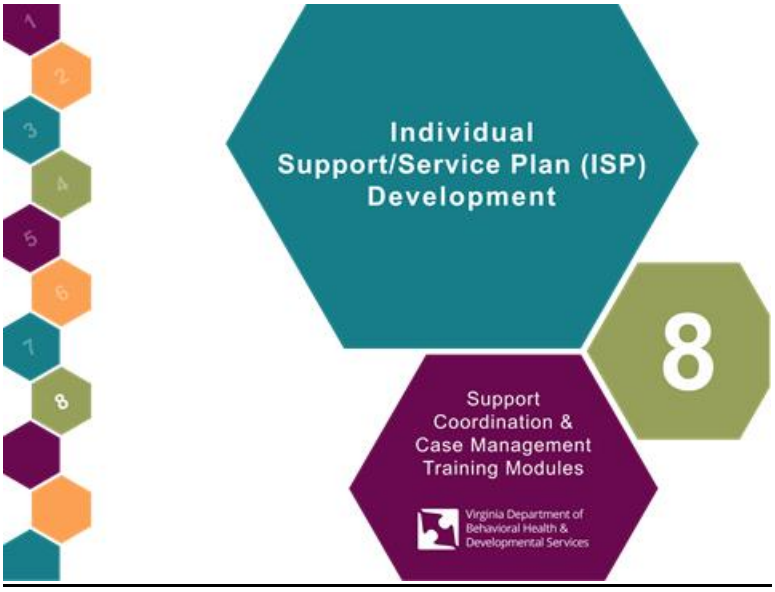
Slide 1



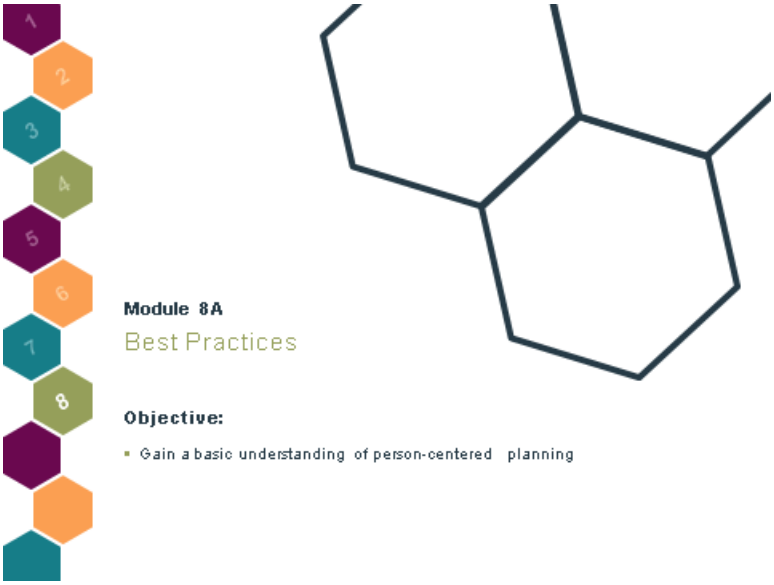
Welcome to Module 8 of DBHDS Support Coordination/Case Management training. This module will cover the Support Coordinator's/Case Manager's role in developing the Individual Support/Service Plan (ISP).

Slide 2

Module 8 is divided into three sections.

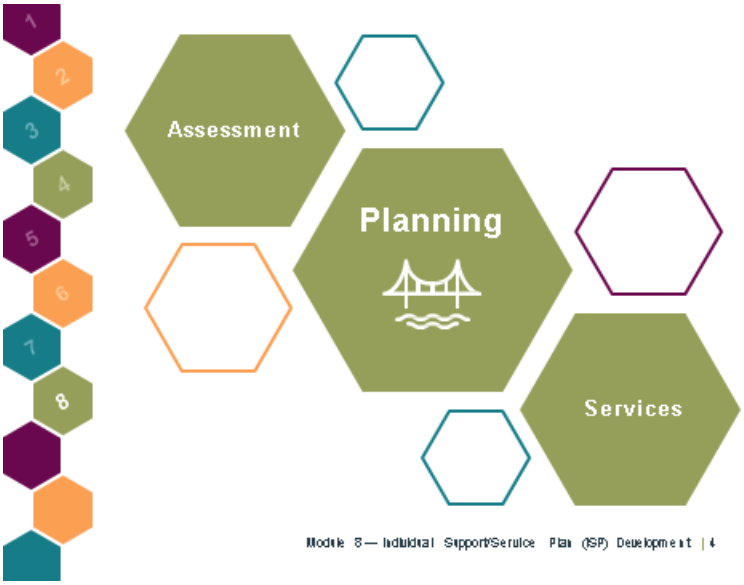
- Section 8a looks at best practices in planning.
- Section 8b reviews the structure of the ISP, the process of its development and ongoing review.
- Section 8c reviews the importance of documentation.

Slide 3



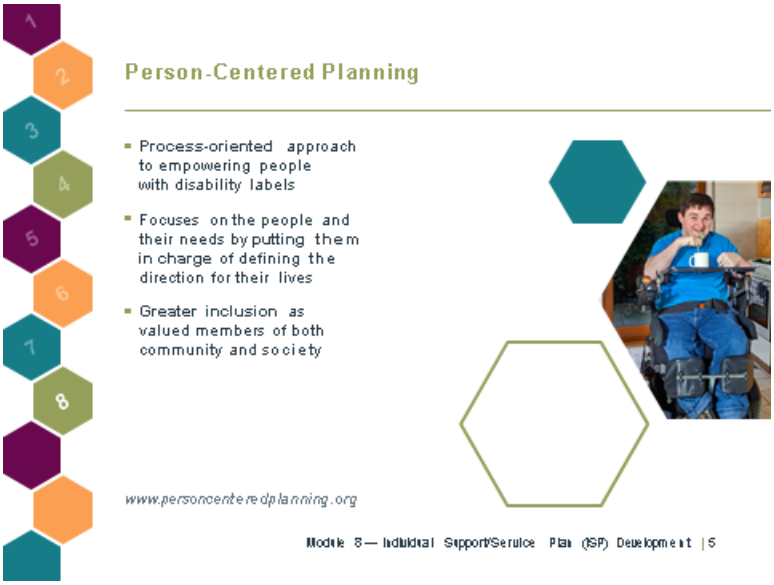
The objective of the Section 8a of Module 8 is to gain a basic understanding of person centered planning.

Slide 4



Planning is the bridge between the assessment and the services to be provided. The assessment process developed an understanding of the person's needs and the resources available. The planning process then translates the assessment information into desired goals/outcomes and the means to reach them.

Slide 5



It is well recognized in the helping professions that using a person centered approach when planning with people is best practice. Person centered planning is a process-oriented approach to empowering people with disabilities. It focuses on the people and their needs by putting them in charge of defining the direction for their lives, not on the systems that may or may not be available to serve them. This ultimately leads to greater inclusion as valued members of both community and society.

The link provided gives additional information about planning from the Cornell University Person Centered Planning Education Site. The link is also listed in the material section of this module.

Slide 6

Person centered planning results in the formulation of an Individual Support/Service Plan. The ISP is to help people achieve better lives. It is not about creating better paper.

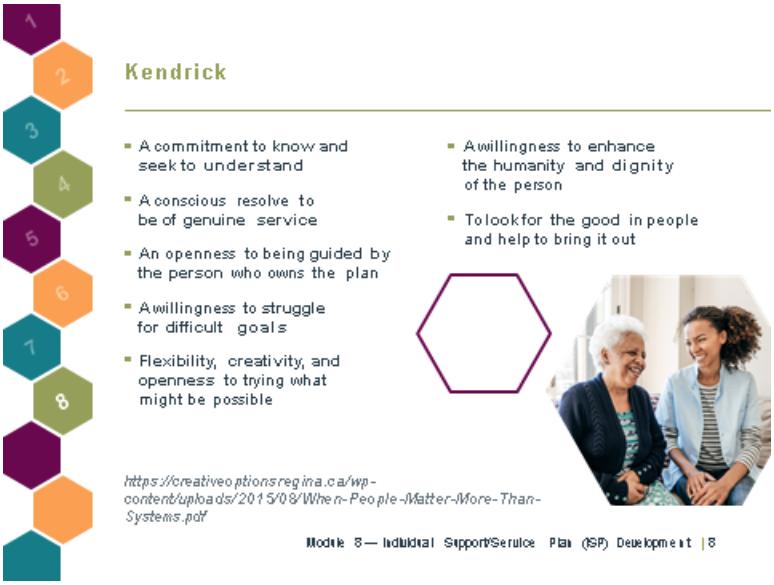
Slide 7

The basis of person centered planning recognizes that:

- the person at the focus of planning, and those who love them, are the primary authorities on the person's life direction; and
- it also believes that the purpose of person centered planning is learning through a shared collaborative process.

People who engage in person centered planning must typically produce documentation of their meetings. But these are only the footprints. The path is made by people walking together.

Slide 8

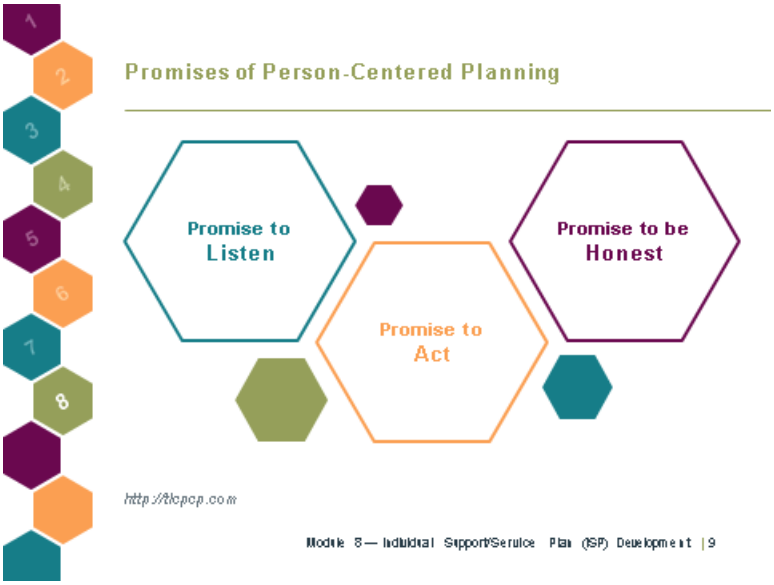


In his keynote presentation for the conference "The Promise of Opportunity", March 2000, Michael Kendrick says that person centered work begins *within* each of those involved in the plan and includes

- a commitment to know and seek to understand;
- a conscious resolve to be of genuine service;
- an openness to being guided by the person who owns the plan;
- a willingness to struggle for difficult goals;
- flexibility, creativity, and openness to trying what might be possible;
- a willingness to enhance the humanity and dignity of the person; and
- to look for the good in people and help to bring it out.

Kendrick's full presentation may be found at the link provided. The link is also listed in the material section of this module.

Slide 9



According to the International Learning Community for Person Centered Practices, there are inherent promises in the person centered planning process.

They are:

- a promise to listen to what is being said and to what is meant by what is being said and to keep listening;
- a promise to act on what is heard and to always find something that can be done today or tomorrow, to keep acting on what is heard; and
- a promise to be honest. At times this may include letting someone know when what they want may take time. It may include situations when the Support Coordinator/Case Manager does not know how to help them get what they are asking for. It may include situations in which what the person is telling the Support Coordinator/Case Manager is in conflict with staying healthy or safe and together the person and Support Coordinator/Case Manager cannot find a good balance between what is 'important to' and what is 'important for' the person.

The link provided is for the International Learning Community for Person Centered Practices. The link is also listed in the material section of this module.

Slide 10

The Support Coordinator/Case Manager plays a significant role in planning with and supporting a person in meeting their goals/outcomes in achieving their definition of a good life. It is important to remember that the type of support needed by someone is unique to that person. Because someone needs guidance in one area of their life, say managing finances, does not mean they need assistance in all aspects of their life.

Some types of support improve a situation. For example, Joshua, who lives in a group home, does not get along with his roommates and dislikes living with 3 other people. The Support Coordinator/Case Manager introduces him to several more independent living options that might suit his preferences better and works with Joshua through the decision making process of choosing a new living arrangement.

Some situations cannot be prevented or improved. In situations like these, support is more about comfort. Knowing more about a person's comfort rituals is very useful. For example, Keisha hates missing work as it causes her a great deal of anxiety. At times due to snowy conditions, it is just not possible to go into the work site. The circumstance cannot be changed, but knowing what comforts, assures, calms Keisha is important when she experiences weather related time off from work.

Slide 11

The person with whom a plan is being developed is always at the center of the planning process. The degree of their involvement depends on their desire to participate, along with the extent to which they are able to participate. When planning with someone, it is best to bring together a group of people that want to contribute their time and talents because they know and care about someone and want to help them identify and achieve their goals. The team should consist of content experts and process experts. People using developmental disabilities services are more likely to use planning teams than those using behavioral health services.

Slide 12

Content experts provide the information that goes into a plan and include:

- the person using services;
- family, friends, service providers and others who know the person well and believes in their vision;
- people who are chosen to participate by the plan owner;
- people that have a good relationship with the person; and
- people who understand what is important to the person especially if that person does not use words to communicate and needs someone to speak on their behalf.

Process experts are those who facilitate meaningful conversations, ensure that the person who owns the plan remains in charge as learning takes place, know how to develop a person centered description and plan and may include:

- the Support Coordinator/Case Manager; and
- anyone trained in how to gather information and organize it into a description and plan

Slide 13

Having conversations is the primary mechanism used in planning and often it is the Support Coordinator/Case Manager who facilitates these conversations. It is important to know that gathering and sharing information from people who know a person well, professionally or personally, may be done outside of a meeting as long as it is done with a signed authorization for disclosure or release of information.

Slide 14

In the process of gathering and sharing information, the Support Coordinator/Case Manager:

- puts the person and their gifts, talents, goals, preferences, needs and choices in the center of the planning process;
- recognizes gifts and talents;
- helps people find and use their voices to state what is truly important to them and for them;
- looks to the future and helps the person plan for positive outcomes;
- uses active listening;
- translates the person's vision for a better or different life into action plans; and
- helps the person achieve a life enriched by community connections and opportunities to contribute.

Slide 15

The staff attending the Person Centered Thinking training were skeptical at best and at least one of them said "I am not really sure why I am here". Over the two days of training, the participants talked on several occasions about a woman they were supporting in a group home; a woman with an extensive psychiatric and criminal history and for whom they just "couldn't figure it out" and "couldn't get it right". Nothing they did seemed to work and they were all feeling very frustrated with how to move forward. They literally described this woman as "the most difficult person" in the group home.

The trainers asked, and captured in writing, "What do you like and admire about this lady? What rituals do you think you can honor? What would a good day look like? What do you think is working and not working?" …

Slide 16

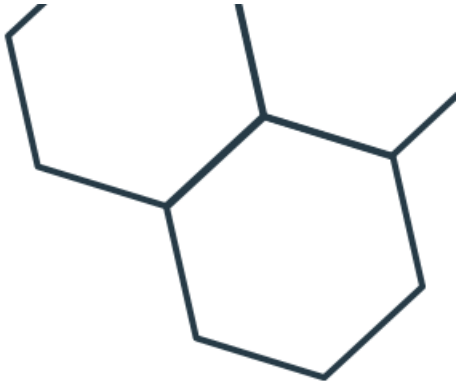
… At the end of the two days, one of the staff from the unit took all the written notes with him. He decided to see what would happen if he brought the group home staff together along with the woman and shared what they had done.

Her response was to say, “I didn’t realize how much you were all listening to me. I didn’t realize how much you cared. No one has ever taken the time to listen this much to me and to try and help me”.

As the staff person later described it, “We have not had a single incident or problem with this lady since then on our shift. We have begun to use person centered tools with other people and it’s working!”

Virginia regularly offers a two-day Person Centered Thinking training in all parts of the state. Person Centered Thinking (PCT) is made up of a set of value based skills that result in getting to know a person and acting on what is learned. The link provided gives additional information about PCT and a schedule of trainings may be found there. The link is also listed in the material section of this module.

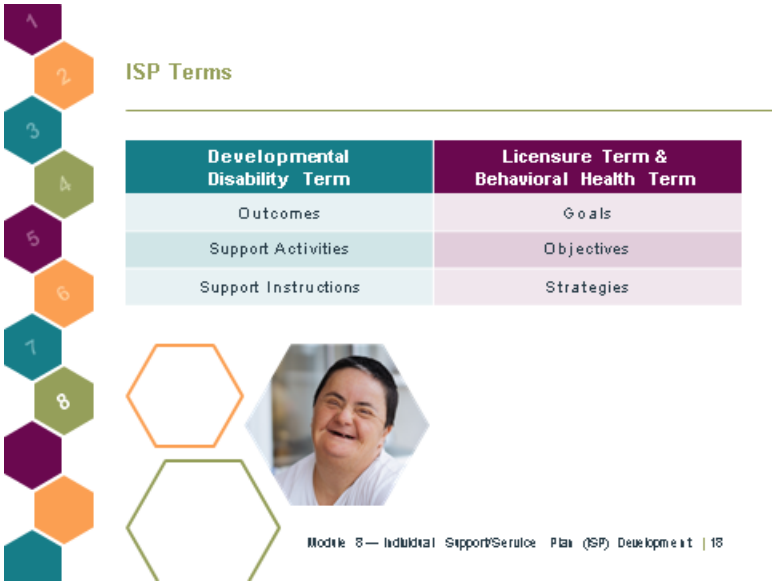
Slide 17



Section 8b takes a look at developing:

- outcomes/goals;
- support activities/objectives; and
- support instructions/strategies.

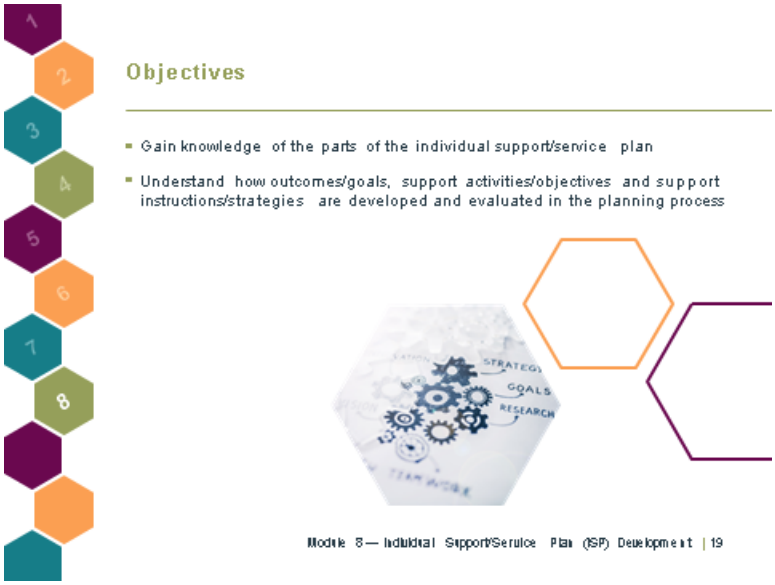
Slide 18



Throughout this section the terms used to describe the different parts of the ISP will reflect the terms used by developmental disabilities services as well as the terms used by licensure and behavioral health services. The terms on this slide will be combined throughout this section of the module.

- Outcomes will also be referred to as goals.
- Support activities will also be referred to as objectives.
- Support instructions will also be referred to as strategies.

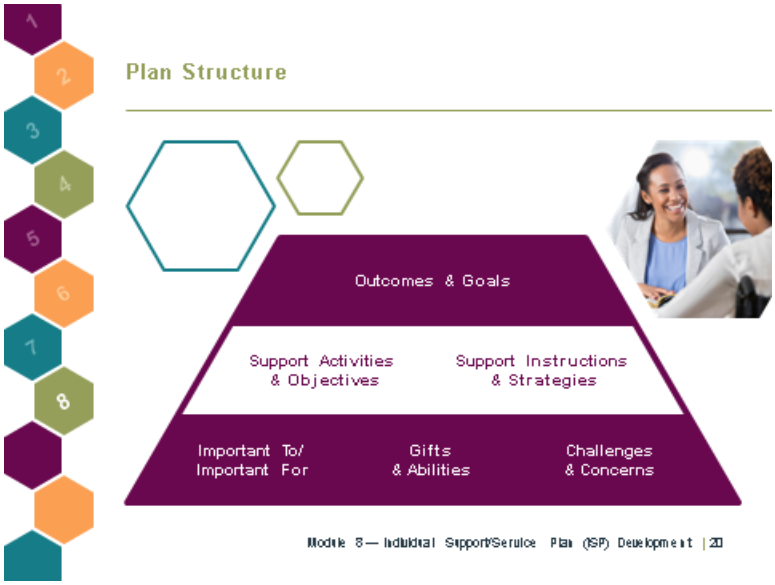
Slide 19



The objectives of Section 8b are to:

- gain knowledge of the parts of the ISP; and
- understand how outcomes/goals, support activities/objectives and support instructions/strategies are developed and evaluated in the planning process.

Slide 20



The ISP translates the assessment information into desired outcomes/goals and the means to reach them by identifying support activities/objectives and support instructions/strategies, including, people and resources, tasks and time frames.

Slide 21

To meet current licensing requirements:

- An initial ISP is developed and implemented within 24 hours of admission to behavioral health or developmental disabilities services. The initial ISP addresses immediate service, health and safety needs.
- A more fully developed, comprehensive ISP is completed as soon as possible thereafter, but no later than:
    - 30 days after admission to mental health and substance abuse services or
    - 60 days after admission to developmental disabilities services.
- The Support Coordinator/Case Manager documents discussion of the ISP development and addresses the proposed services to be delivered, and alternative services with potential risks or benefits.

Slide 22

The steps of the planning process that the person who uses services, their loved ones, providers and supporters along with the Support Coordinator/Case Manager engage in are:

- review the assessment;
- gather supporters and service providers, if applicable;
- identify outcomes/goals;
- formulate support activities and measurable objectives;
- document support instructions and strategies; and
- include a timeline for completion.

Slide 23

The first step in developing the plan is to review the information gathered in the assessments. Some questions to guide this review might be:

- What things are important to the person?
- What is important for the person?
- Which needs and challenges are present in the person's life?
- What are the person's identified and potential risks?
- Which personal preferences are most important?
- What strengths and talents are identified in the assessment?
- How can the person's abilities be built upon in the planning process?
- What are the person's dreams and goals? What motivates them?
- What are the natural supports?

Slide 24

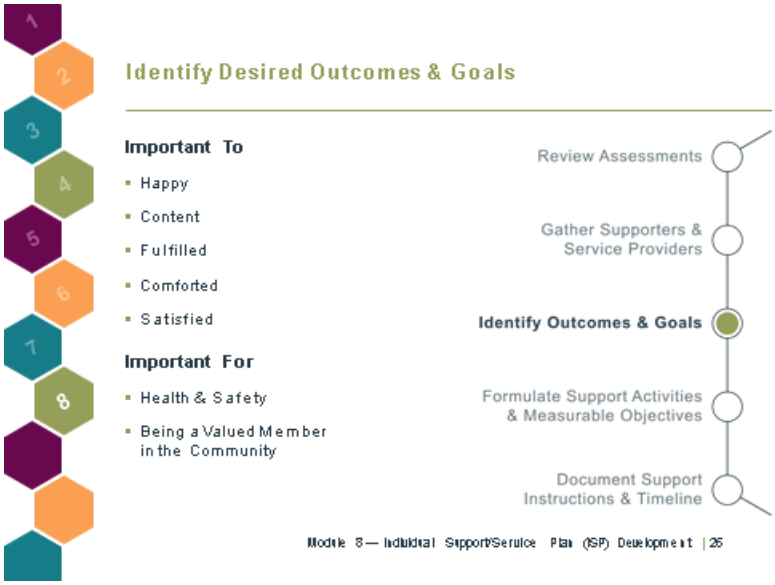
The plan must document how resources, services and natural supports can be utilized to assist the person in achieving their life dreams & goals. The Support Coordinator/Case Manager needs to bring all the necessary people into the planning process with the person. The Support Coordinator/Case Manager can help identify the team member's roles and how each will be involved in implementing the support/service plan.

Slide 25

Next, the person using services along with the team need to identify desired outcomes/goals. Outcomes/goals are the long term, global and broadly stated things the person hopes to achieve. They are person centered and expressed in the person's own words. They are attainable, realistic and written in positive terms. They are built upon abilities, strengths and preferences.

The Support Coordinator/Case Manager solicits and helps write clear statements, as expressed by the person using services. The Support Coordinator/Case Manager seeks to empower and support the person in defining the direction of their life.

Slide 26



Keep in mind all the team has learned about what is 'important to' and 'important for' the person.

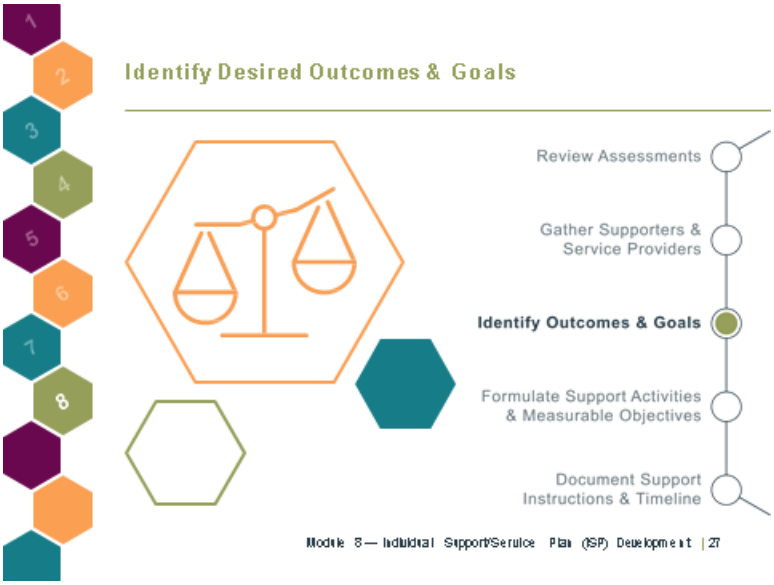
Remember 'important to' are all those things that help a person feel happy, content, fulfilled, comforted and satisfied. When present in one's life, these things contribute to having a good day. They may include:

- daily routines;
- people to be with;
- things to do or have;
- family or pets to care for; and
- hobbies and interests.
-

'Important for' includes things that help someone stay healthy and safe and help a person be a valued member of their community. They may include:

- losing weight;
- having a safe home;
- taking medications as prescribed;
- earning enough money;
- maintaining appropriate distance from someone while talking;
- wearing clothes that others would wear in a certain situation or environment.

Slide 27



Be sure to guide the team in seeing that there is a good balance between what's 'important to' and what's 'important for' in the person's outcomes/goals. Is what is 'important for' the person being addressed in the context of what is 'important to' the person? What needs to stay the same, be maintained or enhanced for the person? What needs to change for the person?

Slide 28

In addition to providing a road map for the services, outcome/goal statements also:

- ensure that the Support Coordinator/Case Manager and the person are in agreement about the goals of the services;
- provide focus to the process so that everyone involved can work towards the same outcomes;
- facilitate the development of specific strategies to reach the goals;
- assist the Support Coordinator/Case Manager and person to monitor progress; and
- serve as the criteria for evaluating the effectiveness of the services.

Slide 29

Support activities/objectives are near-term actions the person will take to work towards a desired outcome/goal. They divide large desired outcomes/goals into manageable tasks, provide time frames for assessing progress and build on strengths, resources and preferences. Once a person's desired outcomes/goals are identified, support activities/objectives need to be developed that will support the person in achieving the outcomes/goals. How does the person want to work towards their outcomes/goals? Support activities/objectives are steps that help move the person toward the outcome/goal.

Support activities/objectives identify:
The role of the person and others in implementing the ISP;
"Sally will tell her Support Coordinator/Case Manager if she feels negative side effects from the medication."

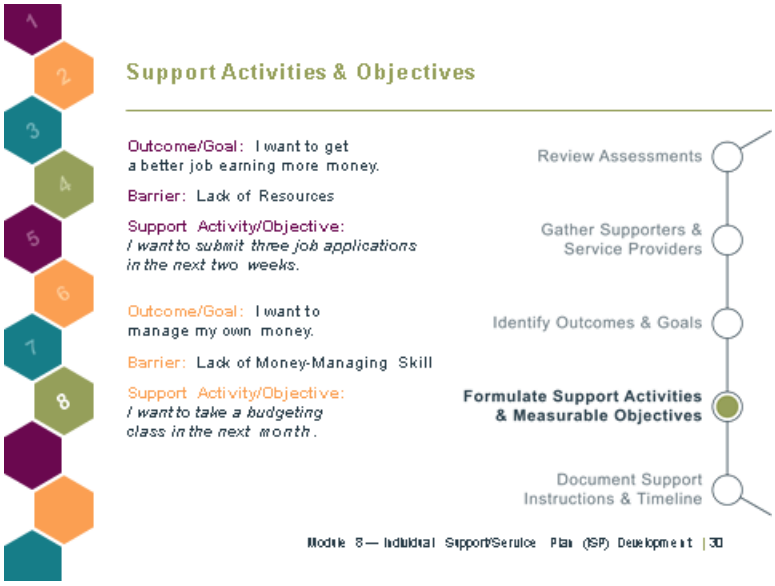
Target dates for accomplishment of the support activity/objective;
"Jose will move to an apartment by February 1, 2019."

Frequency and duration of the supports and services to be provided.
"*The Support Coordinator/Case Manager will meet with Devon in his home once a month for six months."*

Activities/objectives need to be:

- observable;
- measurable;
- achievable;
- concrete;
- specific; and
- have a time frame of when it will be done.

Slide 30



The outcome/goal is where one wants to be. The support activities/objectives are the steps needed to take to get there and they address barriers that keep people from reaching their goals:

An example of an outcome/goal might be:

"I want to get a better job earning more money."
A barrier is a lack of resources.

One support activity/objective toward this outcome might be:
"I want to submit at least three job applications by June 30 2018."

Another example of an outcome/goal might be:
"I want to manage my own money."

A barrier is a lack of money-managing skill.
A support activity/objective might be:
"I will to take a budgeting class in the next month."

Slide 31

Avoid writing support activities/objectives that:

- focus on what staff or natural supports will do;
- are vague and not measurable;
- are not specific to the person's strengths and needs;
- do not directly contribute to the desired outcome/goal;
- repeat the same actions for other outcomes/goals; and
- simply reflect participation in routine activity.

Slide 32

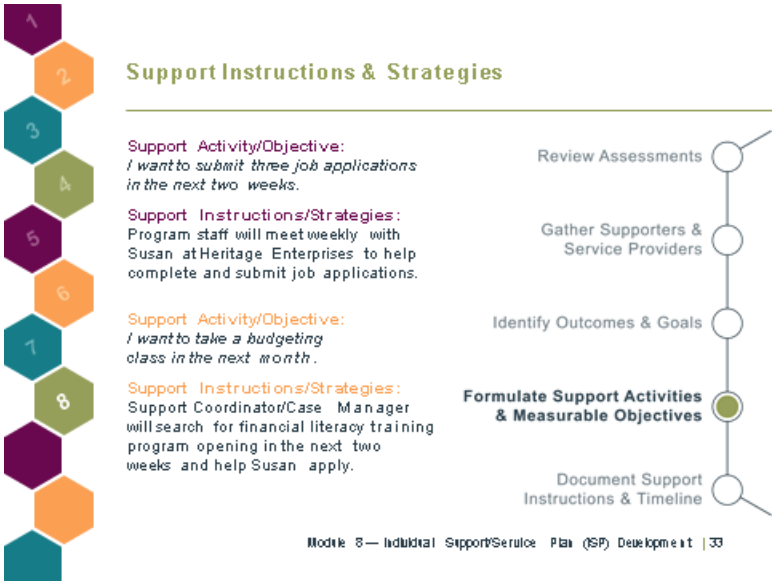
Once support activities/objectives are identified, the support instructions/strategies list the services and supports to be completed by service providers and natural supports to help the person meet the support activities/objectives and the outcomes/goals.

This includes not only the Support Coordinator/Case Manager's role but other relevant developmental, mental health, substance use, medical, rehabilitation, training and nursing services and natural supports as indicated by the assessment and to support billing.

Support instructions/strategies will identify:

- who will be the service provider or person who will provide support;
- what the service type will be;
- the frequency, duration, and intensity of the service or support; and
- the purpose, intent and desired impact of the service or support.

Slide 33



Support instructions/strategies are the tasks that staff and other supporters will complete to help the person meet their outcomes.

An example of a support activity/objective might be:
"I want to submit at least three job applications by January 14, 2019."

A support instruction/strategy could be:
Program staff will meet weekly with Susan at Heritage Enterprises to help complete and submit job applications.

Another example of a support activity/objective might be:
"I want to take a budgeting class in the next month."

A support instruction/strategy could be:
Support Coordinator/Case Manager will search for financial literacy training program openings in the next two weeks and help Susan apply.

Slide 34

Avoid writing support instructions/strategies that:

- identify the frequency of tasks without duration;
- identify the duration of time without the frequency;
- have staff doing too little to accommodate or address the person's challenges or obstacles;
- have staff doing tasks that the person can do on their own.

Slide 35

The final step in developing the ISP is to jointly decide how progress will be measured and recorded.

Measurement involves clearly defining the outcome/goal and support activities/objectives and their target dates. It clarifies how to know if progress is being made by noting the date it was achieved, changed, or deleted.

Slide 36

ISPs for some people may also need to include plans for additional supports, such as:

- communication supports for people with communication barriers, including language barriers;
- behavioral supports;
- safety issues that include identified risks to the person or to others, including a fall risk plan;
- crisis or relapse strategies that identify the signs of a crisis or relapse and what should be done; and
- recovery plans.

Slide 37

Advance directives are another aspect of a good support/service plan. Advance directives are legal documents that convey someone's decisions about future health care. It gives directions about the person's care *ahead of time*, so that later, even *after* they may be found incapable of making informed decisions about care, their directions from the advance directive will be followed by health care providers.

The link provided gives additional information about advanced directives in Virginia. The link is also listed in the material section of this module.

Slide 38

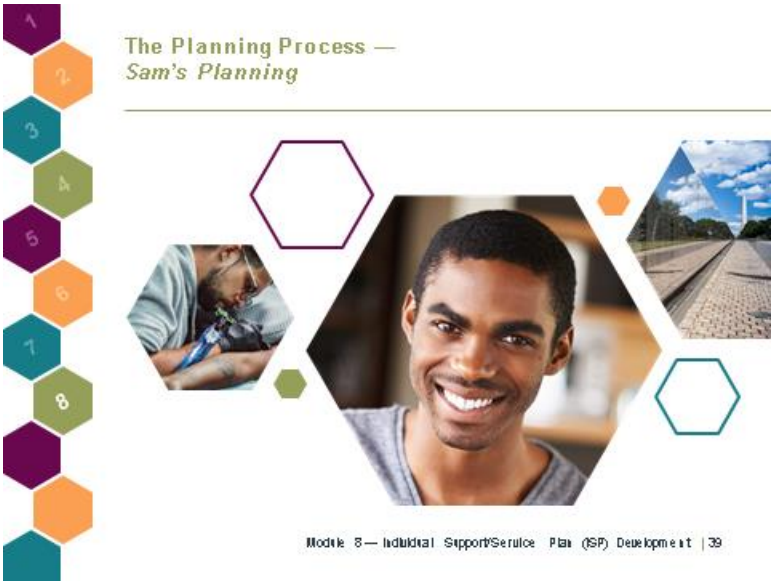
Advanced directives are important because they help:

- increase empowerment and self-determination;
- promote engagement and trust; and
- reduce the need for coercion during a crisis.

Any adult capable of making an informed decision may make a written advanced directive to:

- specify health care they do or do not want to authorize; and
- appoint an agent to make health care decisions in the event they are incapacitated.

Slide 39



Remember Sam from Module 1? As a new Support Coordinator/Case Manager, Jill had been learning more about Sam. She found out that his family including his mother, aunts and uncles were close & were supportive relationships in his life, and that he had a particular interest in the Vietnam War and in tattoos. Jill recognized that he had strengths that include survival skills, that he was good with his hands, that he had previous work experience, and interest in getting a job. She also detected some immediate challenges including finding alternate housing, assessing his daily living skills and a possible need for residential supports, and maintaining the temporary living situation with his mother.

Slide 40

Remember Mary from Module 1? As a Support Coordinator/Case Manager, Rebekah realized that Mary was not happy when her previous Support Coordinator/Case Manager left the agency. She spent time reviewing Mary's chart and visiting with her at her group home in order to get to know more about her. She learned that Mary enjoyed going to church, loved animals and being outdoors. Rebekah recognized that Mary had many strengths including a great personality, a supportive mother and a strong desire to express herself. She also acknowledged some immediate challenges such as the need to find ways to communicate her wants and needs, and a need to address her sadness because she missed her parents.

Slide 41

As stated earlier, outcomes/goals are the long term, global and broadly stated things the person hopes to achieve. They are person centered and expressed in the person's own words.

Sam had the broad outcomes/goals to live on his own and to find a job.

Two of Mary's outcomes/goals were to be understood better and to go to church regularly.

Slide 42

Support activities/objectives are near-term actions the person will take to work towards a desired outcome/goal.

To work towards Sam's outcome/goal "to move into my own place in one month" and address his need to develop independent living skills, Jill and Sam agreed to include the following support activities/objectives in his initial plan:

- Sam wanted to practice cleaning skills daily for the next four weeks;
- practice cooking skills twice a week for the next four weeks; and
- practice laundry skills once a week for the next four weeks.

The support activities/objectives that Mary will do to work towards getting to church regularly and being understood better are:

- once linked to a Speech-Language Pathologist (SLP) for evaluation on which device is best for her to use for communication needs, Mary will learn to use the communication device(s); and
- Mary will visit several churches in the area that her roommates attend and/or other churches of her choice that are near to home, seek possible natural supports at current church for transportation, add to her community engagement schedule to attend church or explore addition of companion services.

Slide 43

Support instructions/strategies are actions staff and natural supports will take to help the person meet the activities/objectives.

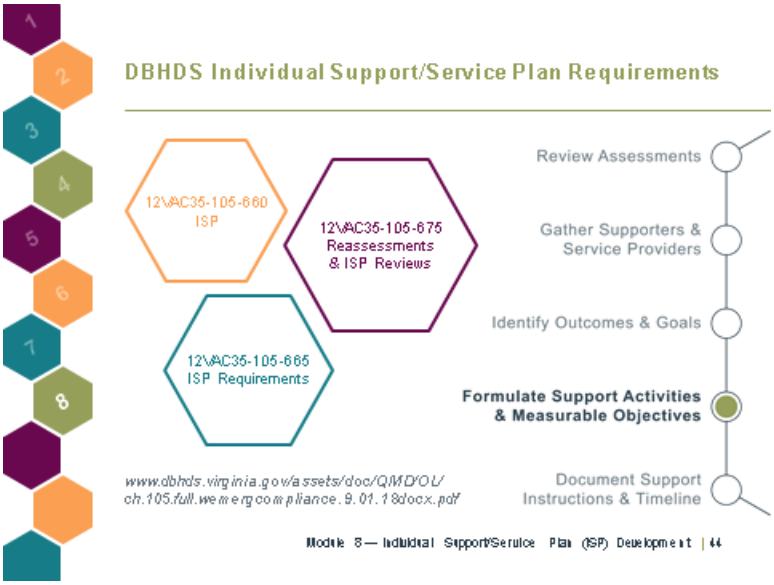
To support Sam in meeting his outcomes/goals, his plan included support instructions/strategies that Jill and his mom will use to help Sam move forward.

For example, Jill will refer Sam to services in the next week for daily living skills training and assistance in his home. She will seek out housing resources and help Sam apply for them in the next month. Sam's mom will help Sam practice his cleaning, cooking and laundry skills for the next four weeks.

To support Mary in meeting her outcomes/goals, her plan included support instructions/strategies that Rebekah will do to help her move forward.

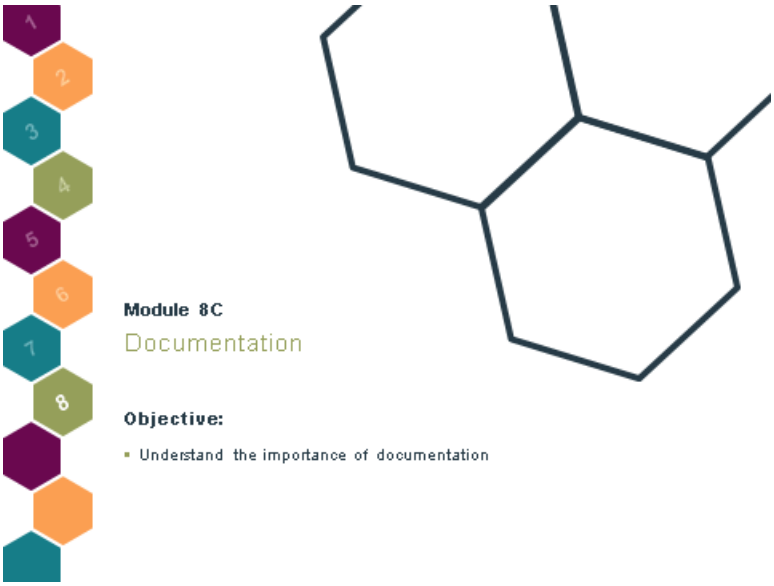
For example, Rebekah will link Mary within the next two weeks to a speech and language pathologist for evaluation on which device is best for her to use for her communication needs.

Slide 44



The link provided is for DBHDS emergency licensing regulations for ISPs, reassessments and ISP reviews. Consult with your supervisor or agency representative to be sure you understand these specific requirements. The link is also included in the material section of this module.

Slide 45



The objective of Section 8c of Module 8 is to:

- understand the importance of documentation.

Slide 46

Documentation:

- enhances the quality of service delivery;
- assists the Support Coordinator/Case Manager in remembering important aspects of the person's life;
- provides information to colleagues and supervisors who must ensure continuity of care in the Support Coordinator/Case Manager's absence;
- ensures compliance with regulatory and funding requirements and standards. Records are audited by a variety of internal and external reviewers regularly to ensure that guidelines are being followed and that the quality of service delivery is optimal;
- offers a way to recognize accomplishments. Well-documented records will indicate past accomplishments the person can be reminded of to help build a sense of self-efficacy and motivation to achieve current goals; and
- helps the Support Coordinator/Case Manager see patterns or trends of effective and ineffective interventions and better assessment of other services that may be helpful.

Documentation is an essential job responsibility for Support Coordinators/Case Managers.

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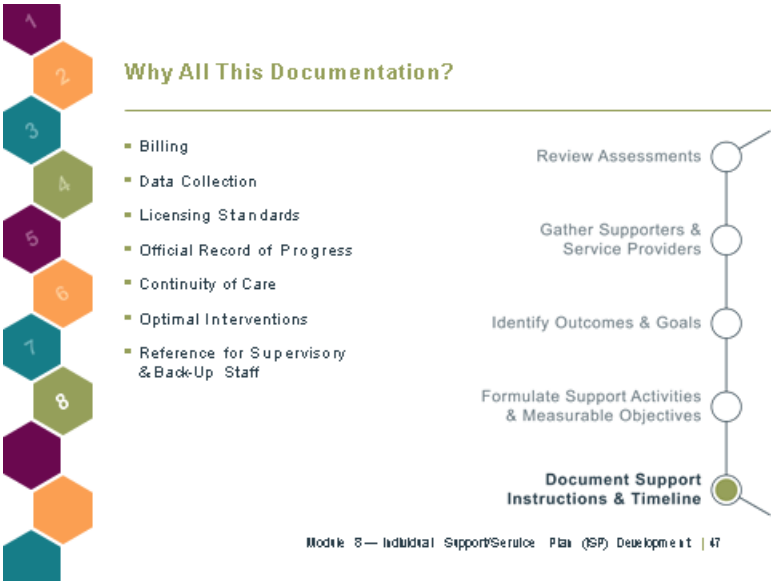

Support Coordinators/Case Managers often have to complete paperwork, such as applications, pre-authorizations, documentation of choice, etc. due to the requirements of many other processes such as:

- billing;
- data collection; and
- licensing standards.

The ISP and its related documents act as an official record of the person's progress and accomplishments, or the lack thereof. Documentation assists with continuity of support services among all staff. When services are provided by multiple people, it's vital for each to have a current record to assist with optimal support strategies. Good documentation also is essential for situations such as when a Support Coordinator/Case Manager is out sick or on vacation and back-up staff need to quickly reference medication and appointment information, and/or when quick access to salient information is relevant to someone in crisis.

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An ISP is a lot like a contract. Therefore, it must be at least signed and dated by:

- the person using services and who owns the plan, or their legal guardian or authorized representative; and
- the people responsible for implementing the plan which would include the Support Coordinator/Case Manager.

If the signature of the person using the services, legal guardian and/or the authorized representative cannot be obtained, the provider must clearly document the attempts to obtain the necessary signatures and the reason why they were unable to obtain it. Failure to obtain required signatures should be discussed with supervisory personnel, as this may result in the need for additional action, for example, obtaining another legal guardian or authorized representative or determining if services can continue to be provided without signature. Failure to obtain proper signatures could result in citation and/or funding payback.

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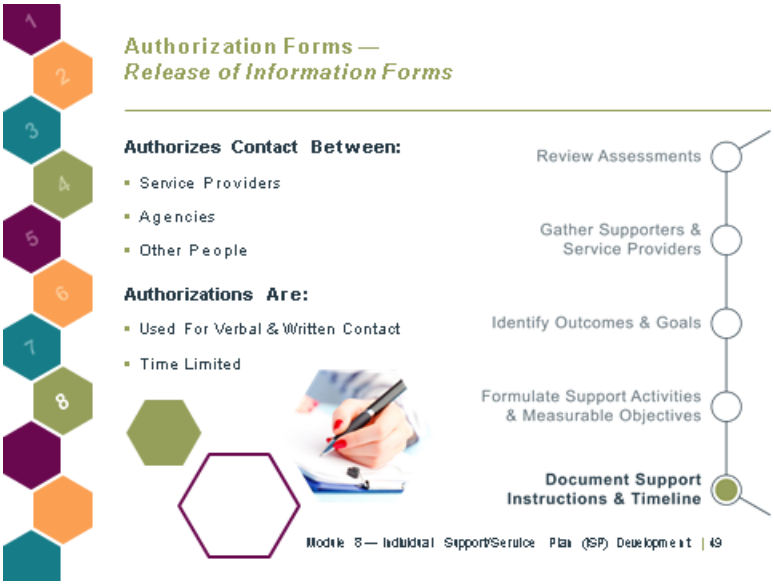


Authorization forms, also known as *Authorization for Disclosure for Release of Information* forms, must be signed by the person who uses services or their legal guardian or authorized representative to authorize contact between:

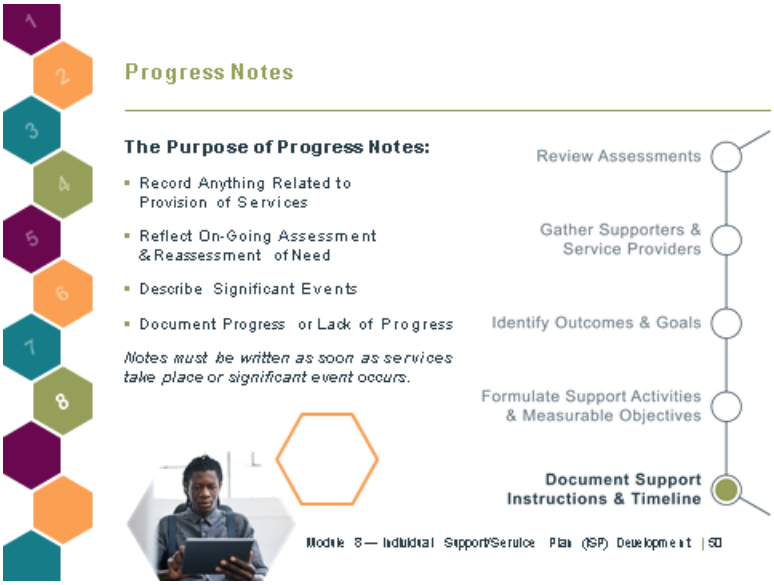
- service programs;
- agencies; and
- other people.

Once the authorization is signed, the Support Coordinator/Case Manager can request needed documents from others. Authorization forms are:

- used for both verbal and written contacts with others; and
- are time-limited, therefore, a Support Coordinator/Case Manager must be aware of renewal dates and have new forms signed consistently.

The Support Coordinator/Case Manager can usually reduce any concerns from the person about signing the authorization form by introducing it during the intake and orientation process. Ask a supervisor about the laws and regulations, such as HIPAA, the Health Insurance Portability and Accountability Act. This Act governs disclosure of information about the people served and agency policies that implement these privacy protections.

Slide 50



The purpose of the progress note is to:

- record anything related to the services provided;
- clearly describe the Support Coordinator's/Case Manager's ongoing assessment and reassessment of the person's medical, mental, and social status;
- describe any significant events that have occurred which relate to the person's response to services; and
- document progress being made towards meeting the outcomes/goals and support activities/objectives in the ISP. Although minimum time frames for completion of progress notes vary, progress notes should be written as soon as the provision of services take place or when any significant event occurs.

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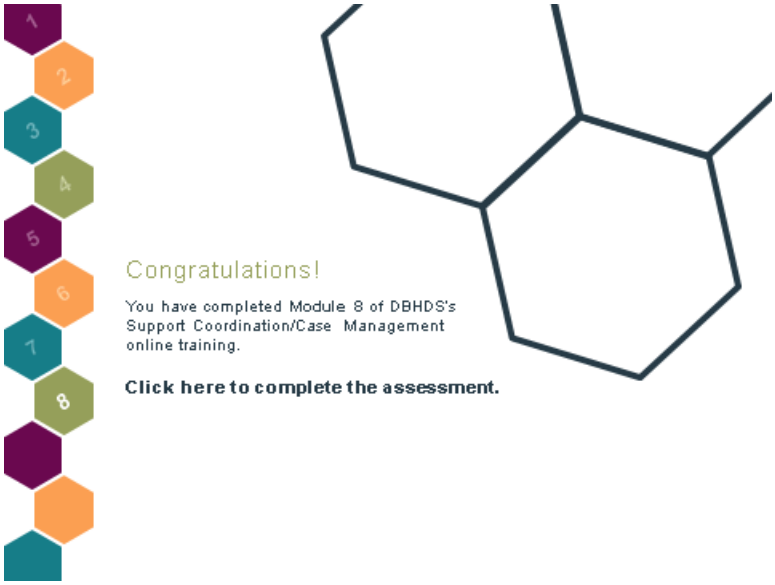

Congratulations!

You have completed Module 8 of DBHDS Support Coordination/Case Management online training. Please note that all of the web links provided in this Module are contained in the accompanying training materials. Please complete the assessment for Module 8 before proceeding to Module 9.

Thank you for your participation!