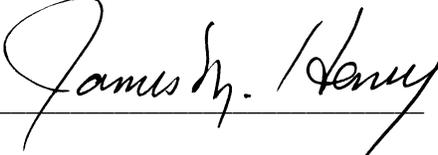


	<b>POLICIES AND PROCEDURES</b>  <b>State of Tennessee Department of Intellectual and Developmental Disabilities</b>	<b>Policy #: 100.1.8</b>	<b>Page 1 of 7</b>
<b>Policy Type: Intermediate Care Facilities for Individuals with Intellectual Disabilities and the Harold Jordan Center</b>	<b>Effective Date: March 15, 2013</b>		
<b>Approved by:</b>  <b>Commissioner</b>	<b>Supersedes: P-206 Individual Support Planning Process</b>		<b>Last Review or Revision: January 23, 2013</b>
<b>Subject: Individual Support Planning Process</b>			

- I. **AUTHORITY:** Tennessee Code Annotated (TCA) 4-4-103, TCA 4-3-2708, TCA 33-3-101, TCA 33-1-303, TCA 33-4-105, Section 1905 (d) of the Social Security Act, and 42 CFR 483.420-480.
- II. **PURPOSE:** The purpose of this policy is provide guidance to the Circle of Support (COS) regarding their role and responsibility for the evaluation, development, implementation, monitoring, reviewing, and revising of the Individual Support Plan (ISP) for individuals with intellectual disabilities who reside in Department of Intellectual and Developmental Disabilities (DIDD) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and the Harold Jordan Center (HJC).
- III. **APPLICATION:** This policy is applicable to all employees, contract staff, and volunteers who provide services and supports to persons residing in department ICF/IID and the HJC.
- IV. **DEFINITIONS:**
  - A. **Active Treatment** shall mean the aggressive, consistent implementation of a program of specialized and generic training, treatment, and health services.
  - B. **Assessment** shall mean a systematic collection of data.
  - C. **Behavior Support Plan** shall mean the document written by a Behavior Analyst which clearly defines the actions and steps that direct support professionals and other caregivers will take to change the behavior of a person supported.
  - D. **Circle of Support (COS)** shall mean a group of people who meet together on a regular basis to help a person supported plan for and accomplish his/her personal outcomes and actions. The person supported is the focus or the center of the COS. At a minimum, this includes the person supported, his/her family member(s) and/or conservator(s), a QIDDP/Case Manager, and the providers of any supports and services that the person receives. Friends, advocates, and other non-paid supports are included at the invitation of the person.

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- E. **Comprehensive Functional Assessment (CFA)** shall mean a systematic and multidimensional assessment that covers physical, cognitive, and emotional functioning, including the instrumental activities of daily living, as well as economic resources, informal social supports, and utilization and perceived need for services.
  - F. **Direct Support Professionals (DSPs)** shall mean staff who provide direct supports and assistance to the persons residing in ICFs/IID and HJC.
  - G. **Individual Support Plan (ISP)** shall mean a person-centered document that provides an individualized, comprehensive description of the person supported as well as guidance for achieving unique outcomes that are important to and for the person in achieving a good quality of life in the setting in which they reside.
  - H. **Personal Outcomes and Actions** shall mean the written statements within the ISP of what the person is working to accomplish within the ISP year. Personal outcomes and actions are developed by the person and his/her COS, starting with what is important to the person and balancing that with what is important for the person which includes their health, safety, and well-being when necessary. They must be observable and measurable actions with specific steps needed to attain the outcome.
  - I. **Progress Review** shall mean a written survey of how the person supported has moved toward accomplishing the personal outcomes and actions, as well as a look at other areas of the ISP and the person's life. A progress review is the integrated product of a discussion that occurs at least quarterly throughout the ISP year.
  - J. **Qualified Intellectual and Developmental Disabilities Professional (QIDDP) or Case Manager (CM)** shall mean the staff member who coordinates, facilitates, and documents all Circle of Support (COS) meetings and the entire Independent Support Plan (ISP) process which includes planning and development of the ISP.
- V. **POLICY:** DIDD ICFs/IID shall plan and implement supports, programs, and services to assist the person in living his/her desired life, as evidenced in the ISP. The DIDD ICF/IID shall monitor and document progress toward achieving the person's outcomes in the ISP. Revisions to the person's ISP shall be made as progress (or lack thereof) occurs and/or when changes in the person's conditions, risks, needs and/or preferences are identified.
- VI. **PROCEDURES:**
- A. Pre-Planning for the ISP
    - 1. The QIDDP/CM shall interview and solicit information from the person supported, advocate (if applicable), family member and/or legal representative regarding the interests, concerns, and preferred outcomes of the person supported, the ISP and any needed revisions to the ISP. The QIDDP/CM shall document all of these communications in writing.

2. The QIDDP/CM shall notify all members of the circle of support of the date, time and location of the ISP planning meeting. All efforts shall be made to conduct the ISP planning meeting at a time that facilitates the participation of the person, their advocate (if applicable), family member and/or legal representative.
3. The QIDDP/CM shall document in writing their efforts to schedule and coordinate ISP planning meetings.
4. Prior to the ISP planning meeting, each staff member involved in the person's COS shall complete a comprehensive functional assessment (CFA) which shall address the following areas:
  - a. Physical development and health.
  - b. Nutritional and oral motor status.
  - c. Sensorimotor development.
  - d. Affective (emotional) development.
  - e. Speech and language development.
  - f. Auditory functioning.
  - g. Cognitive development (including memory, reasoning, and problem-solving).
  - h. Social development.
  - i. Adaptive behavior and independent living skills.
  - j. Vocational skills, as applicable.
  - k. Behavior management needs.
5. The appropriate staff member shall ensure that his/her assessment has been conducted and the final report available for review by the QIDDP/CM at least one (1) week prior to the ISP planning meeting.
6. The QIDDP/CM shall prepare a draft ISP by assembling current information provided by the person supported, advocate (if applicable), family member and legal representative and staff.
7. The QIDDP/CM shall distribute the draft ISP to all members of the COS at least one (1) week prior to the ISP planning meeting.

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8. If a person supported is absent from the ICF/IID (e.g., hospitalized) when the assessments and ISP are due to be completed, the QIDDP/CM shall convene a COS meeting and document in writing the reason the assessment and/or ISP cannot be completed. Documentation shall include the person's current status and, in the case of a hospitalization or rehabilitation, actions being taken to promote the person's recovery and return to the ICF/IID.

**B. ISP Planning Meeting**

1. Each person's ISP shall be reviewed annually and no more than three hundred and sixty five (365) days from the last ISP planning meeting.
2. The QIDDP/CM shall facilitate the ISP planning meeting.
3. Staff members shall be prepared to discuss applicable assessment outcomes and recommended services and supports for the person.
4. In developing the ISP, the COS shall:
  - a. Review assessment outcomes.
  - b. Discuss what is important to and important for the person in each area of his/her life.
  - c. Discuss what is working and not working with the current supports and services from everyone's perspective.
  - d. Develop and prioritize reasonable and attainable personal outcomes and actions that build on the person's strengths and desires and addresses the person's identified needs, risks and/or barriers to attaining his/her desired life.
  - e. Prioritize the outcomes and actions in a developmental progression of skills or steps necessary to attain the outcome and honor the person's preferences and needs.
  - f. Establish projected dates for completion or attainment of each outcome and action.
  - g. Ensure all supports and services needed to attain the personal outcomes and actions are provided in sufficient number and frequency to support achievement.
  - h. Ensure that each individual who is responsible for a specific outcomes and/or action step is clearly identified in writing.
  - i. Ensure services and supports are integrated throughout the plan.



3. Staff members shall record data as prescribed in the plan or other plans (e.g., behavior support plan) to show evidence of the person's progress or lack of progress toward achieving personal outcomes and actions.

D. Monitoring Implementation of the ISP

1. The QIDDP/CM shall verify the ISP and related plans are being implemented as written by:
  - a. Visiting the person at least once a month to talk with the person about his/her satisfaction with how the plan is being implemented.
  - b. Visiting the person in a variable array of service and support locations.
  - c. Interviewing responsible staff to ascertain their knowledge of the plan and the person's progress toward meeting personal outcomes and actions.
  - d. Reviewing training records for DSP and other staff responsible for implementing the ISP.
  - e. Contacting the person's family members, advocate (if applicable), and/or legal representative at least once a quarter to talk about their satisfaction with the plan and any concerns they may have with how the plan is being implemented.
2. The QIDDP/CM shall review and document at least monthly (or more frequently when necessary), the person's progress toward meeting personal outcomes and actions.
3. When the QIDDP/CM finds evidence that the ISP or related plan is not being implemented or documented as written, he/she shall immediately notify the supervisor of the responsible staff so that the appropriate follow-up can occur.
4. The COS shall meet no less than quarterly to discuss and review the progress made by the person supported since the previous meeting. Meetings may occur more frequently if necessary.
5. The QIDDP/CM shall document the discussion and decisions of the COS in a progress review document.
6. The QIDDP/CM shall ensure the ISP is revised when necessary, such as the person's lack of progress in meeting personal outcomes or actions and/or development of significant health issues.
7. The QIDDP/CM shall revise the ISP within five (5) business days of the progress review to reflect recommended changes to services and supports.
  - a. The revised ISP shall reflect the original effective date as well as the date the ISP was amended.
  - b. The revision shall be italicized and followed by the date the revision was made.

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- c. The QIDDP/CM shall ensure that the most current amendment of the ISP is given to the person, family members, advocate (if applicable), and/or legal representative and appropriate staff; including staff of other agencies who work with the person supported.
- d. The QIDDP/CM shall ensure that only the most current amendment of the ISP is filed in the person's chart. Previous versions of the annual ISP shall be extracted and archived in accordance with DIDD policies and procedures.
- e. Staff responsible for implementing the person's ISP shall be trained on any amendments (e.g., personal outcomes and/or actions, services and supports, treatments, etc.) made to the ISP prior to being assigned to assist the person. Said training may include face-to-face training by the appropriate supervisor, health care staff, or train-the-trainer designee.
- f. Supervisors of DSP and other staff shall ensure that staff reviews informational amendments to the ISP (e.g., family change of address). Staff shall indicate their review with a dated signature.

VII. **ATTACHMENTS:**

- A. Individual Support Plan with Person-Centered Prompts