

# Individual Support Plan Guidelines



**FACILITATING  
INDIVIDUALIZED SERVICES AND SUPPORTS**

**July 2014**

MISSOURI DIVISION OF  
DEVELOPMENTAL  
DISABILITIES



Improving lives THROUGH supports and services  
THAT FOSTER self-determination.

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MISSOURI DEPARTMENT OF MENTAL HEALTH

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## **PART I: Overview of Individual Support Planning**

The Division of Developmental Disabilities requires that each individual eligible for Division Supports have an Individual Support Plan. Individuals, their families, providers and facilitators who write plans in cooperation with all individuals receiving supports from the Division shall use this guide. Individual support planning encourages a team approach to involve the individual and community networks in planning for the future. The process involves developing a vision for the future, while coordinating resources and supports to make the vision a reality.

The Center for Medicare and Medicaid Supports (CMS) outcome for “participant-centered support planning and delivery” clarifies: “Supports are planned and effectively implemented in accordance with each participant’s unique needs, expressed preferences and decisions concerning his/her life in the community.”

The Individual Support Plan is an investment in an individual’s life and is driven by the individual, what is important to them as designed through outcomes identified in the support plan.

Individual Support Plan quality outcomes should:

- Be in every individual’s plan – This is to guide service provision in order to meet the needs of the individual.
- Be individually directed - The individual has the authority and is supported to direct and manage his/her supports to the extent they wish.
- Be based on an assessment - Comprehensive information concerning each individual’s preferences, individual needs, goals and abilities, health status and other available supports gathered and used in developing the individual plan.
- Emphasize social networks as an important factor in the quality of life for the individual.
- Incorporate decision-making—Information and support available should help the individual to make informed selections among support options.
- Promote free choice of provider—Assist the individual to freely choose among qualified providers.
- Result in a comprehensive plan—Address the individual’s need for supports, healthcare or other supports in accordance with his/her expressed preferences and goals).

## Person-Centered Values



The Division of Developmental Disabilities Quality Outcomes is defined by values that form the foundation of a planning process:

- An individual support plan strengthens individual authority and provides meaningful options for individuals/families to express preferences, to make informed choices, and to achieve hopes, goals and dreams.
- Individual support planning discovers and understands what is important to the individual/family and what is important for the individual/family; and balances these viewpoints.
- Individual support planning begins with strengths, gifts, skills and contributions of each individual/family.
- Individual support planning is used as a framework for providing supports designed to meet the unique needs of each individual/family, while honoring goals and dreams.
- Individual support planning is a process that enhances community connections and natural supports and encourages the involvement of the individual/family in the community.
- Individual support planning recognizes that connections with other people who love and care about the individual are central to their well-being.
- Individual support planning recognizes that everyone can have relationships with people who are not paid to be there.
- Individual support planning supports mutually respectful partnerships between individuals/families and providers/professionals.
- The individual support planning process respects culture, ethnicity, religion and gender.
- Individual support planning involves listening, action, being honest and realistic; and discussing concerns about staying healthy and safe.



## **ISP TIMETABLE**

**INITIAL ISP:** CMS / Home and Community Based programs require that each individual found eligible for supports which is initially support coordination, have a plan in place within 30 days of acceptance into the program.

The initial plan shall not exceed 365 days. Before the start of any waived support, there must be a plan in place to identify the approved supports / services.

**AMENDMENTS:** If the individual already has an individual support plan, the plan must be amended within 30 days to reflect any new supports that will be provided to the individual upon entrance into a waiver program.

Note: Any new service / support must be justified and noted in the ISP; therefore, an amendment is necessary to reflect the changes within 30 days of the change.

Changing / updating the ISP: Reviews / updates need to occur, not just by reviewing the ISP document, but also through discussions / dialogues with the individual and the circle of support (planning team). ISP's must be reviewed and updated as often as necessary, on at least a quarterly basis. Review and update of the ISP must also occur as often as the individual and/or guardian requests and/or when there is a need for service and support changes as noted above.

Significant changes (for example any change in service / supports, outcomes, legal information, guardianship, limitation of rights, changes in safety / health status) always require dated signatures whereas informational changes (such as clarification to any information already noted in the ISP) do not. Again, the ISP should change as often as there are changes in the individual's life.

Once the amendment has been completed to justify the service / support, the team must assure the ISP continues as a current document. Therefore, 30 days from implementation of the new service / support, it is best practice for the team to meet to gather any additional information that needs to be conveyed in the ISP. This time period gives the team and the individual an opportunity to assess what is working / not working with the changes in any service / support.

The ISP process should be fluid. The ISP should change as the individual's life changes to include any transition. This fluidity and the impact of transitions shall be reflected in the support plan.

**ANNUAL ISP:** While the planning process is ongoing, each plan is only valid for 365 days. ALL annual ISPs must have dated signatures.

An annual individual support planning meeting shall be held 60-90 days prior to the date of expiration so that the renewed plan starts on the same date of the new year. The ISP shall not be extended and therefore, there shall not be any gap in implementation dates. If the individual has a DMH funded support other than support coordination, it must be authorized with each new plan in order to be entered into the support delivery system.



## **THE INDIVIDUAL SUPPORT PLANNING TEAM**

The development of the ISP (the ISP is the document) reflects a person-centered planning process. It involves as many people or organizations as needed to achieve the desired outcomes for each individual. The plan belongs to the individual. The ISP process helps people achieve their life goals and evolves as the individual's life evolves. The planning team consists of an individual (focus individual) and a circle of support ([the support team](#)).

Building the support team: Whenever possible, individuals should freely choose the members of their circle, who may be:

- Family members and/guardians
- Teachers, paraprofessionals
- Friends, peers, acquaintances
- Direct support professionals (staff, care givers, personal care attendant, etc.)
- Other support professionals (support coordinator, case manager, social worker, etc.) and others who are most important to the individual / family and those involved in the individual's life.

A circle of support helps individuals develop their plans. Since the individual support planning team builds and sustains relationships, potential team members will have community contacts with emphasis on naturally occurring relationships and resources. Team members cooperate in solving problems and helping individuals attain their potential, achieve life goals, and to realize their dreams.

Selecting a facilitator for the Individual Support Plan:

The meeting facilitator can be anyone. It may also be a support coordinator or professional affiliated with another agency or provider. The focus individual has additional options, such as facilitating the meeting him- or herself (with support if desired).

Since individual support planning is about relationships, a facilitator either has a relationship with the focus individual, or establishes a relationship with the individual prior to the meeting. The facilitator's ability to ask the right questions, and to communicate directly with the focus individual, will enhance the plan and its process. The facilitator's credibility with the individual, community and support system will dramatically influence the success of the planning process.

Choose a facilitator who has the following attributes:

- Team player; works well with others
- Flexible and open-minded; does not make assumptions
- Individual-centered and skilled at keeping the focus of the meeting on the individual
- Good listening skills and ability to interpret behavior as communication
- Skilled at checking back with the individual and the team
- Consistent and experienced with follow-through

The TCM provider is responsible for ensuring the plan is complete and that all required components are included.

The responsible party “writing” the plan should always gather information from all team members in order to develop a comprehensive document that is representative of the input from all members of the circle.

Understanding communicating styles:



To support others in self-determination, team members must be experienced in listening to and understanding the individual’s communication style. All communication is purposeful, and all people have a need to communicate.

Some individuals have difficulty communicating. Most people express ideas, feelings and desires through words, gestures and body language to convey messages and to respond to others. In some situations, the individual’s method of communication may be perceived as *inappropriate*.

Communication requires a willingness to use all available means in order to understand and to be understood (e.g., pictures, sign language, gestures, body language, augmentative devices, interpreters, etc.). Alternative methods, including interpreters as needed for communication, should always be available at the planning meeting.



## **PART II: Preparing for an ISP meeting**

Scheduling the meeting:

If the document is an annual ISP, the individual and support coordinator should begin planning for the meeting 60-90 days prior to the expiration of the current plan. This will provide enough notice to all participants and to allow adequate time to gather the information needed.

The Support Coordinator is responsible for ensuring that the planning meeting process is in place and that planning team members (circle of support) as identified by the focus individual is invited or has a means for contributing to the process.

The focus individual chooses: time, date, place, meeting topics, the facilitator, and their circle of support. Prior to the meeting, the support team member spends time with the individual to learn more about his/her hopes dreams and preferences.

**ISP COMPONENTS:**



The following section is an outline of “core components” that are areas to be covered in the ISP. This is a combination of *system required* components and a balance of areas that reflects what is most important to (preferences, interest, goals and dreams, etc.) the individual and what is most important for the individual (health and safety needs for example) to assist in the development of a comprehensive plan.

These components may be compiled prior to or after the planning meeting by the support coordinator so that the meeting is focused on the individual.

Each table indicates whether subcategories are mandatory, optional or contingent:

**Mandatory:** These are the required areas to be reflected in the ISP.

**Contingent:** If it is relevant to the individual / family / it is required. If not, it is not necessary to reflect in the ISP.

**Optional:** Any additional information chosen by the individual, family, guardian

NOTE: The following components may be reflected in the ISP by also referring to other documents or sources of information that assist in providing support to the individual.

**DEMOGRAPHICS:** The following are components of the plan that must be developed in the area of demographics.

<b>DEMOGRAPHIC INFORMATION</b>	
Full Legal Name	Mandatory
Statewide ID	Mandatory
Individual Plan Meeting Date	Mandatory
Individual Plan Implementation Date	Mandatory
Regional Office/Habilitation Center	Mandatory
SB40 Board/ACSP	Contingent
Nicknames	Optional
Date of Birth	Mandatory
Healthcare Resources Utilize <b>(Including Medicare, Medicaid, dental insurance and private health insurance)</b>	Mandatory



**LEGAL ISSUES:**

Include information about legal status, restrictions placed by the court system, and dated signatures of the individual, legal guardian (if appropriate) and the support coordinator.

LEGAL ISSUES	
Legal Status	Mandatory
Guardianship (Name, address, phone number and relationship to the individual of the individual’s legal guardian)	Mandatory
Specific restriction placed by court	Mandatory
Specific restriction(s) to legal rights	Mandatory
Consent for Treatment	Mandatory
Signatures	Mandatory
Provider Choice	Mandatory
Voter Status	Contingent

**Review of Previous Years Information, Assessments and Supports:**

There should be a review of the previous year’s information. A review of assessments should be conducted prior to the planning meeting in order to facilitate discussion of findings to incorporate into the plan. Assessments may lead to valuable information about goal setting. There should be a review of service / support definitions to ensure that the required components for those supports are included in the final plan document.

**Assessments may include:**

- Risk Assessment
- Support Intensity Scale (Assessment information and score)
- Behavioral Assessment
- Review of information from support monitoring, health inventories, nursing reviews, event reports, etc.
- Level of Care
- Other applicable assessment / tools

A review of current supports and their progress towards previous outcomes should be conducted prior to the planning meeting in order to identify the ongoing support needs.

The following should be considered:

- Were the supports provided in the manner with which authorized?
- Did the supports address the outcomes and support needs of the individual as identified in the plan?
- Does the level of the current supports meet the individual’s need?



### **PART III: DEVELOPMENT OF THE ISP**

The function of the actual meeting is to gather information from all participants in order to create an individual centered plan that provides a comprehensive picture of what is important to and for the individual. The planning process embodies an ongoing commitment to discover what is important.

#### **1. WHO IS IMPORTANT TO THE INDIVIDUAL:**

Caring for and about other people and having other people care for and about us is what makes our lives meaningful. Many people who receive services have lost touch with or never developed relationships with people who are not paid to be with them.

It is important to know about the individual's *social support network*. This includes who is important to the individual, what the individual likes to do with them and about how often. The information discussed during this part of the planning may assist individuals in maintaining relationships and as well as discovering desires to develop new relationships.

Organizations can intentionally assist people in building relationships with people they already know or can facilitate meeting new people in order to create new relationships with the foundations identified here.



<b>WHO IS IMPORTANT</b>	
Information about the general topic of important relationships.	Mandatory
Information from people who know and care about the individual.	Optional
Information about how to maintain/support relationships with family, friends, neighbors, community members, employers and/or supporters who are important to the individual.	Optional
Information about relationships the individual may want to enhance or explore.	Optional
Supporting Missouri Quality Outcomes <ul style="list-style-type: none"> <li>○ People belong to their community</li> <li>○ People have a variety of individual relationships</li> <li>○ People have valued roles in their family and in their community.</li> </ul>	

**2. WHAT IS IMPORTANT TO THE INDIVIDUAL**

This topic should include a description of what the individual thinks is important to have a quality life. When reading the plan, it should be easy to distinguish the difference between what is important to the individual from what is important to others.

WHAT IS IMPORTANT TO THE INDIVIDUAL	
Hopes, Dreams & Wants	Mandatory
Needs	Mandatory
Likes & Dislikes	Mandatory
What the Individual Would Like to Try	Mandatory
Support Preferences (e.g., Does the individual prefer a female or male for his/her support needs or for a specific task / activity such as bathing?)	Mandatory
Special Interests	Mandatory
Traditions	Optional
Ethnic Heritage	Optional
Cultural Events	Optional
Places That Are Important to the Individual	Optional
Supporting Missouri Quality Outcomes: <ul style="list-style-type: none"> <li>○ People Belong to their Community</li> <li>○ People are Connected to their Past</li> <li>○ Live and Die with Dignity</li> <li>○ Plans reflect how individuals want to live their lives, supports they want, and how they want them provided</li> </ul>	



**3. WHAT DO WE NEED TO KNOW OR DO TO SUPPORT THE INDIVIDUAL?**

This section helps define *what is important for* the individual (Note: What is important for a person may also be what is important to them as well).

This information describes what “OUR” behavior needs to be to support the individual. It may be helpful to develop a list of all of the areas in the support section that needs monthly or on-going follow-up. This may assist in providing the supports necessary to ensure they are being addressed and maintained.

The support section of the plan is a crucial component of the planning process. It is an area that identifies “how” the supports need to be provided day to day. Day to day supports is not an outcome.



Supports describe:

- The *behavior* of the supporters: what are they supposed to do – specifically to assist in the way the individual prefers?
- Specifics about what works and does not work for the individual.
- The specifics or protocols necessary to develop and/or maintain the health, safety, behavioral or risk issues for the individual.

The support section could also be a valuable tool for:

- New supporters in orientation OR new to working with the individual or family.
- Matching the characteristics of staff to the individual supported.
- Use as a teaching and learning tool developed by those who know and care about the individual.
- Use during a type of transition (for example: traveling from home to work, change in schedules, transitioning from weekday to week end, change in supporters, etc.)

Support needs / statements must reflect what an individual needs **daily** to maintain or enhance their quality of life and health/safety needs. The following is a detailed example that displays what is most *important to* and *important for* an individual. This example also displays the importance of utilizing this section as a tool to “teach / train” supporters:

- ✓ *Jennifer has an elevated tub and uses a bath chair. She enjoys her bath in the tub Tuesday, Thursday and Saturday.*
- ✓ *When she is ready to get into the tub, place a towel over the seat of her wheelchair before she transitions.*
- ✓ *Use 1 beach towel, 2 smaller towels: One is to be used for the top of her after she gets out of the tub; 1 folded for her headrest and 1 folded and placed over the right side of the bath chair at her hips -- as she pushes herself up on the side.*
- ✓ *Always check the water temp before she gets in the tub.*
- ✓ *Clean her ears after each bath, her nails (fingers and toes) are clipped every Saturday - she may accidentally scratch her face and neck while sleeping.*
- ✓ *To maintain safety in Jennifer’s wheelchair: When you transition Jennifer in her wheelchair, make sure she is all the way back and in the middle of the seat, then fasten her seatbelt, pull the plastic loops on both sides.*
- ✓ *Whenever Jennifer gets on the van, make sure she has her chest straps on first.*
- ✓ *CAUTION: If she is NOT positioned properly, she is at risk of getting her head caught outside the headrest (left side) - always make sure she is seated properly. It is especially challenging when she is very active.*

The following is another tool, also known as a “**communication chart**” that may also be used to describe supports when we are trying to figure out how an individual is using their communication:

<b>When This Is Happening</b>	<b>And Jennifer Does....</b>	<b>We Think It Means.....</b>	<b>And We Should</b>
During meals/ eating or drinking	Holds her cup up at you	Jennifer wants more to drink	Provide more to drink (usually water). Remember, Jennifer has NO DIETARY RESTRICTIONS for what or how much she drinks, she really likes water!
	Throws her cup down	Jennifer has had enough to drink	Respond by not giving Jennifer more to drink, listen to what she is telling you!
	Goes straight to the kitchen	Jennifer is looking for something to eat	Accompany Jennifer to the kitchen; make sure Jennifer has a choice of snacks. She will respond by pointing to the snack she prefers.



<b>WHAT WE NEED TO KNOW IN ORDER TO SUPPORT THE INDIVIDUAL (these supports include <i>what is important to</i> and <i>what is important for</i>)</b>	
A description of how supports should be delivered.	Mandatory
Describe supports that are currently effective and need to continue to ensure consistency in the way supports are delivered.	Mandatory
Rituals and routines important to and for the individual	Contingent
Primary Language Used (Required if the primary language is other than spoken English. If sign language is used, state what type of sign.)	Contingent
Method of Communication (Required if the primary mode of communication is other than speaking: communication boards, interpreter, etc.	Contingent
How an individual learns best (including <i>how the individual learns</i> optimizes opportunities to reach preferred outcomes)	Contingent
Supporting Missouri Quality Outcomes <ul style="list-style-type: none"> <li>○ People’s communication is understood and receives a response.</li> <li>○ People’s plans reflect how they want to live their lives, the supports they want, and how they want them provided.</li> <li>○ People are provided support in a manner that creates a positive image.</li> <li>○ People express their own individual identity.</li> </ul>	

**3a) Supports needed for health (physical and mental): The plan MUST address the individual's health needs as applicable.**

 <b>WHAT SUPPORTS ARE NEEDED FOR HEALTH – MENTAL AND PHYSICAL</b> <i>(these supports include what is important to and what is important for)</i>	
Prevention (e.g., healthy diet, exercise, weight management, stress management, counseling, etc.)	Mandatory
Maintenance of current health issues ( <i>Knowledge</i> of diagnoses is important)	Mandatory
Improvement of current status of health	Mandatory
Medical, vision, hearing, oral care conditions and supports (per HIPS process 3.090 Health Identification and Planning System Process)	Mandatory
Immunizations and cancer screenings (***) Mandatory for individuals receiving residential supports. Best practice for individuals receiving other supports).	Contingent**
Purpose of medications, treatments, or procedures (i.e., parameters, protocols for contacting physician, such as diabetes, hypertension, etc.)	Contingent
Dietary needs	Contingent
Allergies/Sensitivities/Reactions	Contingent
Mental Health supports (counseling, therapy, medications, etc.)	Contingent
PRN psychotropic medication protocol	Contingent
Self-administration (supports needed to maintain this skill). Note: If the individual is learning to self administer, this is expected to be addressed as an outcome.	Contingent
Adaptive equipment	Contingent
If specific (more detailed) supports are not in the plan, then note where the information is located and that supporters must use this information to guide what supports they provide. (e.g., bowel and bladder management and other individual/private information).	Contingent
Family Medical History (if available)	Contingent
Diagnoses	Contingent
Supporting Missouri Quality Outcomes <ul style="list-style-type: none"> <li>• People feel safe and experience emotional well being.</li> <li>• People are supported to attain physical wellness.</li> </ul>	

**3b) Supports needed for safety, as applicable:**

This information MUST be included when there is a need to highlight important or extensive safety issues. This information is contingent in that it is only required if the individual has needs in this area. The Positive Behavior Support Guidelines explains more on how to develop supports for an individual and are located at <http://dmh.mo.gov>

It is imperative if an *Altered Level of Supervision* is needed to benefit the individual, then a clear description of the *altered level of supervision* must be addressed specifically in the ISP or ISP Addendum to the Plan.

[http://search.mo.gov/search?q=Altered+Levels+of+Supervision&site=dmh&output=xml\\_no\\_dtd&client=dmh&num=10&proxystylesheet=dmh](http://search.mo.gov/search?q=Altered+Levels+of+Supervision&site=dmh&output=xml_no_dtd&client=dmh&num=10&proxystylesheet=dmh)

Altered Levels of supervision may include “Alone Time,” “Line of Sight,” and “1:1” supports, etc. This needs to be a team decision (this includes the individual, guardian, provider agency, support coordinator and others identified by the team to participate).

WHAT SUPPORTS ARE NEEDED FOR SAFETY	
Emergency Safety (supports for emergency procedures, 911 calls, stranger awareness, etc.). <b>Refer to Emergency, Evacuation and Safety Planning Guideline #38.</b>	Mandatory
Support needed while cooking, being away from home, answering the door, water temperature, toxic chemicals, having key to their home, etc.	Contingent
Mobility support needs.	Contingent
<i>Behaviors</i> that places the individual or others at risk	Contingent
Risk Management (see Part IV for guidance)	Contingent
Altered Levels of Supervision	Contingent
Sexual or Other Criminal Offenders (restrictions, supervision, contact individual, pending charges, therapists, Probation & Parole)	Contingent
Supporting Missouri Quality Outcomes <ul style="list-style-type: none"> <li>• People feel safe and experience emotional well being.</li> <li>• People are supported to attain physical wellness.</li> <li>• People are supported in managing their home.</li> </ul>	

#### 4. PLANNING FOR RISK:



NOTE: The following information may also be vital in developing a comprehensive “support section” of the individual support plan (“what we need to know or do to support the person”) as discussed earlier.

Serious risks are actions likely to cause serious emotional or physical harm or death to an individual or others. Risk is unique to each individual’s circumstance: what is threatening for one individual may not be risky for another. The following tools may be utilized to assess some of the most common forms of risk.

#### **HEALTH RISKS**

The Health Identification and Planning System Process (HIPS) is a quality enhancement monitoring process for the discovery and remediation of health and safety concerns. This process applies to individuals supported by Division of DD residential services / supports.

The Health Inventory Tool (HI) is a component of HIPS and is designed to identify health issues that require additional supports which may include advanced training/knowledge to support individuals safely in community residential settings; identifies and prioritizes individuals who will receive a *nursing review* based on the supports they require and the potential risk if supports are not adequate. This guides support coordinators in identifying health indicators to be addressed in the ISP process regardless of a score.

When health indicators are identified it is important to provide information in the ISP which indicates what the identified individual health risks are and what individualized supports are needed to decrease risk. Support information may include specific medical monitoring, what signs and symptoms to observe for and when to report, and daily supports such as specialized diets or therapies.

The HI is to be completed by the support coordinator in accordance with the following schedule:

- As a baseline prior to new (first time) placement (support / service) within 10 working days of emergency supports including transition from a Habilitation Center to community based supports.
- Annually, as designated in the HIPS tracking system.

Any time throughout the year when there is a significant health change that alters the individual's level of daily support needs.

## BEHAVIORAL RISK ASSESSMENT AND PREVENTION

Support Coordinators must, as part of their ongoing support to an individual, consider the risk of behavioral crisis. These include the likelihood of problem behaviors escalating to an extent that the individual or others are placed in danger of injury, that the individual will experience a crisis such that more intensive services will be required including specialized behavioral services, police involvement or psychiatric hospitalization.

All of these place the individual at risk of losing their home and supports in the community, therefore, the planning and development of strategies must be employed to prevent this if possible. An ongoing risk assessment process is the best way to identify high risk behavioral situations.

Below is a table of variables that influence the risk of behavioral crisis. A support coordinator along with the team (circle of support) for an individual should consider these factors, at least annually, to plan for supports for the upcoming year and to review the factors each time they come together with a focus on changing the supports to reduce the risk.

These factors are not specific only to the individual as environmental events significantly contribute to the likelihood of problem behaviors and situations.

Factors that decrease risk of behavioral crisis	Factors that increase the risk of behavioral crisis	Possible Risk Reduction Strategies (examples only, not limited to these and these are not required)
The home setting is generally pleasant and meets the person's physical and emotional needs.	The home setting is unpleasant, or lacking in aspects that are would meet the needs of the individual (for example: person likes to take walks but community has no safe walking paths).	Try to meet needs and preferences with adjustments to the current situation such as daily time to go to the park or indoor path to walk, or look for better support situation.
The individual's typical days are predictable, interesting and allow for flexibility by individual's choice.	The individual's day is monotonous or chaotic with little predictability or changes to the day are made without choice.	Assist and encourage the provider or family to seek assistance such as Regions Behavior Resource Team to develop reasonable daily schedule/planning process with the individual, increase interesting activities and tasks and help the individual to learn to engage in these more frequently by choice.

Factors that decrease risk of behavioral crisis	Factors that increase the risk of behavioral crisis	Possible Risk Reduction Strategies (examples only, not limited to these and these are not required)
<p>Those supporting the individual seem to have positive emotional bond to him/her, and reflect a sense of caring about the individual's success and happiness and talk about the individual in a mostly positive way.</p>	<p>The supports for the individual vary frequently, have no particular relationship with the individual or seem to be irritated or annoyed by the individual, have mostly negative things to say about the individual.</p>	<p>Assist and encourage provider or family to seek assistance such as Regions Behavior Resource Team for strategies to develop better relationship, such as Tools of Choice training and coaching. Encourage all to have more frequent "positive" interactions planned into the day.</p>
<p>There are very few if any restrictions or restrictive supports, if there have been any they have been very limited, in place for only a short period of time and removed quickly.</p>	<p>There are or have been several restrictive supports implemented to maintain safety of the individual or others, or they have been in place for long periods of time and are considered necessary for long periods of time.</p>	<p>Assist and encourage team to seek more proactive assistance and strategies, evaluate need for more specialized Supports such as Behavior Analyst; seek assistance and consultation by Regional DD Behavior Analyst, Behavior Resource Team, consider evaluation of the person centered/quality of life values in the person's daily life, reduce restrictions that are not clearly related to imminent harm.</p>
<p>Those supporting the individual seem to communicate well with each other and utilize the support strategies consistently and as planned.</p>	<p>Those supporting the individual seem to have limited communication and individual ways of implementing or understanding the strategies of support in the plan, or there are limited strategies of support described in the plan.</p>	<p>Assist and encourage the team to find some consultation regarding communication systems including pictures, electronics, speech and language therapy, sign language. Develop training and support for all support individuals to utilize common communication methods</p>

Factors that decrease risk of behavioral crisis	Factors that increase the risk of behavioral crisis	Possible Risk Reduction Strategies (examples only, not limited to these and these are not required)
Upon observation of interactions between the support persons and the individual there are more positive, friendly interactions than corrective, negative or directive interactions, at least 4 positive interactions to 1 negative or correction.	Upon observation of interactions between the support persons and the individual there are limited positive interactions and more directive, corrective or negative interactions or just limited interactions in general, coercive interactions are observed regularly.	Assist and encourage provider or family to seek assistance such as Regions Behavior Resource Team for strategies to develop better relationship, such as Tools of Choice training and coaching. Encourage all to have more frequent “positive” interactions planned into the day. Assist team to develop ongoing check system to encourage and assist supporting persons to be more positive.
The individual is making progress towards the goals and objectives in their individual plan and moving towards the life they wish to lead.	The individual is not making progress towards their life goals or the objectives in their plan and have limited hope to achieve their ideal life.	Assist and encourage the team to evaluate the teaching methods and schedule, increase the learning opportunities, and add more meaningful tasks, practice, rewards. Consider assistance to learn better teaching strategies.
There have been few recent problem behaviors reported or discussed by the team.	There is a pattern of escalating problem behaviors documented or discussed by the team.	Assist and encourage team to seek more proactive assistance and strategies, evaluate need for more specialized Supports such as Behavior Analyst; seek assistance and consultation by Regional DD Behavior Analyst, Behavior Resource Team, consider evaluation of the person centered/quality of life values in the person’s daily life, reduce restrictions that are not clearly related to imminent harm.
There is a regularly utilized and regularly reviewed system to collect data (quantitative) about the individual’s positive and problem behaviors.	Data collection is mostly narrative or the incident reporting system critical review of this information is limited.	Assist and encourage the provider and family to work with the Regions Behavior Resource team or other consultant to develop and utilize more informative data collection system and to understand why this is important.

Factors that decrease risk of behavioral crisis	Factors that increase the risk of behavioral crisis	Possible Risk Reduction Strategies (examples only, not limited to these and these are not required)
The strategies utilized to support the individual when there are problem behaviors seem to be improving the behaviors.	The strategies that are being utilized do not seem to be affecting the behavior or the behaviors are getting worse.	Assist and encourage the provider or family to seek assistance such as Regions Behavior Resource Team to develop more effective strategies, consider more powerful teaching strategies and approach.
The individual has experienced no serious emotional events during the past year.	The individual has experienced at least one emotional event or loss such as family member death, relocation of self or significant other (peer, family, staff), etc.	Assist and encourage the provider or family to provide consistent supportive interactions for the individual, consider temporary schedule or expectation adjustments when the person is more upset than typical, seek counseling supports for the individual, and allow time for healing as is necessary for all persons experiencing such events.

Consideration of the factors above shall assist the support coordinator or team to implement strategies to prevent escalation of risk of crisis or worsening problem behaviors.

If the individual has had incidents of behavior problems that have resulted in significant danger to self, others or property in the past six months and there are factors that might increase risk; the team should consider the need for additional support services such as behavior analysis supports or positive behavior support consultation through the regional behavior resource team or by another Medicaid waiver provider of the service.

## 5. INDIVIDUAL RIGHTS



Individuals are provided information on rights upon entry to the waiver and annually during the individual support planning process. The support coordinator will provide a rights brochure, developed by the division, to the individual and guardian. In addition, information is posted on the division's web-site:

<http://dmh.mo.gov/constituentservices/rights.htm>

<http://dmh.mo.gov/docs/dd/indrightrights.pdf>

The Division has a process in place (Division Directive 4.200) to protect the human rights for all individuals and outlines a referral process to the *Regional Human Rights Committee*.

**NOTE:** A *Human Rights Component Guide* has been developed to assist Support Coordinators and teams to assess limitation of rights and due process. See ([www.dmh.mo.gov](http://www.dmh.mo.gov)) to download this tool.

The purpose is to:

- Ensure individuals receiving services from DMH exercise or are assisted in exercising all rights under the Constitution of the United States and those stated in Missouri Statute.
- Ensure individuals have information on the rights and responsibilities of citizenship.
- Ensure that individuals are involved in any process to limit their rights and are assisted through *external advocacy efforts* (for example: office of constituent services, protection and advocacy, etc.).
- Ensure individuals are entitled to due process when limitations are imposed.
- Ensure Human Rights Committees operate as an objective review committee in protecting the human civil rights for individuals with developmental disabilities.

When the individual's planning team determines that a limitation of rights is necessary, the **ISP process must** ensure the following:

<b>RIGHTS</b>	
The individual, guardian (and others important to the individual) are involved in any process to limit their rights <u>and</u> the individual is assisted through external advocacy efforts.	Mandatory
Plan clearly defines the issue / concern.	Mandatory
Due process has occurred (noted in the plan) as noted in the next sections.	Mandatory
<p>Restrictions are time limited. If a restriction is proposed <u>due process means</u>:</p> <ul style="list-style-type: none"> <li>• Identify the <i>purpose and rationale</i> of the restriction. All limitation of rights <b>must</b> be justified.</li> <li>• Identify the <i>condition of the restriction</i>: when, where, how often, etc.....</li> <li>• Identify the <i>criterion for restoration</i> (must justify continued use): What will it take for the restriction to be lifted?</li> <li>• Identify the <i>review schedule</i>: Document how often the restriction is being reviewed by the team and the human rights committee to asses if the limitation of rights continues to be necessary.</li> <li>• Develop <i>teaching and / or support strategies</i>, as applicable to the needs of the individual. (Teaching / learning may be needed to fade the need for any restriction and to reflect teaching the individual new skills). Limitations of rights need to reflect the specific supports in place to protect the individual and/ or others and to identify the supporter’s role.</li> <li>• Identify <i>monitoring methods</i>: How is the use of the restriction being monitored?</li> <li>• Identify <i>notice of right to due process</i>: Statement indicating that the guardian and individual is aware and agrees to the justification of the restriction.</li> </ul>	Mandatory
<p>Contains information regarding <i>right to appeal</i> (meaning a “right to complain”). If an individual wishes to file a complaint regarding the recommendations of the team and/or Human Rights Committee, they shall be referred to the Office of Constituent Services:</p> <p><a href="http://dmh.mo.gov/constituentservices/rights.htm">http://dmh.mo.gov/constituentservices/rights.htm</a></p> <p><a href="http://dmh.mo.gov/docs/dd/indrights.pdf">http://dmh.mo.gov/docs/dd/indrights.pdf</a></p>	Mandatory
<p>Supporting Missouri Quality Outcomes</p> <ul style="list-style-type: none"> <li>○ People live and die with dignity.</li> <li>○ People have control over their daily lives.</li> </ul>	

## 6. TRANSITION:

When unexpected things happen, people often feel “derailed” or “off balance.” To help the individual move forward after such life events occur, the planning team meets and continues to adjust and modify the plan. While the circle of support is designed to support the individual through difficult transitions, there are times when supporters need to offer extra support, to revisit previous support strategies, and/or to develop more effective support strategies.

<b>WHAT SUPPORTS ARE NEEDED TO ASSIST THE INDIVIDUAL WITH TRANSITION</b>	
Onset of a disability (e.g. accident resulting in a brain injury)	Contingent
Change in marital status	Contingent
Change in day routine (i.e. retirement, graduation, etc.)	Contingent
Change in living environment (i.e. new home, new housemate, new staff, having a baby, etc.)	Contingent
Health-related issues (i.e. life altering illness such as breast cancer; end of life decisions, experience of trauma)	Contingent
Self Directed Services (transition from an Agency based provider directing services to directing own services)	Contingent
Supporting Missouri Quality Outcomes <ul style="list-style-type: none"> <li>• People Live and Die with Dignity</li> <li>• People’s plans reflect how they want to live their lives, the supports they want, and how they want them provided</li> <li>• People have control over their daily lives</li> <li>• People are actively supported throughout the process of making major lifestyle changes.</li> <li>• People express their own individual identity.</li> </ul>	

### **TRANSITION OF YOUTH**

Transition is the change from one stage of life to another. Whether that is from middle school, high school, college, or into the workforce, preparation is the key.

When youth with disabilities have access to person-centered career planning and early work experiences, they are more likely to achieve seamless transition to community employment and post secondary educational experiences.

**The Division of Developmental Disabilities mandates that all plans for individuals age 14 and older *must* contain strategies for developing work skills and /or gaining employment.**

Individualized support plans should reflect an increased concentration towards employment outcomes or post secondary education as the child ages. Even very young children can begin developing skills that will aid them in successful employment outcomes later in life.

Support coordinators play a vital role in encouraging families to have high expectations of their children. Studies have demonstrated that when parents have high academic and employment expectations for their children with disabilities, the children experience greater success in those critical areas. Simply increasing parents' awareness of their children's potential employability and the importance of work are likely to influence positive employment outcomes. Connecting parents to others who have experienced success and attending IEP meetings to help advocate on their behalf are just a few ways for this support to be provided. Ensuring that the ISP reflects age appropriate activities which promote successful transition to employment is crucial. A description of some age appropriate activities and supports follows.

Young children (grades k-5): Encourage participation in careers days, take part in household chores, make choices and decisions about home and school, shared hopes and dreams about what to be when they grow up and practice asking for help to get work done (accommodations). Even young children can volunteer at church or a local food bank, manage allowances and get to know local community/business leaders. These experiences will build expectations and skills around work.

In middle school, students begin to understand how their current educational and personal choices will affect their future life roles, in particular their choices for a career, because middle schools provide youth with the skills, self-esteem, and attitudes they need for a rewarding work life.

Although schools do not require transition planning to begin until age 16, ***the Division of Developmental Disabilities Individualized Support Plan process must reflect supports and actions that will be taken to help improve employment or post secondary outcomes beginning at the age of 14.***

**Ages 14 – 16: The ISP must contain information in the profile and if applicable, goals /outcomes, to reflect the work that is being done with the individual, schools, families to:**

- Build and practice self determination skills.
- Ensure career assessments and interest inventories are being conducted.
- Continue to develop social and other “soft skills” that are critical to success.
- Explore interests, aptitudes, and abilities, and understanding adult roles.
- Assist the individual to learn about available work and career opportunities.
- Expand and build social capital (community connections/business leaders).
- Develop and improve job interviewing skills, resume development, expertise in completing job applications.
- Participate in monitored work experiences such as pre-apprenticeships, volunteerism, entrepreneurships, job shadowing, and community and neighborhood service.
- Develop, improve and practice independent living skills such as budgeting money, shopping, cooking, housekeeping, accessing transportation.
- Students with disabilities may be receiving Supplemental Security Income (SSI) or Medicaid. If a child is age 15 or older and is working, he or she can establish a Plan to Achieve Self-Support (PASS). With a PASS, a child can set aside income for a work goal. Social Security

will not count this income when figuring the SSI payment. *The ISP should identify if an individual is working, if they may be eligible for work incentives and how to access a benefits specialist.*

**Age 16 and above: The ISP should consider adding the following in addition to the above:**

- Identify community support programs (Vocational Rehabilitation, Centers for Independent Living, County Boards, etc.) that may be needed and ensure appropriate referrals have been made.
- Match career interests, skills and academic coursework with real work experiences in the community.
- Identify accommodations that may be needed.
- Describe how the individual will learn about what benefits and services they are currently receiving and how to manage them. This could include social security, personal assistance services, etc.

**Age 17 – Additional Activities**

Social Security and Medicaid Eligibility Determination Recommendation:

- At least six months prior to turning 18 the DD support coordinator should educate the family about Social Security and *MO Health Net* benefits. The support coordinator should, with the family’s permission, assist the family in completing documentation requirements to determine eligibility for social security benefits. In Missouri often individuals who are found eligible for social security benefits may also be found eligible for Medicaid. Beginning the process early helps to ensure a more seamless transition to adult service system. The intent is that eligibility would go into effect on the child’s 18<sup>th</sup> birthday.

<b>TRANSITION FROM SCHOOL</b>	
Age 14 – 16: Skills development activities and unpaid work experiences which lead to improved employment outcomes (See recommended activities above)	Contingent
Service needs identified (employment, independent living skills)	Mandatory
At age 17, preparation for application for SSI if individual will require support/services from Division (e.g. needs job preparation or community employment services)	Contingent
Shortly prior to the age of 18, begin process for Medicaid eligibility if Medicaid reimbursable services will be needed (e.g. waiver services)	Contingent
Supporting Missouri Quality Outcomes <ul style="list-style-type: none"> <li>• People are actively supported throughout the process of making major lifestyle changes.</li> <li>• People have control over their daily lives.</li> <li>• People’s plans reflect how they want to live their lives, the supports they want, and how they want them provided.</li> </ul>	

## 7. EMPLOYMENT AND CAREER PLANNING:

Across the nation states are placing more and more emphasis on employment as the preferred way to experience a meaningful day and become contributing members of their community.

The Division of Developmental Disabilities Employment Policy states:

*“Employment planning (Career Planning) and supports are priorities to explore with all working adults who receive services in order **to ensure that supports, services, and outcomes** are consistent with what the person is seeking and on-going **career planning is expected to be addressed in the Person Centered Planning Process** for all individuals who are of working age so that career advancement opportunities are explored on a regular basis.”*

Career planning helps individuals reach their employment goals. The Division of Developmental Disabilities vision states that *employment is a viable option for all people with developmental disabilities*, and includes the following beliefs:

- People who want to work can work.
- People who are of working age are expected to work.
- People have the right to achieve their career goals.
- People should have prevailing wage; and
- People should have the opportunity to realize economic self-sufficiency.

Career planning involves finding ways for an individual to contribute to the community, and to earn an income that is consistent with the individual’s interests, gifts, talents and preferences.

Each individual service plan should address an individual’s desire and ability to work and the supports they would need to pursue their interests.

<b>CAREER PLANNING</b>	
Career Planning & Job Development (career choice; maintain employment, changing jobs, loss of a job).	Mandatory for ages 16-64 & best practice for ages 14-15.
Supports necessary to pursue the individual’s employment goals	Contingent
Supporting Missouri Quality Outcomes <ul style="list-style-type: none"> <li>• People have valued roles in their family and in their community.</li> </ul>	

**8. SELF DIRECTED SUPPORTS (SDS):** <http://dmh.mo.gov/dd/progs/selfdirect.htm>

The individual support plan is used as the training document for employees. It must provide enough detail in order for everyone to understand the essential needs of the individual.

The Support Coordinator shall use the SDS Employee (Personal Assistant, Community Specialist, and Support Broker) job descriptions as a planning tool for SDS.

The job description: The Individual/Designated Representative determines what task they would like for their employees to provide and what task are allowable; helps the Support Coordinator ensure that the ISP provides enough detail in order for all employees to understand what is needed to provide supports; helps determine the number of hours of supports needed.

<b>SELF-DIRECTED SUPPORTS</b>	
Works to enhance and build natural supports; defines paid and non- paid supports.	Mandatory
Identifies the responsibilities of the individual or <i>Designated Representative</i> (when appointed) when self directing supports.	Mandatory
Justifies any training exemptions on the "Training Checklist".	Mandatory
Identifies the back-up plan which includes provisions for support in the case of scheduled employees not being able to provide the support.	Mandatory *May refer to separate document(s) to attach to the plan.
The ISP is used as the training document for employees and <del>must</del> provides enough detail in order for all employees to understand what is needed to provide supports.  <b><i>The ISP may refer to other documents or sources of information. For example, current food preferences may not be included in the plan but the ISP can refer staff to another source of information to obtain the individual's current food preferences.</i></b>	Mandatory *May refer to information already documented in other sections of the plan.
In the case of a paid family member - the plan must reflect: <ul style="list-style-type: none"> <li>• The individual is not opposed to the family member providing the support.</li> <li>• The supports to be provided are solely for the individual and not household tasks expected to be shared with people who live in a family unit.</li> <li>• The support team agrees that the family member providing the individual assistance will best meet the individual's needs.</li> </ul>	Mandatory
Supporting Missouri Quality Outcomes <ul style="list-style-type: none"> <li>• People have valued roles in their family and in their community.</li> </ul>	

The individual shall work with their planning team to develop a PA job description that helps the Individual/Designated Representative determine what task they would like for their employees to provide and what tasks are allowable.

9. **NON-DIVISION SUPPORTS:** The intent of division services is to supplement and strengthen existing natural supports, such as those provided by family, friends, and the community.

**Supports MUST not be duplicative. Planning teams need to determine an individual's eligibility for Mo HealthNet (state plan) services; Division of DD funded services should not supplant or duplicate state plan services. Referrals for state plan Personal Care Assistance should not be made when the intent is to teach, prompt or accompany the individual into the community.**

Natural supports and relationships are an integral part of everyone's lives and should be fostered and encouraged by all planning team members (circle of support) to assist with the development of a well-rounded *circle* for the individual.

Information should:

- define the support,
- define the purpose of the support
- define the frequency of the support

This information should assist in providing a global picture of all supports available to the individual and to describe the supports needed to wrap around other *available* supports in the community.

<b>NON-DIVISION SUPPORTS</b>	
Information about natural supports available to the individual.	Mandatory
Information about state plan supports. (These supports shall be accessed prior to Division funded supports)	Mandatory
Information about enrollment in Non-Division Waiver programs.	Mandatory
Information about community resources currently being assessed or utilized: (i.e.: Lions, Elks, etc.)	Mandatory
Supporting Missouri Quality Outcomes <ul style="list-style-type: none"> <li>○ People belong to their community</li> <li>○ People have a variety of individual relationships</li> <li>○ People have valued roles in their family and in their community.</li> </ul>	

## 10. REQUIREMENTS OF FAMILY OF MINOR CHILD OR GUARDIAN:

If the individual is a minor child, information from the parent(s) or guardian MUST be included in the plan. If the individual is an adult with a guardian, information must be included if the guardian requests that it be included. The plan (support section or outcome / action steps as applicable) should describe how guardian concerns are being addressed.

It is very important to clearly differentiate what is important to the guardian from what is important to the individual. Information such as this should be included in the plan but it needs to be clear. One way to provide clarity would be to include a section titled “What is important to the guardian” while balancing the needs and preferences of the individual.

FAMILY OF MINOR CHILD OR GUARDIAN	
Parents of Minor Child	Mandatory
Guardian (per request)	Contingent

## 11. MANAGEMENT OF INDIVIDUAL FUNDS

This part of the planning process outlines the ability of the individual to manage their individual funds to the extent that they require supports. While this may apply to all individuals receiving supports, it is a mandatory component for individuals receiving residential supports.

It also provides a tool for the payee of benefits, when appropriate; to prioritize the remaining benefits as directed by the individual within the Social Security guidelines.

<http://www.socialsecurity.gov/pubs/10076.html>

The Division of Developmental Disabilities receives the SSA or SSI benefit checks monthly for those for whom they serve as payee. The Division uses these benefits to pay monthly room and board costs and other necessary living expenses. The Division maintains a NAFs (non-appropriated funds or consumer banking) account balance for any unspent funds.

These balances are available to be used for other needs and wants. Per Social Security guidelines for payees, the funds must be used for basic needs such as food, clothing, shelter, health related expenses or burial plans/life insurance before they are spent on recreational activities.

There are no restrictions from Social Security on what recreational activities an individual chooses.

The Division manages an individual’s NAFs account to ensure that their total resources are less than \$999. If resources increase beyond this amount, the individual will no longer be eligible for Medicaid and will no longer qualify for the Home and Community Based Medicaid Waiver or Medicaid State Plan Supports.

All individuals will have identified their needs and wants for the upcoming year during their ISP meeting. This enables the individual, support coordinator, family member or provider to identify what needs and wants to be purchased from their account.

<b>MANAGEMENT OF INDIVIDUAL FUNDS</b>	
Ability of the individual to manage their individual funds, (which includes room and board and/or individual spending and may include earned income).	Contingent
The supports required on behalf of natural supports or paid providers to assist the individual to manage their funds.	Contingent
Information regarding how the individual wishes to spend / save their funds. (i.e.: dental Insurance, burial plans, leisure activities, etc.)	Contingent
Address payee of benefits and management / distribution of the benefits.	Contingent
Payee status	Contingent
Individual spending information	Contingent
Supporting Missouri Quality Outcomes: People are supported in managing their home. People have control of their daily lives. People’s plans reflect how they want to live their lives, the supports they want, and how they want them provided.	

## **BRINGING IT ALL TOGETHER**



### **12. PERSON-CENTERED OUTCOMES AND ACTION PLANNING:**

Outcomes and action planning is a process used to ensure the individual is assisted to achieve their desired goals.

Outcomes are **required** for the ISP process.

Development of the outcomes and the action plan means commitment, consistency, accountability and implementation to reflect the individual's needs, wants, desires, interests, preferences and capacities.

The Missouri Quality Outcomes are used to develop outcomes and action steps:

<http://dmh.mo.gov>

These reflect best practice and the values for the Division of Developmental Disabilities. The Quality Outcomes defines a “benchmark for typical lifestyle” desired by anyone. Although the outcomes provide us with examples of how they may be defined, the definitions are not a standard.

We may all have the same outcome, but each of us may define THE SAME OUTCOME differently depending on our current situation, life experiences, future goals, preferences and specific steps we want and need to take to reach the ultimate journey.

Action steps may be distinct by our own personalized paths or journeys. For example, the Missouri Quality Outcome that states: “People belong to their community” will be defined differently for one person depending on where they live, who they know, what they want from the community, what they want to contribute to their community and the resources available to access their community.

### **THE FOLLOWING ARE *BEST PRACTICE* COMPONENTS FOR ACTION PLANS:**

**Outcome statement** – always reflects what is *important to and important for* an individual. Outcome statements can be derived from what is working / not working in the person's life. Outcome statements represent *the result, the ultimate place to be, the big picture, etc.*

- An outcome **IS NOT** a service such as “will receive residential services”. The result is not the residential service.
- An outcome **IS NOT** a statement for continued supports, such as, “will continue to receive day services”.
- An outcome **IS NOT** an action step. The action steps are the “stepping stones” to reach the outcome. The purpose of an action step is to help the team to define what it takes (teaching, action from others, etc.), to make the outcome a reality!

The following are the steps in the process:

a) **Current situation:** Defining the current situation helps to justify the need for the outcome. Within the body of the plan or in the action planning section: Ask: Why does the outcome exist?

- The current situation is a short statement to justify the outcome and is a good opportunity to emphasize needs, preferences, desires, etc.

b) **Criteria** – How do we know when the outcome is accomplished?

- Measuring progress: A criterion simply means we have the information we need (data: observations, documentation) to tell us the individual is making progress or has met the outcome or has met one of the specific action steps that leads to achieving the outcome.
- Quality of life goals are often subjective, therefore, detailed documentation and noted discussions with the individual, family, supporters and / or other team members (the circle) is crucial to assess if the outcome or action step has been met. Information from these sources is also crucial in data collection.
- This also helps teams to determine how to proceed. We should always ask: What else do we need to learn?

c) **Action Steps:** This is the action to be taken (broken down in a way that is achievable) for each defined step in the process needed to reach the outcome.

d) **Strategies:** Where there is an action step, there should be a strategy.

- Especially in situations where there are different supporters implementing the outcome, strategies can assist all supporters to know how to consistently implement each action step.

**Strategies shall focus on:**

- How the individual learns best (if teaching is involved)
- Instructions to teach
- Defines what it takes to reach the action
- How to best document progress

This is the information needed to understand the individual's expectations, family / team expectations, staff / agency expectations, etc., to implement each action.

e) **Accountability:** This refers to *who* is responsible.

- This includes names of those responsible. This is up to the individual and team (the circle), but there needs to be someone named as the responsible party to ensure accountability to the implementation of the action.
- Timeline for completion: As *best practice* there should always be a timeline to identify when the action step is implemented (all action steps need not implement at the same time and can be varied throughout the planning year).

The timeline for action steps should only take as much time as needed to begin and to end.

The timeline must make sense to the individual, must reflect progress and assesses if the outcome continues to be important to the individual.

### Ideas for getting started:

Start with assessing what is working / doesn't work:

This tool uses information about the person to assess what needs to be maintained, enhanced and / or changed (also known as what does or does not make sense, or what's working/ not working) to assist in the development of outcomes and action.

	<b>What Makes Sense What works? What needs to be maintained /enhanced?</b>	<b>What Doesn't Make Sense What doesn't work? What needs to change? What must be different?</b>
<b>from Sharon's' perspective: Best Guess</b>	<p>Sharon's family is active in her life Sharon has friends. Sharon has pictures of family and friends to share with others.</p> <p>Having a pet (Josie - her cat).</p> <p>Sharon spends time alone as needed and others respect her alone time.</p> <p>Working part time and making money.</p> <p>Listening to music while doing her chores.</p>	<p>Going places where there are crowds of people or NOT being told this may happen.</p> <p>Going to the workshop- even if it is only 2-3 x per week.</p> <p>Not looking for another job.</p> <p>When staff say they don't have time to talk to her or to or look at her pictures.</p> <p>Feels sad when she misses her mom.</p>
<b>from family or staff perspective:</b>	<p>Sharon's continuous family support.</p> <p>Sharon's mom always tries to be available when needed.</p> <p>Some supporters appreciate / respect Sharon's communication style.</p> <p>Sharon's home, the location and her housemate choice.</p> <p>Her pictures, recliner/rocker - seems "calming". Keeping family informed and calling them when needed.</p> <p>Keeping a busy schedule.</p>	<p>Don't understand why in some places crowds of people are a problem and other times it is not.</p> <p>Sharon is not encouraged to use her pictures when she is upset and not everyone who supports her knows her communication style.</p> <p>Not always sure why Sharon gets "agitated".</p> <p>Capable of more independence (she can learn more about taking care of her home)</p>

**Note:** This is a great tool to use to share different perspectives (parent/guardian’s perspective, staff/supporters perspective, etc.), if not identified in other areas of the plan, especially if the perspective is different from the individual.

**Support needs vs. outcome development:**

The things that are working and need to be maintained should be addressed in the support section discussed earlier in this manual - *What we need to know or do to support the person.*

In reviewing the chart, for example the team should ask:

- How do we support Sharon in the community when there is a potential problem, such as being around “crowds” of people.
- The supporters (staff, family, job coach, etc.) may need to gain a greater understanding of Sharon’s support needs and record this for consistency.
- Supporters may have a good idea of things to avoid such as not going to the mall on Saturdays or holidays – this is a support need important to note in the ISP.
- If extensive supports are needed, the circle of support may need further assistance from an expert (a behavioral specialist, for example, to conduct a “functional assessment”) to better understand why Sharon responds in a way that is not safe for her and / or others.

How do we support Sharon when “we think” Sharon misses her mom: This is another support need to be communicated in the ISP, for example:

The team may need to look at alternatives to calling mom when Sharon is feeling sad, in case mom is not available.

**What is NOT working or does not make sense:**

This side of the chart is valuable information to develop outcomes and action steps:

- ✓ Seeking meaningful work (develop outcome and action steps)
- ✓ Facilitating and enhancing communication in a way that makes sense for Sharon with others (develop outcome and actions steps)
- ✓ Learning how to develop skills to take care of her personal living space (develop outcome / action steps).

Using the above tool to develop an outcome:

**Step 1:** Assess what’s working / does not work, which may also be reflected in the body or profile of the ISP.

**Step 2:** Developing the outcome and rationale - (Note: the “rationale” is also referred as the “justification” or “current situation” and can be noted in the body of the plan or as part of the outcome\ action step section).

Example Quality Outcome: *Sharon’s communication is understood and receives a response.*

Sharon’s definition of the outcome: *I want to talk to others using my pictures.*

Current Situation:

Sharon currently uses few words to communicate and others who do not know her, has a difficult time understanding her communication style. Sharon wants and needs a way to communicate with people she does not know especially if she wants to seek a new job or develops new relationships. Sharon likes to use her pictures to initiate conversation with others; this is her communication style.

**Step 3:** Developing Action Steps – (Ask: what needs to happen to make the outcome a reality?)

**Step 4:** Support Strategies (also known as *learning strategies*).

Example Action Step #1: Develop a communication book.

Implement by: 12/1/12 (this may be the beginning of the planning year),

Estimated completion date: 6/1/13

Responsible individual(s): Sharon, Kathy (mom), Susan (support staff)

Strategies for developing a communication book:

Sharon, with support, will develop a list of people, places and things to begin her communication book by 1/15/13.

Sharon, with support, will budget her money to buy a disposable camera and wallet of her choice by 2/15/13 to take pictures of her favorite people, places and things and so that she has a place to store her pictures.

By 3/30/13 - Family will help with ideas, go through existing family pictures to be gathered and used, may need to get extra copies made for Sharon's use.

**EXAMPLE**

**Missouri Quality Outcomes Action Plan Tool**

Missouri Quality Outcome:	<i>Jennifer has a variety of individual relationships.</i>
Current Situation (Justifies the need for the outcome):	<i>Jennifer does not see her family as often as she'd like. She hears from her mother and brother by phone and on major holidays. Jennifer, her mom and brother would like more contact but need support to make this happen. Currently, support staff makes informal calls to the family to stay in touch 1 x per month.</i>
Individual's Definition of the outcome (Describes how the individual does or would define the outcome)	<i>I need to talk to my family more often.</i>
Support(s) needed or received	<i>1) Jennifer receives residential services from XYZ agency. 2) Jennifer receives spending of 30.00 per month monitored by XYZ agency and regional office. 3) Jennifer receives day services (on-site, group) from ABC agency.</i>
How do we know the outcome is accomplished?	<i>Talking to Jennifer and her staff, review of daily documentation Feedback from family Documentation will show evidence that increased contact, more than 1 time per month, is happening consistently for at least one planning year. Jennifer and her team will determine if Jennifer is satisfied with the increased contact.</i>

<b>What needs to be done? (Action Steps)</b>	<b>Strategies for Implementation</b>	<b>Who's Responsible?</b>	<b>Start/Estimated completion</b>	
Jennifer will learn to keep in touch with her family at least weekly (and at her and her family's) request.  ("Keeping in touch" is defined by the strategies that work for Jennifer).	* Purchase a calling card by 1/1/14 by budgeting individual spending funds.  *Make long distance calls to her mother at least 1 x per week, preferably Fridays after 5 pm and help from family.  *Obtain and/or purchase a calendar and address book to record phone numbers and reminders of days to call.	Staff–Nancy updated monthly and reviewed by SC during visits each month.	2/1/14  2/15/14       2/15/14	2/15/14          Calls are documented weekly.

**Additional Outcome Examples:** The next examples are in reference to a related support need:

**Support Need: Transportation**

Outcome: Jim is employed.

Current Situation: Jim works at ABC Industries. There is no public transportation available in the area where Jim lives and he does not drive. Ridesharing has been explored but no option was found. Jim needs funded transportation to be able to get to work. Without a job, Jim would be at home alone which is unsafe. Without a job, Jim would require significantly more funded supports in order to stay safe.

Action Steps:

- Jim will access Great Rides Transportation System to and from work.
- Jim and his team will seek alternatives transportation.

Responsible Person: Marcy Jones (Jim’s Support Coordinator)

Timeline: Authorized annually for each plan year.

**Support Need: Incontinence briefs**

Outcome: Mark is healthy.

Current Situation: As described in his plan, Mark is incontinent. His salary at work and SSI benefits does not cover the cost of adult briefs. Paying for them would also be a financial hardship on him and his family. Without using briefs, Mark’s incontinence would result in skin breakdown presenting a health and safety risk. It would also result in him losing his job due to hygiene issues.

Action Steps:

- Mark’s briefs are authorized at the beginning of each annual plan.  
Responsible Person(s): Mark’s support coordinator. Timeline: By 5/31/14.
- Mark’s family helps him with his briefs each day before work and as needed on weekends.  
Responsible Person(s): Mark’s family.  
Timeline: Weekly

**Support Need: Support Coordination to access resources**

Outcome: Mary has access to community resources.

Current situation: As needs arise, Mary and her family need assistance to identify and accessing both local and state resources. Without this help, Mary’s needs may likely go unmet resulting in potential health and safety concerns.

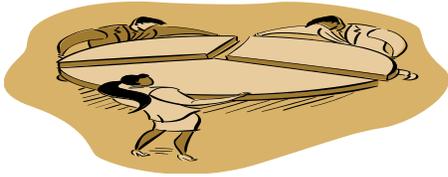
Action Step(s): Mary and her family have at least quarterly contact with the support coordinator to review her ISP and to identify any needs.

Responsible Person(s): Mary’s support coordinator.

Timeline: At least quarterly or as determined by the family.

<b>DEVELOPING OUTCOMES AND ACTION STEPS</b>	
Regardless of whether an individual has funded supports or support coordination only, outcome development is a requirement.	Mandatory
<p><u>MO Quality Outcomes</u> are used as a guide to develop outcomes: For a list of the quality outcomes - refer to the current MO Quality Outcomes Manual: <a href="http://dmh.mo.gov">http://dmh.mo.gov</a></p> <p><u>Outcome:</u> <i>The result from action taken.</i> <i>The big picture</i> <i>The result</i> <i>A means to an end</i> <i>What the individual will ultimately know or be able to do as the result of learning.</i></p>	Mandatory
<p>Describe the current situation:</p> <ul style="list-style-type: none"> <li>• A short summary describing the rationale or justification for the outcome.</li> <li>• This shall be stated in the outcome section of the plan or in the body or profile section of the plan.</li> </ul>	Optional
<p>Individual's definition of the outcome or family's definition (for natural home settings):</p> <ul style="list-style-type: none"> <li>• This identifies what the outcome means specifically to the individual (or the family for natural home settings), in <u>their words</u> if possible.</li> <li>• This helps to reflect that the plan is "voicing" how they define or describe what the outcomes means to them - individually.</li> </ul>	Optional
<p>Action Steps:</p> <ul style="list-style-type: none"> <li>• Specific, individualized, measurable <i>stepping stones</i> necessary to achieve an outcome, to get from point A to point B.</li> <li>• Includes accountability and timelines.</li> </ul>	Mandatory
<p>Strategies (OR learning/support strategies – if learning is to occur):</p> <ul style="list-style-type: none"> <li>• Tips to help achieve the outcome or tips to help the learner to achieve what they want to learn or do.</li> <li>• Individual teaching activities.</li> <li>• Process used to facilitate learning based on an individuals' learning style and support needs.</li> </ul>	Mandatory
<p>Measurement:</p> <ul style="list-style-type: none"> <li>• States the timelines / target dates for completion.</li> <li>• This helps the team to determine if progress is occurring, what needs to continue to occur, if more time is needed to achieve the action taken, if the means of measuring progress is working or not working and if the timeline makes sense.</li> </ul>	Mandatory
Supporting Missouri Quality Outcomes: <b>ALL</b>	

**13. CONTRIBUTORS: (information about this topic is mandatory):**



Includes the following:

- ✓ Those who contributed to the plan through interviews, reports, letters, questionnaires, etc.
- ✓ Those present at the plan meeting.

If the individual is not present at the planning meeting, the team must justify the individual's absence and how the individual was otherwise involved in the planning process.

**NOTE:** The support coordinator assures that individuals and their guardians receive a copy of the ISP document as well as all providers of services that are actively delivering funded supports.

**14. BUDGET: (information about this topic is mandatory):**



The support coordinator will assure that the individual's budget information is part of the ISP document (the budget shall also be attached) and outlines all services received and costs.

This information is vital for the individual, their family, and all service providers as it creates a picture of all paid supports for the individual.

The budget shall outline the following information:

- Time span of service(s)
- Name of each service
- Name of each service provider
- Number of units to be provided in the time span indicated for each service
- Service rate per unit for each service
- Total cost per time span of each service
- Total budget cost for all combined services
- Annual Cost of the individual's identified needs and wants that will be covered by the individual's Consumer Banking Account. (\*\*See section 11, Page 29-30).

**Note:**

The budget is part of the plan and the individual/guardian shall receive a copy.

## ADDITIONAL REFERENCES / RESOURCES



Helen Sanderson and Associates

<http://www.helensandersonassociates.co.uk/reading-room/how/person-centred-planning.aspx>

The Learning Community for Person-Centered Practices

<http://www.learningcommunity.us/home.html>

- Person-Centered Thinking: <http://www.thinkandplan.com/person-centred-thinking.html>

One page profiles

<http://onepageprofiles.wordpress.com/>

<http://www.helensandersonassociates.co.uk>

Copeland Center for Wellness and Recovery: WRAP for People with Developmental Distinctions

<http://copelandcenter.com/>

Cornell University Education Site

<http://ilr-edi-r1.ilr.cornell.edu/PCP/>

Inclusion Press

<http://www.inclusion.com/maps.html>

Kansas Institute for Positive Behavior Support: facilitating person-centered planning

[http://www.kipbs.org/new\\_kipbs/fsi/pcp.html](http://www.kipbs.org/new_kipbs/fsi/pcp.html)

Beach Center – Planning with families

<http://www.beachcenter.org/default.aspx>

Pacer Center – *champions for children with disabilities*

<http://www.pacer.org/tatra/resources/personal.asp>

Laurie Markoff – The Institute for Health and Recovery

<http://www.healthrecovery.org>

Safety First Project: UMKC's IHD & Community Partners improving services for survivors with disabilities:

<http://info.umkc.edu/umatters/2011/06/14/safety-first-project-umkcs-ihd-and-community-partners-improving-services-for-survivors-with-disabilities/>

Person-Centered Career Planning

[http://www.onestops.info/article.php?article\\_id=284](http://www.onestops.info/article.php?article_id=284) <http://careerworksc.com/personcentered.html>

A Manual for Person-Centered Planning Facilitators Angela Novak Amado, Ph.D. and Marijo McBride, M.Ed.

Institute on Community Integration UAP

[rtc.umn.edu/docs/pcpmanual1.pdf](http://rtc.umn.edu/docs/pcpmanual1.pdf)

Families planning Together

[learningcommunity.us/documents/FPTGuide.11-03.pdf](http://learningcommunity.us/documents/FPTGuide.11-03.pdf)

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