

PRINCIPLES OF CAREGIVING DEVELOPMENTAL DISABILITIES MODULE

CHAPTER 4: SUPPORT PLANNING

FACILITATOR GUIDE

CONTENT:

- A. Goal Planning
- B. Individual Support Plans
- C. Support Plan Basics
- D. Roles and Responsibilities of Team Members

Estimated time for this chapter: 1 hour

Needed Materials:

1. Facilitator Guide
2. Participant Guides
3. Blank Individual Support Plan documents for each person attending

Competencies:

1. Explain the purpose of the Individual Support Plan (ISP) or other Division of Developmental Disabilities planning documents.
2. Identify two ways a DCW is involved in the team approach in plan development.
3. Name three parts of the planning documents that help inform the DCW about the person receiving support.

Key Terms:

Back-up plan

Risk assessment

Individual Support Plan (ISP)

Short term goal

Long Term goal

Team assessment

A. GOAL PLANNING

Facilitator Note:

Discuss the following information:

Support planning is a process that we use to help identify the things that a person wants to achieve, the skills that need to be learned, and the barriers that need to be overcome to achieve that dream, and a step-by-step plan to help get them there. It's not really different than the type of goals setting that we all do.

Activity: Have participants turn to the goal planning page in their handout.

Use the instructions for this exercise on the following pages.

Long-term goals

A long-term goal is anything that you want to accomplish in your life. Make it specific, i.e. buy a house, get a degree, lose 25 pounds, etc.

My long-term goal:

Short-term goals

A short-term goal is a milestone, or major "chunk" of the long term goal that you will need to accomplish in order to achieve your long-term goal, i.e. have a credit score of 600, or identify the part of town you want to live in.

My short-term goals:

First steps

First steps are the things that you can do today, or in the very near future, to reach your milestones (short-term goals), and eventually your long-term goal, i.e. open a bank account or get a gym membership.

My First Steps:

Barriers

Barriers are anything that may slow you down, or prevent you from reaching your Goals i.e. poor health, lack of budgeting skills

My barriers:

Facilitator Instructions - Goal Planning Exercise:

Complete the activity by following each of these steps:

- Using the handout provided identify one measurable long-term goal that you have. A good measurable goal might be something like “I want to have my bachelor’s degree,” or “I want to buy a car,” or “I want to be married with 2 children.” An example of a goal that is *not* measurable would be, “I want to be a nicer person,” or “I want to be smarter.” To be measurable, there must be a specific outcome that can be seen, heard, or otherwise measured. For “I want to be a nicer person” it could become “I want to have 4 friends that I visit at least 1 time per week” (being with friends can be seen and measured), for “I want to be smarter” it could be, “I want to complete an expert level Sudoku!” (Completing a Sudoku puzzle can be seen and measured.)
- What are some short-term goals or milestones that you will need to achieve to reach your goal? Note these on the handout provided.
- Next, write down some steps that you can take today to move toward your goals.
- Finally, what barriers could keep you from reaching your goals?

Goal Planning Example: Facilitator’s should model one example on a whiteboard or newsprint pad step-by-step. You may choose to use your own example, or demonstrate an example from a long-term goal provided by the group. Below you will find an example of one of the many ways this exercise could be completed.

Long-term goal:

- Buy a new car

Short-term goals:

- Good credit
- Savings
- Driver’s license

First steps:

- Pay bills on time
- Put \$25.00 per paycheck in the bank
- Study for drivers test 10 minutes each day

Barriers:

- Overspending on fast food and entertainment / Create a budget
- Habit of paying bills late / Write due dates on calendar
- Lack of time to study for drivers test / schedule 10 minutes each day during lunch for studying

Facilitator Note: Begin by explaining your long-term goal, in this example, buying a car. Explain the short-term goals that will need to be accomplished to reach your long-term goal, in this case having good credit, having some money saved, and having a driver's license. Go on to explain that to reach these short-term goals, and ultimately the long-term goal, there are things that will need to be done on a regular basis and skills that need to be acquired. For example, pay bills on time to improved credit score, put money in bank each week to save toward car payment, and study for driving test to get a driver's license.

You may want to comment that these first steps are the equivalent of the outcomes / objectives you will be discussing later in the class.

Go on to discuss the things that could prevent you from reaching your goals like choosing to spend your money on other things, poor bill paying habits, or lack of time to study for the driving test. Identify some solutions for these barriers, creating and sticking to a budget, writing due dates for bills on a calendar, setting time aside each day to focus on the driving test manual etc.

You may want to facilitate a discussion with the participants and have them identify steps to address each of the barriers. You also may want to comment that these actions would become either outcomes / objectives for the individual or they could become team agreements or assignments if this were a real ISP.

Tell the participants that they have just completed a process that is very similar to the ISP process. The purpose of the ISP is to identify the individual's goals, the steps that will be necessary, any barriers or obstacles they may face, and how the individual and the team will address those obstacles.

B. INDIVIDUAL SUPPORT PLANS

The Support Plan describes the person's goals and plans and what works for the person. This can include:

- Likes and dislikes.
- Abilities and special needs of the person in areas like daily living skills.
- Medical issues, communication and movement issues.
- Social and family supports.
- Medication assistance needs, potential health and safety risks.
- Services and supports a person will receive.

The purpose of support planning is to ensure that everyone is working together to achieve the goals identified by the individual being supported. The planning document becomes the roadmap for how services and supports are delivered.

The Support Planning Team:

The support plan is developed during a team meeting that includes, most importantly, the person being supported. The team will also include all the people that are important to the person and may include:

- Person being supported.
- Parent or guardian.
- Support coordinator (case manager).
- Direct care workers.
- Friends, family, advocates, neighbors and others as invited by the individual and their family.

During this meeting, one or more long-term goals will be identified that are important to the person and his or her family. Services, supports, team agreements and assignments, specific outcomes and other action items will then be identified based on this long-term goal.

All Support Plans:

- Are individualized.
- Are developed with the person and, when appropriate, his/her family.
- Documents the individual's strengths, needs, and resources.

C. SUPPORT PLAN BASICS

Facilitator Note: Hand out a blank Individual Support Plan for the class to look at. Take a few minutes to point out the following specific areas in the Individual Support Plan document.

A basic support plan includes some critical information! Be sure to review this document, and the information listed below, in particular, for each individual that you support!

Preferences and Vision of the Future

The vision of the future section identifies the person's 3-5 year goals, such as relationships, community involvement, work, education, where the person wants to live. This is based on the person's goals and should be in the person's own words.

The preferences section should give the Direct Care Worker information about what motivates the individual, activities the individual enjoys, and what to avoid.

Team Assessment Summary

The team assessment summary provides the Direct Care Worker with an overview of the individual's strengths and support needs in areas of health, learning, communication, social skills, self-care, family, etc.

Support Information, includes medication, adaptive equipment, and behavioral health needs. Information in this section changes rapidly, so be sure to check for updates.

Risk Assessment

The risk assessment identifies areas of health and safety the Direct Care Worker needs to be aware of. Some examples include history of seizures, self-abuse, dietary needs, choking, etc.

Back-up Plan

The back-up plan will list names and contact numbers if a Direct Care Worker is unable to provide a contracted support, and timeframes for filling the need.

The areas listed above are some examples. Attendant care tasks, accomplishments, team agreements, and all other plan documentation will also support the Direct Care Worker.

- Each individual receiving services through DES/DDD has an individualized plan, Individual Support Plan (ISP), or an Individualized Family Service Plan (IFSP), used for children 0-3 years of age and their families. They may also have a Person Centered Plan (PCP).
- The support plan provides important information you need to do your job.
- The support plan documents the person's likes, dislikes, individualized needs, and goals.
- The support plan is reviewed through quarterly and annual team meetings, and ongoing monitoring by the Support Coordinator.

Facilitator Note: Ongoing monitoring includes progress reports, reviewing attendant monitoring, and incident reports.

Individuals are in charge of their ISP and entitled to make decisions and choices about their lives, with the least amount of assistance necessary from family, guardians and support systems.

Not all supports need to be written in formal support plans. The team should also discuss informal supports for the person to participate actively and in a meaningful way each day.

Informal supports can be wide and varied. It may be access to a cell phone, so a person can be alone in the community or stay in touch with people important to them. It may include faith communities, natural supports, social groups, online supports, etc. The support planning teams should be creative and flexible in identifying the best ways to help a person be successful!

D. ROLES AND RESPONSIBILITIES OF TEAM MEMBERS

Individual

The individual receiving support is central in the development of the plan. The person is there to talk about choices, hopes, dreams, and any potential barriers. Regardless of any potential participation barriers, including age, cognitive development, and communication ability, this meeting is for the person. The plan belongs to the individual. Teams may need to be creative to accommodate the person's needs and preferences.

People important to the individual including:

Family

Depending on the needs of the individual, the family may play a very large role in the planning process. In fact, if the plan is an IFSP, the planning process focuses on the family, not just in the individual. For other plans, family involvement will vary from person to person. If family members are legally responsible, they must be a part of the planning team. If the person is an adult and legally responsible for himself or herself, it's the person's choice who they wish to invite. Participants in the support planning process could include:

- Family members
- Significant Others/Spouse
- Friends
- Other Advocates

Other Team Members

Other team members contribute in any way that reflects the best interests of the person being supported. This could include sharing assessment information, advocating, making recommendations and determining the specific supports and services that will help the person achieve their goals.

Direct Care Workers

Direct Care Workers support people with developmental disabilities to work toward their goals and help to meet their daily needs. The support plan is the person's map directing you to where the person wants to go and the steps needed to get there.

Before the meeting:

- Get to know the person and develop a respectful relationship.
- Help the person think about what he/she wants to express at the meeting.
- If need be, think of ways to help the person participate in the meeting.
- Prepare to discuss progress, challenges, and changes since the last team meeting.

During the meeting:

- Be professional.
- Be a positive, active participant.
- Speak up and share what you have learned about the person.
- Support the person's participation.
- Focus on the person's desires, capabilities and talents.
- Be an advocate.

After the meeting

- Implement the supports outlined in the plan.
- Carry out the actions you are responsible for.
- Communicate with other team members.
- Complete required documentation.

Facilitator Note:

Wrap up the class by asking if there are any questions and thanking the participants for attending. If time allows you may want to do a summary or more in-depth review of the information covered during the class. If you will be doing additional training following this module, this would be a good time for a break.