COURSE AGENDA

• INTRODUCTION

• PHILOSOPHY OF SERVICE DELIVERY

• INDIVIDUALIZED SUPPORT NETWORKS

• OVERVIEW OF THE PLANNING PROCESS

• PRE-MEETING PREPARATION

• INDIVIDUAL SERVICE PLAN INTRODUCTION

• TEACHING & SUPPORT STRATEGIES/Written Direct Support Instructions
COURSE OUTCOMES

COURSE PARTICIPANTS WILL...

- Learn about the history of services to individuals with developmental disabilities.
- Understand person-centered philosophy.
- Know how to work collaboratively with an individual’s support network to promote person-centered outcomes.
- Be prepared to contribute to the Individual Service Planning process (ISP).
- Know how to prepare the individual for their ISP meeting.
- Understand your role and responsibilities within the ISP process.
- Know when and how to access technical assistance resources.
SERVICE DELIVERY IN NEW MEXICO

PAST

PRESENT
# PROGRAM-CENTERED VERSUS PERSON-CENTERED

<table>
<thead>
<tr>
<th></th>
<th>PROGRAM-CENTERED</th>
<th>PERSON-CENTERED</th>
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</thead>
<tbody>
<tr>
<td><strong>CHOICE</strong></td>
<td>Choices are made by others. The person’s desires may be subtly or blatantly dismissed or ignored.</td>
<td>The person is empowered to make informed choices. Safety nets are put in place to support choices that involve significant risks.</td>
</tr>
<tr>
<td><strong>COMMUNITY INVOLVEMENT</strong></td>
<td>The person is kept “safe” in isolated or segregated environments. Groups of individuals engage in activities on a regular basis that the general public would not do. (e.g. going to the mall every day)</td>
<td>The person has an active role and contributes to the community. He/she is integrated and included in community life. The individual is supported to be a participant of community organizations of their choosing.</td>
</tr>
<tr>
<td><strong>PERCEPTION</strong></td>
<td>Focus is placed on the person’s limitations and challenges. He/she may be seen as an “eternal child,” incapable of substantial growth, sexual expression, meaningful work, etc.</td>
<td>The person is respected as a unique individual and is afforded the same opportunities as anyone else. Emphasis is on the person’s unique abilities, preferences, and accomplishments.</td>
</tr>
<tr>
<td><strong>LIFE OUTCOMES</strong></td>
<td>Outcomes are determined by professionals, designed to “correct” deficits or minimize health risks (e.g. telling someone they have to quit smoking), and developed for convenience of the program/staff.</td>
<td>The person’s long-term vision drives planning. Services and supports are tailored to the person, irrespective of what is convenient for programs/staff.</td>
</tr>
<tr>
<td><strong>CONTROL</strong></td>
<td>Others are in control of the person’s life. The person may be taught to be compliant and do what he/she is told (even if it may lead to abuse, neglect, or exploitation).</td>
<td>The person is empowered to take charge of his/her life. He/she exercises self-determination and self-advocacy skills. Teams honor a person’s decisions and build safety nets.</td>
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--- BENEFITS OF PERSON-CENTERED PLANNING ---
PERSON-CENTERED LANGUAGE

The language we use can reflect our perceptions of others. Language can be used to communicate respect, and it can be used to dehumanize another person.

Choose language that reflects the dignity of people with disabilities. Use words that emphasize the person and his/her strengths/abilities (rather than the disability and the person’s limitations).

<table>
<thead>
<tr>
<th>EMPHASIZES THE DISABILITY</th>
<th>EMPHASIZES THE PERSON</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A MENTALLY RETARDED MAN</td>
<td>1.</td>
</tr>
<tr>
<td>2. SHE DOES NOT TALK</td>
<td>2.</td>
</tr>
<tr>
<td>3. THIS IS “MY GUY”</td>
<td>3.</td>
</tr>
<tr>
<td>4. JACK IS AUTISTIC</td>
<td>4.</td>
</tr>
<tr>
<td>5. THE WHEELCHAIR BOUND</td>
<td>5.</td>
</tr>
<tr>
<td>6. SHE’S A SPECIAL NEEDS PERSON</td>
<td>6.</td>
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</tbody>
</table>

Often times, we may advocate for person-centered services and supports but then turn around and use language that labels or distances the person from others. For example, how many of us answer our home telephone by referencing the name of our street? Two other common occurrences include making reference to “my client” when referring to the person we support and when going out in the community, people may say, “Put the wheelchair group in the van first.”

Usually, no harm is intended. We use these terms for convenience and to create a common language. However, if we truly wish to treat people who have disabilities with respect, our language needs to reflect our person-centered philosophy.

### EXAMPLES OF PERSON-CENTERED VALUES

<table>
<thead>
<tr>
<th>I CONTRIBUTE TO MY COMMUNITY</th>
<th>I COMMUNICATE EFFECTIVELY WITH OTHERS</th>
<th>I FEEL GOOD PHYSICALLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>I CHOOSE THE SUPPORT I NEED</td>
<td>I HAVE LONG-LASTING RELATIONSHIPS</td>
<td>I AM TREATED WITH DIGNITY AND RESPECT</td>
</tr>
<tr>
<td>I FEEL GOOD EMOTIONALLY</td>
<td>I ACHIEVE MY PERSONAL DREAMS AND ASPIRATIONS</td>
<td>MY CULTURE IS HONORED</td>
</tr>
<tr>
<td>I CHOOSE WHERE AND WITH WHOM I LIVE</td>
<td>I HAVE CONTROL IN MY ENVIRONMENT</td>
<td>I AM SUPPORTED TO PURSUE A CAREER</td>
</tr>
<tr>
<td>I LEARN FROM MY PERSONAL EXPERIENCES</td>
<td>I EXERCISE MY RIGHTS AND RESPONSIBILITIES</td>
<td>I MAKE INFORMED CHOICES</td>
</tr>
</tbody>
</table>

**What is important to me...**

**MANY FACTORS DETERMINE THE PERSONAL OUTCOMES WE DESIRE**

VALUES, BELIEFS, EXPERIENCES, RELATIONSHIPS, ETC.)
CULTURE

WHAT IS CULTURE?

- The way of life of a society or group.
- It is defined by shared experiences and/or traditions.
- It may include, but is not limited to, shared values, beliefs, ethnicity, gender, age, family, religion, community, geographic area, language, art, music, food, ideas and/or medicine.

<table>
<thead>
<tr>
<th>EXAMPLES OF CULTURAL GROUPS</th>
<th>EXAMPLES OF COMMUNITY RESOURCES THAT SUPPORT CULTURE</th>
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</table>

WHY IS IT IMPORTANT TO UNDERSTAND AND HONOR THE CULTURAL BACKGROUND OF THE PERSON AND HIS/HER FAMILY?

- To build a trusting relationship
- Promotes communication and clarity
- To avoid violating cultural taboos
- To help the person live a life that matches his/her values, beliefs, and interests
- To support the person through life events in an appropriate manner

<table>
<thead>
<tr>
<th>SOME KEY ASPECTS OF CULTURE</th>
<th>HOW THESE ASPECTS OF CULTURE MIGHT INFLUENCE SUPPORTS AND SERVICES PROVIDED TO A PERSON</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE</td>
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<tr>
<td>GENDER</td>
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<tr>
<td>VALUES</td>
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<tr>
<td>SPIRITUALITY</td>
<td></td>
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<tr>
<td>GEOGRAPHIC AREA</td>
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<tr>
<td>FOOD</td>
<td></td>
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<tr>
<td>LANGUAGE</td>
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</tbody>
</table>
INFORMED CHOICE

INFORMED CHOICE OCCURS WHEN A PERSON CONSIDERS . . .

☑ OPTIONS

☑ CONSEQUENCES

☑ THE BALANCE OF RIGHTS OF SELF AND OTHERS

☑ RESPONSIBILITIES

IN MAKING A DECISION
DIGNITY OF RISK

A PERSONAL OPPORTUNITY TO LEARN AND GROW BY EXPERIENCING THE NATURAL CONSEQUENCES—POSITIVE OR NEGATIVE—OF A DECISION THAT MAY INVOLVE RISKS.

It is the responsibility of the IDT to provide a SAFETY NET to address health and safety when decisions include significant risks.
SOCIAL ROLES

Social roles are the part people play as members of a social group. With each social role you adopt, your behavior changes to fit the expectations both you and others have of that role. McLeod, S. A. (2008). Social Roles and Social Norms - Simply Psychology.

What are socially valued roles?

What are the roles that you have?

How do you identify what socially valued roles a person may have?

How do people acquire socially valued roles?

How can we support individuals to gain more socially valued roles?
NATURAL SUPPORTS

Natural supports typically include close friends, coworkers, and family. They are supports that are unique to the individual.

BENEFITS OF HAVING NATURAL SUPPORTS

... QUESTIONS TO CONSIDER ...

Who are some of your natural supports?

How did you form these natural supports?

What do you do to maintain and/or strengthen these relationships?

What might be some ways to support others to build or further develop natural supports?
COMMUNITY SUPPORTS

Community supports include those that may be available to all people in a particular community/area. Examples can include fellow church members, a familiar cashier at the local grocery store, a police officer, teachers, or a librarian that a person has known for years.

BENEFITS OF DEVELOPING COMMUNITY SUPPORTS INCLUDE...

- Feeling a sense of belonging in the community.
- Building connections with others who have shared interests, hobbies, etc.
- Expanding personal safety nets when in the community.
- Establishing a network that will enhance job-seeking opportunities and/or enable paid support providers to “fade away” from a person’s place of employment.
SPECIALIZED SUPPORTS

Specialized supports are paid to provide a service to the person. They include case managers, provider agency staff (e.g., supported employment specialist, family living provider), advocacy agencies, school system personnel, therapists, agency nurses, etc.

RESPONSIBILITIES OF SPECIALIZED SUPPORT PROVIDERS

<table>
<thead>
<tr>
<th>DIRECT SUPPORT PROFESSIONALS</th>
<th>ADVOCATES</th>
<th>CASE MANAGERS / SERVICE COORDINATORS</th>
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<tbody>
<tr>
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</tr>
<tr>
<td>EDUCATORS / TEACHERS</td>
<td>CONSULTANTS</td>
<td>PROFESSIONALS</td>
</tr>
</tbody>
</table>
CORE TEAM MEMBERS

1. PERSON RECEIVING SUPPORTS/SERVICES (most important person on the team)

2. LEGAL GUARDIAN

3. INDEPENDENT CASE MANAGER

4. HELPER/NATURAL SUPPORT (someone to assist with communication, such as a family member, friend, coworker, etc.)

5. COMMUNITY SERVICE PROVIDER STAFF:
   • Direct support personnel (provide services to the person)
   • Service coordinators (internal “case manager,” “program manager,” etc.)

6. DESIGNATED HEALTHCARE COORDINATOR (person who coordinates medical supports and services)

7. ANCILLARY SUPPORT PROVIDERS:
   • Speech language pathologist (SLP)
   • Occupational therapist (OT)
   • Physical therapist (PT)
   • Behavior support consultant (BSC)
   • Nurse, nutritionist, etc.

8. OTHERS:
   • Family members (not already mentioned)
   • Friends, coworkers, associates, etc.
   • Advocate: corporate, legal, or natural
   • Public school representatives
   
How SHOULD you give input and to whom, if you know you can’t go to the team meeting? This is YOUR responsibility!!

http://nmhealth.org/ddsd/Rules/Regulations/documents/7_26_5_NMAC.pdf, p.2
WORKING AS A TEAM

PRINCIPLES OF TEAMWORK

- Promote mutual respect
- Maintain open lines of communication
- Work towards achieving consensus
- Seek “win-win” solutions
- Foster accountability and interdependency
- Use conflict to stimulate growth

BENEFITS OF USING TEAMWORK PRINCIPLES

DO

DO NOT
FOUR STAGES OF PLANNING

ASSESS/PREPARE
Discover the person’s dreams/desires for the future from the person and people that know them best.
Prepare the person to facilitate and/or participate in the meeting.
Plan authors ensure that all required assessments are completed and distributed to team members 14 days prior to the ISP meeting.
The team reviews assessments prior to the annual ISP meeting.

PLAN
The individual and Direct Support Staff’s involvement is maximized during the meeting.
Action plans are developed that are meaningful, person-centered and link directly to visions and outcomes.
Identify the need for Teaching & Support Strategies/WDSI’s to promote learning and success.
Identify how a combination of natural, generic and specialized supports can support the individual’s ISP.

REVIEW/REVISE
Review progress of the plan and identify barriers.
Revise the plan (as needed/desired by the person).
Implement the revised plan.
Submit required reports to team members.
Schedule and attend team meetings, as required by the laws in New Mexico (see 7 NMAC 26.5).

IMPLEMENT
Complete action steps.
Document progress on action steps including related successes and challenges.
Keep team members informed of progress through regular reporting and updates.
Ensure that Individual-Specific Training occurs in accordance with the person’s ISP.
BEFORE AN ANNUAL ISP MEETING

Team Preparation Overview

- Complete all assigned tasks from previous meetings in accordance with established timelines. Ensure that documentation and reporting requirements are met.

- Learn about the individual’s life experiences, interests, preferences, support needs, etc. Assess his/her progress towards reaching desired outcomes and the long-term vision.

- Review all current reports and assessments. Ensure that follow-up actions occur, as necessary.

- Send completed assessments to team members (e.g., physical therapy evaluation, semi-annual narrative assessment summary), at least two weeks prior to the annual ISP meeting.

- Draft individual-specific training requirements for team members (which will be finalized at the meeting with input from the entire team).

- Work with team members to ensure that they are prepared for the meeting (e.g., developing an agenda with those who will be at the meeting, preparing visual aids, empowering the individual to co-facilitate the meeting).

WAYS TO PREPARE A PERSON TO COMMUNICATE EFFECTIVELY AND MAKE CHOICES DURING A MEETING
TYPES OF ASSESSMENTS

**MEDICAL/PHYSICAL:** Some typical examples include the following: annual physical examination, neurological evaluation, vision examination, dental examination, auditory evaluation, nutritional evaluation, psychiatric evaluation, physical therapy evaluation (gross motor movement, mobility, assistive technology, etc.), occupational therapy evaluation (fine motor movement, sensory issues, assistive technology, etc.), speech/language evaluation (communication, eating/swallowing, aspiration risk screening (ARST), assistive technology, etc.), medication assessment (MAAT), electronic comprehensive health tool (e-CHAT).

**PSYCHOLOGICAL/BEHAVIORAL:** Some typical examples include the following: psychological evaluation, holistic positive behavior support evaluation, and risk assessment.

**OTHERS:** Additional types of assessments include, but are not limited to, the following: semi-annual narrative assessment summary, environmental modification consultation, person-centered assessment (PCA), situational assessment (e.g., job shadowing, job sampling).

<table>
<thead>
<tr>
<th>TYPE</th>
<th>PURPOSE</th>
<th>BENEFITS</th>
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<tbody>
<tr>
<td>Medical/Physical:</td>
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<td></td>
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<tr>
<td>Psychological/Behavioral:</td>
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<tr>
<td>Others:</td>
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</table>

*Team members should advocate for needed assessments/evaluations, provide input and ensure relevant assessment information is incorporated.*
## MAIN SECTIONS OF AN INDIVIDUAL SERVICE PLAN

<table>
<thead>
<tr>
<th>SECTION</th>
<th>NOTES</th>
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<tbody>
<tr>
<td>Face Sheet</td>
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<tr>
<td>Narrative Section</td>
<td></td>
</tr>
<tr>
<td>Vision and Outcome Section</td>
<td></td>
</tr>
<tr>
<td>Action Plans for Desired Outcomes/Action Plan for Health &amp; Safety</td>
<td></td>
</tr>
<tr>
<td>Supports (if applicable)</td>
<td></td>
</tr>
<tr>
<td>Individual-Specific Training Requirements</td>
<td></td>
</tr>
<tr>
<td>ISP Meeting Participant Sign-in Sheet</td>
<td></td>
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<tr>
<td>Attachments:</td>
<td></td>
</tr>
<tr>
<td>- Addendum A</td>
<td></td>
</tr>
<tr>
<td>- Teaching &amp; Support Strategies (T&amp;SS)</td>
<td></td>
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<tr>
<td>- Written Direct Support Instructions (WDSI's)</td>
<td></td>
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<tr>
<td>- Support Plans</td>
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One-Day Person-Centered Planning in New Mexico
Department of Health/Developmental Disabilities Supports Division
June 2019 – Handout Packet
NARRATIVE SECTION

CONTENT AREAS OF FOCUS:

- LIFE EXPERIENCES (with Relationship Information)
- DESCRIPTION OF WHAT IS MEANINGFUL TO THIS PERSON (MEANINGFUL DAY DEFINITION)
- WORK, EDUCATION AND/OR VOLUNTEER HISTORY
- HEALTH & SAFETY
- STRENGTHS, GIFTS, PREFERENCES, AND HOBBIES

Strategies for obtaining information for the narrative sections of the ISP

REMEMBER TO...

- Use person-centered language.
- Be respectful when writing about the person.
- Keep the meeting positive and celebratory.
- Value everyone’s contributions.
THE NARRATIVE SECTION:
MEANINGFUL DAY

MY PERSONAL DESCRIPTION OF A MEANINGFUL DAY IS...

WHAT SHOULD BE INCLUDED IN THE DESCRIPTION OF WHAT IS MEANINGFUL TO THIS PERSON (Meaningful Day Definition)?

- Summarized meaningful, age appropriate choices and activities (with approximate frequencies)
- Purposeful, desired work and/or volunteer
- Opportunities for optimal health, self-empowerment and memberships
- Desired skill development, social, educational and community inclusion activities
- Valued roles, new things to try, learning opportunities and hobbies
- This description may be broader than a person’s vision statements, but should support progress toward achieving the visions and desired outcomes.

How do you know what’s meaningful to a person you support?
THE LONG-TERM VISION STATEMENT

MEANINGFUL VISION STATEMENTS...

- Establish a clear direction for future planning and growth
- Reflect the person’s value system and desires (even if the person’s value system and desires differ from those of other team members)
- Incorporate ideas from the Narrative Section(s) including the Description of What Is Meaningful To This Individual (Meaningful Day Definition)
- Are written in the person’s own words (whenever possible)

THE LONG-TERM VISION STATEMENT describes the PERSON’S long-range (e.g., within one to three years) major life dreams and aspirations for the FUTURE in the following areas:

- Live
- Work/Education/Volunteer
- Develop Relationships/Have Fun
- Health and/or Other (Optional)
VISION ANALYSIS

In order to support the person to achieve his/her personal vision, the team determines what it means to the person in terms of how he/she defines success.

The team analyzes existing skills and resources available to achieve this vision identifies additional supports and skills needed and plans for any barriers (including Assistive Technology needs).

What does successful achievement of this vision look like?

Which of the individual’s strengths, talents and/or existing skills contribute to achievement of this vision?

What progress has already been made towards this vision? (include Assistive Technology the individual already uses)

What still needs to occur to accomplish this vision and overcome any barriers? (e.g. skill development needed, Assistive Technology needed)
DESIRED OUTCOMES

DESIRED OUTCOMES ARE MEANINGFUL WHEN THEY:

- Have meaning for the individual
- Reflect what the individual is motivated to achieve
- Clearly link to the individual’s description of a meaningful day and the relevant vision statement

*Desired outcomes are designed to empower the individual to achieve his/her long-term vision.*

DESIRED OUTCOMES MUST BE MEASURABLE
(What does completion look like?)

*Measurement options:*

- **Natural measurements** (e.g., driver’s license to indicate when a person has learned to drive, or a photo album with pictures of a vacation).

- **How the individual defines success** (e.g., If purchasing a home, a person may define success by the neighborhood it’s in or how many bedrooms it has).

TIPS FOR DEVELOPING MEANINGFUL DESIRED OUTCOMES

- **Analyze what still needs to be accomplished** in order for the individual to achieve the vision.
- **Group related tasks and activities.** Then, for each group of interrelated tasks/activities, ask questions in order to identify an appropriate desired outcome statement. Examples:
  - *If all of these things are accomplished, how will the individual be closer to his/her vision?*
  - *What is the end result of these tasks/activities?*
- **Support the individual to brainstorm how he/she wants to achieve desired outcomes.** The individual’s current life situation, desires, and preferences need to guide this process.
- **Work with the team to make outcome statements measurable.** Include criteria that can be objectively measured, and add a relevant target date to each outcome statement (e.g., “by March 2007”).
- **Critique each desired outcome statement** (using the “desired outcome job tool” included in the resource packet).

A Desired Outcome is **required** for each life area (Live, Work, Fun) for which the individual receives paid supports through the DD Waiver.
OVERVIEW OF ACTION PLANS

- For each desired outcome, a separate action plan must be developed.
- Action steps are the smaller steps which directly relate to achievement of the outcome.

Considerations for Action Plans...

- Draft action plans can be developed in advance of the meeting.
- Numerous action steps may indicate a task analysis, which should be included in a teaching and support strategy.
- Action steps do not include steps that a provider is already required to provide through state regulations, standards, policy, procedure, etc... (e.g. assistance with medication, arrangement of transportation)
- The team should consider how often the person should work on an action step for learning to be successful.
SPECIFIC SECTIONS OF THE ACTION PLAN:

- **PERSONAL CHALLENGES AND OBSTACLES** – what may prevent the individual from achieving the desired outcome?

- **ACTION STEP** – observable/measurable behavior, task/activity to complete, etc.

- **FREQUENCY** – how often the behavior/task will occur, how long it will occur, etc.

- **STRATEGIES/WDSI’s NEEDED** – whether or not a teaching & support strategy sheet or written direct support instructions are applicable to assist responsible team member to teach the action step.

- **RESPONSIBLE IDT PARTY (IES)** – who is responsible for teaching the action step.

- **TARGET DATE(S)** – timeframes for implementing the action step.

- **MEASUREMENT DOCUMENTATION/REPORTING REQUIREMENTS** – documentation/data collection identifying progress towards completion of action step, where it is documented, etc.

If specific services and supports are not available but would support the individual in reaching his/her desired outcome, related information needs to be documented on the bottom of the action planning page so that related follow up can occur.

WHAT IS MY ROLE?
ACTION PLANS FOR HEALTH AND SAFETY RELATED SUPPORTS

THERE ARE TWO TYPES OF ACTION PLANS IN THE ISP FORM!

1. ACTION PLANS FOR DESIRED OUTCOMES
   These action plans relate directly to the person’s long-term vision statement (I want to lose weight.)

2. ACTION PLAN FOR HEALTH AND SAFETY RELATED SUPPORTS
   This action plan does not directly relate to the person’s long-term vision statement

WHAT SHOULD BE INCLUDED IN THE HEALTH AND SAFETY RELATED SUPPORTS ACTION PLAN?

- A list of relevant and needed outcomes.
- Challenges/obstacles that need to be addressed.
- Supports the individual needs beyond those already addressed in action plans for other desired outcomes in order to stay as healthy and safe as possible. These include action steps that have not yet been completed (i.e., actions that are past due) and action steps related to newly identified areas of support (e.g., needed specialized assessments or adaptive equipment).
- Steps that address adequate supports for 1) a condition that is worsening, 2) a new diagnosis, 3) new symptoms, and/or 4) the need to obtain medical tests or evaluations.
HEALTHCARE COORDINATION INFORMATION

There are two main topics that are covered on this page:

- HEALTHCARE COORDINATION INFORMATION
- MEDICATION DELIVERY

ANSWER THE FOLLOWING:

What is a healthcare coordinator?

Who is required to have a healthcare coordinator?

Who can serve as the healthcare coordinator?

What are advanced directives?

How can a team gather information about advanced directives?

Who completes the medication administration assessment tool?

What are the different levels of support with medication delivery?
INDIVIDUAL-SPECIFIC TRAINING

There are four pages in the ISP document dedicated to individual-specific training requirements. These pages cover three categories:

- Support Plans
- Medical Emergency Response Plans/Healthcare Plans
- Other Supports

The IST Serves as the Official Guide For All Team Members on:

- What training topics are required
- Who will receive training
- The Urgency or how soon training needs to occur
- The Type or level of training intensity
- Who is responsible to provide the training

- This form is required to be reviewed annually and updated as training needs arise due to a change in condition or possibly a change in life situation.

- One of the primary purposes of the I.S.T. is to provide assurances to promote health and safety.

- Before the annual ISP meeting, each provider agency supporting the individual identifies for themselves, the type and urgency of training they and/or their employees will need under each required training topic. (Each provider should complete their section of the form at least two weeks prior to the annual meeting and send it to the case manager)

- At the annual ISP meeting, the team will discuss and finalize the draft I.S.T.
ISP ATTACHMENTS

WRITTEN DIRECT SUPPORT INSTRUCTIONS:

WDSI’S are:

- Written therapy instructions that are implemented by natural supports and/or Direct Support Staff

WDSI’S can address:

- Health & Safety needs
- ISP implementation
- Greater participation in daily routine

TEACHING AND SUPPORT STRATEGIES:

WHAT ARE TEACHING AND SUPPORT STRATEGIES? WHO ARE THEY WRITTEN FOR?

WHEN ARE TEACHING AND SUPPORT STRATEGIES NEEDED?

WHY ARE TEACHING AND SUPPORT STRATEGIES IMPORTANT?

WHO IS RESPONSIBLE FOR DEVELOPING THEM?