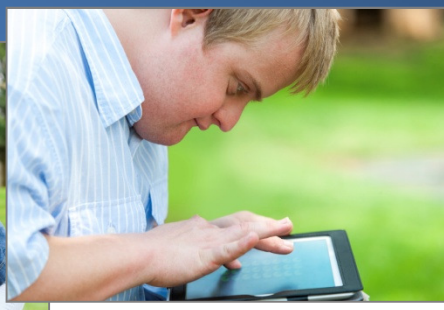
QIDP Professional TRAINING



Illinois Department of Human Services

Module Overview

Module 4 Introduction

Why this information is relevant to you, as a QIDP?

As a QIDP, you are responsible for facilitating Person Centered Planning, which is to say that you are the person who will need to maximize the voice of the person you are supporting and minimize the team's tendency to focus on available resources, obstacles and limitations. To remain person focused while recognizing the larger context can be challenging and as such, you will need to have a clear understanding of Person Centered Planning.

Objectives

Participants will be able to:

- Recognize that Person Centered Planning is an ongoing, dynamic process.
- Describe the steps involved in the process of Person Centered Planning.
- Demonstrate an understanding of the differences between traditional planning and Person Centered Planning, and the benefits of using person centered planning vs. traditional planning.
- Apply the principles of Person Centered Planning to the Individual Service Plan (ISP) development process.
- Generate strategies for involving the individual in their ISP Meeting.
- Develop goals and objectives based upon the guidelines presented in this module.
- Write goals and objectives that are person-first, positive, understandable and measureable.
- Exhibit an understanding of ISP and Person Centered Planning techniques when presented with QIDP application scenarios.

PERSON CENTERED PLANNING

"Person Centered Planning begins when people decide to listen carefully and in ways that can strengthen the voice of people who have been or are at risk of being silenced."

- John O'Brien

A Brief History

Prior to 1971, the only residential option for people with intellectual and/or developmental disabilities were large institutions. Basic care was available and services were provided based upon medical need. Doctors and nurses were the decision makers without consideration of individual or family desires.

In 1971, Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) were established. Regulations were developed to improve services and the QIDP position was created. Focus of care continued to be largely based upon recommendation of experts such as doctors and psychologists and need for active treatment added.

In the 1980s, self-determination became a significant tenet of service. Self-determination is the belief that people with disabilities should have control over their own lives with day-to-day activities being based upon their choice and life goals. Residential options were opened within the community and large institutions were downsized. Service planning focused on the appropriateness of individual participation in a range of residential and day program options. An Interdisciplinary Team (IDT) which consisted of professionals and program employees developed goals and objectives for the person served. The goals and objectives reflected the services available within the programs, rather than a person's interests or life goals.

Person Centered Planning refers to a collection of approaches to planning that places the person served at the center of the process. An individual's team might consist of friends, relatives, neighbors, and even local business representatives all of whom commit to assist the individual in developing and achieving his or her personal goals based upon likes, dislikes, dreams and desires.

How Does Person Centered Planning Differ from Traditional Planning?

The Person Centered Planning process requires a shift in traditional thinking, actions, and ways of doing business to a process in which the individual directs the services and supports. The individual is the central driving force in determining his or her future vision, goals, hopes, dreams, supports and services.

The Person Centered Planning process requires family members, friends, and professionals to:

- Listen to the individual
- Attend to the details
- Be open and sensitive to situations that can be difficult and confusing
- Encourage and contribute to the dreams and desires of the individual
- Identify and support what really matters to the person
- Be willing to agree to disagree

The traditional planning process relied upon experts to develop programs and treatments to help people with disabilities overcome their areas of "weakness." The underlying assumption was that the knowledge of experts better equipped them to make decisions for people with disabilities.

People who value individual differences, who advocate for person centeredness, believe that all people have the right to set individual goals that bring meaning to their lives. Agencies that support person centered planning find themselves continually being challenged to focus on the person rather than the system of available opportunities. This too will be your challenge.

The monograph, *Person Centered Planning* written by Mary Mercer offers ten questions that an agency can ask itself to better gauge their person centeredness.

1. Does the agency focus on deficits and weaknesses or on strengths and preferences?
2. Do the plans promote opportunities to build relationships and help people to be a part of their communities?
3. Do professionals have control over the person's life direction?
4. Is the purpose of the meeting to shape services to each person's vision?
5. Do plans for different people all look the same?
6. Do people at the meeting make decisions for the person?
7. Are people expected to fit into the daily, weekly and monthly schedules set by the agency?
8. Do teams dismiss individuals' goals as unrealistic?
9. Are plans merely meeting regulations?
10. Do service providers assess the quality of plans based upon the dreams and goals of the person with whom the plan has been created?

The Differences between Person Centered and Traditional Planning

Using what you know to be true regarding the differences between traditional planning and Person Centered Planning, fill in the chart below.

Traditional Planning	Person Centered Planning
Doctors, psychologists, Nurses, Occupational Therapists are present at the meeting.	
	Focuses on the person's skills and uses their likes, interests as the basis of the plan.
Looks at the person in need of services as someone who has to get 'ready' for community life.	
The plan is designed to fit the person into a particular program, even if that program is not exactly what the person needs.	
	Meetings are scheduled to meet the time & place needs of the person served.
Goals and objectives are written around daily living, economic self-sufficiency and community integration.	

Person Centered Principles

The Five Accomplishments written by John O'Brien and Connie Lyle are frequently cited as the principles of person centered planning.

Community Presence: The sharing of the ordinary places that define community life.

- Person Centered Planning processes encourage the "building of community" around individuals. They help develop supports to facilitate relationships with people within the individual's community.
- Community as a place to visit, "an outing", is rejected.

Choice: The experience of autonomy both in small everyday matters (e.g., what to eat or what to wear) and in large, life-defining matters (e.g., with whom to live or what sort of work to do).

- All individuals have the opportunity to make informed choices and need to exercise control of their lives. Sometimes, in order to do this effectively, they must be supported by others and have a variety of experiences, either in their natural environment or from within the system.
- Resources to support the person are based on identified needs that the individual may have and are available in the community and/or in an agency.
- Natural supports presently available in the community are used first, then the agency resources. In instances where generic resources may not exist, they may need to be developed within the community.
- The idea that the opinion of a "collective" group of professionals is likely to be superior than that of the person is rejected.

Competence: The opportunity to perform functional and meaningful activities with whatever level or type of assistance is required.

- Person Centered Planning process builds on an individual's strengths, gifts, skills, talents, and contributions.
- Person centered planning rejects the notion that every person with intellectual/developmental disabilities must learn daily living skills at the "100%" level.

Respect: A valued place among a network of people and valued roles in community life.

- A person's cultural background is acknowledged and valued in the planning and decision-making process.
- Person Centered Planning requires that it is the individual who defines what is meaningful in his/her life and what really matters most to him/her.

Relationships: The experience of being part of a growing network of personal relationships that include close friends.

- Existing relationships are strengthened and new relationships are supported.

- New relationships are built and supported.

Person Centered Planning is a dynamic, rather than a static process. The key to Person Centered Planning is a commitment to continued support for a person to better understand themselves and their world so that they may live in a self-directed way. The process begins with the person at the center and grows outward. The individualized support plan is written in an effort to capture the desires and dreams of the person served and to detail the level and types of supports necessary for those to be achieved. It is revised as new opportunities or circumstances arise and when significant changes occur in the individual's life.
It is important to remember that a person centered plan is a means ***not*** an end. Flourishing and well-being is a result of continuous and intentional effort. The finest of all service plans does nothing if not implemented.

The commitment to Person Centered Planning can be challenging for many reasons. Consider the factors below and discuss how they may help or hinder the Person Centered Planning process.

- The size of the agency
- The size of a community residence
- Status of healthcare systems
- Parents who are guardians
- Guardianship through OSG
- Funding
- Access to transportation
- Safety
- Location of community residence
- Availability of employment options
- State and Federal Regulations

<u>Getting to Know the Person</u>
Too often service plans have a description of the person served that revolves around height, weight, health concerns, diagnoses, guardianship, etc., yet when we are asked to talk about ourselves these descriptors do not come up. While there are times when the information may be relevant to our understanding, the knowledge of the person must run much deeper.

Ask yourself how you might get to know a co-worker or a neighbor. You cannot come to know a person without spending time with them and the way you spend that time with them matters. QIDPs have many people on their caseload. Unless you commit to spending time with the people you serve, you will find it difficult to support them in obtaining their goals because you will not have an accurate understanding of who they are, what they want, what their strengths are and how to build upon those strengths.

Getting to Know You

Break into groups of three.

Person 3 will get to know Person 1 using the talking points below.

Person 2 will use the space below to take notes.

- Height
- Weight
- BMI (Body Mass Index)
- Marital status
- IQ
- Medical issues
- Medications
- Prior surgeries
- Biggest failure

After 5 minutes, ask a few of the people assigned as Person 3 to share what they learned.

Getting to Know You

Person 1 will get to know Person 2. Person 3 will use the space below to take notes.

Stay in the same groups and switch roles.

After 5 minutes, ask people to report the difference between the two conversations.

Which did they prefer? Were they comfortable asking/answering those questions?

Below is a narrative written by a QIDP to assist others with understanding and supporting a person served.

Getting to Know Greg: The Beginning of Person Centered Planning

Greg loves being around horses and wants the opportunity to do this every week. He gets up early every morning and tries to live what he refers to as the "cowboy life." He wants to be connected to the horse culture. He likes to watch Bonanza reruns. He works part time at a stable on Wednesday, Thursday and Friday afternoons grooming horses and straightening up the stable. At this time he is looking for a full time job around horses or another part time job to increase both his income and time with horses.

He is learning to surf the internet to further explore his interests. He is looking for affordable housing in the country. He wants to create a budget so he can get his own place and have money to take girls on dates. He listens to country music and likes to attend country western dances. He is looking for a new pair of cowboy boots. He enjoys being outside as much as possible. He likes to attend the State Fair and enjoys watching the competitions especially if they involve horses. He likes to attend the dances there too.

Greg is beginning to volunteer with 4H and is looking to expand his role with this organization. He attends meetings once a month on the 2nd Saturday and will assist with the county fair this year. Greg attends St. Theresa's Catholic Church on holidays with his family. He spends all holidays with his parents and talks to them on the phone at least weekly. He enjoys time with his father at their ranch, even though his father had to sell the horses a few years back. He is also close to his cousins Justin and Jessica, whom he likes to call occasionally. He also likes to email Justin. Greg also is improving his shopping and cooking skills to support his gluten free diet. Greg wants some time each week when he can be alone and would like opportunities to try out new activities in the community without his roommates along.

Discuss the following:

How likely is it that the writer of this narrative learned the information about Greg through one and only one conversation?
Does this narrative make you want to know more about Greg?
What are Greg's goals?
What types of supports might you arrange to help Greg accomplish his goals?
What other questions would you ask Greg?

Discuss your Agency's expectations and practices for QIDPs to get to know the people they support. Does your agency include a personal narrative within the service plan?

If your agency does not have an assessment tool to assist you with developing a personal narrative, or one to aid in Person Centered Planning, the following questions are examples. Wording should be changed to reflect a person's receptive language level.

Questions you might ask…

To better understand values:

- Do you have a religious affiliation?
- Do you attend or would you like to attend services on a regular basis?
- How does your spirituality impact your life?
- What is most important to you in life?
- How would you describe yourself?
- What kind of person are you?
- Who/What do you value?
- Do you have any traditions?
- Tell me about your family.
- What brings you happiness?
- Is there anything that makes you sad, frustrated, or angry?

To better understand preferences:

- Is there anything you can't live without?
- What do you feel very strongly about?
- What do you like?
- What are your interests and hobbies?
- Where do you prefer to spend your time?
- How do you like to spend the day?
- Tell me about your daily routine.
- Is there anything you dislike?
- What makes you smile?
- What things create comfort for you?

To better understand current level of independence and their satisfaction with current circumstances:

- Do you feel as if you have the opportunity to make choices on a daily basis?
- Are your choices listened to and supported?
- Do you receive encouragement to make choices and decisions?
- What supports are available to you?
- Do you feel you receive the supports that you need to live a successful life?
- Are you satisfied with your lifestyle and daily routine?
- What would you like to do more independently?
- What level of supervision do you feel you need for routine tasks?
- What makes you feel safe from harm?

- What are your talents?
- Tell me about the things you are good at.
- What are you proud of?
- Are there any conditions that threaten your health?
- What do you do to promote good health?
- Do you have any physical limitations or medical conditions?
- Do you feel comfortable discussing your choices and decisions with those around you?
- Is there any special assistance you feel that you need?
- What do you feel prevents you from being more independent?

To better understand hopes, wants, and desires:

- Do you have opportunities to learn new experiences?
- What skills would you like to learn?
- What educational goals do you have?
- What have you accomplished in life?
- Is there anything you'd like to try?
- What do you want your future to look like?
- What would you like to do more of?
- What would you like to do less?
- Would you like to work?

To better understand community participation:

- Do you feel you are a valued member of your community?
- Do you belong to any clubs or organizations?
- What are some things that you enjoying participating in with your community?
- Do you volunteer?
- What help do you need to participate in community life?
- Do you feel as if you have valued roles at work and in the community?
- What do you do during the day, the evening, on weekends?
- Where is your favorite place to go?

The ISP

The Individual Service Plan documents the individual's goals as well as the services and supports required to achieve those goals. It is one document but may take many forms. It is the result of a collaborative process, with the person served being the leader of that process. It is not the end of Person Centered Planning. Person Centered Planning is a dynamic process. The ISP may be altered to reflect life changes such as health, support needs and personal desires. The QIDP is responsible for facilitating necessary meetings to make those changes.

Functions of the Individual Service Plan

It is a tool that provides direction and guidance to support staff.

- Tells the reader about who the person is, what he/she wants, and who is helping the person
- Synthesizes pertinent information from assessments
- Identifies expectations for service and support
- Benchmarks skills, strengths and progress

It is a tool that reflects an agency's compliance with regulatory standards. The information below reflects the ISP requirements for Rule 115 Standards and Licensure requirements for CILA.

- Completed within 30 days of admission
- Be reviewed annually
- Include measurable objectives
- Objectives must have target dates of completion
- Include a goal for daily living
- Include a goal for economic self-sufficiency
- Include a goal for community integration
- Goals must be based upon assessments
- Must reflect person's needs and desires/preferences
- Contain signature of individual or guardian
- Identify all persons (staff and otherwise) who contributed to the development of the plan including relationship to the individual, title and agency affiliation, if applicable
- Include names of all service providers
- Include names of person responsible for facilitating goals and objectives
- Must have corresponding monthly progress notes
- Signed by QIDP
- Reflect progress or regress on specified goals and objectives
- Reflect amount of supervision

You may choose to discuss other relevant regulations regarding ISPs here.

Parts of the Service Plan

Service plan formats vary widely but most contain the following information:

Personal Narrative -This section summarizes some or all of what was learned during the planning process and tells the reader about the person and his/her current needs and wants.

Medical/Dental/Nutritional- This section contains a summary of significant medical issues. This includes any medication the person takes and the reasons. There may be nutritional information mentioned here, as well.

Background/Historical- This is a summary of significant events that have happened in the individual's life. These events may be a clue as to what shaped who the person is today.

Social Relationships- Here is where details of the person's social life are outlined. Important people are mentioned, as well as, all types of relationships (e.g., family, friends, work, staff members). Sometimes we draw maps to show how these people are related. These show the connections between people graphically.

Goals/Objectives- This section identifies the areas targeted for learning. The information for this section is gathered through interviews, assessments, and on-going interactions with the person. Both short and long term goals are found here.

Interests and Activities- Discusses interests of the person outside of work and home responsibilities. Leisure activities, hobbies, sports, or just about any other interest can be listed in this section.

Personal Values- This section makes a statement about what is important to the person. This is useful to know because often we are motivated by what we value the most.

Risks/Safeguards – This section indicates potential concerns around risk to the individual and identifies safeguards that are needed to mitigate these risks.

Sources of Comfort and Discomfort- This section will outline what things provide comfort, as well as discomfort to the person. Further, as people grow and change, this area of the plan may have to undergo change. Again, you will learn much about the person as you interact with him/her.

Assessments- The results of assessments or tests may be included here; for example, medical, PT/OT, speech and language, etc.

Strengths and Needs- Discusses strengths to build upon as well as areas requiring support.

Vocation- This section will describe the kinds of work the individual likes to do or would like to do.

Education- A summary of the person's educational background as well educational goals.

Financial - This area discusses financial information about the person including sources of income and needs for the future.

Communication Style- The best way to communicate with the person would be spelled out here. People can and do communicate in a variety of ways and it is important for you to understand how to communicate with each person you will be working with.

Learning Style- How the person learns is outlined. This includes strategies you can use to work most effectively given the person's specific situation.

Personal Rights- Provides information about personal rights that are most important to the person. Also, what, if any, rights restrictions might be in place and details of the situation.

Recent Life Changes- Anything that has recently occurred in a person's life which may have an effect on his/her day-to-day functioning should be noted here. This is another area that would be updated continually.

Vision for the Future- Just as you have dreams and hopes for the future, so do people we support in our programs.

You may choose to discuss your agency's specific format here.

Individual Service Plan Meeting

It can be helpful to divide the tasks associated with the individual service plan meeting into three categories.

- Tasks that should be completed prior to the meeting, including assessments, meetings with the person and their significant others and planning the details of the meeting.
- Facilitating the meeting: The manner in which you facilitate the meeting will determine the quality of the experience for the individual.
- The QIDP is responsible for writing the ISP as well as coordinating implementation of the service plan.

Prior to the Meeting:

Assessments

Assessments are completed for a number of reasons including, evaluation of progress, understanding of regress, establishing strengths and/or limitations and regulatory requirements. Initial assessments are completed as part of the effort to better understand a person's needs and desires. Follow up assessments may be the result of identified need, best practices or regulatory requirement.

It is important to know and understand that the results of any one assessment are best understood in the context of other assessments. A psychological assessment alone will not provide you with a firm understanding of a person's level of functioning. A key role for the QIDP is to review and synthesize information across assessments in a manner that assists the person and their support team with creating a Person Centered Plan.

Through the selection of the assessment instruments and the interpretation of results, all assessments shall be sensitive to the individual's:

- Racial, ethnic and cultural background
- Chronological and developmental age
- Visual and auditory impairments
- Language preferences
- Degree of disability

Initial assessment for individuals with a developmental disability should include:

- **A physical and dental examination**, both within the past 12 months, including a medical history.

- Previous and current medication and the **level of ability to self-administer medications** or participate in a self-administration of medication training program.

- A **psycho-social assessment** including legal status, personal and family history, a history of mental disability and related services, evaluation of possible substance abuse, history

of trauma and resource availability such as income entitlements, health care benefits, subsidized housing and social services.

- An assessment with **form IL 462-1215, "Specific Level of Functioning Assessments and Physical Health Inventory," (SLOF)** for individuals with mental illness.

- **Inventory for Client and Agency Planning (ICAP)** (Riverside Publishing Co., 425 Spring Lake Drive, Itasca, Illinois 60143 (1986) or the Scales of Independent Behavior-Revised (SIB-R) (Riverside Publishing Co., 425 Spring Lake Drive, Itasca, Illinois 60143 (1996)) for individuals with a developmental disability.

- An **educational and/or vocational assessment** including level of education or specialized training, previous or current employment, and vocational skills, activities or interests.

- A **psychological and/or psychiatric assessment**; both must be conducted for individuals with both a mental illness and a developmental disability.

- A **communication screening** in vision, hearing, speech, language and sign language.

- **Others as required** by the individual's disability such as physical therapy, occupational therapy and activity therapy.

Discuss your agency's expectations with regard to the completion of assessments.

Assisting the Individual with Preparation

Meeting with the individual prior to the ISP meeting can and should be an important element of a meaningful and effective service planning. Both the QIDP and the person served benefit from taking time to prepare for the meeting.

Pre-meetings can help to:

- Ease nervousness
- Decide who should be invited
- Decide upon the time, location and structure of the meeting
- Develop an agenda for the meeting
- Review successes since the last meeting
- Decide upon priorities
- Set expectations
- Discuss and explain more complicated topics
- Prevent surprises

WHAT needs to be pursued and accomplished? This is the time to set priorities.

- What are the person's desired outcomes?
- What safeguards are needed? (safety issues/ health issues?)
- What clinical assessments are needed, if any?
- What community inclusions strategies should be in place?
- What obstacles need to be overcome?

WHO will help the person accomplish these goals?

- What networks or services are already in place?
- Consider new opportunities and ideas discovered during planning.
- Consider replacing existing supports and services that may not work for the person anymore.

Participants

Having the right people involved in the planning process is key. The size of the group should be comfortable for the individual. At times, the facilitator may need to keep the number of participants to a minimal level. In this situation, input from outside the planning meeting could be sought; a series of meetings could be scheduled; or small group pre-meetings may be held.

At a minimum, the ISP meeting must include:

- The individual receiving services (and guardian, if applicable)
- The QIDP
- The Independent Service Coordination (ISC) representative

In addition, the ISP meeting may include:

- People who know the person best (caregivers, friends)
- Other family members
- Other people providing supports and services (nurse, social worker, psychologist, nutritionist, occupational therapist, etc.)
- Friends
- Employers
- Church/synagogue members

HOW will it be accomplished? What action steps are needed?

- Consider how outcomes and other additional assistance will be pursued
- Acknowledge any barriers or obstacles
- What additional assistance does the person need help with? (for example, pain management, transportation, etc.)

WHEN will it be accomplished? This is a timeframe for a specific action. Do not confuse this timeframe with the duration of the Service Plan (which is usually ongoing).
For example, will it be accomplished in the next 6 months? Next month? Be sure to use a specific date.

Ask the person and family/advocate to prioritize what needs to be pursued or accomplished. Priorities could be sorted into high, medium, and low priority categories. Then, ask for the group's input. Record the priorities and the discussion.

Location, Date and Time

ISP meetings should be scheduled with consideration to a number of factors:

- The meeting date and time should be set so the person, family, and other key members can attend.
- The meeting place should be accessible and comfortable for the individual and his/her family so people feel free to speak. Consider any special accommodations that may be needed.
- Meeting schedules should be set far enough in advance to give members ample time to make necessary plans and to prepare for the meeting.

Facilitating the Meeting

As a professional providing service, the QIDP not only facilitates the meeting, but also advocates for the person. Balancing these roles is a complex task and the QIDP should be prepared for the contribution he/she will make by:

- Completing or Requesting new or updated clinical evaluations as needed (social work, psychosocial, nursing, psychological, physical, speech, hearing, speech, hearing, occupational therapy, physical therapy, psychiatric, neurological, recreational, educational, and other types of assessments and evaluations)
- Reviewing the previous ISP for possible changes
- Reviewing the progress notes for significant changes or discoveries since the last meeting
- Searching for new information that will impact discussions and decisions at the meeting
- Making arrangements for any special accommodations, such as interpreters

Be sure to have all the tools you will need to conduct the meeting, which may include such things as:

- Necessary reports and other written information
- Copies of last ISP with attachments
- Comfortable chairs in an arrangement that encourages participation by all

To set the stage for a comfortable and successful meeting:

- Provide coffee/juice/water/snack
- Suggest that the person served sit by the person that they are most comfortable with
- Provide an agenda
- Introduce everyone and allow for a bit of conversation prior to starting

Although each meeting has a different purpose and agenda, they all have the same basic structure. Each has a beginning, middle, and end. At the beginning, you set the tone and direction; you create roles and ground rules to guide participant behavior. In the middle, you discuss the agenda and at the end, you confirm agreement regarding necessary actions. Recognizing your role as both leader and facilitator will assist in maximizing the productivity and experience of the meeting for everyone.

Much of the 'skill' in facilitating comes from the facilitator's knowledge, approach, personality, experience, beliefs, values, attitudes, skills, habits and personal expectations. Good facilitators are always learning and looking to improve certain qualities and characteristics within themselves.

During the meeting consider the following:

- Open ended questions will create more dialogue than simple yes/no questions
- Encourage the participant to contribute as much as they can
- Allow for time for the participant to gather thoughts
- Guide discussion to stay on topic

Strategies for Involving People in their Meetings

There are times, despite the best intentions of keeping the meeting focused on the person, when the person seems to feel like a bystander. This feeling may also be shared by the person's family or advocate when service providers talk in technical terms or global issues. The person may have cognitive limitations or learning disabilities that affect their receptive or expressive language abilities. Regardless of the person's abilities, there are some general strategies for involving people in their meetings.

- Look at the person frequently
- Address the person by name
- Ask the person questions
- Refocus questions inappropriately directed towards others
- Do not allow the group to hold third person conversations about the individual (as if the individual is not there)
- Consider a break if needed

The person who is the focus of planning and is physically unable to speak presents a unique challenge. Because the person is unable to verbally participate in the ISP meeting, it is important for the group to take the time and energy to understand the true desires and preferences of the person.

Find a way the person could possibly communicate (e.g. through some varied type of yes/no response mode, a system for pointing or looking at pictures or representations of preferred activities or choices). Allocate time for sharing experiences with the person to gain some perspective on the subtleties of how this person communicates his or her likes and dislikes, pleasures and pains, and other forms of preference-related concepts. Use strategies for seeking

the input of close friends and family members who have known the person for a long time and who already possess some firsthand knowledge of the person's preferences and desires.

Creative ISP Meetings

Break into small groups. Discuss creative alternatives to the traditional service plan meeting scenarios in the left column.

Traditional Meeting	Creative Alternative
Location: Agency conference room	
QIDP sits at the "head" of the table	
QIDP starts the meeting and introduces everyone	
Discussion focuses on assessment results	

Writing Goals and Objectives

"The height of an intellectually disabled person's level of functioning is determined by the availability of training technology and the amount of resources society is willing to allocate and not by significant limitations in biological potential." -Marc Gold, The Principles and Practices of Universal Enhancement, Tom Pomeranz.

Discuss the implications of the statement above.

Planning for the future involves setting valued outcomes/goals. The goal is based on the person's needs, and should be written without regard to the availability of services. The goal statement is an expectation of what the person will accomplish. Goals are written in a positive manner.

The following questions are helpful when discussing potential goals:

1. How will this person's life be better as a result of this goal?
2. Is it something the person and/or guardian wants?
3. Will it increase the number of places and people in the person's life?
4. How does this goal add meaning to this person's life?
5. It is chronologically age appropriate? (young adult, middle age, retirement)
6. It is functional for the person's quality of life and will there be opportunities to practice?
7. Will it enhance the person's physical condition?
8. Will it result in increased skill?
9. Will it yield status enhancement?
10. Acquisition Probability: Do the long range benefits of this goal warrant the time investment now?

Learning Objectives

Learning Objectives are defined as behavior/skill acquisition or change on the part of the person for whom the plan is written. Learning Objectives were previously referred to as "behavioral," "teaching," or "training" objectives that assist the person in achieving their overall goals. A learning objective is an attempt to clearly define the criteria for successful completion of a skill. Objectives are measurable intermediate steps between the person's present level of performance and the desired level as stated in the goal.

Well written Behavioral Objectives are:

- Sequential
- Relate directly to a goal
- For skill acquisition
- Measurable
- Singularly stated

When writing a behavioral objective it should be composed of the following five elements.

- Conditions
- Person
- Behavior
- Performance Criteria
- Timeline

Conditions – Describes the things that have happened or are required to happen or circumstances required to carry out the program. Example: "When checking out at the grocery store . . ."

Person – Use the individual's name, not nickname, not "he" "she" or "you"

Behavior- Specify <u>one</u> behavior in measurable and observable terms. The behavior should be overt (sensed through one of the senses and able to be measured), not covert. Look at some differences between these terms:

COVERT	**OVERT**
Distinguish	Draw
Conclude	Fill in
Concentrate	Underline
Think	Repeat out loud
Recognize	Point to
Be aware	Walk
Infer	Count out loud

Performance Criterion – Describes the degree to which the person will complete the task satisfactorily. It is important to note here that nobody holds themselves to the standard of perfect 100% of the time. The key here is to choose objectives that uniquely fit the person's desires and to measure them using criteria that are both appropriate to the person and to the task.

- How many—i.e., the number of responses; ex.: "will cook spaghetti for her family 2 times"
- How often--# of responses that are time-related; ex.: "will awaken to his alarm Monday through Friday."
- How well—to what degree or at what level of accuracy; ex. "will record the name, telephone number, and time when taking telephone messages..."

Timeline - The timeline is the date by which the performance criteria should be achieved. The timeline date must always include month, date and year.

Consider the following objective:
John will walk from his apartment to work without assistance in less than 15 minutes, without breaking any safety rules, for 10 consecutive working mornings.

Discuss the following:

What is the observable behavior?
How well will John need to complete the behavior?
How many times will John have to successfully complete the behavior?
Are there any particular conditions or given circumstances required and if so what are they?
How will it be measured and/or recorded? By whom?

Writing Learning Objectives

Use the 5 elements of behavioral objectives to create strong, one sentence objectives for each of the following behaviors.

Behavior	Learning Objective
John cleans.	
Sophie brushes her teeth.	
Greg does laundry.	
Cynthia knows her meds.	
Richard goes to the library.	
Aubrey pays the cashier.	
Doug makes his bed.	
Gina makes dinner.	
Eddie goes grocery shopping.	

Plan Implementation

At least monthly…

The QIDP must review the services plan and document that:

- Services are being implemented as identified in the service plan.
- The person is or is not making progress.
- Services continue to meet the individual's needs or need modification.
- Actions are recommended and implemented when needed.

Annual Reassessments

Annual reassessments for individuals with an intellectual/developmental disability include:

- A physical and dental examination including a review of medications.
- The Specific Level of Functioning (SLOF) for individuals with a mental illness or Inventory for Client and Agency Planning (ICAP) or Scales of Independent Behavior (SIB) for individuals with a developmental disability.
- An annual psychiatric examination for individuals with a mental illness.
- A risk assessment that evaluates potential risks to the health, safety and welfare of the person served as well as relevant strategies/safeguards to mitigate those risks.

Need for modifications to ISP

Recognizing that life circumstances change there will be occasions when the individual service plan no longer captures the needs of the person. When this occurs revision to the plan can be made. Revisions can only be made to a service plan through a team meeting. Changes may be made by attaching an addendum to the ISP. Addendums are filed with the current ISP and distributed to all appropriate parties.

The addendum must:

- Be dated
- Be approved in writing by the participant or guardian, if appointed
- Be approved in writing by the responsible waiver QIDP
- Be approved, in writing, by the participant's Independent Service Coordination (ISC) representative

Learning and Teaching

For many years the classic learning theory concepts and techniques of successive approximations, chaining and backward chaining have been the cornerstone of teaching people with intellectual and developmental disabilities. In recent years, total task teaching has gained professional preference. The primary difference is that in chaining the learner is only assisted with the "step" of the task they are learning and with total task the learner is assisted through the entire task. The clear advantage of total task is that all parts of the task are completed, "rehearsed", each time the task is completed.

Learning Modalities are the sensory channels or pathways through which individuals give, receive, and store information. Everyone has a mix of learning styles. Some might find they

have a dominate style of learning, while others use different styles in different circumstances. People with autism learn and communicate best using visuals. Teaching new skills to individuals with developmental disabilities takes time, patience, and persistence. The key is to recognize and understand what techniques best suit individuals served to ensure quality of learning. The same applies when teaching support staff. Understanding that people learn through different senses can help you set the stage for engagement and learning by creating supports that maximize interest and curiosity.

Consider the Following Information about Learning Styles

- Visual learners learn best by seeing and watching
    - Looking at pictures
    - Watching videos
    - Reading
    - Using flashcards
    - Writing on the board
    - Looking at charts or diagrams
- Auditory learners learn best by listening, hearing, and speaking
    - Listening to lecture
    - Joining discussion groups
    - Reading out loud
    - Repeating what they are learning
    - Asking a lot of questions
        - Getting verbal reinforcement
- Tactile/kinesthetic learners learn best by moving, experiencing, doing, and touching.
    - Drawing
    - Building or creating
    - Touching materials
    - Doing physical activities
    - Role-playing
    - Going on field trips

Recommended Reading & Resources

Although we will try to cover a great deal of material with you today in class, the topic of Person Centered Planning is a broad one that requires continued study and attention throughout your career. We recommend the following resources as good places to start with regard to furthering your knowledge and understanding of this important topic.

- A Little Book About Person Centered Planning, Volume I by *John O'Brien and Connie Lyle O'Brien*
- Implementing Person Centered Planning: Voices of Experience, Volume II by *John O'Brien and Connie Lyle O'Brien*
- Innovating for People: Human-Centered Design Planning Cards by LUMA Institute
- Person Centered Planning by Don Kincaid (As found in Positive Behavioral Support: Including People with Difficult Behaviors in the Community by *Dunlap, L.K. Koegel, and R.L. Koegel*
- Person Centered Planning: Helping People with Disabilities Achieve Person Outcomes by *Mary Mercer*
- The Principles and Practices of Universal Enhancement, 4-Volume Set by *Thomas E. Pomeranz, Ed.D.*
- Service and Support Agreements: The Foundation for Futures Planning by *Art Dykstra*
- Person Centered Planning Education Site, *Cornell University* http://www.personcenteredplanning.org/index.cfm