Habilitation Data Collection Tool- Residential/DTA

For DSPs working in one of the EHR Residential Settings or Day Program (DTA) there will be a book that will contain all of the data collection tools for the entire month in every setting. It is critical that you document the progress of the outcome on that tool immediately after you implement the outcome so that you are charting accurate data. If there are gaps in the tool(s), notify your immediate Supervisor.

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Habilitation Outcome Data Collection

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Individual Served: ▓▓▓   Month/Year: ▓▓▓

Outcome #1: ▓▓▓

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

The provider will chart a "+" if: ▓▓▓
The provider will chart a "–" if: ▓▓▓
The provider will chart an "R" if the individual refuses to engage in this outcome at all
The provider will chart a "B" if there is a barrier to implementation (Chart the date, outcome number and reason for barrier on the back of this data collection tool)
The provider will chart an "A" if the individual is absent from the program for the entire day.

Outcome #2: ▓▓▓

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

The provider will chart a "+" if: ▓▓▓
The provider will chart a "–" if: ▓▓▓
The provider will chart an "R" if the individual refuses to engage in this outcome at all
The provider will chart a "B" if there is a barrier to implementation (Chart the date, outcome number and reason for barrier on the back of this data collection tool)
The provider will chart an "A" if the individual is absent from the program for the entire day.

Printed Name	Signature	Initials	Printed Name	Signature	Initials

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Monthly Progress Report

- For any program, all data collection tools will be collected each month and the data will be scored and documented onto the monthly progress report (MPR).

- Any adjustments such as phase changes etc. will occur at that time for the following month.

- The MPR will be turned into the individual's DDD Support Coordinator as well as to the individual's responsible person monthly.

Individual's Name: [ ]   **Month/Year:** [ ]

#1 Outcome Statement: [ ]

Criteria for Success: 100% of all opportunities for [ ] entire month(s).

Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	June 2012	July 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012

Phase Change (if applicable): [ ]

Barriers (if applicable): [ ]

#2 Outcome Statement: [ ]

Criteria for Success: 100% of all opportunities for [ ] entire month(s).

Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	June 2012	July 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012

Phase Change (if applicable): [ ]

Barriers (if applicable): [ ]

#3 Outcome Statement: [ ]

Criteria for Success: 100% of all opportunities for [ ] entire month(s).

Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	June 2012	July 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012

Phase Change (if applicable): [ ]

Barriers (if applicable): [ ]

Individual's Name: ▓▓▓   **Month/Year:** ▓▓▓

BTP Outcome Statement: ▓▓▓

Criteria for Success: _100% of all opportunities for ▓▓▓ entire month(s)._

Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	June 2012	July 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012

Phase Change (if applicable): ▓▓▓

Barriers (if applicable): ▓▓▓

Target Behavior Data:			
Target Behavior	Frequency	Intensity	Comments

Team Agreements and Assignments:

Assignment	Responsible Person	Due Date	Status

Report prepared by: ▓▓▓   Title: ▓▓▓   Date: ▓▓▓

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