Guidelines for QDDPs

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NDCPD
Minot State University
Center of Excellence

Guidelines for QDDPs
(Qualified Developmental Disability Professionals)

This training manual was developed by the North Dakota Center for Persons with Disabilities to be used by North Dakota community provider agencies participating in the Community Staff Training Project through Minot State University. We encourage the use of this publication for not-for-profit organizations for educational and research purposes. We request that appropriate acknowledgment be given. Requests for use of this publication for any other purpose should be submitted to Minot State University, NDCPD, Community Staff Training Project, Box 36, Minot, ND 58707.

Acknowledgments

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Table of Contents

Chapter 1: Introduction

Objectives:
After reading this QDDPs will be able to:
1. List values that guide the QDDP in supporting individuals with intellectual and developmental disabilities.
2. Define system centered planning.
3. Describe the difference between active treatment and active support
4. Give an example of a waivered service in North Dakota.
5. List examples of natural supports available in at least three different environments.
6. Recognize qualities of the OSP that are person centered.
7. List educational and experiential qualifications for a QDDP position.

Qualified Developmental Disability Professional (QDDP)

The title QDDP encompasses a myriad of responsibilities. A QDDP is a leader, manager, coordinator, educator, counselor, and often responsible for the fiscal activities of programs under their supervision. A QDDP's direct responsibilities may be all of these or only a few. Each agency that serves people with disabilities distributes the duties uniquely. A QDDP in Agency A may have the title of Program Coordinator and be responsible for every aspect of residential services for assigned people. A QDDP in Agency B may be referred to as a Program Administrator but delegate some duties to staff. The distribution of duties may vary, but the accountability does not. A QDDP ensures quality programs/services for the people supported in the employing agency. The QDDP is in a pivotal role to affect the lives of the people supported.

History

Prior to 1971 most facilities for people with intellectual disabilities were supported by state or local funds. An amendment to the Social Security Act in 1971 (Title XIX) established facilities called Intermediate Care Facilities for the Mentally Retarded or ICF/MRs (now called Intermediate Care Facilities for Individuals with Intellectual Disabilities or ICF/IID). With the establishment of these facilities came regulations to monitor and improve services. These regulations defined the Qualified Developmental Disability Professional (QDDP) as a person who coordinates and monitors the Person Centered Service Plan (PCSP) of each person supported. The PCSP along with ISP (Individual Service Plan) are part of the OSP (Overall Service Plan). Program plans are sometimes referred to as IEPs (Individual Education Plans), IHPs (Individual Habilitation Plans), ELPs (Essential Lifestyle Plans), or even ISPs (Individual Service Plans). Whatever acronym is used the QDDP is ultimately responsible for the supports provided.

Title XIX cites qualifications for QDDPs that include:

- At least one-year experience working directly with people who have intellectual or other developmental disabilities
- At least a bachelor's degree in a human service field or a bachelor's degree with module certification (tag w180 in Interpretive Guidelines). The memo dated July 1, 2009, referencing DDD-PI-097 (PI-09-09) gives specific guidelines. These are available on the http://www.state.nd.us/robo/projects/816/816.htm website.

Even though these regulations have been revised, the QDDP's role has not changed. More details regarding the professional role and qualifications can be found in the online North Dakota Developmental Disabilities Policies and Procedures Manual.

Person Centered Planning

Values

Rules and regulations provide guidelines or parameters for agencies. Usually regulations represent the minimum standard acceptable in service delivery.

Values are the impetus for creativity or innovation. Most of us want to go beyond the minimum requirements and provide supports and services that are creative and focus on the desires of the person supported. Values or principles that embody "what services should be" are necessary to be a successful QDDP. Essential values include:
1. Active treatment
2. Active support
3. People First language
4. Self-determination and choice
5. Protection and exercising of rights
6. Dignity of risk
7. Least restrictive alternative
8. Building relationships
9. Natural supports
10. Age appropriateness
11. Valued social roles
12. Confidentiality
13. Meaningful work
14. Personal outcomes
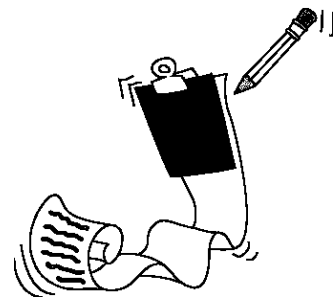
This is not an all-inclusive list but should be descriptive of the principles QDDPs hold regarding the people they support. QDDPs are expected to model these values. They are expected to recognize and intervene where values, principles, or rights have been violated. QDDPs are responsible for challenging and educating those who hold conflicting values, myths and misunderstandings about the people they have accepted a responsibility to serve. QDDPs work for change in the lives of individuals supported. In seeking individualization and change, the

QDDP may encounter conflicts with systems that are currently in place. Professionals who welcome this will grow and develop better services.

Person centered planning is not merely an annual meeting to produce an Overall Service Plan (OSP) where the QDDP is responsible for the PCSP (Person Centered Service Plan) of this document. It is a collaborative, ongoing action between the individual supported and those committed to helping the person define and pursue a meaningful life and desirable future. It is a means for uncovering what is already there. Person centered planning focuses on the person and their desires and needs, not systems that may or may not be available. Team members help the person figure out where they want to go and how best to get there.

In their paper, "The Five Accomplishments," John O'Brien and Connie Lyle list five principles of Person Centered Planning:
- **Community Presence –** the sharing of ordinary places that define community life.
- **Choice –** the experience of autonomy (independence) both in small everyday matters (e.g. what to eat or what to wear) and in large life-defining matters (e.g. with whom to live or what sort of work to do).
- **Competence -** the opportunity to perform functional and meaningful activities with whatever level or type of assistance is required.
- **Respect –** having a valued place among a network of people and valued roles in community life.
- **Community Participation –** the experience of being part of a growing network of personal relationships that include close friends.

The QDDP helps the team avoid adopting "System Centered" planning, where people receiving supports are molded to fit into existing agency programs. It is one of the ongoing challenges the

QDDP will have - to refrain from molding the "person centeredness" around agency policy, work schedules, budgets, staffing patterns, available programs and services. This challenge requires that the QDDP step to the side of the planning process and become part of the support team. It means being less concerned with the roles or status of other professionals on the team and being a partner in the planning. The QDDP must also be aware when other professionals face this challenge – when they become more of a molder of services and less of a partner. This requires a clear understanding of what Person Centered Planning is and what it looks like in the processes of team facilitation – both in the actual team meeting and in the management of agency resources to implement the plan.

Ongoing self-evaluation in the following areas will keep a person centered focus. Reflecting on these questions will help a QDDP ensure that plans are Person Centered rather than system centered:

- Do I have a commitment to know and seek to understand the person supported?
- Do I have a resolve to be of genuine service?
- Am I open to being guided by the person?
- Am I willing to struggle with difficult goals?
- Am I flexible, creative, and open to trying other possibilities?
- Is my work enhancing the humanity and dignity of the person supported?
- Do I look for the good in people and help to bring it out?
- Am I or the staff I supervise actively engaged with the people we support?

Active Treatment

The term active treatment is synonymous with Title XIX regulations. It describes the Federal expectations of support provision. The definition of active treatment is:

> *A continuous program that includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services. (W196 Interpretive Guidelines: Intermediate Care Facilities for Persons with Intellectual Disabilities).*

The QDDP is designated as the primary professional to ensure that this aggressive plan is fulfilled and, if necessary, revised to meet the needs of the person supported. To keep the PCSP continuous, aggressive, and consistent during implementation, the QDDP must be involved in the lives of the people supported. The QDDP should know the person well. It is not enough to know of them; he or she must know the individual personally. This requires that the QDDP is on the "scene" where the plan is implemented, across all environments - residential, vocational, community. Being present in these environments is necessary to determine if the plan is implemented as it was intended, and whether or not, the person supported is safe, healthy, treated with respect and growing more independent in these environments. The QDDP must constantly evaluate and monitor the effectiveness of the plan so that appropriate modifications will be adopted. The premise of services to people is growth.

QDDP – Licensing of providers and Medicaid funding

The expectations, standards and business practices of organizations and corporations who provide services and supports to individuals with intellectual and developmental disabilities are based in part, by the requirements of the funding source and licensing entities.

In the state of North Dakota, the Department of Human Services-Developmental Disabilities Division is responsible to license and enroll the providers who offer services and supports

through the Developmental Disabilities system. The licensing requirements are prescribed in North Dakota Administrative Code 75-04-01; the Purchase of Service in 75-04-02 and Reimbursement for providers is contained in 75-04-05. Currently the licensing standards in 75-04-01 require the providers to meet standards which result in accreditation by the Council on Quality and Leadership (CQL), certification as an Intermediate Care Facility for People with Intellectual Disabilities or for Extended Service results in accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF).
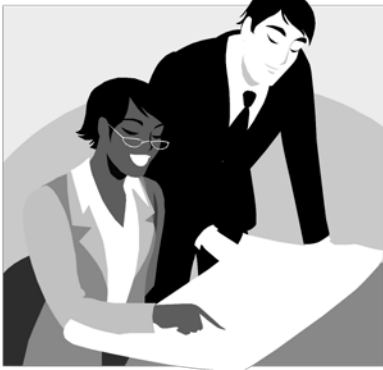
Medicaid is the primary funding source for services. If the individual does not meet the requirements to receive Medicaid funding, the person is responsible to pay for most of the services they receive.

Medicaid is a joint partnership between the Federal government and the states with each contributing a certain share of the cost for services. Medicaid funding for ND citizens with intellectual and developmental disabilities is typically accessed through 2 Medicaid programs:

1. **The Medicaid State Plan** which covers traditional services such as inpatient hospital, clinic, physician, home health, ambulance, OT, PT, speech, etc. and the **ICF/IID institutional group home**.

    The role of the QDDP originated in 1971 when Congress authorized ICF/MR (currently ICF/IID) services as a state plan option under Medicaid. Federal regulations at 42 CFR Part 483, Subpart I, Sections 483.400- 483.480) in eight areas, including: governing body or management, client protections, facility staffing, active treatment services, client behavior & facility practices, health care services, physical environment, and dietetic services. The current set of Federal regulations was established in 1988 and is currently undergoing revision.

2. **The DD Home and Community Based 1915c Waivers** which offer services in the community to an individual who would benefit from treatment and services provided in an ICF/IID group home if the community waiver services were not available. Rather than living in an institutional group home, the person can receive community services as an alternative.

    Home and Community Based services include but are not limited to: Waiver group homes (congregate care, TCLF, MSLA), ISLA, SLA, Day Supports, Family Support Services (In Home, Family Care Option, Family Care Option III), Extended Services, Infant Development, and the numerous self-directed services that are available to individuals who live in the home of a primary caregiver.

Although the waivers provide States with some flexibility determining the services they provide, who can provide the services, how health, safety and quality are determined, the State must make certain assurances to the federal government in order to have the waiver approved:

- o every individual must have an individual plan of care developed by qualified professionals
- o necessary safeguards must be taken to ensure health and safety of recipients
- o every individual has a free choice of qualified provider
- o the State has a way to account for all funds and know where the money is spent, for what people and what services

The Qualified Developmental Disability Professional (QDDP) is an integral part of the service delivery system. It is important for the QDDP to understand the licensing and funding requirements since the methods for service planning, rights, health and safety, program monitoring, and financial accountability are based on these standards and regulations.

Active Support: Active support is an approach to realizing active treatment by in real world settings. Active support comes from a model developed in Australia and Great Britain which has been eagerly adopted by providers in ND who helped to pilot it's use here.

The purpose of Active Support is to assure that people with disabilities are actively, and consistently engaged in meaningful activities throughout the day, regardless of the level of disability-related support needed.

Active support brings together a number of evidence-based strategies for engaging people in gaining experience and learning new skills.

While Active Treatment focuses on what the agency provides, active treatment focuses on what the individuals receive and how to help people enjoy relationships with family and friends; gain new experiences and skills and be actively and consistently engaged in meaningful activities.

The enclosed chart compares these two approaches. Learning to give Active Support requires further training and mentoring so that the QDDP learns to provide AS at the individual and team level and to instruct other staff in how to provide AS as well. Core components include

- Identifying personal preferences and preferred routines and activities
- Identifying opportunities for individuals to be engaged within each activity. Identifying new opportunities that are a match for the person's interests and skills.

- Identifying the level of support and instruction needed for the person to participate.
- Listening to and reading the person's response to activities and adjusting or individualizing support
- Providing that support consistently throughout the day.
- Supporting more than one person at the same time as needed.
- Assuring that the team or shift has planned how to make sure each person receives active support.
- Communicating as a team to solve problems and measure progress.

Inclusive Opportunities and Natural Supports

Person centered planning requires explicit, creative and sustained effort to increase social resources. The QDDP should be vigilant in using integrated community environments when guiding the development of the Person Centered Service Plan portion of the Overall Service Plan. The opportunities of developing relationships, learning in the actual setting, acquiring skills and competencies, educating the community about disabilities, and acquiring valued social roles are natural by-products of participation in inclusive environments.

Because it is much easier to develop plans that use service system settings, it is tempting for the team to gravitate toward these options. The QDDP should steer the team to first consider how the plan can be carried out in community settings, (e.g. using the local Red Cross safety course rather than setting up a class just for people you serve). The QDDP should be familiar with the possible types of natural supports in the settings selected. Natural supports are any assistance, relationships, or interactions that allow a person to secure, maintain and advance in the community of his/her choosing in ways that correspond to typical routines and social actions of other people and that enhance the individual's relationships.

Dean lives in a group living arrangement but has his own kitchen, bedroom and bathroom. He is semi-retired and still has a part time job delivering the local newspaper in the early morning hours 6 days a week and working at a local retail store three afternoons a week cleaning the store. Dean uses the local public transportation to get to his afternoon job. He has learned his paper route and walks this with minimal supervision. Some customers on his route keep an eye out for Dean and are concerned about him when he is late. Dean's route changes with the amount of daylight. He will not deliver papers unless the sunrise has occurred. Dean's safety is also checked by using a GPS application on his cell phone which he carries on his paper route and when he uses public transportation.

Below are 5 general categories and examples of natural supports.

From the list below – identify some natural supports that are at work in Dean's life.

Employer Supports
- Co-worker mentor
- Co-worker training
- Employee assistance program
- Restructuring duties
- Scheduling flexibility

Community Supports
- Independent Living Center
- Safety courses
- State Assistive Technology systems
- Neighbors
- Church groups

Transportation Supports
- Taxi
- Family
- Bicycle
- Bus/public transportation

Personal and Independent Living Supports
- Neighbors
- Neighborhood Watch groups
- Digital watch/alarm
- Housemates
- Technology for security (Life-Alert, alarms, cognitive aids)

Recreation and Social Integration Supports
- Jaycees
- YMCA
- Parks and Recreation
- Company Sponsored Activities
- After work with co-workers

By being active and familiar with the community, the QDDP, as well as team members, can tap into supports that will assist an individual to develop a sense of social belonging, dignity and self-esteem. The agency can also promote the use of natural supports by encouraging people to be involved in community programs, activities, projects, volunteering, being employed and having social contact with family, relatives, and neighbors.

Lisa is learning more aspects at her job at the YMCA laundry. Her job coach knows that to gain all she can from her job she needs to be able to socialize and join in on conversations in the break room. Many of the employees have a passion for gardening outside of work and much of the conversation centers around how their plants are doing. The job coach wants the employees to naturally ask Lisa questions and comments and not use the job coach as a "liaison." The job coach suggests that Lisa wear a t-shirt or sweatshirt with a picture of a plant or aspect of gardening. She also suggests that Lisa begin learning about gardening and maybe even go to local events for gardening enthusiasts.

The scenario above illustrates the use of co-workers as natural supports to social integration. The skills of the observant job coach made the use of this natural support possible.

Relationships

It is a core belief of Person Centered planning, that a quality life includes a circle of support other than paid staff. Even though a person may appear to prefer being isolated, it is necessary to establish continuity in the lives of the people we serve. The staff in a person's life change quite frequently for a variety of reasons. Relationships other than with agency staff can be a part of that stability.

The QDDP should consistently evaluate the activities of the Person Centered Service Plan portion of the Overall Service Plan against how vigorous it will provide opportunities for developing and maintaining new relationships for the person supported. Even though relationships cannot be forced, plans can be developed that create more chances or occasions for relationship building. Merely being present in the community, (e.g., going to the park or using the grocery store down the street), does not afford circumstances for relationships to begin and be nurtured. For friendships to begin and be sustained, opportunities to share mutual interests, competencies and social interaction should be identified and fostered. It is the responsibility of the QDDP to judge the sufficiency of the plan in this area and make necessary adjustments. Some question to help the QDDP consider in developing a support plan that will foster and sustain meaningful relationships include;

- Are opportunities left to the staff to discover or does the team embed training for these opportunities in the goals and objectives?
- Are specific directives given in the PCSP portion of the OSP or is it expected that the direct support professionals (DSP) take the lead? The DSP may need specific examples of how to foster relationship opportunities or the need might be to actually teach a social skill.
- Does the person need a support or is a learning objective needed for the person to achieve progress in this area?

- Are the DSPs exchanging information as needed to assure that Active Support to achieve progress is consistently provided across staff?

For more information on building relationships, see the *Friends and Fun* module in the North Dakota Community Staff Training Curriculum.

Valued Social Roles

Valued social roles assist an individual to develop a sense of dignity and self-esteem. When someone is a homeowner, an employee, a greeter at church, the secretary of the church circle, they are recognized as being capable. When they are viewed as capable, common myths about people with disabilities are overcome.

The QDDP and the team should judge if the plan and its activities pursue this value. The QDDP is responsible for ensuring that the supports necessary to fulfill the person's social roles are in place. These supports may be social skills training, matching the person to natural supports such as a mentor, transportation, or *adaptive* equipment/technology solution. Isolation causes myths to develop about the isolated group (people with disabilities) by the empowered group (the community at large). People with disabilities have been isolated and many misguided ideas about their capabilities have been perpetuated. Until the isolated group can mingle and engage socially with the empowered group, these ideas will persist. The QDDP is obligated to do more than assist and monitor passive plans that assure the basics such as food, shelter and safety. The Person Centered Service Plan must actively pursue valued social roles.

Study Questions Chapter 1

True or False

_____1. To qualify as a QDDP the applicant must have at least one year of experience working directly with individuals with intellectual and developmental disabilities.

_____2. QDDP is an acronym for Qualified Developmental Disabilities Professional.

_____3. A QDDP must have a Bachelor's of Science degree in a human service field.

_____4. When a person supported does not meet eligibility for Medicaid they are no longer eligible for services.

_____5. Medicaid is a joint partnership between a state and the federal government for services to people with developmental disabilities.

_____6. When an agency policy or procedure conflicts with the basic values of person centered planning the QDDP should address the policy/procedure conflict with agency leadership.

_____7. A desirable quality in any PCSP is giving DSPs permission to determine what social skills need instruction on any given day.

_____8. If you are providing Active Treatment then you know how to provide Active Support.

Multiple Choice

_____9. System centered planning is
   a. Desirable
   b. Fitting people into existing programs and services.
   c. Will not be a factor in the PCSP.
   d. Requires the QDDP to be a professional in charge.

_____10. An example of active treatment is
   a. Developing a transportation plan for an individual that requires collaboration with the city bus system.
   b. Expecting DSPs to use the same training methods for all people supported.
   c. Delegation of monitoring a PCSP to the DSP.
   d. Using charts and graphs to track progress.

11. An example of active support is
   a. Telling a person to take out the trash
   b. Allowing the person to go to see a movie
   c. Helping the person make a salad they might like by doing it together
   d. Going with the person to a medical appointment

Paragraph

12. What are some naturally occurring supports in your city/town/region pertaining to transportation?

13. What should a QDDP do when a team member, guardian, or DSP has conflicting values or has violated the rights of a person supported?

Chapter 2: Plan Development

Objectives:

After reading this QDDPs will be able to:
1. List assessments that are **required** to be completed or reviewed annually for the PCSP.
2. List three broad responsibilities of the service provider.
3. List considerations for determining what assessment information is needed for the annual PCSP.
4. Compare formal and informal assessments.
5. Define self-assessment.
6. List three ways to gather assessment information.
7. List three ways to get the information needed to individualize supports.
8. Identify best practices in interviewing for assessment information.
9. Identify considerations in making good observations.
10. Arrange assessment activities of the PCSP process in the suggested order.

Goals of Person Centered Service Plans

Services must be based on the needs and preferences of the individual and their personal goals. They must be consistent with the principles of least restrictive environment and self-determination. Services must also;
- recognize each individual's history, dignity and cultural background;
- Affirm the protection of each individual's civil and legal rights;
- Provide services and supports that promote:
  - community inclusion and self-sufficiency;
  - social relationships, natural supports and participation in community life;
  - allow for a balance between safety and opportunities;
  - provide opportunities for the development and exercise of age-appropriate skills, decision-making and choice, personal advocacy, communication

The provider is responsible for supporting the individual to develop functional skills, reduce dependency on support providers and to develop decision-making skills. The process for meeting this responsibility is the Person Centered Service Plan.

Person Centered Service Plan Development

Person Centered Service Plan development is actually a cycle that continues as long as the person is receiving services. Once a plan is put on paper, it continues to evolve or change to meet the preferences and needs of the individual. Those revisions happen for many reasons, e.g. changes in living arrangements, social roles, employment, health conditions, etc. The QDDP needs to administer/monitor these changes and evaluate the effectiveness of the current plan. Identifying strategic points in this cycle will assist the team in moving forward to provide individualized services. Assessment is one of those strategic points.

Assessment

Assessment is vital to planning. Assessment is gathering data or information and making judgments. Just imagine how buying a home would turn out if little thought was given to the preferences of the purchaser, or if little information was gathered from a potential client when planning a wedding. How odd it would be for the realtor or wedding planner to use their personal preferences. A Person Centered Service Plan is no different – it must be based on the preferences and needs of the person – not what the team thinks the person needs or wants.

It is important that the QDDP plan and prioritize the assessment process.
- What does the team need to know?
- Does the person want to change directions in some aspect of his/her life (i.e., new job, place to live)? If so what does the team need to support the change?
- What information will the team need to have in order to understand and plan for the change?
- What progress has been made in the past year?
- Have support levels changed? What works for the person?
- What have we learned this past year that would change our approach to teaching new skills? What does the person like? What motivates them?
- How actively engaged is the person in a variety of meaningful activities throughout the day?
- What is typical of a person of the same chronological age and has that been considered in program planning?

Remember the QDDP plans and prioritizes – not all questions or areas of a person's life can be addressed annually. Some lower priorities can be addressed later.

During the Person Centered Service Planning process, the team must respect the individual and/or his/her legal decision maker's right to decide what information they want to share and with whom. These matters should be approached with sensitivity. The discussions and decisions reached should be documented. Individuals and their legal decision makers may waive some assessments areas in consultation with the licensed provider and DD Program Manager. However, these rights must be balanced against the provider and State's ability to help assure the health and safety of the individuals supported by Medicaid public funding. Assessments related to the health, safety and protection of the person for the purpose of identifying service type, amount and frequency, or assessments required to authorize services cannot be waived.

Formal Assessments

One of the most common types of assessment is that which compares knowledge or abilities against established criteria or the performance of others of the same age, gender or grade level. Classroom teachers assess their students according to the standards set by the state Department of Education. A child must know or pass certain criteria to be able to progress to the next grade. In order to have the privilege of driving, applicants must demonstrate their knowledge in written and practical form according to criteria set by the state Department of Transportation. The SAT examination evaluates knowledge in several areas and yields a score indication of how the person compares to others. These types of assessments will produce a picture of deficits and strengths.

Examples of formal or standardized tests are:
- Achievement tests
- Ability and intelligence tests
- Psycho-educational batteries
- Tests of perceptual development
- Tests of adaptive behavior
- Personality assessments

These types of tests have been given to a large group of people to set the standard of what is the "normal range" for a person who is of a certain age, gender or grade level. Formal assessments are used for eligibility to services, to depict the level of support a person might need, or the person's preferred learning style. Formal assessments provide supporting information only.

Informal Assessments

Informal assessments do not compare groups of people or yield scores. Instead, these assessments produce an overall picture of the person being assessed. Criteria for evaluation are set by the person conducting the assessment. Informal assessments can be checklists, interviews, observations, inventories, and even a journal. Evaluation of the information is then judged by whoever uses it. Informal assessments are much more useful and functional in the Person Centered Service Planning. However, even with informal assessments the process

demands foresight so relevant information is gathered and examined. Some examples of informal assessments include the Residential Individual Plan of Protective Oversight (IPOP) and the Risk Management Assessment Plan (RMAP).

> *This year has been eventful for Byron as he has settled into his own private room in a group living setting. He lives with 5 other people. Byron completed his education and is now in adult services in an urban area. He has lived in this residential setting for 2 years. The annual team meeting will be in one month and Jennifer, the QDDP, is completing Byron's self-assessment and risk assessment so these can be given to the team members. Byron has had an increase in challenging and inappropriate behaviors – particularly when asked to do routine household and personal hygiene tasks. A behavior plan has been in place for 9 months. Previous self-assessments yielded very little definitive information regarding Byron's dreams for his life.*

Consider the team member who will be attending the team meeting. What other information should a team member have before the meeting so good planning can result?

With the myriad of tools to assess and the questions people may have, the planning process can seem overwhelming. Remember that the planning is person centered and is built on the dreams and goals of the person supported. To start the assessment phase of planning it is necessary to know the person well. Their desires and dreams should drive the assessments other professionals will do – start the process with the self-assessment.

Self-assessments

Self-assessment is a process but also an instrument. It is the impetus to all Person Centered Service Plan coordination. It is pivotal to quality services and supports.

Most career planners use a self-assessment to help their clients identify strengths and weaknesses. A definition of the self-assessment by a career counselor is:

> *"It is the process of determining where you have been, where you are, and where you are going by examining your current needs, personal strengths and your personal weaknesses."*

Based on that knowledge, clients can then pursue a career that is suited to their talents. Consultants who specialize in corporate quality improvement use self-assessments to aid the company to clarify their mission, define results, set goals and develop quality improvement plans. Self-assessments provide an opportunity to take inventory of an individual's life, an agency's mission, or a business's service or product.

People with disabilities, like anyone else, have the basic human right to control their lives and make their own choices. For decades this was not true. Service providers are now in the business of restoring that control to the people they support. The self-assessment assists in careful reflection of what that control really means to an individual. It will have a different meaning for every person supported.

The self-assessment is not a test. It is not an assessment of the person supported. It is designed to help the team gain an understanding of how the person perceives the current supports and services and what he or she might want or need in the future. It is a measure of the person's reality. Definition of a quality life is different from person to person. An agency that embraces person centered values will put listening to and learning from the individual at the center of their organizational life. The self-assessment is part of that listening and learning.

A temptation every QDDP will face is to find a self-assessment questionnaire or survey and adopt it as the "self-assessment" they will use. It is an easy way to manage the process, but the survey or questionnaire is only a tool. The process is the interviewing, observing, reviewing records, and sampling activities. These processes are not the same for everyone and thus cannot be put in a survey or questionnaire. Having a written guide may be necessary to help new QDDP and DSPs understand the process; but remember, the survey or list of questions is only a tool in the process.

While a variety of individualized approaches and assessment tools can be used, if an agency is accredited by a particular entity, the QDDP is responsible to speak to the standards of that accrediting body. A national accrediting agency, the Council on Quality and Leadership (CQL), developed a set of outcomes or results that people with disabilities want from their supports. CQL's Personal Outcome Measures were developed from interviews of people with disabilities.

An agency can use these Personal Outcome Measures as a framework to design and provide the needed supports after it discovers how the person defines his or her outcomes. The outcomes should act as triggers to guide the plan development as it applies to each individual. The indicators below can be used as measurements or the framework for self-assessments.

- People are connected to natural support networks.
- People have intimate relationships.
- People are safe.
- People have the best possible health.
- People exercise rights.
- People are treated fairly.
- People are free from abuse and neglect.
- People experience continuity and security.

- People decide when to share personal information.
- People choose where and with whom they live.
- People choose where they work.
- People use their environments.
- People live in integrated environments.
- People interact with other members of the community.
- People perform different social roles.
- People choose services.
- People choose personal goals.
- People realize personal goals.
- People participate in the life of the community.
- People have friends.
- People are respected.

*For more information on the Council on Quality and Leadership visit their website at http://www.thecouncil.org/

The self-assessment can be a pre-meeting interview based on CQL outcomes but it isn't required to be so. Furthermore, these outcomes are not the only areas that may need to be assessed for each person. See training module *Assessment and Setting Goals*, Chapter 4. How assessment of services by the people supported and how the agency evaluates the services against the standards will vary from one agency to another.

Self-assessment Drives the Process

The process of assessment for planning and supporting someone according to his or her preferences is not a quick paper and pencil exercise. It is unique - the person receiving services sets the standards. Informal evaluations are selected and completed based on what the self-assessment has produced. The self-assessment should drive the types of assessments done by all team members. **See figure 2.**
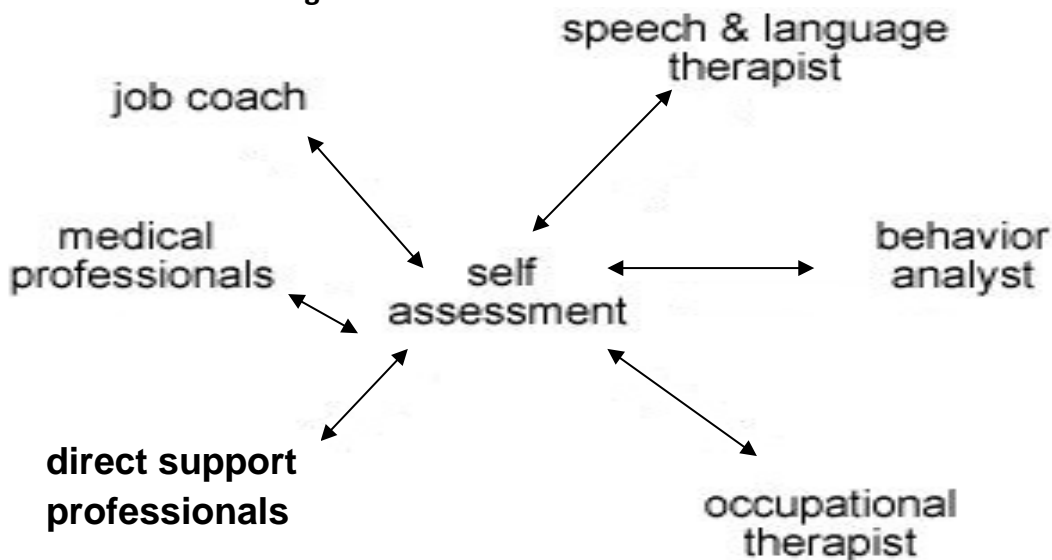

Figure 2 *The self-assessment drives the process.*

The scenario below will help illustrate the point.

> *Team A has been working together for two years. They have been supporting Dottie in her living, vocational, social and medical preferences and needs. Her team consists of residential direct support staff, a job coach, the occupational therapist, speech and language consultant, a psychologist and her parents. Dottie makes her own decisions and does not have a guardian.*
>
> *In the past two years Dottie's self-assessment has assisted in identifying vocational preferences. She has decided to pursue a goal of working in a part-time customer service position. With this information Dottie's team can now do informal assessments concentrating on the skills and supports she already has and what she will need in order to be successful in this type of job. The occupational therapist will look at what accommodation she would need on the job site. She would also assess what assistive technology would work for her mobility needs. The speech and language consultant would take a look at what Dottie brings and needs for successful communication with customers and co-workers. Direct support staff may assess transportation and work schedules. The job coach would do inventories of job duties as well as potential co-worker training. The nurse may assess medical issues related to the job site. When the team meets, they will have a thorough picture of what supports Dottie already has and what she needs to be a successful employee and co-worker.*

The self-assessment gives direction to the team member regarding what, where, when and how they will gather information. The self-assessment sets the course. Consider the information gathered from a self-assessment below. What would be some questions that will need to be asked? What information will be needed for the team to support Darrel?

> *For the past 6 months Darrel has expressed an interest in going to bars and suggesting that he make some friends. He has displayed friendliness* to female staff that at times could be considered inappropriate (*personal space and comments).*

The self-assessment should determine what environments are relevant for further assessment. The QDDP assists the person supported and team members to narrow the focus for what the Person Centered Service Plan should stress for the year or specified time period. It is very easy to see many routines or environments as important. The QDDP, in cooperation with the individual supported, provides leadership in selecting the specific functional assessments for each person. In the previous example, what specific environments or issues should be assessed to prepare for the PCSP?

Assessment Progression

The self-assessment guides the assessment activities of the team. The team members need time to visit the person's environments, gather data, and research prior to the Person Centered Service Planning meeting. **See Figure 3.**
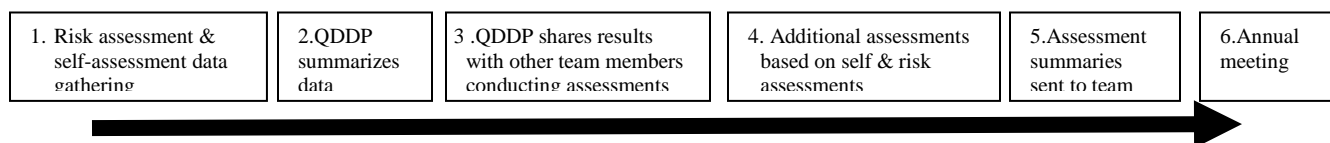
1. Risk assessment & self-assessment data gathering	2.QDDP summarizes data	3 .QDDP shares results with other team members conducting assessments	4. Additional assessments based on self & risk assessments	5.Assessment summaries sent to team	6.Annual meeting

Figure 3 A*ssessment Progression*

Approximately two months prior to the annual Person Centered Service Plan meeting, the QDDP will send written notice of the PCSP meeting date to all team members. This timeline is far enough ahead so that unforeseen events (e.g. illness, family events, etc.) do not interfere with all of the assessment, communication, and other activities that need to take place in order to have a productive meeting. Two weeks prior to the annual meeting, the QDDP will send a copy of the completed individual self-assessment and Risk Assessment (RMAP) to all team members. Any other pertinent assessments may be shared with team members at this time or distributed at the meeting. If the team member has access to Therap, the RMAP will be available for review in the system. See Chapter 4 for more information on specific timelines in North Dakota.

Title XIX regulations require a **comprehensive functional assessment**. The requirement states:
> *The individual's interdisciplinary team must produce accurate, comprehensive functional assessment data, within 30 days after admission, that identify all of the individual's*
> - *Specific developmental strengths including individual preferences*
> - *Specific functional and adaptive social skills the individual needs to acquire*
> - *Presenting disabilities and when possible their causes*
> - *Need for services without regard to their availability*

Skill, informal, and adaptive behavior assessments all examine the environment and the level of engagement the person may have with it. For instance the Supports Intensity Scale uses observation and interviews to determine the level of support someone would need in various domains/environments (i.e. health, communication, adaptive skills). This scale is used to globally assess services needed.

Risk Management Assessment Plan (RMAP)

The RMAP assesses the person's risks without supports. It is a report and subsequent plan for managing risks in the life of the person supported. It can be compared to a list of facts the

receiving agency or staff member need to know in order to provide quality services. It identifies the risks and the mitigation plan a person will need from the agency or provider. This is sometimes referred to as the RMAP.   Risks in areas such as activities of daily living, behavior, financial, or community living activities, are reviewed via interviews with those who know the person best including the individual, legal decision maker, and secondary providers. Support levels are analyzed. This assessment is completed upon entrance into services and update or reviewed on an annual basis or as needed. The risk assessment and the self-assessment should be shared with the team members at least two weeks prior to the meeting.

Individual Plan of Protective Oversight (IPOP)

This assessment is similar to a risk management plan in that it provides the information staff will need to know in order to support a person. A new staff member would be able to consult this document and know whether a person supported will need much or little oversight in cooking, orientation in the community, or self-care. It is sometimes referred to as the IPOP.

Methods for Gathering the Information

Gathering and analyzing data to meet standards and regulations can be complex. The support needs and goals of the people supported dictate the type of data and information that must be gathered. The QDDP directs this process. The better the QDDP knows each individual, the more the assessment process can be tailored to his or her needs and preferences. This process is developed and perfected by practice.

When an individual can actively participate in the process, some of the more traditional assessment strategies will suffice. These can be questionnaires or surveys, group discussions, telephone interviews, internet surveys, or one-to-one interviews. A group discussion may not be an effective method for a person who is able to understand the questions but is easily distracted. A person who likes to take their time and be thoughtful on each question would do better with a written questionnaire. People who prefer their privacy may feel more comfortable answering questions on the telephone or on the internet.

It is important to use individualized accommodations for those who need assistance in reading and answering the questions. Sometimes this may involve becoming familiar with the use of an augmentative communication system or having someone who knows them well help with the assessment. It may mean making a web site questionnaire readable by screen readers or designed for people with visual impairments.

Interviews

The interview is the most effective and preferred assessment for many people with intellectual and developmental disabilities. Even if some people chose a questionnaire a follow-up question/interview may be needed. Be mindful of the following guidelines:

- Ask the person's permission. If they refuse, respect their choice. Perhaps, they can be asked again later.
- Have the person choose when/where the interview will be conducted.
- Ask what can be done to make the person more comfortable with the interview.
- During the interview explain why the interview was scheduled.
- Provide the person a copy of the standards/outcomes/questions they will be asked.
- Affirm the person's right to decline to answer questions or to end the meeting.
- Tell the person that the interviewer's notes will be used to remember what they have answered.
- Avoid making assumptions without adequate information.
- Rephrase questions if needed.
- Ask permission to follow up with others who may have more information.
- Ask the general questions first. Then, if needed, rephrase or ask more specific questions.
- Emphasize that the person can choose what information is kept confidential.
- Ask the person for permission to have someone present that knows them well, if needed.
- Suggest having the interview away from the place where services are given, if it will help them feel relaxed and open about giving information.
- Use open-ended questions rather than those that require yes or no responses.
- If information is given by another person, always verify it with the person being interviewed.
- Check back with the person to make sure the interview conclusions do not contradict his or her perception of supports and services he or she is receiving.
- Watch vocabulary. For example, pop and soda may mean the same to one person, but some people have not been around others who use the word soda.

Written media

It will be necessary to gear the written surveys to the reading ability of the person being interviewed. Some suggestions are:

- Use vocabulary that is familiar and easily understood.
- Use symbols. Using facial expression such as to depict satisfaction levels may elicit more responses than using words.
- Too many questions per page or too many pages may defeat completion or even attempting the survey. Put it in a fun format.
- Watch font size and colors, especially for people with visual impairments.
- Make directions easily understood and simple. Test the survey on a few people and observe them as they complete it.

Observation

One of the greater challenges for QDDPs is gathering data from individuals who have difficulty communicating and/or understanding interview questions. In these circumstances it is important to spend time observing how people interact in various settings. Observing requires paying attention to what the person says and does not say. To whom do they speak? How engaged are they with others or the activities? Do they use the setting or environment freely? Do they seem stressed, happy, withdrawn when they are in this particular setting? Is this a consistent conclusion that can be drawn over several observations? Are staff actively supporting or passively monitoring the individual?

Observations need to take place over several time periods and situations to conduct this type of assessment. One or two observations of the person will not be enough to form conclusions and make recommendations.

Sample Activities and Experience Choices

Much of the frustration with the self-assessment processes is the difficulty in obtaining answers to the questions/inquiries regarding the identified outcomes. Many items relate directly to the opportunities of choice-making and control the person has now and has had in the past. It is difficult for people to dream for the future when they don't understand or know options available. For years, people with disabilities did not make their own choices.

This may be a typical scenario:

> *Dottie was placed in an institution when she was 5 years old. Now she is in a community setting at the age of 35 and when asked if she likes where she lives, she says, "Yes". In fact, she agrees with every living arrangement, every job, every roommate and every activity offered to her.*

Can we expect anything other than a "yes" from Dottie? She doesn't know what her options are. She has never had the opportunity to make choices.

The self-assessment process is premised on the assumption that the individual has had access to and knowledge of a range of options and meaningful choices in real life experiences. Not knowing how to choose can be the result of being sheltered and never given opportunities to make a choice. It can be the result of being taught to depend on others for decision-making or being treated as though you didn't understand options. Support providers must remind themselves that they cannot undo years of "choice-less" living in only a few months. However, there is an expectation that the QDDP and team use creative ways to find out more about the person. It may mean sampling many different options, many different times, and many different ways. The QDDP may spend the next year or two observing and developing a plan to teach the individual how to recognize options, make choices and understand the consequences of choices.

Using Skill Assessments to Design Service Plans

Once the self-assessment and the risk assessment are completed, the team should preview these results to determine what further assessments should be done. As in Dottie's scenario above, her dream of a career in customer service and subsequent need for transportation will prompt the team to assess her current abilities and strengths in the area of getting around her community. The team will need that information to build the relevant supports for her.

Assessments in social skills, finance, taking medications, exercising rights, or health all play a part in informing the team and the person supported about supports that will need to be included in the PCSP. With that information, planning can be more focused.

Ecological Inventory

This assessment strategy examines current environments in which the individual is expected to function. These may include domestic, community, recreation/leisure, employment and educational environments. The environments are then divided into sub-environments. Activities and skills that are needed to participate in each sub-environment are also identified. A person can then be assessed in terms of the discrepancy (difference) between their present skills and those identified as needed to function in the current and subsequent environments.

Figure 1 *Top-down assessment in ecological inventory and discrepancy analysis.*

The progression of the assessment is top-down. For example;

> **Environment** - home
> **Sub-environment** – bathroom

Activity in sub-environment – bathtub (use of automatic tub chair)
Skills needed - task analysis on using the tub chair
Skills the person has now - task analysis on using the tub chair
Program objectives - may include instruction on using the chair, supports and additional assistive technology needed.

This method requires the user to be focused on specific environments of importance. Too many ecological inventories can be overwhelming. Only those places that would be compatible to what has been identified from the self-assessment should be investigated.

ND Assistive http://ndipat.org provides information about assistive technologies that can be used to bridge the gap between what a person can do and what the environment requires. This organization can help during the environmental analysis assessment and will loan equipment to be tried out before funds are committed to purchasing something.

Component Model of Functional Life

A more comprehensive assessment approach looks at the individual's current or desired routine. The routines can be broken into core skills, then further evaluated by examining the extension skills needed to perform in the environment and finally enrichment skills are assessed. These are skills that would add to the quality of the routine. For example, if a person has identified being able to use the Laundromat down the street as a desired routine, the process would look like this:

- Core skills would be identified first;
  Core skill -Using the washing machine and dryer at the Laundromat
- Then Extension skills would be assessed.
  Extension skills:
    - Knowing when to initiate using the Laundromat
    - Preparing to go
    - Monitoring the quality and tempo of laundry skills
    - Problem solving
    - Terminating the task.

- Finally enrichment skills are assessed. These are skills that would assist the person to be appropriate in communication and in problem solving.
  Enrichment skills:
    - Expressive communication while at the Laundromat
    - Social behaviors
    - Common courtesies
    - What to do while you wait

Both the Ecological Inventory and the Component Model of Functional Life (F. Brown et al. 1987) look at the natural environments where the person is now or wants to be. These models are flexible and give a framework from which to design assessment. It is possible to adapt and

change what to assess based on what the individual has indicated as important to them. This assessment identifies capacities and supports the person already has and existing barriers for goal attainment.

The QDDP may need to assist fellow team members in determining how to do skill assessments. It should not be assumed that the team member knows what to do with all the information they are given prior to the meeting and that they will be pro-active in gathering more specific assessment information. Remember, the QDDP is the administrator/monitor of the plan and is held accountable for it.

As the coordinator of the Person Centered Service Plan, the QDDP may be asked why certain assessments were done or why others were not done. The QDDP is also responsible for interpreting assessment results to others (family members, staff, regulators, and persons supported). Be pro-active. Consider what questions parents, guardians, Developmental Disability Program Managers, and other specialist might have and investigate before the meeting. This will save time and resources and allow the plan to be implemented with more efficiency.

It is important to consider the learning style and abilities/disabilities of the person supported when gathering assessment information. For example, a person who has difficulty understanding time concepts, will have difficulty with assessment questions pertaining to their vision of the future. Assessments that require circling choices that are pictures would be more appropriate for a person who is good at detail and visual information. A more thorough explanation of learning styles and accommodations are available in the training module *Achieving Personal Outcomes* in the North Dakota Community Staff Training Program (module 18).

The information gathered from assessments can be shared with other team members before the meeting. This is standard procedure for working committees and agency boards. Agendas and information regarding issues are sent to the members to save time in the information exchange phase of the meeting. It also gives team members an opportunity to question the information and gather more data before the meeting.

The QDDP is the coordinator for the team before, during and after the Person Centered Service Planning meeting. Professionalism and collaboration with other team members are necessary to bring about successful coordination of a program plan. If deadlines are allowed to erode or if team members are not informed of changes, efforts in coordination will be more difficult.

Summarizing and Using Results

Once the assessment process is completed it must be reviewed with the person supported. The QDDP should discuss the conclusions he/she has drawn and determine if there are conflicts with the individual's perspective. The QDDP will also need to request permission to share this personal information with the team.

The self-assessment is valuable information. It should dictate the direction other assessments will take. The QDDP should ensure that each team member uses the information to make recommendations in their area of expertise. If this is not evident, the QDDP bears the responsibility to ask questions before the team meeting. This shows respect and can give the team members time to make revisions if needed. In some situations, team members have not had experience with the self-assessment or Person Centered Service Planning. The QDDP may need to guide team members and educate them in the process.

Assessment and Direct Support Professionals

Direct support professionals (DSPs) who work in residential and vocational programs should be involved in providing information for the self-assessment and subsequent informal assessments. Valuable information can be overlooked if DSPs are not trained on how to do the assessments or informed of the purpose of the assessments. Just like any other team member – the DSPs should have a thorough understanding of the results of the individual's self-assessment. DSPs need to understand the desires and dreams derived from the self-assessment and be able to see the value of the probes and examinations they are making in the assessments delegated to them. The QDDP may delegate much of the assessment to DSPs. However, merely handing assessment questionnaires for completion won't yield the in depth information DSPs possess about an individual. The assessment procedures should provide a clear link between the self-assessment and the assessments staff are completing. When the purpose is clear, DSPs will be more likely to provide relevant information.

Assessment and Family/Guardian

The role of the guardian and/or family in assessment process will vary. Some family members will be actively involved in gathering data, others will choose not to participate. This level of involvement depends on the need for further interviewing and the individual's desire to have his or her family included. If the person supported has a guardian, the self-assessment process should also include the guardian's person-centered dreams, desires and perception of services and supports. However, the team must keep in mind that the plan is centered on one person - the individual supported. The guardian should be included but not dominate the process. A guardian has the responsibility to promote the development of the person supported. Sometimes a guardian will have their own dreams for the individual which may not be a match for what that person has expressed. A guardian may need your support to tease out the

difference. The QDDP should always inform the guardian but look to the person supported to find out their preference as well. Balancing guardian and family wishes with the wishes of the person supported can be a delicate balancing act at times. On one side, the QDDP must work with the guardian to assist the individual in making choices. On the other side, the QDDP must support the desires of the person supported as the plan is centered on his/her desires. This is good tension as it will afford the QDDP the opportunity to educate the guardian about the planning process, standards and the mission of the agency. On the negative side, it may reveal gaps between the individual, guardian, and/or the agency. Issues that will impact the individual's ability and freedom to make choices now and in the future are important. In any case, the QDDP must ensure that rights are not being violated.

If the individual supported is their own decision maker (no guardian), their preference as to who should be included in the self-assessment should be honored. Families can be a very valuable source of information and support. Families learn to support their adult children in making their own decisions at different rates and at different times. Families often rely on a son or daughter to send a strong signal about a boundary or an activity. The person with developmental disabilities may need your support to send a clear signal about what is important to them. The family member may need your help to understand how their vision for their child's future or safety can be realized in a different way.. The QDDP is expected to have expertise in many areas but is not expected to "fix" these issues. Remember to access the expertise of other professionals who have been trained to work with families. For further information on families use the *Working with Families* module from the ND Community Staff Training curriculum.

Study Questions Chapter 2

True or False

_____ 1. Supports to people with I/DD must include a balance between safety and opportunity.

_____ 2. A PCSP can be revised when preferences or needs of the person change.

_____ 3 Formal assessments compare people with disabilities to people without disabilities.

_____ 4. A good way to gather information about a person supported may be to interview their sibling(s).

_____ 5. An example of an informal assessment is assessing the person's interactions, abilities and skill level mood across daily environments.

_____ 6. The self-assessment should be exclusively composed of the personal outcome measures.

_____ 7. Enrichment skills are not a necessary part of learning a skill to become independent.

_____ 8. It would be appropriate to assess for problem solving skills related to teaching someone to take their own medications on time.

_____ 9. The self-assessment is designed to help the team gain an understanding of how the person perceives the current supports and services.

Multiple Correct

10. Check those circumstances where a PCSP would need revision.

_____change in living arrangement   _____goals have been achieved

_____change in diet   _____change in employment

_____change in health   _____objective has been achieved.

11. Check the general responsibilities of a provider of supports to people with I/DD.

_____all financial decisions

_____helping the person supported develop decision-making skills.

_____reduce dependence on support providers.

_____contribute to the educational system of the community.

_____ support an individual with I/DD to develop functional skills.

12. Check the assessments that must be reviewed on an annual basis for all individuals;

.____IPOP   ____Self-assessment   ____medication administration

____RMAP   ____Social Network   ____Social skills

____IQ   ____Finances   ____rights

____Functional skills   ____transportation   ____vocational preferences

Short Answer

13. Read the following scenario. List at least four assessments that will be needed by team members before serious discussion can be made regarding supports Jarod will need to move towards his goal. Give your reason or justification for listing that assessment. What information will that assessment yield and how will it help the team determine supports for Jarod?

> *Jarod is 22 years old and acquired his disability through a severe infection when he was a teenager. He uses an augmentative communication system and he is not independently mobile. He uses an electric wheelchair. He is very interested in architecture and buildings. He wants to have a girlfriend. This has been his desire for several years but when asked about his goal for the coming year he was quite adamant that this was his first and foremost goal.*

a.

b.

c.

d.

14.   The QDDP has decided that she would like to observe Jarod. List some considerations she/he should remember before doing the observation(s).

15. When interviewing for the self-assessment you should;

a. avoid telling the purpose of the interview.
b. always verify information given by people who know the person.
c. match the interview environment to the person's living and working desires.

16. Explain what is meant by the statement "the self-assessment is a measure of the person's reality".

17. Number the steps of the assessment in the order they should occur.

__ Risk assessment & self-assessment data gathering

__Team Meeting.

__Team conducts assessments based on self and risk assessments.

__Summarize assessment data.

__assessment summary sent to team members.

__share results with team.

Chapter 3: Facilitating the Person Centered Service Planning Meeting

Objectives:

After reading this QDDPs will be able to:
1. List methods for coaching a person supported to lead or participate in their team meeting.
2. Identify characteristics of an efficient team meeting.
3. List responsibilities of the meeting facilitator.
4. Identify elements that comprise each phase of the team meeting.
5. Produce an example of a learning and support objective.
6. Identify the result of a PCSP
7. List general documentation requirements of the team's discussion.
8. Demonstrate how to pull the information from the plan into calendars, charts, and guides the person and the DSP use in their every day schedule.

Supporting the Person to Prepare for Their PCSP Meeting

When all the information has been gathered, it is necessary to confirm findings with the person supported. Spend time clarifying goals, confirming perspectives on services and talking about issues from the self-assessment. When the self-assessment is complete, support staff members prepare the individual for participation in his or her meeting. The individual may need support/coaching on how to participate in the meeting. Teams should adapt the process to fit the abilities and needs of the person supported and his or her family.

Below are some specific strategies for involving the person in their meeting*
- Schedule the meeting time and team members with whom the individual feels comfortable.
- Have the individual choose the place for the meeting.
- Talk with the person before the meeting to make sure that he or she is comfortable with the meeting format and content.
- Ask the individual's parent, guardian or advocate for suggestions about how to make the person more comfortable in the meeting.
- Ask the person supported if there is someone special he or she wants to invite to the meeting.
- Ask a team member to interpret for the individual.
- Help the person communicate personal interests and desires by taking pictures or making a video or audio tape to play during the meeting.

*Source: The Council on Quality and Leadership in Supports for People with Disabilities (2000) *Assessment Workbook*.

Persons uncomfortable with attending the full meeting should be offered options for alternative or supported participation. The individual may start with attending only part of the team meeting the first time. Some people who refuse to attend a meeting with the full team may agree to meet with a few of the team members. Even with preparation, it's possible that something may not go as expected. The following are general guidelines for supporting the individual at the meeting.

- Always address the person directly and check his or her response. Determine if they understand what was said.
- Take a break if the person is getting upset.
- Give the individual options to leave, stay, take a break or to leave at a specific time.
- Never assume that the person can't participate because of one bad experience. The team should discuss what can be done to increase the person's involvement in the planning meeting.

Over time a positive experience will go a long way to encourage the individual's continued involvement in the whole planning process.

Leading their own meeting

Whenever possible, the individual should lead his/her own meeting. Even if the individual declines, it is good to involve the person in the planning and facilitating as much as possible. Some practical ways are:

- Bring items of interest identified by the person supported and use them as spring boards for discussion on past accomplishments, e.g. pictures, souvenirs, a cake baked by the individual, a video, cards received from special occasions.
- Have the individual practice facilitating a segment of the meeting. This can build confidence and possibly expand their involvement at their next meeting.
- Seat the individual/guardian strategically so they have eye contact with all team members.
- Have the person design the meeting invitations, sign them and assist with sending or delivering them.
- Meet with the individual/guardian before the meeting to answer any questions and help anticipate any issues.

There are many creative ways to get their involvement in the meeting. DSPs can be a good source of ideas.

QDDP's Role in Meeting Facilitation

What makes a good meeting?

Most people have attended well planned and efficient meetings. They include:

- An agenda that has commonly understood goals and objectives

- A clear process for reaching those goals and running the meeting
- An awareness of personal preoccupations and interest level of participants

A facilitator is not quite the same as a leader or chairperson. A facilitator accepts the responsibility to help the group make necessary decisions and plans in the time available. A facilitator should not make decisions for the group but suggest ways that will help the group move forward. Assuming the role of facilitator AND QDDP will require moving between two roles during the meeting. The QDDP is a participant/ team member but also a facilitator. The QDDP is a neutral servant to the group. Sharing the role of facilitator or delegating segments of the meeting to a co-facilitator is also an option.

Good Facilitation Includes:

Work or activities BEFORE the meeting:

- **Agenda** -*The agenda is a map or timeline the group will follow. The meeting will run more smoothly if the facilitator knows, in detail, what areas should be covered. Anticipate topics that may surface in each item and be prepared to address the topic. The agenda follows the OSP. Team members should know what will be covered or what is expected in each item. The agenda should be reviewed and opened to the group for changes or additions at the start of the meeting. Mentally run through the agenda or OSP so approximations of time for each item can be set. This will help in setting an ending time and help everyone stay on course.*

- **Distribution of information - timely and complete** -*In order to reduce the time in the information exchange phase of the meeting, ensure that assessment summaries and other information are distributed before the meeting. Giving team members what they need for good preparation will allow them time to examine and reflect. Be sure to inform team members of particular topics the individual or guardian has requested NOT be discussed at the meeting.*

- **Preparation of the room** -*Assure the participant's comfort during the meeting. Space, temperature, and equipment needs should be tested well before meeting time so unexpected failures or conflicts can be worked out. Always have a backup plan.*

During the meeting:

- **Know people by name** -*Begin the meeting by having each person introduce themselves.*
- **Establish timelines and ground rules** -*Emphasize speaking to the individual using plain English (no professional jargon or acronyms). A diplomatic early intervention to enforce ground rules establishes the seriousness of the facilitator. It helps everyone be more self-disciplined.*
- **Keep on course** -*Make the group move forward after lengthy discussion by summarizing or paraphrasing.*

- **Keep written record**. -*Record key points on a flipchart, projection screen, or any mode that allows view by all team members. As pages are filled, they are torn off and taped to the wall. Using someone in the group to draw symbols and pictures will also help everyone to understand.*
- **Encourage participation** -*Encourage expression of various viewpoints. Call on people who haven't spoken and give them opportunity to address the issue. Notice those who are confused, agitated or unhappy with the debate and encourage them to share their concerns. Don't let discussion continue between two people. Ask for comments from others in the group.*
- **Help the group make a decision** -*Look for minor points of agreement and state them - it helps morale. When testing for a consensus, state in question form, everything that you feel participants agree on and be specific.*
- **Helping individuals follow decision-making.** ***As goals are set and decisions are made decide how the person will be aware of what is decided in the flow of conversation.***
- **Stick to time limits** -*Make the group deal with going beyond the time limit. What item should have less time or do they agree to extend the time for the meeting. It is often wise for the facilitator to be flexible about time, especially if a decision is about to be made.*
- **Focus on closure** -*Make it known that the team needs to agree and make decisions. Summarizing key points of an issue will help the group step back and look at the ground covered.*
- **Take breaks** -*These can be quick. Arguing over when to take a break can waste time. A statement "OK - I want everyone to stand up for 1 minute and stretch" can be a quick energizer.*
- **Do not allow private conversations** -*Stop and focus on the people conducting their own private meeting and ask them to share their thoughts.*

Phases of the meeting

It is not the intent of this manual to specify what the agenda or topic progression should be. The module *Team Planning* describes the elements and process of each phase in detail.

Orientation phase

This segment of the meeting establishes the climate. It is not unusual to have people rely on the facilitator to be more active at the beginning. The facilitator can use this portion of the meeting to:

- Orientate new members to expectations of the meeting
- Review goals and responsibilities of the team
- Review past activities and the purpose of the meeting
- Have members introduce themselves
- Review and make any necessary changes to the agenda

Information phase

A review of the individual's past accomplishments focuses the team on the present program plan. The information phase should be open to any new information or questions that were formed since assessments were sent to the team members. The team can take time to discuss past accomplishments and celebrate if appropriate.   The team may need to clarify any issues and determine if enough information is available to move forward with the material synthesized from the self-assessment and the risk assessment.

Decision-making –Writing Valued Outcomes (Goals) and Objectives

This segment of the meeting will consume the most time and energy of the team. The goal of the Person Centered Service Planning meeting is to design **outcome-based services** in response to the individual's needs as identified in the assessment. **Valued Outcomes** are behaviors, actions, or status attained by the individual that can be observed, measured, and can be determined reliable and valid. Valued Outcomes could also be referred to as **Goals.** Valued Outcomes/Goals are general, but they can be observed (everyone will know when the outcome has been attained).

Outcomes are achieved by **Learning Objectives** and **Support Objectives**.
- **Learning Objectives** include behavior/skill acquisition or change on the part of the person supported.
- **Support Objectives** include supports or actions taken to enhance an individual's quality of life or ongoing actions or assistance that will be provided to/for the individual. Support Objectives are generally actions on the part of the staff or the agency. Support objectives should have specific instructions for staff regarding what will be done for the individual and the level of assistance by staff. It should also state what results or data will be collected if necessary.

  For example, Darrel (chapter 2) has indicated his desire to make friends but his behavior has highlighted the need for skill acquisition regarding personal space and appropriate social exchange. Darrel's Person Centered Service Plan to achieve his desired outcome (more friends) will include both learning objectives and support objectives. Darrel will need to learn new social skills (learning objective) but also be given support to practice and implement those skills in real situations (support objective).

In the above example the support objective of practicing the social skills should help the team build on its knowledge of Darrel. A quick summary of the practice session would help all team members make judgments of how Darrel is doing. In that summary, staff could note how much

time was spent, in what type of environment, and what they saw him do. In order for this information to be reported, the support objective should include staff instructions regarding assistance and, if necessary, data to be collected.   Not all support objectives will require this level of explanation or detail - it depends on the intent of the support.

Determining how to assist the person to reach their goal(s)/valued outcome(s) requires the creative talents of all members. The goals identified by the individual, no matter how unrealistic or unattainable they may seem at first glance, need to be honored and pursued by the team. The person's desires should not be judged and made to fit the mold of what the team thinks is appropriate.

If Tom expresses an interest in becoming a fighter pilot or park ranger, the team needs to respect the goal and assist the person to achieve the outcomes the goal represents for the individual. Does being a fighter pilot mean wearing the uniform, flying, talking on the radios, being around powerful noisy engines, being around other pilots, working in lookout towers, or being in the outdoors?

This discovery may take time. It may take several months to find out what the goal means to the individual. Sampling bits and pieces of the desired outcome can help the team see the goal from the individual's perspective. Once the team can identify how the person perceives the desired outcome/goal, then more refined supports can be created.

Don has stated that he wants to go fishing in the next year. The QDDP is not exactly sure what "fishing" means to Don. Does it mean watch someone fish? Does it mean learning how to use a rod and bait the hook? Does it mean going fishing with a friend or DSP? Could it mean that Don wants to fish from shore at the nearby river with his neighbor who tells him about fishing all the time? The QDDP determines that more information needs to be gathered so that objectives are exactly what Don is stating.

It would be a breach of trust to disregard the desired outcome of the individual and treat it as unreasonable. If the team does not assist in pursuing the identified dreams, they should not expect the person to view the self-assessment or planning process as valid and worth the effort.
The **goal** (what will occur) will provide direction on what **objectives** (needed steps along the way) should be written. **There is no specified number of required goals nor objectives**, only what the team feels is reasonable and do-able for the person and their situation.

Most people will have goals in the areas of living, working (day-time hours if the person is retired), and leisure/recreation. In some cases, the assessment process might tell the team that the person's biggest priority is to explore some options in these major life areas (i.e. explore

new recreation options, learn about jobs or volunteer opportunities in an area that they have shown some interest, etc.). The QDDP will be challenged to assure that the exploration takes place without a gap in service across the year and that the team comes together again as needed to consider the result.

A premise of person centered services is that attaining overall goals is a combination of learning new things (learning objectives) and supports (support objectives). Not having a skill should not limit the person's access or dreams – that is when supports are provided. The team should address strategies to support the person in learning new skills that will lead to increasing their independence and ability to lead a self-directed life. With rare exceptions (i.e. person with dementia) the PCSP will include a combination of learning objectives and support objectives. These learning and support objectives should be designed to systematically assist the person to attain the overall goals.

Objectives/activities of the plan should include: the steps along the way, the person responsible, methods or strategies and an approximate date of completion. Select learning objectives that are
- functional and result in continued practice
- enhance competence as well as build skills
- promote inclusion and relationships

When writing learning objectives:
- Be specific. The behavior, skill, support, or status must be observable and apparent to at least two observers watching at different times
- Make it measureable. Express the objective in a way that can be quantified, such as an action was taken, a status was accomplished or a skill was performed a certain number of times.
- Ensure it is reliable and stable. Different observers conducting the same measure should obtain the same results.
- Define behaviors properly.
- Include the projected start date for objectives, the criteria for identifying when the desired behavior/skill has been achieved and when the objective must be reviewed.
- Identify the staff position responsible for implementing each objective.
- Identify appropriate methods that will be used to support the individual or accomplish the outcomes including the physical and social environments, equipment and materials required. Techniques that are consistent with the consumer's communication mode and learning must be included.

The team should assist the individual to prioritize his/her activities for the year ahead. Refer to *Assessment and Setting Goals* module and *Writing Behavioral Objectives and Measuring Behavior* module for more information.

Writing the actual objectives during the meeting can consume too much time. The team may expect the QDDP to develop the objectives after the meeting and distribute a draft for their approval. The team should agree on the specific supports and services that will be provided and who is responsible.

The methods are not required to be included in the OSP/PCSP component of the plan as methods may frequently change. Method change should not require a revision to the plan. Methods will not be included in the QER (Quality Enhancement Review). Methods should be specific enough so anyone can read them and implement the objective as written. Methods should be made available to the Developmental Disabilities Program Manager, person supported, and any legal decision maker on request.

This phase of the meeting may also include discussion of barriers to goals/outcomes. Avoid a tendency to ignore or gloss over these issues. Barriers can be conflicting values, negative reputation of the person supported or behaviors that interfere with progress or contradict

 realization of a goal or objective. The person may have a history of setting fires. This behavior can impede obtaining competitive employment or moving to a more independent residential setting. Even though Person Centered Service Planning emphasizes capacities and accomplishments, the team must also wrestle with negative issues. The team needs to honor the person's needs and address prerequisites for the individual to achieve their outcome. Positive and practical behavior support plans may be needed as well as medical, psychiatric or neurological supports. The facilitator's responsibility will be to keep the team focused on the behavior and not the person. Redirect tendencies of team members to cast blame, use labels, share professional battle stories or take on the mission of fixing the person.

It is essential that team discussions at the OSP meeting are documented to:
- Reflect the discussion points of the team meeting
- Capture the meaning of meeting conversations
- Document important or divisive issues
- Serve as a reminder of issues that were discussed, conclusions that were drawn and follow up that is needed.

Documentation of team discussions ensure that critical decision-making is recorded and provides reference as to why certain proposals or actions were accepted or rejected. It is a place to go when time passes and memories fade. The documentation will accurately reflect the interpretation of the issues discussed and what if any conclusions were reached. The documentation of the team discussion should not be a verbatim record of the discussion word by word, but should outline major points of the discussion, conclusions, recommendations, and follow up as applicable.

The team discussion should be described in each of the appropriate Assessment Areas in the OSP-PCSP section. In the event that the documentation of the team discussion exceeds the space capacity in each section of the OSP in Therap, a Word document can be attached to the OSP to provide additional documentation of team discussion.

Summary

The last phase can often feel like an epilogue. It is equally important as the previous phases. People have given lots of energy to the decision-making segment of the meeting and are ready to end their participation. However, it is important to take the time needed for this phase. If all issues have not been addressed, the team will need to decide to continue or reconvene. When directing this phase, begin by summarizing the major points (goals, proposed objectives, issues) of the plan. Ending the summarization with a positive will leave everyone on a more up-beat note. Take the time to review the commitments of each team member. When a team member makes a commitment in the plan verbally, they will be more likely to follow through.

End the meeting on time and direct the team to set future dates if more time is needed for specific issues.

Study Questions Chapter 3

True or False

_____ 1. If, at the summary phase of the team meeting, all issues have not been addressed, the team will need to decide to continue or reconvene.

_____ 2. The documentation of the team discussion should be a verbatim record of the discussion.

_____ 3. A written objective should include the projected start date, the criteria for identifying when the desired behavior/skill(s) has been achieved and when the objective must be reviewed.

_____ 4. A written objective should be observable and apparent to at least two observers watching at different times.

_____ 5. A PCSP may often not have learning and/or support objectives.

_____ 6. In the information phase of the team meeting the team may need to clarify any issues and determine if enough information is available to move forward with the material synthesized from the self-assessment and the risk assessment.

_____ 7. The agenda should follow the OSP.

_____ 8. An efficient team does not need an agenda.

_____ 9. It is more likely that a person will participate in the team meeting when they have a part in preparing for the meeting.

_____ 10. The team should discuss what can be done to increase the person's involvement in the planning meeting.

Multiple Choice

11. The QDDPs role during the team meeting is;
    a. being a professional that makes decisions for the team.
    b. acting as a participant but also a facilitator.
    c. acting as a representative of the agency's administrative team.

12. The agenda
    a. is the OSP.
    b. follows the OSP.
    c. is written by the team.

13. Written documentation of the team's discussion should include
    a. important or divisive issues.
    b. accurate reflections of the issues discussed.
    c. lists of all discussion of the decision-making phase.
    d. both A and B.

14. Good team meeting facilitation includes;
    a. establishing ground rules
    b. starting the team meeting when all have arrived.
    c. allow private conversations.

15. Support objectives

        a. are not measurable.
        b. require that an assessment be directly related to the outcome.
        c. are actions on the part of the staff or the agency.

Paragraph

Questions 16 – 19 are based on the following scenario.

> *It was determined that Jason's goal of attending a NASCAR race in
> Tennessee would help in developing some self-determination skills in the
> area of budgeting. Jason's team also suggested some support objectives
> in planning and arranging the trip.*

Write a learning objective and support objective from the information in the above scenario.
Be sure to address the components of learning objectives on page 35.

    16. Learning objective

    17. Support objective

    18. Think of one more functional skill that could be developed (one that would result in
    continued practice) as a result of this goal. You do not need to write the objective.

    19. Determine what is needed in this support objective. (Staff instructions, who will do
    what and when)

        Jason will purchase his flight/ticket.

Questions 20 – 23 will be based on the following scenario.

The team has decided that Sherrie's love for animals should be the basis for some skill building in self determination and relationships. Sherrie is non-verbal and relies on others to direct her daily activities.

20. Write a learning objective that would be functional and result in a skill that she could use across environments.

21. Write a support objective that would be related to her love of animals but be exploration in nature.

22. Using her love for animals suggest some supports that could be built so Sherrie could start building some relationships.

23. Sherrie's team wrote the following support objective to help her explore possible jobs or volunteer opportunities that would build on her interest in animals:

    Sherrie will visit some places where animals are present.

    Please revise the objective to make it measurable and provide staff instructions that will detail how this support is to be provided and the data they should record following the activity that will give staff the information that they need to take the next step.

Chapter 4: Person Centered Service Plan Implementation and Monitoring

Objectives:

After reading this QDDPs will be able to:
1. Identify responsibilities of the QDDP in the implementation phase of the PCSP
2. Identify aspects of quality in written objectives/plans
3. Construct a timeline of the OSP
4. List elements of monitoring an OSP
5. Identify possible problems when progress is lacking in a PCSP

One of the key responsibilities of a QDDP is to monitor the PCSP portion of the OSP. This involves tracking and reviewing the PCSP's objectives on a monthly or quarterly basis. Monitoring also assumes that follow-up to problem areas will be timely and directed to the staff and/or the programs involved. This monitoring is of the full plan which may include vocational, residential, or other programs attended by the person supported.

The QDDPis usually responsible to compile the complete written record of the team meeting. Such records include the assessment summaries, a record of the team's decision-making and objectives agreed upon for the year ahead. Depending on how duties are assigned, the QDDP might write the learning and support objectives or delegate this to other staff in the program.

The assessment process described in Chapter 2 should lead the team to write goals (Global statement(s) of a desired outcome(s)) that will support the person supported to the quality life they have described in their self-assessment. The objectives (more specific steps that are measurable) of those goals will be the active part of the PCSP. This will be monitored consistently by the QDDP.

If the assessment process has been vague, agency centered, or has gathered little information in the self-assessment, the resulting PSCP will be aimless. It will lack purpose and look the same from year to year. If, however, the team has made purposeful assessment of areas drawn from the self-assessment, the goals should produce objectives that produce data. The team will use these data to make decisions that will support attainment of the person's outcomes. These data can also be useful for the agency to plan allocation of resources. The PCSP can be considered the grassroots of supports to people with disabilities – it should be used as a tool for individual planning but also agency strategic planning.

Finalizing the Plan

This module will not review how to write objectives. This is covered in the module *Writing Behavioral Objectives.* Remember Byron in chapter two? Take notice of how goals and

objectives were developed.

> Byron's self-assessment has yielded very little information for the team to use to support him in developing his PCSP. The QDDP has completed it but the team doesn't feel comfortable basing much of their planning on what they have. With the lack of self-assessment information the team tends to focus on the risk assessment and the progress of the behavior support plan started 9 months ago.

> The QDDP is convinced that a person with a disability should have a say in their life planning so it was proposed to pursue a goal of a more detailed self-assessment and come back with a better picture of Byron's desires. The team narrowed the focus to the vocational area of Byron's life. The goal: Define Byron's vocational interests. The team wanted to achieve this goal within the next 6 months. It was proposed to get this information in several ways; by trying different jobs, a formal vocational assessment, and taking inventory of Byron's leisure interests.

> Another area of need was household chores. It was felt that he was quite capable of learning to do laundry, room cleaning, and some simple cooking. Since the team did not want to overwhelm Byron and keep within the limits of the positive behavior support plan, they decided to focus on room cleaning. The goal: Byron will complete household chores independently.
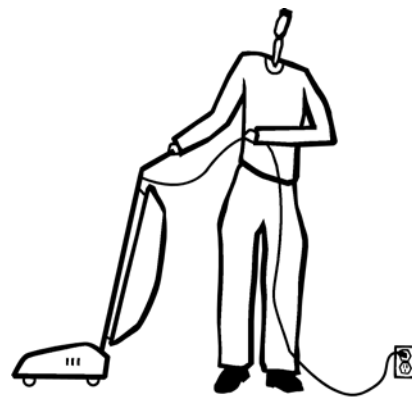
> The QDDP wrote the following objectives to address and move Byron toward achievement of the two goals.
> 1. Given 7 different job experiences, Byron's engagement in three different aspects of each job experience will be rated by an observer over a period of 2 consecutive days on each job experience.
> 2. Complete an interpreted vocational assessment by 6-30-2012.
> 3. Take inventory of past leisure activities in the past year.
> 4. Given 7 new leisure/recreational activities, Byron's engagement in the activity will be rated by an observer.
> 5. Given a visual room cleaning checklist, Byron will complete the checklist independently, once a week, for 3 out of 4 weeks.

This team decided to tackle the most important aspect of Person Centered Service planning - obtain a valid self-assessment. The objectives for this goal is dependent on the actions of agency staff in obtaining information and data. These are **support objectives.** The room cleaning objective addresses the goal of household chores. This is a **learning or behavioral objective**.

In planning the objectives, the QDDP must ask, "what information will help the team and person supported move closer to the goal?" If the QDDP/ team decided the most important aspect of the self-assessment was to find a way for Byron to give valid and reliable answers to questions from the self-assessment the goal would change. The goal might look like: Byron will communicate responses to self-assessment questions. This will change data collection from rating scales and interest inventories in the first goal mentioned to finding ways for Byron to communicate his preferences that have been proven to be reliable and valid.

Direct Support Professional

The QDDP is responsible to write the objective (a statement of an expected behavior) that is related to the achievement of the goals based on the decisions that were made at the PCSP meeting. These objectives will either teach a skill or state an observable activity that will be accomplished (sometimes called a support objective). Support objectives should specify special actions that are not common to all people supported. For example, it is not necessary to include a support objective for provision of a balanced diet unless that diet is pureed, portion controlled, or includes special eating equipment.

Most objectives will be implemented by team members, direct support professionals or by the person supported. The success of the written plan will, in part, depend on the training and support of those responsible to carry out the plan. It would be a mistake to write the plan's objectives apart from those who will directly be responsible to carry out the activities. To successfully manage and lead the program plan, the QDDP should consult with DSPs and probe about how the teaching procedures or activities should be formulated.

It is also important in this process to prevent agency parameters from dominating how plans will be carried out. If the team has placed a high priority on sampling aspects of various jobs, then the resources to carry this out must also be a priority for the agency. If the appropriate service/support is not currently available, the QDDP is responsible for working with agency leaders and others on the individual's support team to identify alternatives that would support the individual's goal. Lack of an existing service option should not be an insurmountable barrier.

Effective managers affirm and trust the capabilities of support staff. When DSPs are given shared responsibility for developing the methods they will be implementing in the PCSP, they not only feel affirmed, they understand the purpose and importance of each objective. The QDDP doesn't step out of objective development but leads the process. Consider the limited teaching experience of most DSPs, especially teaching people who have challenges in learning. Keep in mind that DSPs will have varied backgrounds and experiences in working with people with disabilities.

DSPs need the following skills in order to effectively implement teaching

plans with people with cognitive disabilities:

- Least to most prompting
- Using correct reinforcement procedures
- Using effective error correction strategies
- Understanding a task analysis

Achieving Personal Outcomes, Supporting Individuals in the Community, Job Coach Training, and Developing Communicative Interactions from the North Dakota Community Staff Training Curriculum can provide the basic information for staff who will be implementing learning objectives.

When leading the process of writing objectives, the QDDP should be mindful of the following points:

Objectives should be efficient to implement. *The procedures used to teach the skill or behavior should be easy or efficient to carry out. The DSPs should have the time, materials and resources to implement the objective. The resources should be easily accessible. If part of the teaching procedure is to ride the city bus, then city routes and bus schedules should be provided to the DSPs so they can plan accordingly.*

Documentation should be easy to understand. *Written procedures for teaching and documenting results of each teaching opportunity should be easy to read and concise. Easily understood forms/instructions that don't take a lot of time to read or complete will help ensure that DSPs carry out the teaching plan consistently and correctly.*

Implementation should occur in natural environments. *Teaching procedures should be written so that the skill or behavior can be taught in natural environments and at natural times. They should also be written so that the teaching can be embedded in daily routines. A range of motion exercise program can be embedded in house cleaning, personal cares or on a job site. Making a bed should be taught during the morning routine. Natural environment means the use of generic community services such as Laundromats, grocery stores, churches, coffee shops, banks, beauty salons, etc.*

Delivered in a timely manner. *Teaching procedures and finalized objectives should be delivered and reviewed with DSPs as soon as possible. Timely turn around conveys the importance the QDDP places on the Person Centered Service Plan and its implementation.*

Relate to desired outcome. *QDDPs may need to help support DSPs understand how their successful teaching of this objective is connected to the personal goals and dreams of the individual supported. The QDDP helps DSPs understand that if the program is not*

implemented or if it does not produce the desired behavior/skill change, the progress of the person supported will be hindered.

Documentation is a necessary part of being accountable. *The general rule is that if it is not written down it did not occur. In order for the QDDP to prove their accountability a consistent review of the plan should be evident in written notes. These notes can be in electronic or manually written form.*

It is best if the QDDP is able to personally present new program plans to support DSPs in a fashion that communicates their significance. Provide copies for everyone to read and ask DSPs to sign off after reviewing them. To express and impart your professional value of support plans and the role of DSPs in their implementation, formally present new or revised plans and discuss them with DSPs. Devote as much time as necessary to ensure that DSPs understand teaching procedures, documentation, schedules for implementation, and the need for consistent implementation. They should also understand their partnership in making the plan successful. Ask them for suggestions for changes and their feedback on progress or lack of. A verbal agreement to the plan will help ensure DSPs commitment to their responsibilities. Subsequent formal, face-to-face reviews with DSPs are also recommended.

Delegation of DSP's Training

The most effective way to achieve accountability is for the QDDP to directly train DSPs in the implementation of the program plan. When this is not possible delegation of the training by the QDDP to supervisors or managers is a valid option. This delegation assists in timely implementation of revised plans. **All current staff should be trained by the date of the OSP.** As new staff are hired or assigned, it is important that they are instructed on the new programs before they begin working with the person supported. It is important to be mindful of the potential changes that can occur when a piece of information is passed down through people, however. Similar to the "telephone" game where the message is passed around the circle – by the time the final person receives the message, it can be very distorted. This distortion or change may not be intentional but is a product of individual perspectives. Since the QDDP will be directly accountable for the correct implementation of support plans, the QDDP should always follow up DSPs training with observation and interviews.

Individual Supported

When the plan is written and ready for distribution, the person supported should be given a copy that he/she can understand and keep. This may mean that the plan will look different than the one in a master file or the copy given to DSPs. The contents will still render the same outcomes. This copy may need to have more pictures, symbols or varied order. It should be

meaningful so that the person can explain it to someone who is not familiar with the plan or team process.

The QDDP should spend time explaining the written copy. This may include recalling the discussion and decisions made at the meeting or reviewing their goals. It is important to assist the person in understanding how the program objectives will help them progress toward their goal. Reviewing the activities they will be doing with support DSPs will help them visualize what they will be doing and how DSPs will assist them.

It is also important to emphasize that the QDDP will be observing and periodically meeting with them to see how the program is progressing. The person supported will provide feedback throughout the duration of the plan.

Guardian/Family

Sometimes a face-to-face meeting with guardians is not possible or necessary but open and ongoing communication regarding the plan needs to occur. They should have the opportunity to ask questions and be informed of how the program will be monitored. Family and guardians will not always initiate the communication and it is a trial and error process to see what type of communication works best. Some families like phone calls versus written reports. Some prefer

e-mail. Whatever style it is, it is advantageous to make your communication frequent and emphasize positive gains based on the plan. It is poor leadership to communicate with guardian and family only when there is a crisis or problems. To assist the guardian in understanding the significance of the plan they need information on how it is working. Specific information on gains, even small, will further their trust in person centered planning process. For further information on family dynamics refer to the *Working with Families* training manual in the ND Community Staff Training Curriculum.

Other Team Members

Any team member that has been named as a provider of a support or service should receive a copy of the written plan or have electronic access (Therap) and some type of follow-up communication. Ongoing communication regarding progress of the overall plan and their specific support is the responsibility of the QDDP. Consistent communication will symbolize commitment to the individual's goals and the person centered planning process.

Timelines

In the state of North Dakota specific timelines have been established with the Department of Human Services Developmental Disabilities Division regarding the Overall Service Plan- Person Centered Service Plan process.

- An Admission plan must be developed prior to the start date of services to address the health and safety needs of the individual and to ensure staff is trained when the person starts the service(s).
- Within 30 days of the start of services a 30 Day Comprehensive Plan will be developed. This plan is essentially the first comprehensive annual plan. Within 10 working days following the 30 Day Comprehensive meeting, the QDDP must submit the written plan to the DD Program Manager for approval. The DDPM has 5 working days following that to approve the plan and to authorize the service for the next year. (This means the start date of the 30 Day Comprehensive OSP is 15 working days following the 30 day comprehensive team meeting.)
- The OSP-PCSP must be reviewed and updated at least annually. (Annual is defined as one year minus one day). The due date for the annual plan is one year minus one day from the start date of the previous plan.
  - The QDDP will consult with the individual and legal decision maker to select a convenient time, date and location for the PCSP meeting.
  - Two months prior to the annual Person Centered Service Plan meeting, the QDDP will send written notice of the PCSP meeting date to all team members. Two weeks prior to the PCSP meeting, the QDDP will send a copy of the completed individual self-assessment and Risk Assessment (RMAP) to all team members. If the team member has access to Therap, the RMAP will be available for review in the system.
- After the annual PCSP meeting is held, the QDDP must submit the new written annual plan to the DDPM for approval. The plan must be submitted to the DDPM at least 5 working days prior to the end date of the current active OSP so the DDPM has time to review and approve the plan. The new annual plan must be approved by the DDPM on or prior to the end date of the current Active plan in order to meet the one year minus one day timeline. (Example: 30 Day Comp/Annual plan is in effect from 8-1-12 to 7-31-13. The next annual plan must be developed by the team, written by the QDDP and submitted to the DDPM at least 5 working days prior to 7-31-13 which is the end date of the current plan, so the new plan can be approved and start on 8-1-13.)

Monitoring the Plan

Most job descriptions for a QDDP emphasize the responsibility of monitoring the Person Centered Service Plan of the people under his/her responsibility. In Title XIX regulations this monitoring is described as "aggressive and consistent". Roget's thesaurus lists a synonym for aggressive as "being on the offensive". A stock broker's reputation is built on how well he/she

monitors the stock market and advises changes based on the trends they see. You would not want to hire a broker that is passive, inactive or slack in their duties. The same can be said for QDDPs who are charged with the responsibility of monitoring the life plan of someone who needs assistance in reaching his or her goals.

Elements of Monitoring

Monitoring the plan should include
- Observation of the individual and support providers in all environments
- Review of plan documentation – data as specified in the PCSP
- Review of anecdotal data (progress notes, medical notes)
- Interviews and possibly assessments

When practiced, these methods can give a thorough picture of how the program is progressing. Good monitoring is reflected in realizing the desired changes for the person supported. Monitoring is a means to an end. Written reports, observations, and program summaries are part of the process, but the true test of good monitoring is a plan of coordinated supports that actively assists the person to reach his or her goals.

The plan should adhere to the timelines set in policy by the funding agency and those established at the meeting. The QDDP monitors projected dates of accomplishment. When support or learning objectives are not meeting the expected deadlines, the QDDP should be investigating. Often, unforeseen circumstances can make plans change, but as the plan coordinator, the QDDP should then seek alternative solutions. This may mean revising deadline dates, making revisions to procedures, retraining DSPs, or seeking alternative providers.

In some instances, the QDDP may need to act as an advocate. This may mean confronting a business for better service or seeking out a professional that will treat the individual as a valued customer. As consumers we expect to have service in exchange for our dollar - and we should expect the same for support recipients.

Another aspect of effective monitoring is assessing the knowledge DSPs have regarding the individual and his or her goals. In addition to providing orientation to the plan for new employees, the QDDP needs to make regular probes of the plan progress with seasoned DSPs. DSPs will feel part of the team if they are kept informed on learning and support objectives progress. Creative and innovative methods to inform DSPs can aid in getting their attention amid busy schedules. These methods may be a chart depicting percentage gains (or losses) of a particular learning objective. It could be a photograph of an accomplishment from the past week or personal notes to DSPs informing them of the completion of an objective.

Observe DSPs actively implementing segments of the plan. This should include both planned and unannounced visits to learn if DSPs:
- Follow the teaching procedures consistently?
- Document accurately?

- Know and follow the schedule of implementation for a particular objective?

During the visit, tell DSPs what they are doing right and how they can make corrections or improvements in their interactions and teaching techniques. Spend time mentoring, modeling plan implementation, and problem solving with staff. Timely feedback will aid in preventing erosion of methods and inconsistency among DSPs. QDDPs should follow your agency's policy in documenting these visits.

Good monitoring is also reflected in a changing or evolving plan. This is not to assert that a properly monitored plan needs complete revisions every 3 or 6 months. The plan should aim to progressively bring that person closer to their goals and help them take more control over their life. A plan that has continuity will have evidence of that progression in continued growth and successive steps towards these goals. The plan may run smoothly for several months. But when people change, their plans should also be revised. A valid and appropriate plan shows evidence that it has changed according to the person's needs/desires and there is progression toward assisting that person in attaining more control.

Monitoring Practices

It is not the purpose of this manual to prescribe what reports should be written or how often monitoring should be done. It is important to steer away from perspectives that emphasize the process more than the product. Ultimately the QDDP will be responsible to answer questions that a written report may not.

When Programs are not Progressing

Occasionally a well-designed program may not be progressing as planned. After varied results or no progress, the QDDP should observe the program being implemented and examine the following:
- Are DSPs consistently following the teaching methods across DSPs and time?
- Do DSPs understand the methods and can they justify their data? Are they clear about what physical prompts, verbal prompts or independent mean?
- Is the instruction schedule being followed? Have there been many unscheduled interruptions to instruction?
- Have the person's goals changed? Do they understand why they are working on this skill?
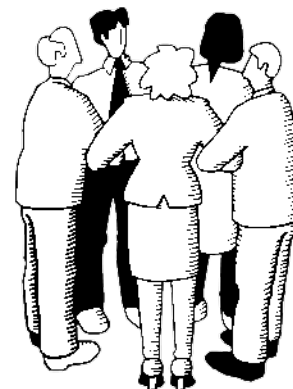
Nothing is more reliable than observing firsthand the actual implementation. The QDDP is

accountable to the progress of the programming. Knowledge of the program dynamics will be expected.

In most circumstances the DDPM and QDDP will collaborate regarding changes to OSPs when behavior programs need revisions, a change of placement within the agency is considered, when life circumstances require revisiting the PCSP. These would be points at which all team members need to give input. When revisions to support or learning programs are needed the QDDP and DDPM can collaborate but a team meeting does not need to be called.

Summary

Monitoring the "continuous and aggressive, consistent implementation" of the plan is one of the major responsibilities of the QDDP. When surveyors, inspectors or DDPMs have questions, they will expect the QDDP to have the answers or know where to find it. This level of insight into the person supported and the progress of their personal plan can only come by consistently and aggressively acting as a sentinel for the forward movement of the plan. It is an activity or part of the QDDP's job that will produce changes in the quality of life of people receiving support.

Study Questions Chapter 4

True or False

_____1. The QDDP tracks and reviews the PCSP's objectives on a biannual basis.

_____2. Support objectives should specify special actions that are common to all people supported.

_____3. DSPs need to know how to apply "least to most prompting" in order to implement learning objectives.

_____4. Written objectives and the subsequent methods should be implemented in natural environments.

_____5. The OSP-PCSP annual date is one year plus one day of the previous OSP-PCSP.

_____6. The OSP-PCSP must be submitted to the DDPM at least 5 working days prior to the end date of the current active OSP.

_____7. Effective monitoring requires actual observation of the specific teaching program implementation.

_____8. It is not a requirement of monitoring programs to observe prompting skills of DSPs.

_____9. Observing the implementation of the OSP-PCSP is only required in the programs of your agency – not any programs delivered in services outside your agency.

Multiple Choice

10. If an OSP-PCSP is active until July 15, 2015, the new annual plan must be approved by the DDPM on or prior to
      a. June 14, 2017
      b. July 16, 2016
      c. July 14, 2015

11. When a new OSP-PCSP has been developed and program methods have been written it is expected that all staff have been trained by
      a. the date of the OSP
      b. within 15 days of the new active OSP-PCSP
      c. within 5 days of the approval of the DDPM

12. Written support & learning objective methods should
      a. be easy to implement without a lot of training.
      b. be written at the PCSP.

      c. be delivered in a timely manner.

Paragraph

13. A copy of the program (learning or support objective methods) should be given to the person supported. List at least one way to make the program understandable to the individual.

14. Describe what aggressive and consistent monitoring of the OSP-PCSP should look like. List specific actions the QDDP should be taking to be aggressive and consistent.

15. List at least three ways a QDDP could communicate progress (or lack of) to DSPs that would not require a group or individual meeting.

Questions 16 – 18 will use the scenario below to answer the questions.

> *Curt has been monitoring the PSSP of Jason for the past 6 months and*
> *little progress has been made on the behavior program objective.*
> *GERs and T-logs seem to indicate that all procedures are being*
> *followed but data is flat – there has been little change in the targeted*
> *behavior. The DSPs are frustrated with the lack of change.*

16. List two steps the QDDP (Curt) should do before questioning the skills of the staff?

      a.

      b.

17. If Curt decides to observe the actual implementation of the program what specific things should he be looking for.

18. What are some questions the QDDP could ask the DSPs to understand their expectations of the behavior program?

Chapter 5: Record Keeping

Objectives:

After reading this QDDPs will be able to:

- List at least 5 reasons for record keeping.
- Identify legal documents that are needed for providing services.
- List information that will be needed by a receiving agency that will help in providing services.
- Describe the purpose of a social history.
- Describe best practices when using written documents.
- Describe the purpose of the HIPAA law.

The agency has a responsibility to know and record what has transpired from the time an individual has enrolled to the present. Keeping records is important for the following reasons:

- It provides a baseline
- Helps to plan for the future
- Assists in following regulations
- Provides memory for teams
- Assures continuity
- Assists in funding
- Gives accountability
- Assists the agency in overall planning and evaluation
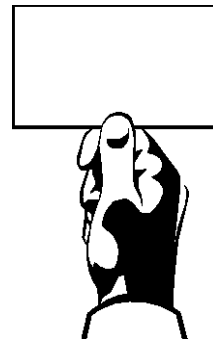
Imagine coming to work and receiving a phone call. Services are being requested for a woman with a disability by the DDPM. The specifics on what would be needed to support her have not been shared - only that it is an emergency placement and this person will need to move into residential services by the end of the week. She needs to be enrolled by Friday and move into a residential setting there by Saturday. When she arrives, her records include the following:

- Medical assistance number
- Names of her closest family members
- A report on a physical done 6 months ago

How could your agency provide supports based on the information given? What further information is needed? This would be a very difficult start for this person. Sometimes life circumstances necessitate quick changes. No matter what the life circumstance, good records will assist in making the change as smooth as possible.

For a smooth transition, records from the current agency are needed to give insight to her

requirements for supports and services. A determination should be made as to what daily routines will need supervision and/or physical assistance. The number of hours of staff support will be a primary concern. Is the person able to communicate her needs/desires? If so, how does she do this? Does she have any special equipment or assistive technology to help with daily living?

Legal documents are needed. Is she her own guardian? If not, what type of guardianship does she have? Who and where is the guardian? Does she have limitations? Who is giving consent for this move? Where are the releases of information? In addition you will need:

- Social Security card
- Sources of financial support (personal bank accounts, SSI, SSDI, SSDAC, insurance, child support)
- Documentation of any personal property
- Doctor's orders for medications or treatments and a current Medication Administration Record
- A birth certificate

An understanding of the individual's personal, social, vocational, and health needs and goals is needed. This information tells a lot about the person and cannot always be conveyed in a record or past plans. This information can be ascertained from pre-placement visits and interviews with agency staff. However, records of past learning and support objectives, behavior support plans, progress in objectives, employment and job coach reports, as well as records of Behavior Support and Human Rights Committee's involvement will help you build the kinds of supports needed. How or where does one begin? It is the responsibility of the QDDP to keep records that will prevent a crisis situation similar to what was just described when a transfer between programs takes place.

Record keeping can consume more time and energy than needed if those responsible do not understand the rationale or importance of the information needed. The statement: "if it is not written down – it did not happen" may prematurely motivate an agency to develop cumbersome forms and practices. Documentation of all activity may have been true a decade ago, when services were evaluated primarily based on processes and documentation. However, current evaluation processes focus primarily on outcomes experienced by service recipients.

Types of Records

Legal Documents

Legal documents provide the necessary proof that certain criteria have been met for provision of services, limitation of rights, or consent. The following is a suggested list of what may be

included, however special circumstances such as health maintenance or legal problems may necessitate additional documentation:

- **Guardianship** – *a legal document that specifies who is guardian over an individual and what powers and rights have been restricted. This document should also specify the duties of the guardian regarding reporting to the court.*
- **Birth Certificate** – *should be an original document*
- **Releases or consents** – *Even though a guardian may need to sign releases, the ward's signature should also be obtained.*
- **Review of rights limitation** – *This should have the signature of the local human rights committee. The review should state the methods, rationale, any comments or requests from the committee, schedule for next review and a plan for reinstatement of the rights.*
- **Inventory of assets** – *This may include personal financial accounts, personal property, and insurance policies.*
- **Social Security card** – *Should be an original document.*
- **Advance directives or will**.
- **Documents related to forms of payment** – *SSI, SSDAC, SSDI, recipient liability, food stamps, rent assistance, housing assistance, Medicare, Medicaid and redetermination information, county report on income, fuel assistance.*

Person Centered Service Plan

This document (as previously mentioned) is an ongoing record of the activity of the agency and team in providing supports and services to assist the person reach their dreams and goals. It provides memory regarding discussion and decision-making by the team. This document includes:
- Meeting notes of discussion during team meeting, e.g. assessments, goals, decision-making.
- The written goals and objectives, including teaching procedures or activities and data collection.
- Progress reports on each objective – monthly or quarterly with the minimum being quarterly. Best practice recommendations include a monthly review of progress for learning objectives and at least quarterly for support objectives. Remember the plan must be data based as stated in Title XIX regulations.
- Written assessment summaries and/or reassessments.

If the person receives services from other agencies, e.g., public school, preschool program, vocational services, etc., the plans from these agencies should be incorporated into one coordinated plan reflecting the work and activities of everyone providing supports and services.
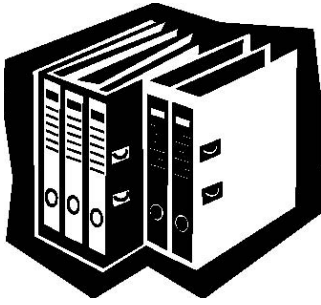
The North Dakota Century Code 25-01.2-14 requires the following;

Any institution, facility, agency, or organization that provides services for *developmentally disabled persons shall have a written individualized habilitation plan developed and put into effect for each person for whom that institution, facility, agency or organization is primarily responsible for the delivery or coordinating the delivery of services. A school must have an individual educational plan for each of its developmentally disabled students. A plan required under this section must:*

1. *Be developed and put into effect within thirty days following the admission of the person.*
2. *Be reviewed and updated from time to time, but no less than annually.*
3. *Include a statement of the long-term habilitation or education goals for the person and the intermediate objectives relating to the attainment of those goals. The objectives must be stated specifically, in sequence, and in behavioral or other terms that provide measurable indices of progress.*
4. *State objective criteria and an evaluation procedure and schedule for determining whether the objectives and goals are being achieved.*
5. *Describe personnel necessary for the provision of the services described in the plan.*
6. *Specify the date of initiation and anticipated duration of each service to be provided.*
7. *State whether the developmentally disabled person appears to need a guardian and determine the type of protection needed by the individual based on the individual's actual mental and adaptive limitations and other conditions which may warrant the appointment of a guardian. Any member of the individual plan team may petition, or notify any interested person of the need to petition, for a finding of incapacity and appointment of a guardian.*

The social history, completed by a person trained to gather and compile the information (i.e., licensed social worker), is included in this section. This document should be updated when life changes occur. It serves as a running history and provides valuable information regarding past experiences of the person supported.

Medical
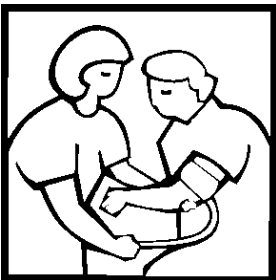
This section should include all activity related to medical visits and medication administration. It should include a copy of the standing orders, past originals of the medication administration record, copies of doctor's orders and information on ongoing health concerns. This section should also include information regarding special diets, psychiatric issues, occupational, and physical therapy services and supports. The agency nurse will assist in compiling the correct information for this section.

Progress Notes

Progress notes are logged by those in consistent contact with the person. These notes provide a progressive, sequential picture of the individual's activities, and establish any trends or patterns. They can be used to share information and to document any out of the ordinary occurrences. The notes should include the day, time, location, an objective description of actions or events, outcomes and any follow-up plans. These notes are not intended for subjective communication between staff or administration. (See the *Writing Objectives* module in the ND Community Staff Training Curriculum for information on objective/subjective language). Progress notes are considered legal documents. They should be available for review by all people with a right to know. Agency policy dictates how long records should be archived.

Storage

Recently companies have been moving to web based data storage. Providers deliver applications via the internet, which are accessed from web browsers and desktop and mobile apps, while the business software and data are stored on servers at a remote location. In North Dakota, Therap has been adopted by the state to provide this service to agencies serving people with developmental disabilities.

Security and sharing of information with guardians, DDPMs, and other professionals who need to know has become more instant and transparent. This has eliminated the paper shuffle and has reduced the time it used to take to communicate between programs and with families.

The QDDP will need to monitor daily logs or GERs (general event records), T-logs(significant event log) , ISP data, behavior support reporting and other information that will affect the services provided. This service will not eliminate all paper but it is important that the QDDP ascertain what records will need to be copied to paper and what is stored exclusively in electronic form.

Web based data storage also eliminates the need to update physical records in programs such as residential and vocational programs. These programs will be sharing the same information service, Therap. Staff are given rights to view records of people supported and communication across programs is ongoing. Staff need to be reminded that what is written in GERs, and other communication can be viewed by many people. It is important that information about individuals and related areas be professional and objective. Paper records may still be used for other purposes and will need updating as the need arises.

Records at Place of Service

Because records can be considered legal documents, staff training on how to document and maintain the record is critical. Following are some tips:

- When a mistake is made, draw a line through the mistake, write "error" near the strike out along with the author's initials.
- Never use white out.
- When documenting about other individuals in progress notes, use "housemate 1 or co-worker". Do not use any identifying information about others in the document.
- Draw a line through any unused space.
- Use blue or black ink only.
- Sign your name, title and date.
- Write information in chronological order.
- Use objective language. Ask yourself, "How would you write the information if it were about someone in your family?"

Records for the Person Supported

Written records and access to web based data storage for the individual should be clear and significant to them. Each document should be explained and stored where the person has unrestricted access. Training on web based storage should be provided and given as an option to paper records. As previously discussed, the person centered plan and related documents should be written so the person supported can understand them. The way the information is organized and presented should be meaningful. This may necessitate the use of pictures or use of electronic aids (sounds, graphics) to tell the story and plan of the person.

Confidentiality

The QDDP is held accountable for the confidential use of these records. Information should be available only to those who need to know. There should be a system to control access to the information. Information that is in paper files should have some monitoring system to assure only approved people have access to the file.

HIPAA (Health Insurance Portability and Accountability Act)

As of April 14, 2003 all agencies must implement policies and procedures to protect health information of the people they serve. These procedures are safeguards and all staff must be aware of how they are expected to implement them. HIPAA covers three rules: privacy, transaction and code sets, and security. Agency policy will dictate how these regulations are implemented in each setting.

Other Forms/Records

Occasionally issues or procedures arise that necessitate keeping records of that activity or outcome. These records may be for policy or agency specific issues and only assist in accountability. Rationale for the specific records should be clear and purposeful. Oftentimes, forms can eat up valuable staff time and become obsolete. A periodic review of current forms or record keeping procedures will help in weeding out those that are no longer relevant. Forms and reports should be easy to read and convey as much information as possible in a single page. In the age of information overload and busy schedules, often readers scan documents rather than read long narratives. Charts, graphs, bulleted sentences, bold headings tend to take the least amount of the readers time and pass the information along concisely.

Study Questions Chapter 5

Paragraph

1. A student from the local high school will be transitioning to Agency ABC supported employment program. List at least three things the supported employment coordinator will need to determine the level of services needed.

2. List some ways the receiving agency can learn about the person they will be supporting.

3. Why are progress notes important in determining needs of a person who might be entering services?

4. How does your agency provide for compliance with the HIPAA?

5. When would a social history be updated?

    a. Every annual PCSP

    b. Every 5 years

    c. When life changes occur

Chapter 6: Behavior Support Plans

Objectives:

After reading this QDDPs will be able to:

- Describe the QDDP's role in behavior supports.

- Describe the purpose of the Functional Assessment.

- Arrange the steps of systematic positive behavioral support.

- Defend the practice of defining the challenging behavior as the first step in planning behavior supports.

- Describe the roles of the Behavior Support and Human Rights committee in positive behavior support.

- List characteristics of quality behavior support plans.

- Describe the role of emergency restraints in behavior support.

Nothing draws attention and energies of service providers more than challenging behaviors. Staff and supervisors desire to provide safe living and working environments. Agencies want to

provide services and supports that meet the needs/desires of the people supported. When a person displays behavior that is interpreted as negative it is hard not to question what is causing this dissatisfaction. Support providers tend to seek immediate relief from the challenging behavior or jump to conclusions about the cause. Staff may be caught off guard and perpetuate the behavior by using inappropriate methods to avoid reoccurrence. For all involved it becomes hard to step back and take an objective view of the situation. The QDDP must be responsive to these circumstances but not reactive.

Effective support for challenging behaviors is centered on the following principles:
- Problem behavior usually serves a purpose.
- Functional assessment is used to identify the purpose of problem behavior.
- The goal of behavior support is education not simply behavior reduction.
- Problem behavior typically serves many purposes and therefore may require more than one intervention.
- Behavior supports involves changing social systems not individuals.
- Lifestyle change is the ultimate goal of behavior supports.

Taken from: Communication Based Intervention for Problem Behavior , Carr E., Leven L., McConnachie G., Carlson J., Kemp D., Smith C., Brooks Publishing, 1994

The QDDP often feels the pressure to create a quick fix. However, thoughtful leadership in planning behavior supports is more likely to result in positive outcomes. Direct support

providers can be affected by problem behaviors in varying degrees from minor irritation to debilitating fear and anxiety. A challenging behavior can make the workplace unpleasant and staff may feel insecure about their abilities to act appropriately.

The QDDP, along with supervisory staff should ensure that, until a formal plan is implemented, proper methods are used to protect the person exhibiting the problem behavior and others. Staff should also be informed of the procedures/process to implement until the formal plan is ready to begin. The delay in establishing a plan can be perceived as a lack of support from the QDDP and supervisory staff. During the data gathering process, keep staff informed of the progress of the plan. Management has a moral and legal responsibility for the welfare of employees.

The behavior support plan is part of the OSP and not separate from it. Before the team decides to pursue development of a behavior support plan, it may helpful for the team to step back and look at the PCSP and current monitoring results. Are programs producing the desired positive results in learning and support objectives? Have any changes in services or the person supported made necessary a change in the PCSP? Does the current PCSP reflect the self-assessment results**? Developing a behavior support plan is labor intensive and should be considered when the problem behavior interferes with continued growth in relationships, learning, safety of others and the safety of the individual supported.**

Functional Assessment

A functional assessment is basic to developing a plan that will impact the challenging behavior and increase positive adaptive behavior. It is beyond the scope of this module to teach everything there is to know about conducting a functional assessment and designing a positive behavior support plan. If creation of behavior support plans is within the scope of duties of the QDDP, refer to the *Positive Behavior Support* and *Designing and Implementing Positive Behavior Supports* from the ND Community Staff Training Program for specific details on how to conduct a functional assessment and how to link the functional assessment to the behavior support plan.

The functional assessment provides baseline of data to use in designing effective behavior support(s). It is easy to become distracted by the familiarity staff may have with the individual supported and skip the formal functional assessment. They may feel they know why the behavior is happening and want to develop the methods immediately.   This is often a huge mistake and will waste the time of the person supported and the staff.

Jesse was beginning to display aggressive behavior when asked to do routine personal hygiene tasks and he seemed to be generally more irritable. These statements were being made by all residential staff and they felt he was just becoming stubborn, particularly trying to get out of doing chores around the house. Staff wanted to restrict some regular outside activities that Jesse was involved in and use a checklist. If he conformed to the requests and got all his duties done, he could go to a movie or other activity he enjoyed. Staff were ready to set up the check list and started to decide what could constitute earning an activity.

The QDDP first wanted a description of the behavior DSPs were describing. Once the description was agreed upon, the QDDP asked that data be taken on when this occurred throughout Jesse's day. Was this happening at the vocational program, mornings, evenings, or weekends? All time periods were observed and a scatter plot was developed. From the data, it was clear that these behaviors only occurred between the hours of 4pm and 8pm on weekdays. From this data other questions began to surface:

- *Was Jesse irritable during this time because he was tired?*
- *Which staff were working during these times?*
- *What was the activity level like at these times?*
- *How were the requests being made?*

More data was collected through observation by the QDDP and an intervention was tried that seem the least intrusive – Jesse was encouraged to to take a short nap after arriving home after work and eat his evening meal later to accommodate for the nap.

People change, and circumstances change. It is important to emphasize the value of the functional assessment process to staff. The purpose of the assessment is to understand the structure and function of the behavior in order to design and teach the person effective alternative behavior(s). Functional assessment information should be gathered by interview, observation, questionnaires and review of past programming and medical data. Data should include actual baseline of the targeted behavior(s).

The process

Positive behavior supports involves a systematic approach. The flow chart below represents a suggested process to identify the behavior in observable and measurable terms. Each step may be modified to fit a particular circumstance but the QDDP is accountable for a thorough functional assessment of behavior.

```
┌─────────────────────────┐
│   Challenging behavior   │
└─────────────────────────┘
            │
┌─────────────────────────┐
│     Team meets. Define   │
│     behavior & need for  │
│       intervention.      │
└─────────────────────────┘
            │
┌─────────────────────────┐
│   Functional behavioral  │
│    assessment conducted  │
└─────────────────────────┘
            │
┌─────────────────────────┐          ┌─────────────────────────┐
│     Team meets, agrees on│◄─────────┤    Plan is monitored     │
│  hypothesis and develops │          │   and changes made       │
│          plan.           │          │       if needed.         │
└─────────────────────────┘          │        Ongoing           │
            │                         │    discussion of plan    │
┌─────────────────────────┐          └─────────────────────────┘
│   Staff training. Committee│                    │
│     approval if needed   │                      │
└─────────────────────────┘                      │
            │                                      │
┌─────────────────────────┐                      │
│    Plan is implemented   ├──────────────────────┘
└─────────────────────────┘
```
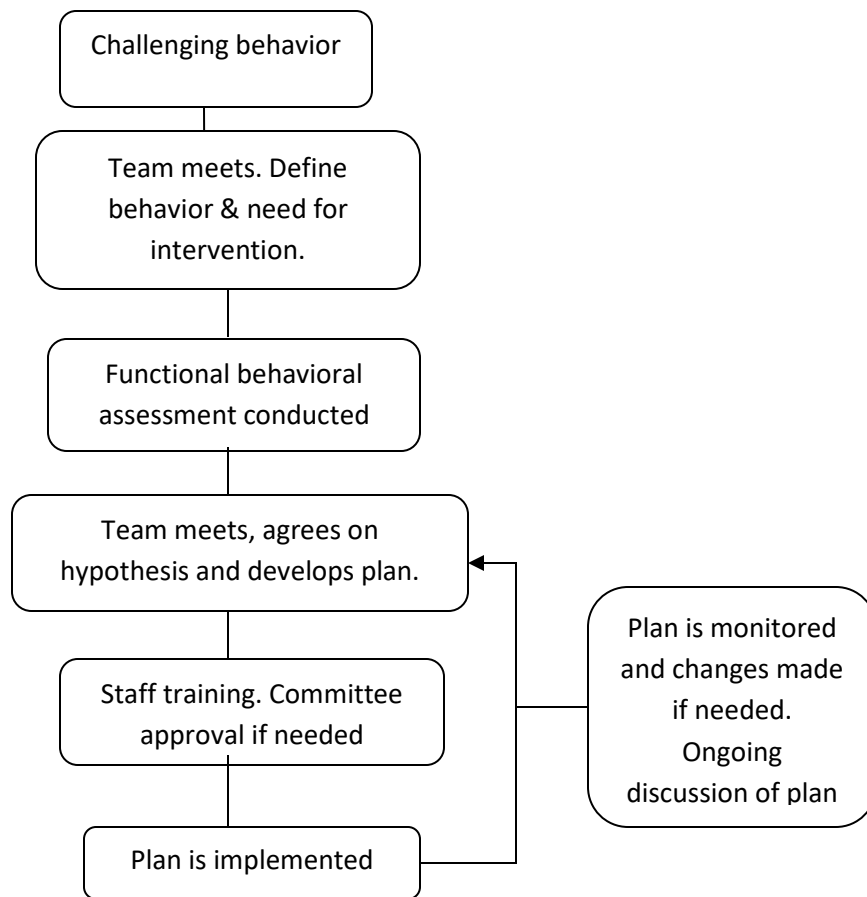
If possible, it is advised to involve a psychologist or behavior analyst in this process from the beginning. They will not only have valuable expertise but can provide an objective view.

Defining the Behavior

The challenging behavior must be defined in observable and measurable terms. The description given should be a consistent picture of the behavior each time an employee is interviewed. If it is not consistent, there will be a disagreement on which or what behavior is targeted. Information should include when the behavior is observed and what is occurring before and after. As staff are interviewed, actively listen for issues of control, retribution, respect for the individual, and patterns of interactions. Ask:
- Do DSPs feel they are losing control when the behavior occurs?
- Do they feel it is a reflection on their performance?
- Do they perceive the person as "getting away with" the behavior?
- Do interviews reveal a pattern of reduced or no interaction with the person? Do you recognize a lack of respect for the individual?

Other issues relating to the individual should be investigated as well. These issues may include:

choice making opportunities, natural support network, and lifestyle satisfaction. When people have little choice, control, or support, they feel isolated. Being dissatisfied with your life can manifest as challenging behaviors. According to Abraham Maslow, fulfillment of basic physical needs is necessary but so are social, esteem and self-actualization needs.

As the challenging behavior you want to replace becomes more specifically defined, it will be easier to determine whether it is necessary to change the behavior. Consider the following:

- Is the behavior dangerous to the person or others?
- Does the behavior interfere with the individual's ability to participate in the community?
- Does the behavior limit their ability to learn?
- Does the behavior result in increased dependence on staff or other supports?

Data Collection

Once the behavior is defined, data must be collected to provide a baseline. Accurate data will also aid in communicating facts about the behavior. The method of data collection depends on the nature, frequency and circumstances that surround the behavior. To determine the appropriate type of data collection instrument, see *Designing and Implementing Positive Behavior Intervention Programs*, in the ND Community Staff Training Curriculum. To obtain accurate data, staff must be trained on the specific data collection methods.

Data collection does not end once the behavior support plan begins. Data are important throughout the entire intervention. Variables such as health, changes in schedules or activities or changes in staff can have an effect on the intervention. It is important to be consistent in the method and kind of data collected.

Environmental Analysis

Some challenging behaviors are a result of an improper "fit" between a person and his/her environment. Some people need a great deal of stimulation and opportunities to socialize and be active in the community. Others desire more privacy, alone time and only occasional opportunities to socialize. Other considerations may be:

- Has there been a recent change in residence, job or family?
- How much control does this person have in their environment - do they have roommates who limit their access to people, things, choices, etc.?
- Do they desire to have more personal possessions?
- Do lighting, noise, and arrangement of their space pose problems?

- Do they feel safe?
- Are they happy in their job and feel a sense of self-worth?
- Can they move about with independence in their environment or are they overly dependent on others?

Functional Analysis

This part of the process will aid in forming a hypothesis regarding the function of the problem behavior. Gathering information by observation, data collection and interviews will help form a hypothesis or speculate on the reason why the behavior is functional for the individual. What purpose does the behavior serve?

- Does it help the person avoid people, requests or circumstances?
- Does it produce a tangible (a thing or activity) in return?
- Is it intrinsic - rewarding in itself e.g. thumb sucking or rocking?
- Does the behavior gain attention?
- Does the behavior serve as a means of communication?

An antecedent-behavior-consequence (ABC) analysis can reveal a pattern in either the antecedent or consequence to problem behaviors. In order for this tool to be effective, staff must be clear on how to define the antecedent and consequence and have time to complete the ABC data collection tool. Questionnaires that probe about the specific behavior can disclose suppositions staff may hold regarding the problem behavior. Objective observers can visit regularly at different times and settings to validate the data by direct support staff. Observations should also verify that what was described by staff is indeed the actual behavior and identify any new problems not previously reported.

The antecedent is an event or "trigger" that may cause a behavior. For instance Dennis has begun to flip the lights on and off which is disturbing when people are trying to enjoy their evening. Since staff and others on the team do not understand this behavior they decide to record what happens just prior to this behavior (the antecedent). It was also suggested that maybe what happens after the light flipping (the consequence) could give a clue as to why the behavior is persisting.

The hypothesis should answer the question, "What did the individual want to happen as a consequence of engaging in the problem behavior?" Once a reasonable hypothesis is verified, the assumption must be tested. More observations will need to take place. Data will help us determine if the assumptions were correct. It is the beginning of an ongoing analysis of the function of the behavior. In fact, the problem behavior may change and be molded by changes in goals, staff, living and working circumstances, age, family, etc. Life is not static. Functional analysis and assessment are ongoing processes that must be continued periodically throughout

the entire course of the intervention.

Selecting Strategies

The functional assessment should direct the selection of support strategies in order to provide for long-term positive behavior change. See *Designing and Implementing Positive Behavior Supports* module in the Community Staff Training Program for more information on how to link the assessment to the support plan. Because behavior supports must respond to the motivation behind the challenging behavior if they are to be effective, the support plan must address both the source of the challenging behavior and the behavior itself. Then the team uses one or more of the following proactive supports to promote positive behavior and eliminate the need for the challenging behavior:

- Changing setting events or antecedents in some way to make challenging behavior less likely.
- Helping the person learn more acceptable replacement behaviors (i.e., positive communication and social skills) that serve the same function as the challenging behavior.
- Changing the consequences or reinforcers that have been identified as maintaining challenging behavior.

Sometimes teams have trouble selecting supports based on the function of the behavior even when members have been heavily involved in the functional assessment process. Moving from a "punishment" mentality to focusing on positive supports and preventing challenging behaviors requires a significant shift in philosophy and behavior for some team members. It may take time and some successful experiences with more proactive supports to convince them to abandon the less effective reactive methods that they have used in the past.

The written objective of the behavior support plan should be stated positively. Instead of stating the objective as eliminating or reducing the problem behavior, the objective should state what adaptive or productive behavior will be formed to support the function of the challenging behavior. For example:

> *It has been determined that Juan is using hitting peers to express his desire to be left alone and be given some time to retreat to a private spot. It is then necessary to teach Juan a more adaptive and appropriate way to communicate his desire – this becomes the written objective of the support plan. Methods and teaching strategies will be implemented to teach the skill and also address what to do when Juan reverts to physical aggression. Data would continue to be collected on physical aggression with the goal of seeing a reduction in this behavior. Data on the use of the adaptive skill would also be collected with an expected increase. The positive strategy must be meaningful to Juan and it must be taught across all settings with consistent implementation. Failure to design and carry out a plan consistently will provide intermittent reinforcement of the*

problem behavior, which will maintain the behavior and make change difficult.

Support strategies may also involve changes in environment. For Juan – provision of a private space is also part of the support plan. When support strategies are used alone they may not be addressing all the possible functions of the behavior and may not be effective. For example, a particular behavior may be identified as serving the purpose of gaining attention but it also may satisfy the desire for more social contact. The support plan will need to address both functions to be effective. The support plan's methods should address reinforcers and schedules of reinforcement. Staff will need to be familiar with the methods of prompts, fading and shaping. See *Achieving Personal Outcomes* of the ND Community Staff Training Curriculum for more information on effective reinforcement.

Teams may consider more restrictive strategies, only if consistent and correct implementation of positive support strategies has not been effective. Methods that restrict behavior or use punishment, and/or those that are not considered to be the normal pattern or condition of life experienced by same age peers, may be considered restrictive. These methods may include timeout, overcorrection, response cost, use of mood altering medications, physical restraint or guided compliance. Agency policies on the definition and use of negative or restrictive procedures vary widely. QDDPs must limit the strategies to those approved by the agency and follow agency procedures for submitting behavior support plans for approval by the Human Rights and the Behavior Support Committees. In other regions this might be called the Behavior Intervention or Behavior Review Committee.

In addition to determining whether a restrictive behavior support plan may be implemented, the Human Rights Committee establishes timelines for review and re-approval. The committee assures that each service recipient's rights are supported. This can be done through touring the agency, reviewing accident and incident reports, surveying family and individuals supported and reviewing policies and procedures. The Behavior Support Committee ensures that the least restrictive alternative is used when goals and objectives are written for behavior support plans.

Before approvals are sought from these committees, data must document that all other less restrictive means have been exhausted without success. These committees serve as an objective review of methods. The committees are looking for:

- Sound behavior support methods
- Strategies for teaching more socially appropriate behaviors that will serve the same function
- A plan for restoring any rights restrictions proposed in the plan

The Behavior Support Committee will also give suggestions on data collection. The committee exists to assist QDDPs and teams in their responsibilities. Even if the support plan does not

involve restrictive contingencies, the committee can give valuable expert advice on methods and assist in planning for the future.

When the committees and team have approved the plan, it is ready to be implemented. The written plan should be regarded as part of the Person Centered Service Plan. Staff will be trained and expected to implement the procedures similar to any other training objective. It is important to make the written plan:

- **Understandable** – *Write the methods in understandable terms with complete directions including methods for circumstances that may be encountered that may not be usual. If circumstances arise that have not been foreseen staff need to know what their next step would be.*
- **Efficient** – *The data collection should be easy and not cumbersome. Staff should understand why they are collecting the data.*
- **Have staff agreement** – *Staff should agree with the methods and understand the purpose. They agree that the methods are workable. If staff do not buy into the program it may not succeed.*
- **Practiced or role play** – *Methods should be role played with clarification and feedback on correct implementation of each technique until all who need to implement the plan are clear and comfortable with the strategies.*
- **Have a timeline** – *Staff should understand the timeline for implementation. They should not perceive it as a quick fix to eliminate a problem but a teaching program to assist the person to develop more effective behavior. As the QDDP you will be responsible to monitor the progress, provide feedback and make revisions if it is not producing the changes expected within the time established.*
- **Be implemented consistently** – *Emphasize consistency across settings and staff.*
- **Provide for staff stress** – *If the challenging behavior is such that it can cause staff to feel threatened or cause stress the plan should address how they will be supported to deal with these feelings.*

For behavior support plans to be successful, they need to be monitored by observation and interview of the individual and staff. DSPs need consistent feedback in the form of data, constructive criticism, and praise. They need to know that their consistent efforts are making the desired change. The QDDP is responsible for timely responses to the data.

When implementing a behavior support (or any teaching plan), if there is no change in the data for 10 data points (i.e., two - four weeks), it is time for the QDDP to determine why the plan isn't working and provide support to the people who are implementing the plan so that the person supported will make progress.
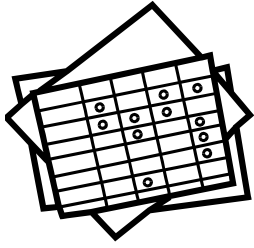
Data points are points or occasions when data is recorded as stated in the methods of a teaching plan. For example - staff are teaching a person supported to call for refills on their medications. The steps in the teaching plan require staff to start with a verbal prompt. A data point is recording the level of the prompt –they needed verbal prompts to find the correct telephone number.

Support provided when there is lack of progress depends on the reason for lack of progress. If there is a lack of progress or data that shows a decline:

- First, determine whether or not, the plan is being implemented consistently across settings and staff. Also, find out if the data is being recorded accurately.
- If the answer is no, the QDDP and supervisors need to decide if it is a staff training issue or a supervision issue and take appropriate corrective actions.
- If the answer is yes, the plan is being implemented correctly and data is being recorded accurately, then a revision to the teaching plan (methods, prompts, reinforcement) is in order. Don't waste the staff and/or the service recipient's time on ineffective support strategies.

Below is a partial list of questions Title XIX uses to determine the quality of behavior practices. A complete list is available within the regulations.

- Are behavior support plans and the use of psychotropic medications approved and reviewed by a specially constituted committee and is consent given by the individual and guardian?
- Is there a record of restraint usage and corresponding revisions in the active treatment program?
- Is there a clear progression in how techniques are implemented from the most positive, functionally appropriate approaches to the most intrusive approaches authorized?
- In emergency situations, is the least intrusive technique chosen to decrease challenging behavior?
- Are behavior support plans effective at reducing maladaptive behavior?
- How long has the plan been in place?
- Is the plan monitored for safety and effectiveness?
- Is the behavior support plan individualized or do plans follow canned strategy?
- What changes have occurred in the individual's daily life as a result of the plan?
- Does the team follow the behavior support loop: assessment, plan, implement, monitor and reassessment?
- Is staff behavior consistent with facility policy on behavior support?

- Are records available on restraint use? Does documentation present a clear picture of the events prior to, during, and following restraint use?
- Does the PCSP address medical contraindication for restraint?
- Does the PCSP address medical or dental restraints?
- Do staff understand the desired and side effects of any chemical restraints used?

Emergency Restraints

Occasionally, staff may need to use an emergency intervention not authorized in the plan. Usually these interventions are intended to restrict the movement or normal functioning of a person's body. These are reactive strategies and should be used only when a dangerous behavior is exhibited and injury must be prevented. All staff who need to provide physical intervention in order to prevent injury must be trained in therapeutic responses to aggression. Staff should be able to demonstrate the hierarchy of these types of intervention and identify the appropriate use of emergency procedures. Title XIX standards require that records be kept on the use of these emergency restraints and revisions to plans reflect changes if they have been implemented.

Summary

Behavior support plans can consume time, energy and resources. They can also be a tool to assist individuals to participate in the community and realize their dreams. The QDDP should lead the process of behavior support to ensure agency policy and regulations are followed and that the methods are individualized to the person and their goals. The QDDP can also use this process of assessment, analysis and support to examine practices and systems within the community and agency that produce these problem behaviors. Person centered planning is only meaningful if the agency is dedicated to planning and changing to support the individual's needs and dreams.

Study Questions Chapter 6

True or False

_____1. Direct Support Professionals should be able to demonstrate the hierarchy of physical intervention and identify the appropriate use of emergency procedures.

_____2. The first step in the systematic approach to positive behavior supports is to have the team meet and develop a hypothesis.

_____3. The goal of positive behavior supports is education not simply behavior reduction.

_____4. Before a behavior support plan is determined to be needed it is good to ask "Are programs producing the desired positive results in learning and support objectives?

Paragraph

5. What should the QDDP do when the behavior support plan is not producing the desired results?

6. List some important points a QDDP should cover when training staff on a new behavior support plan.

7. Why would the goal of a behavior support program be written to increase a desirable behavior rather than reduce the undesirable behavior?

8. The QDDP has sensed that not all staff agree on the definition of the behavior but they are all in agreement on why the challenging and defiant behavior of the individual is happening. What steps could a QDDP do to get the staff on track in the systematic approach to behavior support?

9. Jason's current behavior support plan is yielding little progress. Nothing has changed within the past 6 months and it is obvious staff are frustrated. What should the QDDP do first in dealing with this scenario?

10. The definition of the challenging behavior is "yelling, swearing, using threats". The QDDP has determined that data will be collected using a time sample. Why would this not be the best method of collecting data? Consult Achieving Personal Outcomes & Writing Behavior Objectives.

Chapter 7 The DSP Role in Plan Implementation

Objectives:

After reading this QDDPs will be able to:

- List methods that will involve DSPs in the PCSP process.
- Apply adult learning principles to OSP implementation.
- Identify DSP competencies in assessment, facilitation of services, documentation, and providing supports.
- List examples of the person centered approach in the QDDP - DSP relationship.

Direct Support Professionals (DSPs) are a key element of quality supports for people with intellectual disabilities. They are the interface through which philosophies, policies, and PCSPs are translated. Their actions directly influence the quality of life for people supported. The relationship between the QDDP and the DSPs can be just as important as the quality of the PCSP portion of the OSP.

In many agencies that support people with intellectual disabilities, QDDPs write the plans and the DSPs implement what is written. Unfortunately, this role separation characterizes the DSP as the one who follows plans, procedures, or regulations outlined by others. When people with the most familiarity with the person are not at the meeting, significant information can be overlooked.

The lack of participation in the planning process can lead to a relationship between the QDDP and the DSP that focuses on compliance and diminishes the professional competence and commitment of DSPs. It contributes to staff disillusionment and turnover. Further, staff turnover compounds the compliance type relationship as QDDPs will be supervising plan implementation with inexperienced staff that are just beginning to learn person centered values and processes. Their skills/competencies in the person centered process are still developing. This cycle can be continuous and frustrating.

Unfortunately, there are no quick fixes. This cycle may be discouraging but it should not be an excuse for not including DSPs. Front line staff must feel that their opinions/suggestions are a valuable part of the PCSP process. The most effective approach is when QDDPs commit to regular communication with DSPs regarding plan development and implementation. Keep DSPs updated about progress and support them with shared problem solving when there is limited or no progress.

Sometimes it is difficult to involve DSPs in the team planning process because of scheduling and other obligations. When it is not possible for DSPs to actually attend the meeting there are creative ways to include their input and build ownership. For example:

- Completing checklists referencing what works and doesn't work in specific situations prior to the team meeting.
- Using video conferencing when DSPs could participate in the meeting remotely and only for a shorter period of time.
- Reviewing assessment information in person or at staff meetings prior to the team meeting.
- Anticipating questions staff may have about the team's decisions. The why, what and how questions. DSPs need to understand the reasons behind the decisions.

In any supervisory or collaborative relationship, communication is the element that will cultivate the working relationship. QDDPs will need to be present in the DSP's work environment. Visiting the vocational and residential programs consistently, being present for staff meetings, using email and Therap, and meeting with new staff during their orientation are several ways to communicate. It is also important to model the person centered approach we hope DSPs will emulate.
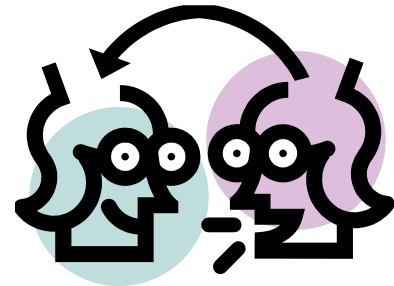
- Invite a DSP or two to have coffee or breakfast to just talk about the people they support.
- Make short video clips of the PCSP in action for a person supported for new staff to view.
- Give DSPs the opportunity to reflect on the dimensions of the PCSP that are working well and not so well. This can be done in a team meeting or an informal meeting.
- Move away from viewing yourself as an expert with knowledge, power and control to the professional being called to walk along side and support those who support.
- Look for ways to report progress to staff via visuals, graphs, short notes. Make sure DSPs see the evidence in data and that they are making a difference.
- Recognize employees - Employees who have exemplified using creativity to support the desires and preferences of the people supported need to be made visible. Tell the story and emphasize the values the employee used.
- Have an open door - Be willing to listen and take the time for employees even when it may not be convenient to you.
- Clear the way - Work to remove barriers that are inhibiting outcomes for the individuals receiving support, e.g. resources, communication modes, schedules.
- Support employee ideas - If the idea is not feasible, explain why or keep them informed on the progress of their ideas.
- Ensure that everyone knows that the primary customer is the person supported. Never allow your attention to shift from supporting the individual to supporting preferences of employees. For example staff schedules should be designed around the needs and

preferences of the individual first and not the employee. Staff should be guided to recognize the connection between their actions and the results it will have on the people supported.

- Create a culture of encouragement and appreciation - Make employee recognition spontaneous and real. Employees may lose their "I'm number one" coffee mug but they will remember the "thank you" or handshakes. Remember the extinction theory - Good work that goes unrecognized will gradually disappear.
- Review the outcome standards - On a regular basis, discuss and tell stories about how the outcomes look and should look in the lives of the people supported. Identify issues both in the agency and the community at large that inhibit personal growth of the people supported.

The work of a QDDP depends on DSPs that are trained, supervised, and coached to implement the philosophy of person centered planning. DSPs are expected to be competent in 15 areas as identified by the National Alliance for Direct Support Professionals. The focus for plan development can be found in these competency areas: Facilitation of Services, Assessment, Participant Empowerment, Provide Person Centered Supports, and Documentation. Below are the specific areas of competencies that pertain to program development and implementation. The QDDP can consider their training and supervision in these areas vital to DSP skill development and quality PCSP development and implementation. He/she may work with the front line supervisor to provide training and supervision in these areas.

Participant Empowerment -
The competent DSP promotes participant partnership in the design of support services, consulting the person and involving him or her in the support process.

Assessment -
- *The competent DSP initiates or assists in the initiation of an assessment process by gathering information (e.g., participant's self-assessment and history, prior records, test results, additional evaluation) and informing the participant about what to expect throughout the assessment process.*
- *The competent DSP conducts or arranges for assessments to determine the needs, preferences, and capabilities of the participants using appropriate assessment tools and strategies, reviewing the process for inconsistencies, and making corrections as necessary. The competent DSP discusses findings and recommendations with the participant in a clear and understandable manner, following up on results and reevaluating the findings as necessary.*

Facilitation of Services -
- *The competent DSP assists and/or facilitates the development of an individualized plan based on participant preferences, needs, and interests.*

- *The competent DSP assists and/or facilitates the implementation of an individualized plan to achieve specific outcomes derived from participants' preferences, needs and interests.*
- *The competent DSP assists and/or facilitates the review of the achievement of individual participant outcomes.*

Documentation –
- *The competent DSP maintains accurate records, collecting, compiling and evaluating data, and submitting records to appropriate sources in a timely fashion.*
- *The competent DSP maintains standards of confidentiality and ethical practice.*
- *The competent DSP learns and remains current with appropriate documentation systems, setting priorities and developing a system to manage documentation.*

Provide Person Centered Supports-
- *The competent DSP provides support to people using a person centered approach.*
- *The competent DSP modifies support programs and interventions to ensure they are person centered.*
- *The competent DSP challenges co-workers and supervisors to use person centered practices.*
- *The competent DSP is knowledgeable about person centered planning techniques.*
- *The competent DSP assists individuals in developing person centered plans.*

*15 NADSP Competency Areas (n.d.) National Alliance for Direct Support Professionals.

All DSPs receive training that is meant to prepare them for the demands of the position. This training will give them the basics in the philosophy and process of Person Centered Service Planning. However, the QDDP is responsible to ensure the DSP understands the specific plan of each person supported. This specific training may be delegated to a supervisor or other agency staff, but the QDDP is ultimately responsible for the quality of PCSP and the implementation and outcomes of the plan. The training on implementing the PSCP may take place in a staff meeting, or a small group meeting, or individually with DSPs. Merely providing a written copy of the plan for staff to read and initial will not assure that staff will understand and successfully implement the plan. Group discussion about the plan aids in clearing up questions and vague explanations. Adult learners need stories or real life examples to help them envision authentic efforts.

The most effective method of teaching and conveying the specific elements of the PCSP is "just in time". This is where the QDDP is observing the implementation of the plan and coaching the staff as it happens. The deepest kind of learning for any learner occurs when it is embedded in

the real context of the work. Learning that is interwoven rather than separate from the work is the most effective. It is important to understand some adult learning principles such as;

- Adult learners must be active participants in the learning process.
- Learner motivation is enhanced by experiences of success (e.g. repetition with reinforcement).
- Learning is dramatically increased when multiple senses are involved (e.g., hearing, saying, touching, doing, etc.).
- Generalization of learning is enhanced when practiced in varied contexts.
- Individual, cultural and sub-cultural styles of learning need to be reflected in designing learning experiences for staff.
- The employee's self-concept will affect their learning.
- Employees tend to be motivated to learn when they feel accepted and affirmed by the trainer/supervisor.
- Learning is enhanced when adults associate new knowledge with previous knowledge.
- Adults are more motivated when they understand the purpose and importance of training.
- Learning is directly influenced by the physical and social environment.

The QDDP is responsible for plan implementation but relies on the skill, values, and commitment from DSPs and front line supervisors to put the plan into action. The success of this "team" depends on the relationship the QDDP has with both DSPs and other supervisors. The QDDP's leadership abilities directly impact quality of life for the person supported.

True/false

1. _____ The most effective method of teaching and conveying the specific elements of the PCSP is "just in time".

2. _____ Adults are more motivated when they understand the purpose and importance of training.

3. _____ Training staff on the PCSP should never be delegated.

4. _____ Direct Support Professionals (DSPs) are a key element of quality supports for people with intellectual disabilities

Paragraph

1. List methods that would include DSP input into the PCSP.

2. Describe how you would apply one of the principles of adult learning in training staff on a specific program from a PCSP.

3. Make two recommendations to the QDDP regarding modeling the person centered approach in the following scenario.

   While reviewing current progress it became apparent that staff are not consistent in data collection and their comments in t-logs reveal that each staff is interpreting and implementing the methods different. This has been an ongoing problem - one which the QDDP has addressed previously.

4. Describe how you would coach a supervisory DSP to assists in the initiation of an assessment process*.*

Chapter 8: Policy Procedure and Regulations

Objectives:

After reading this QDDPs will be able to:

- Describe the QDDP's role in monitoring policy and procedure interpretation.
- List the steps in reporting abuse, neglect, and exploitation.
- Find the appropriate resource for regulatory questions.

Interpretation of Policy and Procedures

The QDDP's position requires knowledge of all factors that affect the growth of the person receiving support. The QDDP will be the person who will be able to answer staff questions regarding policy, procedure, regulation, and best practices. This necessitates more than just a surface knowledge of policy/procedure but an understanding of how programs can be individualized within the parameters of regulation or policy. With that knowledge the QDDP, in collaboration with the rest of the team, can make recommendations for change to policy/procedure and steer the agency towards more person centered and family friendly practices. The QDDP should be attentive in looking for opportunities to make changes that reduce barriers to full community inclusion and the attainment of personal outcomes.

The QDDP's professionalism and support of regulations and standards will enhance the services provided. It is easy for QDDPs to become disappointed and negative when external monitors find deficiencies in the supports he/she designs. However, a professional welcomes review of programs and services and views the process as an avenue for improvement. The relationship with surveyors and program managers will either make the process a learning experience or a difficult encounter. It is easy for an agency to become comfortable in its practices. However, leaders should be projecting the attitude that reviews are meant to prod and sometimes push those in support roles to new and better practices - not just identify deficiencies or problems.

Abuse Neglect and Exploitation

The agency is required to have policies and procedures to protect both staff and people supported. These policies and procedures specify routines that are reasonable and prudent. Familiarity with these will help ensure that the rights of people supported are upheld and decrease the likelihood that an employee would act in an unreasonable or careless manner. Training regarding commonly held rights of people in community-based programs and how staff

are expected to advocate for these rights is included as a part of staff training at orientation and annual reviews. The ND Community Staff Training Project module *Legal Issues* reviews the definitions of abuse, neglect and exploitation as well as constitutional and human rights.

Staff may need to refine their personal definitions of abuse and neglect as it relates to their interactions with people with disabilities. They may encounter situations where a discipline practice they use at home with their children could be considered neglectful or abusive. Arbitrarily withholding activities as a consequence without a formal program or restricting access to property or areas as a result of a house mate's actions are examples of common strategies that were probably used by the employee in other working or family situations. It is not possible to cover all possible scenarios in employee orientation but a thorough review of rights and staff role as an advocate can help prevent incidents of abuse and neglect. Staff training in how to de-escalate and defuse potentially dangerous behavior as well as positive and proactive behavior supports is critical. The QDDP may not be the person who carries out this training, but should work with staff supervisors and staff development specialists if they identify a training need for an individual staff person or team of staff (i.e., residential staff where a specific individual lives).

Protection and Advocacy System

The Protection and Advocacy (P&A) system was created by Federal legislation to protect the rights of people with developmental disabilities in 1975. In 1986, advocacy services to people with mental illness were added. Congress enacted legislation in 1990, which expanded the P&A system, to include individuals with concerns related to assistive technology, employment and SSI/SSDI benefits. There is a P&A system in each state and territory in the United States.

The advocate's job is to work only for the person with a disability. The presence of an advocate does not imply that the team or agency is negligent. In correctly carrying out their jobs, advocates make sure that the human services network respects the rights of people with disabilities. Sometimes an advocate will point out rights of persons with developmental disabilities that staff may have overlooked. If the concern is valid, the agency will address the issue. Rather than viewing advocates as problem finders, think of the advocacy system as a problem solver. There may be instances where a guardian is refusing to give consent for a residential change or an individual cannot control their spending habits. Advocates may assist in finding solutions.

Incident Management

The QDDP is accountable to the agency policy and procedures in handling reports of neglect, abuse or exploitation. The QDDP may not be directly involved in conducting the investigation, but become involved when recommendations need to be implemented. It is important that

employees understand the rationale behind the investigation process and their role and responsibilities.

Immediately upon witnessing, suspecting, receiving a report of abuse, neglect or exploitation from a service recipient, staff are required to report the incident to the supervisor or management staff according to state procedures.

For further information on Protection and Advocacy's incident management reporting determination guidelines, please refer to the Department of Human Services – DD Division bookshelf at http://www.state.nd.us/robo/projects/816/816.htm Click on "PI's: then "Current PI's" where you will be able to find the policies for:
- Restraint and Seclusions Policy
- Serious Events Abuse, Neglect and Exploitation Policy

Health Facilities
There are currently 68 ICF/IID facilities in North Dakota. Each are surveyed annually by the Division of Health Facilities, and based on the survey results are recommended for certification by the Division of Developmental Disabilities, North Dakota Department of Human Services. For Further information on the regulations, please visit the Department of Health's website: http://www.ndhealth.gov/HF/ Select Intermediate Care Facilities (ICF/IID).

Department of Human Services - Developmental Disabilities Division
The North Dakota Department of Human Services, Developmental Disabilities Unit, licenses programs and services for persons with developmental disabilities, under the statutory authority of Chapter 25-16 [Go to http://www.state.nd.us/robo/projects/816/816.htm click on Developmental Disabilities>Regulating Authority>State Regulating Authority>North Dakota Century Code> Title 25]of the North Dakota Century Code and the regulatory authority of Chapter 75-04-01 of the North Dakota Administrative Code [Go to http://www.state.nd.us/robo/projects/816/816.htm click on Developmental Disabilities>Regulating Authority>State Regulating Authority>North Dakota Administrative Code> NDAC 75-04-01

The intent of licensing review is to ensure the existence of those structural standards necessary for provision of quality services to individuals with developmental disabilities. These requirements apply to all entities offering or providing basic services as identified in NDAC 75-04-01-17.

For further information on Century Code and Administrative Codes that each agency is subject to following, please visit the bookshelf at http://www.state.nd.us/robo/projects/816/816.htm where you will click on the regulating authority tab where is will provide you links to

Administrative and Century codes that affect the services that providers must follow within the State of North Dakota.

Study Questions Chapter 8

True /false

1. _____ The QDDP's role in regarding policy, procedure, regulation, and best practices necessitates full knowledge of how plans can be individualized within these parameters.
2. _____ The QDDP should avoid making recommendations for policy, procedure, regulation, or standards.
3. _____ The resource for finding current state policy issuance on seclusion and prone restraint is PI 10-02

Paragraph

Search for answers to questions 4 & 5 at http://www.state.nd.us/robo/projects/816/816.htm

4. What are the criteria for determining serious events?

5. Under which paragraph do you or would you qualify as a QDDP (or QMRP as stated in the policy issuance).

Search for the answer to question 6 at http://legis.nd.gov/cencode/t25.html   Then click on 25-01.2 and scroll down to section 25-01.2-15

6. What would you do if a parent or guardian refuses a doctor's recommendation of medication?

Chapter 9: Leadership

Objectives:

After reading this QDDPs will be able to:
- List some common characteristics of leaders.
- Define the leadership role of the QDDP in the agency, community, regional, and state arenas serving people with I/DD
- Identify good communication strategies
- Identify conflict management strategies.
- List strategies for professional development

Some QDDPs may not regard their positions in the agency as a leadership position. If the QDDP is somewhere in the middle of the organizational chart, he or she may ask, "How can I lead when there are so many influential people above me?" The QDDP's accountability to the Person Centered Service Plan and the general welfare of the people supported makes leadership inherent in the position. The QDDP will be the person responsible for making decisions and answering questions regarding the people supported. It will be impossible to carry out these responsibilities if there is no authority to influence or make changes.

There are many books written about leadership - particularly for the business community. Is leadership in human services any different? Leaders in human services may not be concerned with exactly the same issues as for-profit businesses, but both recognize that effective leaders focus on capabilities of others and help them identify a sense of purpose. These practices are parallel to person centered planning principles. The set of assumptions the agency holds about people should apply both to staff and service recipients. According to *AchieveGlobal** the following strategies make up good leadership:

- Create a compelling future by creating, communicating and sustaining a vision.
- Let the customer drive the organization by knowing what customers want and need and by helping the organization use this information to make key decisions.
- Involve every mind by giving employees the responsibility, resources, training and support they need to improve their work and the organization.
- Build personal credibility by walking the talk all the time, not only when it's convenient.
- Share mistakes as well as successes. Encourage others to do the same and demonstrate personal commitment.

Individualization of support services and the movement to Person Centered Services has required agencies to switch from vertical reporting systems to peer networks. Staff members pass information across horizontal lines and provide each other with support and feedback.

Successful leaders no longer tell employees what to do but teach them why and how to do their tasks. This requires on-the-job day-to-day communication with staff. Decentralized support programs require structure as well as staff who are fluent communicators and problem solvers.

Role Model

The QDDP must be visible in the settings where people receiving supports live, work and recreate. The QDDP or supervisor presence in the places of services should not produce undue anxiety in the staff but instead be regarded as routine and a time to receive new information and feedback. Leaders are willing to pitch in but also provide correction, redirection and convey an expectation of excellence.

The standards set by leaders for professional dress and interactions with staff, service recipients and other professionals will be viewed as the standard of the agency. That does not mean that there is no need for written guidelines, only that the behavior of leaders will convey more than written policy and procedures.

Communications regarding the agency outside of work should reflect the loyalty employees have towards the people supported and the commitment all staff have in providing quality services. Gossip, negative or deriding comments about leadership in the agency or spreading confidential information can impact the ability of the agency to support people with disabilities in attaining their personal outcomes by creating barriers to inclusion and limiting staff recruitment and retention.

Communication

Good communication cannot be over-emphasized for effective leaders. Communication begins with listening. Effective listening means:

- Stop talking – it is not possible to talk and listen at the same time.
- Make the listener feel comfortable and relaxed. See the other person's point of view and allow open discussion.
- Demonstrate interest. Watch body language and get rid of distractions.
- Allow time for the point to be made. Don't interrupt.
- Do not respond if you are angry.
- Do not argue or criticize.
- Ask questions.

Communication is more effective if it is spoken in the receiver's language. When providing feedback:

- Understand the receiver and use their frame of reference.
- Use an illustration or example familiar to the receiver.
- Be specific. Focus on the behavior and not the person. Remember to focus only on the behavior that is under the control of the receiver. Feedback should address the needs of the receiver.
- Do not give more than what the person can receive. Sometimes there may be a great deal to say but recognize that the receiver can work with only part of it.
- Feedback should also be timely.
- Use the same standards of confidentiality with employees as with people supported. Coaching, disciplinary actions or special work circumstances should not be shared with other employees unless they need to know.

Conflict Management

In the course of a week, we are all involved in numerous situations that need to be dealt with through negotiation; this may be at home, work and in recreation activities. A conflict or negotiation situation is one in which there is a conflict of interests. What one person wants isn't necessarily what the other wants and both sides may prefer to search for solutions, rather than giving in or breaking off connections.

Conflict is destructive when it:
- Takes attention away from other important activities
- Undermines morale or self-concept
- Polarizes people and groups, reducing cooperation
- Increases or sharpens differences
- Leads to harmful and irresponsible behavior

Few of us enjoy dealing with conflicts - either with bosses, peers, staff, friends or strangers. We usually want to avoid the conflict and hope that time will make it diminish. However, there are many times when we should use conflict as a critical aspect of creativity and motivation. Resolving conflict can be mentally exhausting and emotionally draining.

It is important to realize that conflict that requires resolution is neither good nor bad. There can be positive and negative outcomes. It can play a productive role for you personally and for your relationships. Conflict is constructive when it:

- Results in clarification of important problems and issues
- Results in solutions to problems
- Involves people in resolving issues important to them
- Causes authentic communication
- Builds cooperation among people through learning more about each other

The important point is to manage the conflict, not to suppress it and not to allow conflict to escalate out of control. Techniques for avoiding/resolving conflict:

- **Meet conflict head on and seek to understand** - *We all feel our point of view is profound and worthy of attention. The first step to being heard is to listen.*
- **Stick to the issue** - *Don't dredge up the past. Address the present issue only.*
- **Plan for and communicate frequently** - *Many times conflict arises because assumptions were made or miscommunication occurred.*
- **Be honest about concerns. Check your attitude and emotions** - *The right frame of mind is imperative for addressing conflicts properly. Take time to calm down if you're angry. If you have any desire to "get even", dispel those unhealthy feelings before you proceed.*
- **Discuss differences in values openly and speak for yourself -** *Don't assume others want you to speak for them and that you know how they feel. Let peers develop enough courage to speak for themselves and address their own conflicts.*
- **Continually stress the importance of following policy -** *Sometimes conflict can cloud what we know is policy.*
- **Communicate honestly and avoid playing "gotcha" type games.**
- **Provide more data or information than is needed.**
- **Use time to your advantage** - *You do not need to respond on the spot to every item brought up during a discussion. Don't be afraid to ask for time to think over things brought to your attention. The goodwill created from showing such obvious respect for the other person's point of view is immeasurable.*

You will be constantly negotiating and resolving conflict throughout all of your professional and personal life. Organizations are becoming less hierarchical, less based on positional authority so it is likely that negotiation will be an even greater component of organizations in the future. Conflict management skills are among significant determinants of career success. Understanding these techniques and developing your skills will be a critical component of your career success.

Stress Management

Stress and burnout are major problems in the workplace. Books, magazines and television regularly include topics on coping with stress. Controlling stress is an important factor in disease prevention and reducing lost work time and turnover. Burnout costs agencies billions of dollars each year.

Stress and burnout are sometimes used to describe the same situation but they refer to two different phenomena. Stress is the response a person has when demands are placed upon them. It can be positive or negative. Burnout is a result of continuing intense and negative pressures - as a result a person finds no meaning or attraction in his or her job. Both stress and burnout can cost health and job if staff are not vigilant in protecting themselves. The QDDP's workload can become unmanageable if the person views themselves as the only person who can fulfill the responsibilities. Work overload can be because of working excessive hours, working in a situation that is new and not being prepared or periodic overload where sudden and excessive demands disrupt schedules such as crisis management and on-call duties.

The nature of human services can cause stress because of the continual necessity of providing for the needs of people. Workers never see an end or culmination of their work. Usually those who have minimal needs move on to more independent settings and are replaced by those with greater needs. Continuous giving can deplete anyone. DSPs are also stressed when they have limited authority yet are asked to assist people with disabilities in making decisions but play no role in the decisions-making process. Finally, teaching people with intellectual disabilities new skills can be repetitive and time consuming. It may take a year or more to see significant gains. Staff may feel disappointed and frustrated because they work hard but achieve little.

As part of the management team it is important to recognize stress and subsequent signs of burnout in yourself and other staff - for the safety of the people you serve and the welfare of employees. Signs to look for include:

- Difficulty sleeping
- Increase in off-the-job behavior (sick, late, not showing up)
- A person's attitude of compassion and caring has turned to "nobody really cares"
- Withdrawal
- Lack of concentration

Stress can be controlled by asking, "What is creating the tension?" For some, it is a result of working too many hours because they want to please their supervisor. For others, it is their perception of work and not the work itself. Some people make events out to be "disastrous" or "horrible". They attach too much meaning to events. Whatever is identified, it needs to be recognized by the person as the source.

Sometimes the best way to reduce stress is to help oneself or others develop a personal stress management system. This system should include some or all of the following:

- Exercise
- Good diet and nutrition
- Opportunities for learning
- Setting reasonable standards for oneself
- Include a variety in work and non-work situations
- Design a self-improvement program
- Know personal energy limits
- Provide for time for relaxation
- Reward accomplishments

Family Liaison

Families are a valuable resource and partner in delivery of quality supports. They can be powerful advocates on behalf of people with disabilities and your agency. Families provide a support that staff, volunteers or programs cannot duplicate. The QDDP's relationship with the families of service recipients is central to person centered planning processes. Families are as diverse as the people receiving supports. Therefore, one approach does not fit all in building good relationships.

The ND Community Staff Training Project provides *Working with Families* as a module for staff training. It gives information on family dynamics that should be part of every QDDP's repertoire. To be a leader in dealing with families the QDDP should:

- Understand family systems
- Understand how families relate as adults
- Eliminate roadblocks to collaboration with families
- Develop systems for collaborating with families
- Teach DSPs to respond to families in "the moment"
- Teach the family about the system but also collaborate to change the system
- Reach out to families

Source: *The Language of Collaboration* by Cathy Haarstad

The QDDP may find dealing with families on a continuum from very passive or non-involved to those that are almost over-involved. Both extremes may produce anxiety among staff. It is usually the families that are perceived to cause problems or request staff to work outside current practices, who receive the most attention. All families need attention - not just those causing a stir. In *The Language of Collaboration,* the author

suggests policies, procedures or practices that will aid an agency in being family friendly.

Does your agency:

- Emphasize the value and importance of families in written and spoken comments at all levels?
- Work with schools and other providers to educate and support families in preparing their children for the circumstances, risks and challenges of adult life?
- Work with schools/providers to orient families to the adult service system and teach them how they might ease their child's transition to adult life?
- Use feedback and input from families to design or revise programs?
- Develop policies and strategies that address the unique needs of families whose children have significant and multiple disabilities?
- Provide information in a family friendly format using fact sheets, newsletters or handbooks that are brief and easy to read?
- Develop an internal system of effectively tracking and resolving concerns expressed by families?
- Identify family expectations prior to enrollment?
- Find areas of potential conflict and develop good solutions?
- Get families together with administrators who make decisions about services?
- Invite people for sleepovers and extended visits when considering possible enrollment?
- Use a variety of techniques that are effective in helping individuals contact/spend time with their families?

This resource is an excellent guide to use in evaluating your attitude and agency practices in dealing with families. It also provides a section on practical approaches staff can use "on the spot" when conflict arises with families.

Leadership in the Community, Region, and State

The QDDP's responsibilities include the person supported and their individualized plan. It also includes making services, dreams and goals a reality by changing systems. At times the QDDP may feel that it is enough to monitor and lead within the agency. There is just not enough time and energy to do more than that. However, in the long run, the investment of time and energy may reap benefits for the people supported and the agency. Issues directly related to individuals, such as transportation, employment, and housing, become more pressing as service providers and families seek to use community resources rather than set up separate housing or transportation. The community first needs to know the agency and management, before it will be ready to assist in tackling issues and agency priorities.
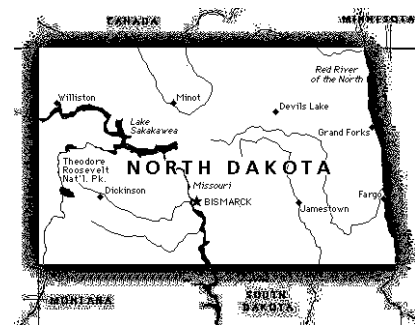
Networking with other organizations that serve similar populations such as schools, nursing homes, mental health programs, and daycare is valuable time spent. Grants are more likely to be awarded when it is evident that a cooperative effort has been made and the money will benefit more than one segment of the population. There is always more strength in numbers - especially when an issue is brought before local government. Providing community-based services cannot be done in a vacuum. Building connections with individuals and organizations inevitably will open opportunities.

The need to be visible and connect with the local community is also evident on the regional and state level. Influence with lawmakers will continue to open systems that have either been closed or need changing. It has been many years since the state of North Dakota was ordered to reduce the population of its state institution. However, service delivery methods and needs continue to change. Those groups who organize and pool resources to influence legislators will realize allocations of resources and law changes that will help them do their job.

Developmental Disabilities Program Management

Developmental Disabilities Program Managers (DDPM) are located in the regional offices of the Department of Human Services, Developmental Disabilities Division. DDPMs assist families and individuals to find services that fit their needs. DDPMs monitor services according to what is established in the Person Centered Service Plan. At the team meeting an Individual Service Plan (ISP) is written to specify what services are contracted. The DDPM is responsible to monitor the progress and fit of the services. The DDPM along with surveyors and other inspection personnel should not be perceived as adversaries but as partners in providing services. Remember to keep DDPMs informed of progress in the Person Centered Service Plan as well as general needs for providing services. They are able to be partners in advocating for more staff time, equipment, transportation needs, or changes in services.

Professional Development

With the emergence of high-speed communication and overload of information, it is a challenge to keep up with changes in human services. QDDPs are faced with changes in regulations and rules - resulting in new policy and procedures. There is a new product in assistive technology or innovations in service delivery that need attention almost daily. Each piece of information needs the QDDP's attention. As a human service professional, it is important to set aside time to read and assimilate new developments, innovations, changes and network with other professionals. Professional development is not only necessary to keep up with changes but also it will motivate and improve the services provided. It will open opportunities to further a career and develop more funding sources such as grants for the agency.

The National Association of Qualified Developmental Disability Professionals (NAQ) was formed in 1996 by Trinity Services staff as the result of a recognized need by QDDPs to establish a strong resource for research, networking, and addressing issues that concern QDDPs. Although there were a few states that had formed groups by and for QDDPs, the need to form an organization that would address the historical, conceptual, methodological and ethical issues confronting the QDDP on a national level was evident. The national conference of QDDPs provides a forum to share information pertinent to the diverse interests of QDDPs.

Purpose: The purpose of this organization shall be: to promote, protect and advance the interests of qualified mental retardation professionals in service, application, research and other means of improving human welfare.

Goals: The goals of this organization shall be to:
1. promote an outcome-based approach to service delivery and the provision of supports for people with disabilities;
2. provide training in best and promising practices;
3. disseminate relevant information, including research findings, through its newsletter and annual conference;
4. engage in advocacy in the public interest;
5. make public statements consistent with its purposes.

Code of Ethics: A Qualified Developmental Disability Professional (QDDP)/Qualified Mental Retardation Professional (QMRP) is the key person responsible for drawing together family, friends, and staff, as well as marshaling resources and energy in order to enhance independence and improve the quality of life for the individuals they represent. It is a position grounded in the principles of servant leadership. The QDDP performs his/her duties with the strongest possible commitment to personal and professional ethics and standards of conduct. To assess, understand and support people in achieving important outcomes and goals in their lives, it is necessary to understand the responsibilities and values of one's profession. The following Code Of Ethics is to be a guidepost helping QDDPs along this journey.

- In all situations, the primary commitment of the QDDP is to the person with developmental disabilities.
- In all relationships, the QDDP promotes the individual's welfare, dignity, and respect by consistently advocating for their right to self-determination. QDDPs work to assist each person in identifying and reaching their goals. Inherent in this responsibility is enabling individuals to advocate for their own concerns in appropriate and effective ways.
- The QDDP supports individuals in understanding their rights and works to ensure that they are free to exercise them. If needed, education regarding responsibilities in relation to rights is also provided.
- When assisting individuals to make informed choices, the QDDP obtains and provides all the information necessary in language and format that can be comprehended as easily as possible.
- Should an individual need assistance in making sound, safe decisions, through the appointment of a legal guardian, the QDDP keeps the appointed guardian aware of the person's rights and opportunities to make choices.
- The QDDP is committed to assisting persons with disabilities in choosing and crafting a life supported by societal norms around age, intimacy, livelihood, and community participation.
- The QDDP is committed to maintaining the highest standards of confidentiality.
- In the development of each individual's goals or plans, the individual with the disability remains the key person in the process. The QDDP involves those persons who know and are committed to fully supporting the person being supported.
- The QDDP facilitates the contributions of all staff including those professionally trained persons who are involved in the provision of supports and services.
- Whether as an organizational representative or independent practitioner, the QDDP interacts with others while maintaining the highest levels of responsibility, integrity, and standards of moral conduct.
- As a professional in the disabilities field, the QDDP is always prepared to partner and collaborate with colleagues. He/she provides guidance, training, motivation and instruction as the situation requires.
- The QDDP proactively identifies any barriers to the achievement of positive outcomes for the persons he/she represents and strives to remove or lessen those barriers or identify alternative pathways.
- The QDDP actively assists individuals to establish and maintain meaningful relationships with family members and persons with and without disabilities in their local communities.
- In order to provide the best possible services, the QDDP will demonstrate his/her pledge to continued learning by consistently seeking ways to increase his/her knowledge of current trends and best practices.

Rev. 10-22-09

QDDP Certification: In response to many inquiries regarding training and qualifications from around the country, the National Association of QDDPs (NAQ) has embarked on a ground-breaking project to develop national standards to define and shape the role of Qualified Developmental Disabilities Professionals (QDDPs), also known as Qualified Mental Retardation Professionals or case managers. Individuals, organizations, accrediting bodies, and state regulatory agencies are interested in training that can be applied in a wide variety of work environments and equip QDDPs with a strong understanding of developmental disabilities and methods of working with people who may have varied personal goals, disability-related needs, vocational aspirations, and living arrangements.

As an organization representing QDDPs from across the nation, the NAQ embarked on a partnership with the North Dakota Center for Persons with Disabilities at Minot State University to develop training that would provide a well-rounded understanding of best practices in the field with a strong ethical component and in a competency-based format. NAQ developed the course content based on Minot State University's training curriculum for QDDPs of developmental disability organizations throughout the state of North Dakota. In order to reach as many interested persons as possible, the program has been designed as an on-line certification.

NAQ QDDP Certification was being beta-tested with participants from across the country, who work in different programs and settings, including ICFs/IID and waiver programs, among others. Their feedback was used to adjust course content, streamline the application process, and test the procedures for evaluating portfolios.

Applying for the Program. You can view more information on the NAQ website, at www.qddp.org, or contact the NAQ by phone at 815-485-4781. QDDPs from North Dakota should share information about training they have completed in North Dakota when contacting NAQ. .

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Study Questions Chapter 9

True/false

1. _____ Networking with other QDDPs across the nation and state is a good way to develop professionally.
2. _____ QDDPs responsibilities in leadership require involvement in activities that change systems.
3. _____ In conflict management, a good strategy is to allow the issue to escalate so the real issue can be defined.
4. _____ A good communication strategy is to ask questions.

Paragraph

5. A good leader allows the customer to drive the organization. Explain what this means in the agency you work in.

6. How would a QDDP practice their role as a leader in the community they work in? Give two specific examples.

7. A good leader is a role model. List 3 specific examples of being a professional role model in your agency.

8. List one source for professional development a QDDP could use.

Answer Key Study Questions

Chapter 1

1. T
2. T
3. T
4. F
5. T
6. T
7. F
8. B
9. A
10.
    - Individual plan of care developed by qualified professionals.
    - Safeguards to ensure health and safety of recipient
    - Individual has free choice of provider
    - State has a way to account for funds
11. Any of the following;
    - City bus transportation
    - City cab
    - Co-worker or family provided transportation
    - Bike and bike paths
    - City bus route map
12. Challenge the value and use education and examples to help the agency or person change their misunderstanding.

Chapter 2

1. T
2. T
3. T
4. T
5. T
6. F
7. F
8. T
9. T
10. The following should be checked
    - Change in living arrangement

- Goals have been achieved
- Change in health
- Change in employment

11. The following should be checked;
    - Helping the person supported develop decision-making skills
    - Reduce dependence on support providers
    - Support an individual with I/DD to develop functional skills

12. The following should be checked;
    - IPOP
    - RMAP
    - Self-assessment

13. Skills/assessments should be closely related to the following;
    - Assessment in the area of social exchanges with the opposite sex (age appropriate), what experiences and skills does he possess?
    - Social sexual assessment – does he have an appropriate understanding of consent and sexual behavior.
    - Knowledge of potential places to make connections, what are his interests and how to start a conversation
    - Communication skills in social exchanges
    - What does Jarod's understanding of friendship and friendship with the opposite sex include?
    - Transportation
    - Appropriate grooming and dress.

14. The answer should include some of the following;
    - What communication skills should she expect to see?
    - How does Jarod display satisfaction, or dissatisfaction?
    - How will staff know what is expected of them as they observe?
    - How many observations are necessary?
    - What is the observation be expected to yield?

15. B

16. The answer should address the different perspective people with I/DD may have of the goal(s) they have chosen. Even though staff, the QDDP and team may have their own idea of the goal it is important that the team educate themselves in how the person supported perceives it. If a vacation has been listed as a goal what does that really mean to the person? Does it mean time away from work? Eating anything they want for a week? Seeing a favorite football team in the real time and place?

17. 1 – risk assessment and self-assessment data gathering

6 – team meeting

4 – team conduct assessments based on self and risk assessments

2 – summarize assessment data

5 – assessment summary sent to team members

3 – share results with team

Chapter 3 Answers

1. T
2. F
3. T
4. T
5. F
6. T
7. T
8. F
9. T
10. T
11. B
12. B
13. D
14. A
15. C
16. Possible areas of training or learning objectives might be;
    - Using a calculator
    - Using a stamper to sign checks
    - Calculating days to vacation
    - Budgeting for specific needs of the vacation
17. Possible areas of support objectives might be ;
    - Opening a savings account
    - Determining transportation
    - Buying tickets
18. Response should be geared toward a skill learned.
19. Response should make the support objective measureable and more descriptive of who will do what and how.

20. The learning objective could be related to social skills, communication or vocabulary about animals, how to start a conversation about animals. The skill should be broad enough to be able to be used across environments.
21. The support objective should be related to sampling activities with animals, sampling places where animals might be present. Exploration should measure her skills in social exchanges, social appropriateness, and her like or dislike of the activity. It should be measurable.
22. The response might be related to communication supports (pictures, timelines for activities with animal that she has planned, conversation starters). Selecting some options for volunteering.
23. Response should make the support objective measureable and more descriptive of who will do what and how.

Chapter 4 answers

1. F
2. F
3. T
4. T
5. F
6. T
7. T
8. F
9. F
10. C
11. A
12. C
13. Use pictures, time line, charts, set up a simple website of the plan, create a collage,
14. Looking for opportunities to observe and assess the progress of the plan. Reading T-logs, GERs, and making judgments on how these data relate to should relate to current progress or lack of progress. Inferring and making conclusions about progress but looking for more details to confirm the program's progress. Making suggestions for changes and being proactive.
15. Email (group and personal), chart, graphs, personalized notes, regular feedback on observations.
16. Review all documentation prior to observing, review skill levels of staff (training completed, hire dates, documentation), consider any changes for the person supported (family issues, personal problems, etc).

17.

- Follow the teaching procedures consistently?
- Document accurately?
- Know and follow the schedule of implementation for a particular objective?

18. The questions could include asking the staff about their perceived goal of the program, how they interpret their documentation, what they feel the function of the behavior might be (has that changed from the inception of the plan), problems with implementing the program.

Chapter 5 Answers

1. Accept any of the following;
   a. Transportation needs, current skill level in public transportation
   b. Current level of support (hours, supervision)
   c. PCSP goals in employment
   d. Current progress in employment related goals
   e. Medical information
   f. Parent support
   g. Contacts for emergency
2. Accept any of the following;
   a. Review current PCSP and assessments
   b. Visit and observe
   c. Talk to people who know the person well
   d. Read social history
   e. Read current progress notes and significant event notes
   f. Invite the person out for coffee.
3. Progress notes provide a sequential, progressive picture of activities, trends, and patterns that are an objective picture of current functioning.
4. Accept any of the following and any response that indicates protection of information;
   a. Use of initials instead of full names on documents people might see
   b. Privacy screens on computers
   c. Administrator of electronic documents monitors privileges of users, passwords are changed consistently, logins are used on all computers etc.
5. C

Chapter 6 Answers
1. T
2. F

3. T
4. T
5. Accept answers that depict research into possible implementation difficulties such as;
   a. Is the support plan being implemented consistently by all staff across settings.
   b. Is data recorded the same, staff understand the keys in documentation (e.g p=physical prompt)
   c. Do staff understand the goal of the program
   d. Do staff agree on the definition of the target behavior
   e. Are staff informed on the progress of the program.

6. Accept any of the following;
   a. The team's determination of the function of the behavior (how did the team come to a particular conclusion).
   b. Make the plan easy to understand – make sure the reading level, directions, and layout of the written directions are easy to follow.
   c. Do staff understand how to document data
   d. Do staff understand the purposes behind the support plan
   e. Have you addressed the most obvious "what ifs" (have some back up if all does not go as the plan expects).
7. Accept answer that is stated closely to the following"

"The purpose of the plan is to help the person develop adaptive and productive behavior. Simply eliminating a behavior will not produce lasting results or growth."

8. Accept answers that speak to coaching staff in coming to an agreement in defining the target behavior. Such as;
   a. If an ABC analysis has not been done – complete one and have staff collect data across several people, times, and setting.
   b. Review with staff the purpose of defining the behavior (objectively)
   c. Have each staff give their measurable and observable definition of the behavior and allow them to see the variances in definition across staff.
9. Accept answers that depict the QDDP researching areas that may be causing the lack of progress such as;
   a. Checking consistency of data collection
   b. Viewing GERs and T-logs (progress notes) for evidence that the methods are being implemented correctly or even that the plan is being used.
   c. Observe frequently.

10. The answer should defend the response not just say that time sample is not measuring the behavior. It maybe include some of the following;
These behaviors may not be occurring frequently. Yelling, swearing, and using threats have a definite beginning and ending so frequency might be the best measurement method. Time sampling is usually the best choice when the recorder has to engage in other activities during most of the observation period. It is also better for the observer who needs to observe and record for only short periods of time. Time sampling is often used for non-obvious behaviors or behaviors that are too time consuming to count because of the frequency.

Chapter 7 Answers

1. T
2. T
3. F
4. T
5. Accept any of the following;
    a. Have staff complete a checklist of what works and what doesn't prior to the team meeting.
    b. Use video conferencing
    c. Review assessment information with staff prior to the team meeting
    d. Anticipate questions staff might have regarding team decisions.
6. Accept answers that show application of any one of the principles of adult learning on page 75-76. It should not repeat what the principle is but show how it is used in a real life application of it.
7. Accept answers that show application of one or more of the principles listed in modeling the person centered approach on page 73.
8. The answer should include competencies a DSP should use in assessment on page 74;
    a. Informing the person served in what to expect in the assessment process
    b. Arranging for assessment
    c. Using the appropriate assessment technique
    d. If observation – what to look for
    e. How will they discuss the findings with the individual.

Chapter 8 Answers

1. T
2. F
3. T
4. Answer should include the follow;
   a. Events that result in medical treatment for mental and physical health beyond first aid.
   b. Unauthorized use of seclusion, physical or chemical restraint including in an emergency basis.
   c. Alleged sexual abuse or inappropriate sexual contact.
   d. Death of a person in services
5. Can list the PI or the paragraph identifiers;
   a. 483.430(a)(1)
   b. 483.430 (a) (2) i,ii, and iii
6. Answer should include the following information.

25-01.2-15. Right to refuse services.

An adult recipient of services, or, if the recipient is a minor or under guardianship, the recipient's guardian or parent, must be given the opportunity to refuse generally accepted mental health or developmental disability services, including medication, unless those services are necessary to prevent the recipient from causing serious harm to the recipient or to others. The facility director shall inform a recipient or guardian or parent of a minor who refuses generally accepted services of alternate services available, the risks of those alternate services, and the possible consequences to the recipient of the refusal of generally accepted services.

Chapter 9 Answers

1. T
2. T
3. F
4. T
5. Accept an answer that address in some fashion how the PCSP is at the core of all services.

The PCSP and what it dictates as program resources for accomplishment of goals and objectives should drive the organization's activities.

6. Accept answers close to the following;

     a. Serving on committees of the community that affect services, attitudes, and opportunities for people served.

     b. Networking with community organizations that serve a similar population.

7. Answer such as;

     a. Dress

     b. Interaction with staff, individuals, families

     c. Being a good listener

     d. Professional behavior such as timeliness, sharing new information and techniques.

     e. Managing conflict constructively

     f. Being proactive.

8. Accept answers such as the following;

     a. Joining the National QDDP organization

     b. Joining national organizations related to disabilities

     c. Reading recent publication of research related to disabilities

     d. Pursuing QDDP certification