

# Paperwork Reduction

## Individual Support Agreement Training 2010



# Some background information before we begin

- Before 2005, there were 2 review teams, the Red and Blue Teams with 10 reviewers and 2 full time nurses
- The 2 teams each reviewed the services provided by 8 of the 16 agencies on an annual basis.
- In between reviews, each team member was contact for 1 to 2 agencies and was available for more direct consultation and training.
- In 2005, the Division of Developmental Services was combined with some parts of the Division of Disability Aging & Independent Living. While the number of reviewers remained the same, additional focus was placed on aging and traumatic brain injury services.
- A new Quality Review Process was developed to include these additional services and a schedule was put in place which called for reviews at each agency to happen every two years.
- Team members also became contact for 5 to 7 agencies. TA was only allowed in reference to the Quality Review.

- After using the new cross population review process for a little more than a year, and receiving feedback that the agencies preferred to have reviewers with experience in their services doing their reviews, 2 review teams with 5 reviewers each and two shared nurse were formed one for Developmental Services and one for Aging & TBI services.
- With budgets cuts, travel restrictions and the resulting loss of state employees, the teams were downsized to 3 reviewers each and the DS team having one part time nurse.
- A new Quality Services Review Process was developed by a QA committee which included 3-4 DS directors, consumer, GMSA and family representatives, 2 reviewers and 2 members of DDAS leadership. The current QM review process was developed.
- At the same time state budget cuts resulted in changes to services at the agencies, among them fewer service coordinators with larger caseloads and less time for each individual consumer.

- The committee developing the new review process agreed the pressure on the system and service coordinators needed to be addressed and one thing to look at was ways to reduce the amount of paperwork required to provide services.
- A subcommittee was developed with the same 3 DS directors, DDAS leadership people, 2 reviewers and consumer & family representatives. In addition the review team nurse and a service coordinator were added.
- The subcommittee discussed several issues and ideas and made recommendations for changes to the ISA format and process as well as eliminating or changing other documents.
- These proposed changes were reviewed by Green Mountain Self Advocates, DDAS leadership the division's DS Team and presented to the DS Directors' group for their comment.
- The changes were approved earlier this year and are being presented here today.

# Why This Training....

- ISA development, monitoring and tracking of outcome data are significant parts of service coordination.
- The ISA is the “key” that keeps everything together.
- Effective ISA’s ensure that...
  - The person has a voice and responsibility for the direction of their supports.
  - Support staff understand expectations of them.
  - Makes service coordination easier. Tasks are clear/predictable.
  - Allow for creativity in supporting the person.



# Also...



- Guidelines originally written in consumer friendly language that left some areas unclear.



- Some requirements clarified over time (budget information, communication plan).
- ISA Basic Form updated to further clarify areas and improve the quality of the ISA.
- ISA timelines and process modified in response to increased caseload demands

In the beginning...

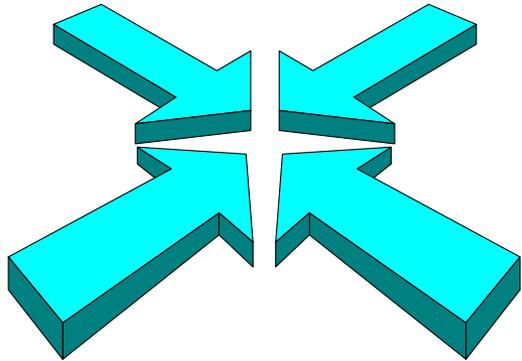


*There was...*

# Working Document

## STATE OF VERMONT

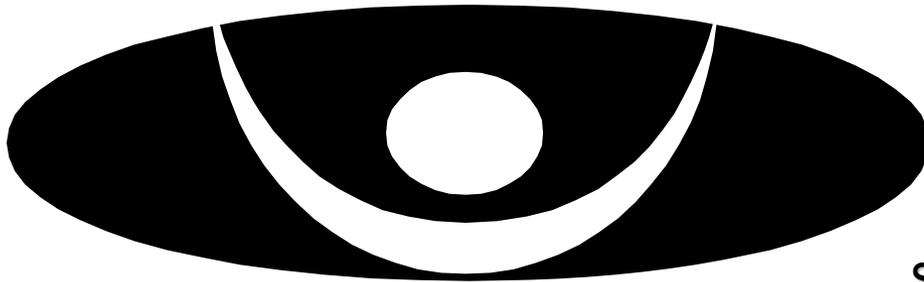
DEPARTMENT OF DEVELOPMENTAL AND MENTAL HEALTH SERVICES  
DIVISION OF DEVELOPMENTAL SERVICES



INDIVIDUAL SUPPORT AGREEMENT GUIDELINES

SEPTEMBER, 1998

*Then there was...*



STATE OF VERMONT  
Division Of Developmental Services

# Individual Support Agreement Guidelines

Revision Date: March 2003

*Now we have...*



# Individual Support Agreement

## Vermont Developmental Disabilities Services

May 2010

Name: \_\_\_\_\_

Designated Agency: \_\_\_\_\_

Provider: \_\_\_\_\_

Provider: \_\_\_\_\_

Check if:  Self-managing or  Family-managing  Shared-managing

Individual Support Agreement Term:

Begin date: \_\_\_\_\_ End date: \_\_\_\_\_

New:

Person(s) responsible for meeting your health needs:

Agency/Service Coordinator  Family/Guardian  Self

Old:

8. WHO IS THE PERSON (BY NAME) RESPONSIBLE FOR ASSURING YOUR HEALTH NEEDS ARE MET?

*New:*

1. What are your long term goals and dreams? Where do you want to live? Ideal job? Who do you want to live with? Dream vacation? What do you want to learn?

*Old:* WHAT DO SUPPORT PEOPLE NEED TO KNOW ABOUT YOUR GOALS AND DREAMS IN ORDER TO HELP YOU?

WHO SHOULD PEOPLE TALK TO IF THEY WANT TO LEARN MORE ABOUT YOUR GOALS AND DREAMS? *This question was eliminated because it was felt it was understood that the person and/or members of the support team are the ones to be talk to about his/her goals.*

*New:*

2. What do you expect to be different as a result of receiving supports? What outcomes do you expect to meet with the help of your supports? These outcomes must be clearly stated and measurable.

*Old:*

1. WHAT DO YOU EXPECT TO BE DIFFERENT OR TO CONTINUE AS A RESULT OF RECEIVING SUPPORTS?

3 .What are the areas of support you are funded to receive? How much support and what is the cost of the support that you are funded to receive? What is your authorized funding limit? *(Only change made was removal of references to funding for Goods)*

Waiver     Medicaid     Fee-for-Service (TCM, Clinic, Rehab, PASRR)     ICF/MR

Funded Area	Amount of Support	Cost (Yearly)
Service Planning and Coordination	Hours/Week	
Community Supports	Hours/Week	
Employment Services	Hours/Week	
Respite – Individual	Hours/Week Days/Year	
Clinical Interventions	Hours/Week	
Crisis – Individual	Hours/Week	
Housing and Home Support	Hours/Week Days/Year	
Transportation	Miles/Week Van (Annual cost)	
Administration costs		
<b>Total Authorized Funding Limit</b>		<b>\$</b>

*New:*

4. What do service coordinators, workers, and others need to do to help you reach your outcomes? Describe what support people do to support you for each outcome, i.e. when, where, and how they support you.

*Old:* 2. WHAT ARE THE SUPPORTS YOU EXPECT FROM SUPPORT PEOPLE? DESCRIBE WHAT SUPPORT PEOPLE DO TO SUPPORT YOU, WHEN AND WHERE THEY SUPPORT YOU, AND HOW THEY NEED TO SUPPORT YOU. 3. HOW WILL YOU AND OTHERS KNOW YOUR EXPECTATIONS ARE BEING MET?

*New:*

5. What kind of information should be gathered, and how often should information be collected on each of your outcomes to tell if you are making progress? Who is responsible for collecting the information?

*Old:* 4. WHAT INFORMATION SHOULD BE GATHERED, AND HOW OFTEN IN ORDER TO TELL IF YOUR SUPPORTS ARE WORKING? HOW IS THIS DOCUMENTED? WHO IS RESPONSIBLE FOR GETTING THIS INFORMATION?

*New:*

6. How often will the QDDP review each outcome?

*Old:* 5. HOW OFTEN SHOULD A QDDP REVIEW THE INFORMATION COLLECTED ON EACH OF YOUR EXPECTATIONS TO KNOW IF SUPPORTS ARE WORKING?

**6. NAME THE PERSON RESPONSIBLE FOR COORDINATING YOUR ENTIRE ISA (THIS MUST BE A QDDP – SEE GUIDELINES FOR DETAILS). HOW OFTEN? (THE ENTIRE ISA MUST BE REVIEWED AT LEAST ONCE A YEAR.)** *This question was eliminated for a couple of reasons. First, it is understood and outlined in the regulations that the QDDP reviews the ISA and they are identified in the approval page. Secondly it is also part of the regulations that the ISA is reviewed at least annually and with the change to the two year ISA, emphasis will be placed on a more comprehensive annual review which will need to be done by the QDDP, the consumer and support team.*

*New:*

**7. List additional supports, services, accommodations, adaptive equipment, and resources your provider(s) will coordinate or provide.**

*Old:* **7. LIST ADDITIONAL SUPPORTS, SERVICES AND RESOURCES YOUR PROVIDER(S) WILL COORDINATE OR PROVIDE.**

*New:*

**8. How much of your day and night can you be left alone? Under what circumstances?**

*Old:* **9. HOW MUCH OF YOUR DAY AND NIGHT DO YOU NEED SOMEONE WITH YOU TO BE SAFE?**

9. Describe other specific restrictions that you have? For example, are your activities or your rights restricted in any way? You and your guardian (if you have one) must give approval for this to happen (unless it is court ordered) and they must be included as a part of this ISA. *(No Changes)*

10. What do others need to know about the way you communicate to better understand and support you? How would you like others to communicate with you? *(No Changes)*

*New:*

11. Check off the documents below that apply to this ISA.

- Behavior Support Plan       Special Care Procedures Plan
- Communication Plan       Work Plan
- Other \_\_\_\_\_

*Old:* 13. INCLUDE ANY APPROPRIATE ATTACHMENTS TO THE INDIVIDUAL SUPPORT AGREEMENT

(CHECK ALL THAT APPLY):

- EDUCATION PLAN       BEHAVIOR SUPPORT PLAN       SPECIAL CARE PROCEDURES PLAN
- COMMUNICATION PLAN       WORK PLAN       OTHER -----



# Individual Support Agreement Required Approvals Form

*New:*

We have reviewed the Individual Support Agreement with all current supporting documents and indicate our approval below:

*Old:*

**WE HAVE REVIEWED THE INDIVIDUAL SUPPORT AGREEMENT WITH ALL THE ATTACHMENTS AND INDICATE OUR APPROVAL BELOW:**

_____ Individual	_____ Date
_____ Guardian (If you have one)	_____ Date
_____ Service Coordinator (If other than QDDP)	_____ Date
_____ QDDP	_____ Date
_____ Agency Providing Services (Only if QDDP is not employed by Agency)	_____ Date
_____ Physician (Required only for clinic, rehabilitation, transportation and ICF/DD)	_____ Date



# Individual Support Agreement Review/Change Form

*(Changes: was 2 forms, now 1, Expectations changed to Outcomes)*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

QDDP completing this form: \_\_\_\_\_

ISA begin date: \_\_\_\_\_ Annual review date: \_\_\_\_\_

What is the status of each of the individual's outcomes?

What are the individual's comments about his or her satisfaction with supports?

What is the guardian's (if the individual has one) level of satisfaction?

What are the family's comments (if applicable)?

What are the provider's comments? (If ISA changes, complete an ISA change form.)

Check here if a change is made in the ISA and provide the information on the back



# Some things to remember with the Annual ISA Review

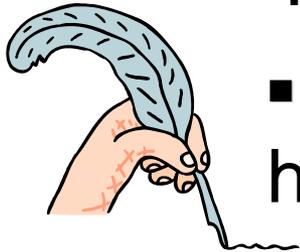
- A specific Team Meeting is not required for the review.
- Information can be gathered through other meetings or contacts such as:
  - Home visits
  - Phone calls with guardians
  - Supervisory/Status meetings with support staff
  - One on one meetings with the individual
  - Other contacts as appropriate
- Important that information and input is gathered and recorded for all necessary members of the support team.
- All required team members need to sign the form to indicate their participation/approval.

# Attachments and Other Related Documents

- Documents we are going to look at:
  - Person's Story and Update
  - Home Visit Requirements
  - Behavior Support Plan
  - Psychiatric Medication Support Plan
  - Special Care Procedures

# The Person's Story

- The person's story is their history!



- Consider using first-hand accounts or having the person dictate or write their story.

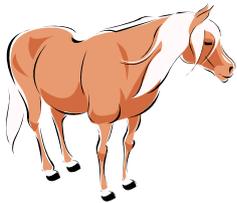
- The person's story must be written within 60 days of the date that paid supports are first provided.

- Must be signed and dated by the person(s) who wrote the story.



# The Person's Story Update...

- o is a continuation of the person's story, like the next chapter in a biography.
- o is updated annually, or sooner if significant events occur in the person's life.



- o Must be signed and dated by the person(s) who wrote the update.



Vermont Developmental Disabilities Services  
Home Visit Requirements  
May 2010

The overall stability of the consumer's medical, psychiatric, and emotional well-being, as well as the shared living home in which they live should be assessed on a uniform basis. A number of factors may affect the home, and ultimately the consumer, including additions to the home or family, familial stressors, and the stability of support services (community, employment, respite). All of these factors should be assessed regularly, and visit schedules adjusted to meet the needs of the consumer, the home provider, and agency staff. It should be kept in mind that **Monthly Home Visits are Best Practice.**

When consumers are having significant issues in any area of their lives, increased frequency of in-home contact by the services coordinator with both the consumer and the home provider is required.

Services coordinator will make a **minimum once a month visits** to homes when there is a:

- First time shared living provider. (first year)
- First time out-of-family home placement for consumer. (first year)
- Change of home placement for consumer. (first year)
- Change in services coordinator. (first year)

- Period of instability for the client including but not limited to:
  - medical issues, psychiatric issues, emotional issues.
  - Familial or provider issues including a change in household make-up (e.g., newly married, separation, loss or addition of household members), significant changes in staffing.

Monthly visits should continue at least 3 months past resolution of the issue to ensure a return to base level of stability.

- Individual(s) on Act 248.
- Addition of a second consumer to an existing developmental home. (first year)

Services coordinator will make a **minimum every other month visit** to **all** other homes

- Which have been in place and stable for more than one year.
- In homes where 2 consumers are living and receiving services coordination from 2 services coordinators, and both consumers have been in the home for more than one year, case managers may collaborate and visit on an every other month schedule which would allow for a case manager to be in the home each month.

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**Disability and Aging Services  
Licensing and Protection**

**Blind and Visually Impaired  
Vocational Rehabilitation**

# A few reminders about Behavior Support Plans

- Behavior Support Plans need to be updated when significant changes occur, not just annually.
- Updated Behavior Support Plans need to be reviewed and signatures of approval obtained when the plan is updated.

Now, we will talk more about Behavior Support Plans in relation to the Psychiatric Med Support Plan

# PSYCHIATRIC MED SUPPORT PLAN

Is no longer required as  
Attachment A

# The History

- The psychiatric med support plan was originally designed to provide information to direct service workers in the field.
- Trends that we were seeing seemed to lean toward it being “just a required piece of paper” that was completed and filed away in the chart.
- It was not consistent across all agencies.

# So, Here's what we came up with

- The important pieces of information in the psychiatric med support plan, could easily be captured elsewhere.
- The expectation is still – to provide information to direct service workers in the field.

- If a consumer is on a stable medication with a predictable outcome no plan is necessary. Examples of this might be a medication for sleep or anxiety medication.
- If a consumer is on a more complicated medication or combination of medications that impact behavior or require monitoring more closely the expectation would be to include this in the behavior support plan.

- #1 – on the psychiatric med support plan is list medications, target symptoms/ diagnosis and prescribing physician.
- EFS already captures all this information.
- #2 – Indicate parameters for use of medications prescribed “as needed” or PRN.
- This would be spelled out in a behavior support plan

- #3 – Describe side effects or red flags that need to be reported to the prescribing physician.
- It is an expectation with any medication, that staff are familiar with the possible side effects. Any special red flags identified by the physician or team could be spelled out in the behavior support plan or in simpler circumstances the OTHER section of the EFS. A good thing to remember is your consumer should be the same or better on a new medication, anything other than that could be a reportable side effect. It should also be clear, when to report side effects and to whom it is reported. This could also be added to either the other section of EFS or behavior support plan.

- #4 Describe other supports that are helpful for the person's symptom's.
- This information would be captured in the behavioral support plan.
- #5 Describe plan for data collection, review and monitoring of medication effectiveness, side effects, and dosage.
- Medication dosage is listed on the medication sheets and in some cases, like prn meds the effectiveness is also written on the medication sheets. Team meetings that discuss ISAs and Behavior support plans would be a good place to capture this information.

## Person's Story & Outcomes for ISA Training

JF is a 51 year old woman with a diagnosis of PDD NOS who recently moved from a supported apartment to living with one of her nieces, Kathy, in a developmental home situation. Her relationship with Kathy changes depending on her mood and if she feels Kathy is “doing what she’s supposing to”. She often complains that she does all the house work and cleans up after Kathy. This isn’t the case but JF is focused on her area of the home, which is like a mother-in-law apartment minus a kitchen in the lower level of the house. It is her responsibility to take care of this area.

She can be very talkative and overly friendly with those around her to the point of alienating them. She lacks the ability to pick up on basic social cues and realize that she may be crossing personal boundaries, asking questions or sharing information that should be private. This is one of the reasons she had to move into a more supportive living arrangement.

She does enjoy being with family and truly cares for them, especially young children who she becomes very protective of. While this is a positive thing, it has the potential to cause conflict between her and the child’s parents if she isn’t reminded that she is not the child’s mother and needs to respect their decisions.

She has a variety of interests and contact s with in her community. Chief among these are attending local dances and volunteering at the senior center in town. She enjoys planning and organizing activities for the seniors to do and has helped with holiday dances. She works part time at the local Council on Aging doing office work. Her interest in the job fluctuates and unless monitored, she will get caught up in “office gossip”, engage in personal conversations with coworkers sharing problems from home or working on one of her projects for the senior center. So far the Council on Aging has provided her with supports around this, but have recently asked for one on one support or she may loose her job. When asked about it, she said she would appreciate the support but it’s OK since she’s ready to retire soon or thinks she should be able to.

2. What do you expect to be different as a result of receiving supports? What outcomes do you expect to meet with the help of your supports? These outcomes must be clearly stated and measurable.
1. JF wants to keep her home clean and organized without the current conflict with her niece, Kathy. She would like to work with Kathy to develop a routine and understanding of what areas of the home she is responsible for and what areas are Kathy's responsibility.
2. JF would like to develop more friendships and work on improving her relationship with relatives, especially when it concerns young children. She would appreciate assistance from those around her to recognize boundaries and common social cues.
3. JF wants to keep her job at the Council on Aging with the assistance of a job coach to stay focused on her job tasks and avoid work place distractions.

4. What do service coordinators, workers, and others need to do to help you reach your outcomes? Describe what support people do to support you for each outcome, i.e. when, where, and how they support you.

3. A job coach will support JF on the job site redirecting her back to her job duties as necessary while working with her to develop a work routine that has built in appropriate breaks and times to socialize or work on personal things.

5. What kind of information should be gathered, and how often should information be collected on each of your outcomes to tell if you are making progress? Who is responsible for collecting the information?

3. Detailed Job Task/Duties list that JF will use as a check list with built in break times. JF will check off these tasks including the breaks. The Job Coach will record number of times JF needs to be redirected back to job tasks, as well as percentage of job tasks completed independently with out redirection. This data may be used to determine if the Job Coach should advocate for some changes in job tasks which may be a partial cause for JF's current issues.

6. How often will the QDDP review each outcome?

3. The QDDP should review and discuss the data monthly with the Job Coach to determine if there are changes needed at the job or even if a different job needs to be considered. The entire outcome should be formally reviewed every six months.