POLICIES AND PROCEDURES State of Tennessee Department of Intellectual and Developmental Disabilities	Policy 100.1.8	Page 1 of 8
Policy Type: Intermediate Care Facilities for Individuals with Intellectual Disabilities and the Harold Jordan Center	**Effective Date: September 1, 2016**	
Approved by: Debra K Payne **Commissioner**	**Supersedes: September 26, 2011 P- 206 Policy; March 13, 2013 Policy 100.1.18** **Last Review or Revision: March 2016**	
Subject: Individual Support Plans		

I. **AUTHORITY:** Tennessee Code Annotated (T.C.A.) 4-4-103, T.C.A. 4-3-2708, T.C.A. 33-3-101, T.C.A. 33-1-303, T.C.A. 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 Circles 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 the 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 the DIDD ICFs/IID and the Harold Jordan Center (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 or 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 legal representative(s), a QIDP/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.

E. **Comprehensive Functional Assessment(s) (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 Staff** shall mean those staff members (e.g. Habilitation Therapy Technician, Developmental Technician) 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 a comprehensive description of the person supported as well as guidance for how to accomplish unique outcomes that are important to the person and for the person in achieving a good quality of life in the setting in which the person resides.

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 forward 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 Disabilities Professional (QIDP) or Case Manager (CM)** shall mean the staff member who coordinates, facilitates and documents all Circle of Support (COS) meetings and the entire Individual Support Plan process which includes the planning and development of the ISP.

V. **POLICY:** DIDD ICFs/IID and the Harold Jordan Center shall plan and implement supports, programs, and services to assist the person in living his/her desired life, as evidenced in the ISP. DIDD ICFs/IID and the Harold Jordan Center 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 QIDP/CM shall interview and solicit information from the person, advocate (if applicable), family members and/or legal representative regarding the person's vision for their life. This includes interests, concerns, and goals of the person supported and any revisions to the plan. If the person does not communicate verbally, the QIDP/CM will solicit information from those who know the person best. The QIDP/CM shall document all of these communications in writing.

2. Since the person supported is the one driving the ISP process, the ISP meeting shall be scheduled at a time that is convenient for the participation of the person, their advocate (if applicable), family member(s) and/or legal representative.

3. The QIDP/CM shall notify all members of the circle of support of the date, time and location of the ISP meeting.

4. The QIDP/CM shall document in writing their efforts to schedule and coordinate ISP planning process.

5. Prior to the ISP 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; and

    k. Behavior management needs.

6. The appropriate staff member shall ensure that his/her assessment has been conducted and the final report available for review by the QIDP/CM at least two (2) weeks (14 calendar days) prior to the ISP meeting.

7. The QIDP/CM shall prepare a draft ISP by assembling current information provided by the person supported, advocate, if applicable, family member(s) and/or legal representative and staff.

8. The QIDP/CM shall distribute the draft ISP to all members of the COS at least one (1) week prior to the ISP meeting.

B. ISP Meeting

1. Each person's ISP shall be reviewed annually, within three hundred and sixty five (365) days of the last scheduled ISP review meeting.

2. If a person supported is absent from the DIDD ICF/IID or Harold Jordan Center for an extended period of time (i.e., a hospitalization or rehabilitation lasting more than 15 days past the 365 day deadline) during which the assessments and ISP are to be completed:

    a. The COS shall convene and document in writing the reason the assessments and/or ISP cannot be completed.

    b. Documentation shall include the person's current status and, in the case of a hospitalization or rehabilitation, what is being done to promote the person's recovery and return to the DIDD ICF/IID or Harold Jordan Center.

    c. Upon the re-admission of the person supported from extended leave, within 30 days, the person supported will be re-assessed, and the COS shall reconvene to have the ISP meeting.

3. The QIDP/case manager shall facilitate the meeting, ensuring that all necessary information is discussed in plain language and all salient and cultural viewpoints are considered.

4. Everyone who is a member of the COS shall come prepared to actively share their data, observations, opinions, and concerns with the person supported.

5. In developing the ISP, the COS shall:

    a. review assessments;

    b. discuss the person's vision of a preferred/good/desired life and what they want to accomplish.

    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 and honor the person's preferences and needs (ICF/IID W233):

        1. What will the person do?

        2. What type of support does the person need so they can achieve their outcome?

        3. What's the acceptable level of performance (action steps)?

        4. What will it take to get them where they need to be?

    f. formulate strategies for implementation (steps or actions) in a logical sequence in which the completion of one action step serves as the

building block for the next (ICF/IID W 228) (e.g., if the long term outcome is for the person supported to be able to travel independently in the community, the sequencing may involve training the person to recognize traffic signs, cross the street safely, and to obtain help when needed if lost or an emergency arises):

1. What does the person want to do (I Want)?
2. What are the supports needed for the person to accomplish what they want to do ((I Need)?
3. What will the person do (actions) to move toward completing that outcome? What steps will they take (I Will)?

g. establish individualized projected dates for completion or attainment of each outcome/action which is based on the person's rate of learning (the projected date of completion is not the same for all persons supported and not the same for all the actions/outcomes in the person's ISP - ICF/IID W 230);

h. ensure all supports and services needed to attain the personal outcomes and actions are provided in sufficient number and frequency to support achievement;

i. ensure there is a clear link between the outcomes/actions and the functional assessment(s) data and recommendations (ICF/IID W 227);

j. ensure each action clearly states one expected learning result which is stated in behavioral terms providing measurable indices of performance (ICF/IID W 229, W 231).

1. Behavioral terms include only those behaviors which can be seen or heard and are oriented toward the person supported not oriented toward staff.
2. Measurable indices are quantifiable criteria used in determining successful achievement of the action.

k. ensure there are interventions related to each outcome and action that specify who is responsible;

l. ensure services and supports are well integrated throughout the plan;

m. ensure that the input of providers involved in the person's life (e.g., school, work, volunteer services, day site) is represented in the plan, and indicates the services and supports provided by those providers; and

n. ensure all the essential elements of supports and services the person would need to transition to another residential setting (e.g., another home within the DIDD ICF/IID or another provider) is noted (e.g., the steps the COS shall take to prepare the person).

6. The QIDP/case manager shall be ultimately responsible for:

a. integrating all the information and decisions discussed into the final written ISP that is in plain language;

b. that the ISP reflects the life the person desires;

c. that the ISP is implemented as written;

d. that the ISP is reviewed and revised in accordance with this policy;

d. that copies shall be distributed to the person supported who has ownership of the plan, advocate, if applicable, family member(s) and/or legal representative;

e. that copies be made available to all relevant staff, including staff or other agencies who work with the person supported and filed in the person's chart; and

f. that the effective implementation date of the ISP is noted on the plan and the plan implemented within thirty (30) calendar days after the ISP planning meeting.

C. Implementation of the ISP

1. All staff members identified as responsible for implementing any part of the ISP shall be knowledgeable of the plan and any programs or interventions/instructions **prior** to providing supports and/or services.

   a. Training shall be provided regarding the staff member's assignment to assist the person supported.

   b. Supervisors of direct support staff and other members of the COS shall ensure staff are implementing plans as written for each person supported.

   c. Upon obtaining evidence that a plan is not being implemented or documented adequately, the supervisor shall ensure the direct support staff and members of the COS receive corrective feedback and/or retraining immediately.

2. When mitigating circumstances arise that prevent the person or members of the COS from fulfilling planned services and supports (e.g., a change in the person's health condition or a natural disaster), documentation to that effect shall be made in the person's chart and documented in the progress review.

3. Staff members responsible for implementation of the plan shall routinely document their efforts to assist the person, the person's observable behavioral responses to those efforts, and any recommended changes to approaches, programs, supports, and/or services.

3. Staff members will record data as prescribed in the plan or other plans (e.g., BSP, skill development program) to show evidence of the person's progress or lack of progress toward outcomes and actions.

C. Monitoring the implementation of the ISP

1. The QIDP/CM shall verify and ensure the ISP and related plans are being implemented as written by:

    a. visiting the person at least once a month to observe and talk with the person about his/her satisfaction with how the plan is being implemented;

    b. varying the site of visits to include an array of places in which supports and services are provided;

    c. interviewing responsible staff to ascertain their knowledge of the plan and the person's progress toward outcomes and actions;

    d. reviewing training records; and

    e. contacting the person's family member(s), advocate if applicable, and/or legal representative at least once a quarter to discuss their concerns and gauge satisfaction with services and supports.

2. The QIDP/CM shall review and document the person's progress toward ISP outcomes and actions at least monthly, or more frequently, if significant changes occur in the person's life.

3. When the QIDP/CM finds evidence that the ISP or related plan is not being implemented or documented as written, he/she shall notify the supervisor of the responsible staff and follow up to ensure approaches, programs, supports and/or services begin immediately.

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 significant changes occur in the person's life.

5. The QIDP/CM shall arrange the meeting room that facilitates the attendance and comfort of the person supported.

6. The QIDP/CM shall review previous documentation and facilitate the progress review meeting, steering the discussion of the person's progress toward his/her outcomes and actions, and ensuring all necessary information is discussed and all salient viewpoints are considered.

7. The QIDP/CM shall document the discussions and decisions of the COS in a progress review document.

8. Revisions made to the plan due to lack of progress or significant health issues should be documented.

9. If decisions made during the progress review require changes to the ISP, the QIDP/CM shall revise the ISP within five (5) business days.

    a. The revised ISP shall reflect the original effective date as well as the date the ISP was amended.

b. Revised information shall be bolded and followed by the date the revision was made.

c. The QIDP/CM shall ensure that only the most current amendment of the ISP is published and filed with copies given to the person, family member(s), advocate if applicable, and/or legal representative and relevant staff including staff or other agencies who work with the person supported.

d. The QIDP/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 for records.

e. Changes to the personal outcomes and/or actions or any other approaches, programs, treatment, supports, and/or services shall require face-to-face training by the appropriate supervisor, health care staff, or train-the-trainer designee. Staff responsible for implementing the person's ISP shall be trained on any amendments made to the ISP prior to being assigned to assist the person.

f. Amendments providing information only shall require staff to read the revised information and sign that they have done so.

VII. Attachments: None