

SCPA Core Competencies - Tier 2

SCPA 201 provides instruction for using the online modules and is omitted from the PDF version. Learners must complete module 201 when accessing the online courses in the state learning management system.

Hint: Click on the module title to navigate to the module.

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SC/PA 202: Individual Support Planning

1. SCPA - Oregon ISP Process - Services, Desired Outcomes, Risks, and Ancillary Supports

1.1 Oregon ISP Process – Services, Desired Outcomes, Risks, and Ancillary Supports

Individual Support Planning: Services, Desired Outcomes, Risks, and Ancillary Supports

Tier 2: Must be completed within 90 days of start date

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Notes:

1.2 In this course we will cover

In this course...

- Understanding how assessments lead to the Individual Support Plan (ISP)
- Ensuring ISP requirements are met



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1.3 In this course we will cover

In this course...

- Facilitating conversations that lead to long-term goals and short-term planning, evaluating progress toward and monitoring ISP outcomes
- Identifying and addressing risks in the ISP
- Understanding and connecting people to ancillary supports



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1.4 At your organization



At your organization

- Talk with your supervisor and/or training team to ensure that you understand your responsibilities regarding ISP outcomes, supports, and services.
- Know what documentation you need to complete and who to talk to if you need assistance.

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1.5 Oregon's ISP Process

Oregon's ISP Process



The Oregon ISP process includes standardized forms which are to be used whenever Centers for Medicare and Medicaid Services (CMS) funded Intellectual and Developmental Disabilities (I/DD) services are delivered.

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1.6 ISP documents

ISP documents

The required ISP process includes documents to collect:

- Person centered information
- Identification of risks
- Agenda items
- Development of the ISP
- Making changes to the plan
- Career Development Plan (as required)

The collage shows several overlapping forms from the Articulate Storyline software. Visible forms include:

- Person Centered Information**: A form for collecting personal details like name, date of birth, and contact information.
- Identification of risks**: A form with checkboxes for identifying potential risks or challenges.
- Agenda items**: A form for listing topics to be discussed in the ISP meeting.
- Development of the ISP**: A form for outlining the goals and objectives of the service plan.
- Making changes to the plan**: A form for documenting any updates or modifications to the existing plan.
- Career Development Plan**: A form for setting career goals and outlining steps for achievement.

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1.7 ISP is built from information gathered

ISP is built from information gathered



The ISP is built on information gathered from the perspective of the person, her family, guardian or designated representative, and others directed by the person such as people who provide supports.

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1.8 Planning begins with conversations

Planning begins with conversations

It is your role as a Services Coordinator or Personal Agent (SC/PA) to facilitate the development of each person's ISP.

This involves leading conversations about a wide range of topics.



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1.9 Gathering information about the person

Gathering information about the person

Prior to the ISP, facilitate conversations about...

What is important To the person.

What is important For the person.

What the person wants to do, try, or learn.

Risks in the person's life.



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1.10 The person's needs and supports

The person's needs and supports

Prior to the ISP, facilitate conversations about...



Natural supports that are important to the person.

The person's support needs, as well as available and/or currently provided supports.

The person's options, choices, and preferences in supports and services.

Available resources and funding requirements.

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1.11 Using person centered skills and tools

Using person centered skills and tools

Person centered information, in the context of what is currently happening in the person's life, should drive the ISP.

- There are many person centered skills and tools that you can use to help gather information and facilitate the development of a person's ISP.



There is more information about person centered practices and planning in other modules.

See the Resource folder for a handout on person centered practices as well as additional awesome stuff.

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1.12 Assessing needs

Assessing needs

Assessing a person's needs is a required part of gathering information for planning a person's services and supports.



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1.13 CMS funding for services

CMS funding for services



Funding from CMS may be used to pay for services that are:

- Identified as “needs” using required tools, such as:
 - Level of Care assessment.
 - Needs assessment.
- Documented in the ISP.

There is more about using CMS funds in another module.

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1.14 Private information

Private information

When gathering information or assessing someone's needs, be aware that some questions you will be asking are very private or sensitive in nature and may be uncomfortable for the person to answer.



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1.15 Respectful gathering of information

Respectful gathering of information

Remain respectful and gather information in a way that works best for the person.



- ✓ Use the person's preferred method of communication.
- ✓ Consider having some conversations in private if the person is more comfortable that way.
- ✓ Ask if there is someone the person would like to have help with providing sensitive information.

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1.16 Identifying risks

Identifying risks

Assessing potential risks in a person's life is part of the ISP and needs assessment process.



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1.17 Gathering information about risks

Gathering information about risks

Prior to the ISP, facilitate conversations about risks.

This does not mean you have to do it all by yourself.

Gather information from the person and others who know the person well, such as providers, guardians, family members, or others in the person's life.



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1.18 If a person chooses not to discuss risks

If a person chooses not to discuss risks

Be aware that a person may not want to discuss some risks with you.



When possible, gather information from others who know the person. Be mindful of privacy issues with giving information to others.



Use your professional judgment to complete the risk tool with the information available to you.

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1.19 Documenting the person's choice

Documenting the person's choice not to discuss risks

Document:

- The person's choice.
- Any decisions made by the person and/or others, such as a guardian.
- Follow up needed or done.



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1.20 Taking risks and the person's choice

Taking risks and the person's choice



An adult has a right to direct how risks in his life are addressed.

Ensure the person is offered information about risks and choices in an accessible and meaningful way to help him make informed decisions.

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1.21 Facilitating the ISP development

Facilitating the ISP development

In order to facilitate a person's ISP, you must first identify what the issues are.



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1.22 Find out what is working and not working

Find out what is working and not working

Collect and sort the perspectives of the person and others who are a part of his ISP team to find out:

- What is working right now?
- What is going well?
- What is NOT working right now?
- What could be better or needs to change?



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1.23 Using information gathered about what is working and not working

Using information gathered about what is working and not working



Use the information you gathered from people's perspectives to facilitate conversations aimed at...

- Problem-solving.
- Negotiating a balance between what is important To the person and what is important For him.
- Action planning and developing meaningful Desired Outcomes.

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1.24 Adding information to the

Optional use of the ISP Agenda

The optional ISP Agenda can be a helpful tool to use in capturing what is working and not working in the person's life, and in preparation for the ISP meeting.



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1.25 This is how sorting What is Working and What is Not Working might look:

This is how sorting What is Working and What is Not Working might look:

	What's working?	What's not working?
Person's perspective		
Family/Guardian's perspective		
Others' perspectives		

See the Resource tab for more information on sorting What's Working and Not Working.

Working/Not Working chart includes person centered concepts, principles and materials used with permission from %crpage% o

1.26 Agreements and disagreements

Agreements and disagreements

Writing down each person's perspective will not only show what is working and not working, but it will also make it easy to see where people agree and disagree.



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1.27 Facilitating productive conversations

Facilitating productive conversations



Identifying where people agree and disagree will help you facilitate more productive conversations by...

- Finding common ground between people.
- Showing areas to focus on when action planning with the person and/or her ISP team.

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1.28 What would you change if you could?

What would you change if you could?

Another way to gather information about what is working or not working is to ask the person if he would change anything in his life.



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1.29 VIDEO – What Adam would change



In this video, Adam talks about what he would change in his life.

Select the Resource tab to read Adam's one page profile.

Select the Transcripts tab to read a transcription of this video.

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Notes:

ADAM: Honestly, I would just wanna have my family nearby, close to me and not far, not out of state, no, just stay with me or just be on my, or take care of myself and do what I need to do. That's what I do best. It's, I mean, like, it's like if you, it's like losing family. It's like, it sticks with you forever. And um if you keep losing people you're just gunna eventually not have anybody left to help and they you won't be able to take care, you won't be able to see em, they won't be able to take care of you as much, but if it's, like, up to me, I would just rather have my mother back, honestly.

1.30 Reflecting on Adam's wishes

Reflecting on Adam's wishes



From Adam's perspective, his family not being nearby and his mother passing away do not work.

If you were Adam's SC/PA, consider how you could use this information:

- What is most important To Adam?
- What Desired Outcomes might be interesting to him?
- What supports could be helpful?

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1.31 Desired Outcomes

Desired Outcomes

Facilitate the development of person centered, meaningful Desired Outcomes in a person's ISP.



See the Resource tab for information and a video about developing meaningful outcomes from Helen Sanderson Associates.

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1.32 Facilitating meaningful Desired Outcomes

Facilitating meaningful Desired Outcomes



Desired Outcomes:

Relate to something the person wants to do, try, or learn.

Are driven by the **balance** between what is important To and important For a person.

Address the person's independence, well-being, productivity, and dignity in a way that works for the person.

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1.33 Prioritizing

Prioritizing

Sometimes, the person might want to accomplish something that will not be able to happen within the ISP year.

This does not necessarily mean that it will never happen.

- Help the person and the ISP team prioritize what to focus on first.
- Strive for choices that will help the person reach their desired outcome.



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1.34 Facilitating long and short-term planning

Facilitating long and short-term planning



If possible, assist the person in taking **steps** towards her aspirations.

- Address what is most important To her, while supporting what is important For her.
- Small steps and incremental successes are great - celebrate them.

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1.35 Don't lose sight of dreams

Don't lose sight of dreams

The ISP should reflect what is important to the person.

Do not lose sight of long-term goals, even if they cannot be accomplished right now.



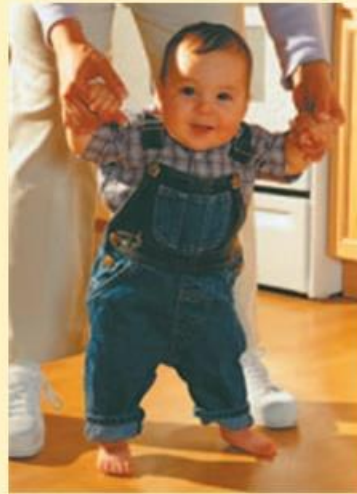
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1.36 Planning ahead with children

Planning ahead with children

Facilitate conversations that explore the future with children and families.

Ask in simple terms, “what do you want to be when you grow up?”



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1.37 Sometimes simple questions are best

Sometimes simple questions are best



In the following video, Cainan answers the question, “what are your goals for the future?”

Watch how he has a very different reply when he is simply asked what he wants to be when he grows up.

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1.38 VIDEO – Cainan’s dreams for the future



*Select the Resource tab to read Cainan’s one page profile.
Select the Transcripts tab to read a transcription of this video.*

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Notes:

CAINAN: Things like, um, to master a comprehension test. I’m still having some trouble about answering questions on the comprehension test. Um, all tests, um, on the mental transbooks, I really want to work on, too, because, I haven’t, I haven’t got 90 or 100. I’ve been getting 10, 20, 30, 40, 50, or 60, or 70 something like that.

MOM: What about goals in life, not just for school.

CAINAN: Um, goals for life? Well, obeying my parents. Um, yeah.

MOM: What do you want to be when you grow up?

CAINAN: Um, a bus driver and a bull rider.

INTERVIEWER: Bus driver and a bull rider?

CAINAN: Yeah. Yeah.

INTERVIEWER: Tell us a little bit about those things.

CAINAN: Um, well, I’ve, I’ve, I like to play, I like to play pretend. I like to play games where I pretend of being a bus driver at my grandma Eddy’s house cuz my grandpa, my great grandpa, um, Chuck, he has an exercise bike outside and so I pretend that that is my bus that I’m driving and then I have, um, my grandma Eddy be a mom for somebody and I pick up that kid. And I pretend I pick up that kid on my bus, take them to school and then take them back home. Yeah. Yeah, it’s fun. And then, bull rider, um, bull riders, I’ve, last year, my first year at Roosevelt, um, Mrs. Anderson showed us a video about people trying to, um, ride a four, a five year old bull, which people

couldn't ride him, cuz, cuz it wasn't, like, like when they instantly got on, like it wasn't like, it was, it was, it was instant, it was instant kicking and bucking. It wasn't like, it wasn't like slow, it was fast, not like a regular bull when you go slow kicking and bucking. It was, it was quick kicking and bucking and so people couldn't stay on him for 8 seconds, because they kept falling off of him. They kept falling off of him when he bucked and kicked and stuff like that. And then my mom also told me more about bull riding. So, that interests me too.

INTERVIEWER: Have you ever been to a real, um, bull riding?

CAINAN: Huhu. I haven't been to a real bull riding. I haven't.

BROTHER: Our other grandpa, Chuck. Um, he used to be a bull rider.

MOM: You mean uncle, Chuck.

BROTHER: My uncle, Chuck

CAINAN: Yeah

Brother: used to be a bull rider, so yeah, that's how mom knew.

1.39 Transitions begin early

Transitions begin early

Assist to ensure that transition to adulthood can begin early enough, so the child has as many opportunities for her future as possible.

For example...

- Preschool into first grade
- Middle school into High school
- Graduation
- College
- Career and employment



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1.40 Writing person centered

Writing person centered Desired Outcomes



Person centered Desired Outcomes should be:

- Clearly written.
- Meaningful to what is important to the person and what she wants to accomplish.
- Measurable—what will happen by when and who will help?

See the Resource tab for a tip sheet on writing S.M.A.R.T. desired outcomes.

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1.41 Desired Outcome steps and implementation

Desired Outcome steps and implementation

Desired Outcomes in the ISP also need to include:

- Key steps to work toward the outcome.
- Any paid services that support the outcome.
- Implementation information, such as...
 - Who is responsible?
 - Timelines.
 - Frequency or by when?
 - Where to record progress.



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1.42 Supports are not outcomes

Supports are not outcomes



Supports for basic needs should not, in themselves, be considered Desired Outcomes.

However, there may be supports *involved* with a person's Desired Outcomes, if he needs supports in order to reach his aspirations.

There is more on balancing what is important to and for a person in another module.

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1.43 Supports help people

Supports help people strive toward outcomes

Providing support with a person's activities of daily living (ADLs) and instrumental activities of daily living (IADLs) is often a critical *part* of assisting him in striving toward Desired Outcomes that reflect his **hopes, dreams, and aspirations**.



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1.44 Building skills in the context of

Building skills in the context of Desired Outcomes



In many Desired Outcomes, there are also elements of what the person might **learn** or **work on**, in the context of what he wants to accomplish.

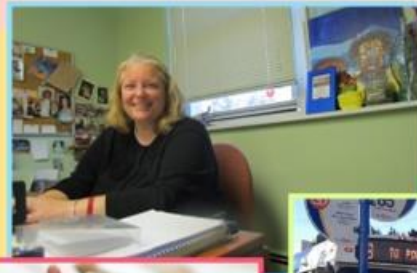
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1.45 For example

For example

Desired Outcome: Renee has a good job she likes.

Skill building involved: waking up on time without help, riding the bus



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1.46 Another example

Another example



Desired Outcome: Zoltan joins a book club.

Skill building involved:
Personal hygiene, social interactions, reading

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1.47 VIDEO – Adam’s tattoos



In this video, Adam discusses new tattoos he would like to get to commemorate his Cherokee heritage.

Select the Resource tab to read Adam’s one page profile.

Select the Transcripts tab to read a transcription of this video.

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Notes:

ADAM: Well I kind of want to get a tribal one. I’m part Cherokee, so I want to get, like a, like a, um, kinda like a um Dream Catcher, but with a wolf in the middle of it; that’d be kind of nice. I know my mom, me, my aunt and my grandmother are all part Cherokee. It’s funny. I really want to check out that Ancestry.com thing and see where I, see where my ancestors came from. I would love it.

1.48 Reflecting on Adam's video

Reflecting on Adam's video

Adam wants to get more tattoos, for several reasons.

- Note that budgeting and hygienic care of his tattoo are NOT things he is particularly interested in, and would not likely work towards without some incentive.



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1.49 Building skills in an enjoyable way

Building skills in an enjoyable way



However, in the context of his Desired Outcome of getting a new tattoo, Adam will actually end up working on building important skills, in a way that is enjoyable and interesting to him...

- Budgeting
- Health
- Social interactions

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1.50 Documenting chosen supports

Documenting chosen supports

Document in the ISP the supports and services the person has chosen to receive.

Each support must meet an assessed need.

The image shows a stack of four forms from the 'Chosen Supports' section of an Individual Service Plan (ISP). The forms are titled 'Chosen Case Management Services', 'Chosen K Plan Services', 'Chosen Waiver Services', and 'Chosen K Plan Residential Service'. Each form contains fields for service name, provider, start date, and other details. The 'Chosen K Plan Residential Service' form also includes a section for 'Additional Chosen Services'.

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1.51 Documenting natural supports

Documenting natural supports



Natural supports are included in the ISP, as they meet an assessed need which would otherwise be supported with a paid service.

Natural supports include family, friends, neighbors, community resources, etc.

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1.52 Documenting funded services

Documenting funded services

Funded services in the ISP include the service setting and details of the specific service chosen.

Funded services include Waiver, K plan, K plan residential, State Plan Personal Care, etc.



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1.53 Managing risks with supports

Managing risks with supports



Many risks can be addressed with adequate supports.

- Explore natural and community supports before funded services.
- When risks are identified that are outside of the scope of I/DD services, refer the person to the appropriate ancillary services.

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1.54 A person has a right to decline supports

A person has a right to decline supports

A person might decide that she does not want any support with an identified need.



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1.55 What to do if someone declines supports

What to do if someone declines supports



If a person declines supports, you might:

- ✓ Assess whether declining the support poses a risk to the person or others' health or safety.
- ✓ Look at her assessed needs to make sure the proposed support would really meet the identified need.

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1.56 Informed choices and options

Informed choices and options

- ✓ Facilitate conversations to ensure that the person is informed of possible consequences of declining support for her need.
- ✓ Problem-solve with the person to see if another, more preferred, support method or option might meet her needs.



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1.57 If a person's choice poses a risk

If a person's choice poses a risk

If the support the person declined will pose a risk to his or others' **health** or **safety**, you must...



- ✓ Document the person's choice.
- ✓ Assist the person to make informed choices by providing information about the possible consequences of not addressing the risk, in a way that he understands.
- ✓ Connect the person with community resources that can help.

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1.58 You may need to intervene

You may need to intervene

Depending on the person's health and safety needs, you may need to intervene.

- If the person's choices pose a serious risk to her or others' health or safety, you need to intervene.
- Always check with your supervisor if you are unclear about what to do.



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1.59 Intervening for safety

Intervening for safety

If you think someone is in danger, you must do something.



- ✓ Contact law enforcement for a welfare check.
- ✓ Contact protective services if you are concerned for the person or others' safety.
- ✓ Assure the person and others' immediate safety.
- ✓ Contact the person's guardian (if applicable) and/or ISP team members to facilitate longer term solutions that work for the person as well as keep her and others safe.

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1.60 If a person is in danger

If a person is in danger

If you think someone is in danger, **call 911.**



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1.61 Reporting standards

Reporting standards



You are required to report any suspected or alleged abuse or neglect.

When identifying individual risk and safety considerations, take into account a person's informed and expressed choices.

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1.62 Itemized services

Itemized services

The ISP must itemize services to be delivered, as defined in Oregon Administrative Rules (OARs) and Expenditure Guidelines.



See the Resource tab for a link to OARs.

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1.63 Frequency and timelines

Frequency and timelines

Services in the ISP must include...

- Frequency
 - How often will the service be provided?
 - Examples: 24 hours a day, 20 hours a week, once a month, one time only, etc.
- Timelines
 - The plan year, or start and end times for services if they are different than the plan year.



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1.64 Chosen providers

Chosen providers

Services in the ISP must also include...



- Chosen provider(s)
 - Provider type and organization (if applicable)
 - Examples: a personal support worker, ABC Provider Organization, or Mom
- The person's preferences on how each service is delivered.

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1.65 Funding sources for services

Funding sources for services

The ISP must identify the funding sources for all supports provided.

- For example:
 - K Plan
 - Waiver
 - General Funds
 - State Plan Personal Care



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1.66 Know the rules

Know the rules



Ensure funding requirements are met and documented correctly.

Familiarize yourself with the current Expenditure Guidelines and all applicable OARs.

See the Resource tab for a link to the Expenditure Guidelines.

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1.67 Risk management in the ISP

Risk management in the ISP

Ensure that strategies to address risks in the person's life are developed and documented in the ISP.

This includes back-up plans in case primary support is or becomes unavailable.



There will be more about helping a person balance choices and risks, offering a person alternatives to risky behavior, person centered practices, as well as choice counseling in other modules.

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1.68 Reflecting risks and

Reflecting risks and risk management in the ISP

The image shows a 'Risk Management Plan' form. At the top, it asks for 'Emergency preparedness (natural disasters, power outages, connectivity, etc.)' and 'Preexisting issues (physical, emotional, financial, sexual, neglect)'. Below this is a table with two columns: 'Risk' and 'How is the risk addressed?'. The table has several empty rows for input. Below the table, there are sections for 'Does this person have a history of...?' with checkboxes for 'Yes' and 'No', and 'Back up Plans in the event that primary support is unavailable'. It also includes fields for 'Name', 'Work/School/Other supports', 'Other', and 'Other'. At the bottom, there are fields for 'Person completing form' and 'Date'.

List risks identified through the assessment process and indicate the strategy to address each risk in the ISP.

Strategies may be written directly into the ISP.

- ✓ Indicate if written strategies or support documents are in place.
- ✓ Note who is responsible for documents and where they can be found.

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1.69 Protocols and support documents

Protocols and support documents

Familiarize yourself with various types of support documents that address the management of risks in a person's life.



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1.70 Health and safety support documents

Health and safety support documents



- Document protocols that address serious, known health risks in the person's life, such as:
 - Aspiration / choking
 - Seizures
 - Constipation
 - Dehydration
 - Diabetes
 - Pica
- Know how to locate and complete required forms.

See the Resource tab for links to access DHS Staff Tools and Forms.

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1.71 Safety plans

Safety plans

Safety plans look different depending on the person's supports.

If a person is supported by his family, there may or may not be a safety plan.



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1.72 Behavior supports documents

Behavior supports documents



Behavior support plans are written after a functional behavior assessment has been completed by a qualified behavior professional and approved by the person's ISP team.

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1.73 Safety supports documents

Safety supports documents

There may be additional types of documents specific to a person's needs that instruct others on how to support him to stay healthy and safe.

Know what support documents are in place to keep the person safe.



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1.74 Ensuring the ISP is current

Ensuring the ISP is current



A person's ISP is an evolving document and must be maintained to remain current.

An ISP is authorized for one year or less.

Facilitate...

- A new ISP at minimum each year.
- Changes to the person's ISP as needed throughout the year, as directed by his needs and preferences.

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1.75 Planning for evaluating progress

Ensure that progress towards Desired Outcomes occurs and is documented, to assure accountability for the ISP's implementation.

- Depending on the person and her ISP team, these details will be included in the ISP or in separate implementation documents.
- This will help you know what to look for when you monitor her ISP and services.



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Observing changes in the person

When determining the need for further evaluation or assessment, consider what you already know about the person, compared to any new symptoms or changes in behavior.

Seek out mental health resources whenever needed.



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3.11 Dual Diagnosis

Dual Diagnosis



“Dual Diagnosis” is a term applied to the co-existence of both I/DD and mental health diagnoses in a person’s life.

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3.12 *Keep in mind*

Keep in mind

Persons with a dual diagnosis can be found at all ages and abilities.

The co-existence of I/DD and a psychiatric disorder can have serious effects on the person's life.

It is critical that accurate diagnosis and appropriate treatment be obtained for the person in a timely manner.



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3.13 Mental health services

Mental health services



Depending on the person's mental health diagnosis and availability of local resources, mental health services may include but are not limited to:

- Individual and/or family counseling or therapy
- Supports with medications
- Crisis services
- Short-term residential treatment
- Education and advocacy

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3.14 Addictions and substance abuse

Addictions and substance abuse

A person might be susceptible to addiction and substance abuse just as anyone in the general population.



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3.15 Additional supports may be needed

Additional supports may be needed



- The person may require additional support to access and benefit from addictions services such as counseling and recovery programs.
- The person has rights and responsibilities regarding substance use and abuse, but he may need additional education and support to make informed choices.

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3.16 What are trauma informed services?

What are trauma informed services?

Trauma informed services are a way of structuring service delivery to **minimize additional harm** and **maximize recovery** to a person who has experienced trauma.



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3.17 Knowledge about trauma

Knowledge about trauma



Trauma informed services...

- Recognize the prevalence of trauma and its effects on people and communities.
- Integrate knowledge about trauma into supports, such policies, procedures, practices, and support settings.

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3.18 Survivor centered approach

Survivor centered approach

Trauma informed services...

- Promote a survivor centered approach to supporting people.
- Emphasize “safety first” for the person receiving supports.
- Are designed to promote recovery and minimize additional stressors that can lead to re-traumatization.



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3.19 Trauma informed services in your area

Trauma informed services in your area



Trauma informed services are found in a variety of organizations including child welfare and protection, domestic violence and mental health and addiction services.

Familiarize yourself with resources in your area.

See the Resource tab for more information about trauma informed care and services.

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3.20 Speech and language therapy

Speech and language therapy

Speech and language therapists specialize in the evaluation and treatment of communication and swallowing disorders.

Speech and language therapy is a support prescribed by a licensed practitioner.



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3.21 Occupational therapy

Occupational therapy



Occupational therapists provide evaluation and treatment so the person can develop, recover, maintain or increase daily living and work skills through the therapeutic use of everyday activities.

Occupational therapists are licensed practitioners who may prescribe adaptive or therapeutic equipment.

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3.22 Physical therapy

Physical therapy

Physical therapists provide evaluation and treatment to help restore and/or maintain physical condition and fitness through exercise and other treatments to promote functional movement.

Physical therapists are licensed practitioners who may prescribe adaptive or therapeutic equipment.



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3.23 Nursing services

Nursing services



Nurses provide medical care, support, and coordination to a person with medical issues.

- Nursing services are performed by licensed practitioners.
- Health insurance covers specific amounts and types of nursing services.
- CMS funds may be accessed for specific nursing services such as education and delegation of nursing tasks.



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3.24 Nursing Care Plans

Nursing Care Plans

Nurses develop Nursing Care Plans (NCP) that:

- Describe the medical, nursing, psychosocial, and other needs of a person and how those needs are met.
- Include the tasks that are taught or delegated to a qualified provider or to the person's family.



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3.25 Positive behavior support

Positive behavior support



Positive Behavior Support considers what is important To the person and For the person, and implements those values into a comprehensive plan to address challenging behavior.

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3.26 Skills, relationships, and participation

Skills, relationships, and participation

Positive Behavior Support focuses on valued outcomes such as teaching or strengthening skills, enhancing relationships, and increasing participation in the community.

Behavior specialists may recommend adaptive or therapeutic equipment.



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3.27 Positive behavior support resources

Positive behavior support resources

Familiarize yourself with Positive Behavior Support resources in your area, which focus on proactive ways to help a person...



- be safe.
- understand behavior.
- improve his ability to communicate.
- build skills.
- decrease barriers.

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3.28 Assistive technology

Assistive technology

Assistive Technology (AT) can be used by a person in order to do things that might otherwise be difficult or impossible for her to do without assistance.

AT can help a person be more independent and better able to access her community.



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3.29 Simple or complex assistive technology

Simple or complex assistive technology



AT items can range from simple to complex, to help a person with anything from manual tasks like personal care or operating household objects, to more intricate activities such as communication and medication management.

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3.30 Assistive technology devices

Assistive technology devices

AT can also include devices, such as for mobility, as well as hardware, software, and other items that a person can use to access computers or other information technologies.

- Familiarize yourself with the AT resource website as well as a tool available to explore ideas and obtain devices or technology.



See the Resource tab for a link to Assistive Technology online.

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3.31 Provide resources for ancillary supports

3.32 Getting connected to

3.33 Ask for help

Ask for help



Ask your supervisor for help or if you have any questions.

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SC/PA 203: Guardianship and Informed Consent

1. SCPA - Health and Welfare - Guardianship Informed Consent

1.1 Guardianship, Informed Consent

Guardianship and Informed Consent

Tier 2: Must be completed within 90 days of start date

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1.2 In this course we will cover

In this course...

- Basic overview of guardianships and alternatives to guardianship
 - Types of guardianships
 - Key differences in scope and limitations of authority over a person's choice
 - Guardianship processes
- Informed consent
 - Your role in obtaining informed consent
 - Options if a person is unable to give informed consent



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1.3 At your organization



At your organization

- Talk with your supervisor and/or training team to ensure that you understand your responsibilities regarding providing information and resources about guardianships, guardianship alternatives, and informed consent.
- Know what training is required and/or offered at your organization.
- Know who to talk to if you need assistance.

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1.4 What is guardianship?

What is guardianship?

Guardianship is intended to **protect** a person (or in some cases, others) from harm, by appointing another person to be the primary decision-making authority in his life.



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According to Oregon Revised Statute (ORS):



A guardian may be appointed for an adult person only as is necessary to promote and protect the well-being of the protected person. A guardianship for an adult person must be designed to encourage the development of maximum self-reliance and independence of the protected person and may be ordered only to the extent necessitated by the person's actual mental and physical limitations.

- (ORS 125.300)

For more information on ORS 125.300 see the Resources tab.

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1.6 Guardianship may affect many aspects of a person's life

Guardianship may affect many aspects of a person's life

A person's guardian may have the authority to make many decisions about the person, such as:

- Health care and treatments
- Finances
- Where to live
- Formal education
- Supports and services
- Legal issues



Presume capacity – don't assume someone has a guardian.

For more information on guardianship see the resource tab.

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1.7 How is guardianship appointed?

How is guardianship appointed?



There is no such thing as “being one’s own guardian.” A person either has a guardian or does not.

All guardians are appointed by the courts.

- A person is considered a competent adult when she turns 18 years old, even if she has a severe disability or a high level of need.
- Guardians are not automatically appointed at age 18.

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1.8 What does “incapacitated” mean?

What does “incapacitated” mean?



Guardianship may be appointed by a court when a person is determined by the court to be “incapacitated.”

Incapacitated means that the person cannot make decisions well enough to get health care, food, shelter, or other care necessary to avoid serious physical injury or illness and therefore needs continuing care and supervision.

Be aware that a person may be incapacitated in some areas but not in others.

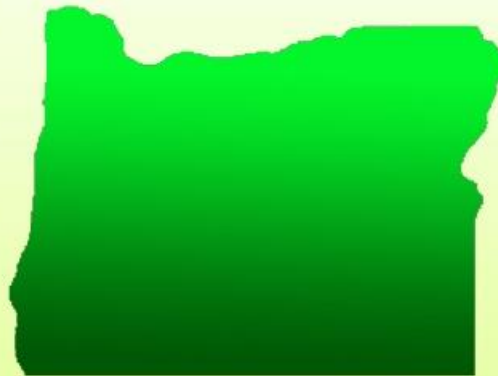
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1.9 Typical responsibilities of guardians

Typical responsibilities of guardians

A guardian's specific responsibilities are decided by the court to reflect what the person needs.

- Familiarize yourself with the names and roles of guardians in the lives of people for whom you provide case management services.
- Know how to access Oregon's guardianship statute(s), ORS Chapter 125, so you understand what decisions a guardian can and cannot make.



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1.10 Other responsibilities of guardians may include, but are not limited to:

Responsibilities of guardians may include, but are not limited to:



- Acting in the person's best interests.
- Seeking supports for a person in the least restrictive environment.
- Determining and monitoring services, such as residence, employment, or attendant care services, unless there is a conflict of interest.
- Consenting to release of confidential information.

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1.11 Guardian responsibilities

Guardian responsibilities

- Making end-of-life decisions
- Acting as a representative payee
- Consenting to and monitoring:
 - Medical procedures and treatments
 - Education
 - Other supports
- Reporting to the court about the guardianship status at least annually



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1.12 Documentation

Documentation

Do not assume someone has a guardian.



- A person's file should contain official documentation (guardianship papers) naming all guardians, including the type and scope of guardianship appointed.

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1.13 Permission to disclose information

Permission to disclose information

- Only give out information about someone if you have documented permission to do so:
 - It is requested by the person's legal guardian.
 - Express permission has been given by the person, his legal representative, or guardian.



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1.14 Guardianship limits a person's rights

Guardianship limits a person's rights

Although guardians must attempt to maintain the person's independence to the greatest extent possible, a person's rights are often significantly restricted when a guardian is involved.

Check the guardianship order to determine the scope of the guardianship.



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1.15 Examples of rights limited by guardianship

Examples of rights limited by guardianship

For example, a person who has a guardian may not be able to:

Choose where she lives.

Decide on what medicine to take or doctor to see.

Choose a provider

Choose to get a driver's license.

Own, possess, or carry a self-defense weapon.



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1.16 A person retains legal and civil rights

A person retains legal and civil rights

A person retains all of his legal and civil rights, except those that have been specifically granted to his guardian.

- For example, a person who has a guardian still has rights to:
 - Have his perspective sought, understood, and recorded
 - Voting
 - Sexuality
 - Marriage
 - Participate in his own ISP
 - Contacting an attorney
 - Accessing his own records



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1.17 When a person and his guardian don't agree

When a person and his guardian don't agree



At times, a guardian will want something that a person doesn't agree with, and vice versa.

Even if what the person wants is not possible at this time, it is your role to:

- Gather and record the person's perspective and what is important to him.
- Facilitate conversations and planning that involve what is meaningful to the person.

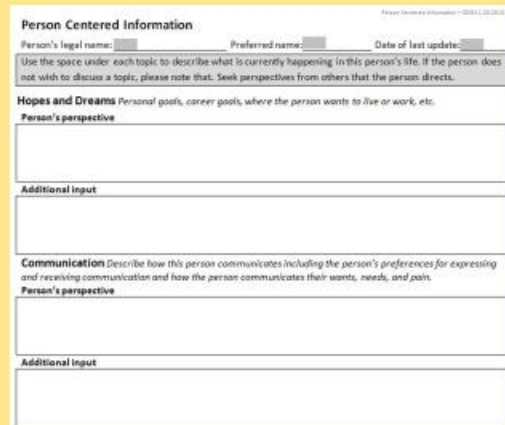
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1.18 Reflecting the person and others' perspective in the ISP process

Reflecting the person and others' perspective in the ISP process

Your role includes facilitating the development of the person's Individual Support Plan (ISP).

- The person's ISP should reflect his own perspective, even if the decisions about services are made by his guardian.
- Others' perspective, including guardians, can be captured in person centered information gathering documents.



The form is titled "Person Centered Information" and includes fields for "Person's legal name:", "Preferred name:", and "Date of last update:". Below these is a large text area with the instruction: "Use the space under each topic to describe what is currently happening in this person's life. If the person does not wish to discuss a topic, please note that. Seek perspectives from others that the person directs." The form is divided into two main sections: "Hopes and Dreams" and "Communication". Each section has a "Person's perspective" text area and an "Additional input" text area. The "Hopes and Dreams" section includes the subtext: "Personal goals, career goals, where the person wants to live or work, etc." and the "Communication" section includes: "Describe how this person communicates including the person's preferences for expressing and receiving communication and how the person communicates their wants, needs, and pain."

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1.19 Video – Adam



Adam talks about why it is important to him to be in charge of his ISP, so his voice is heard.

*Select the Resources tab to read Adam's one page profile.
Select the Transcripts tab to read a transcription of this video.*

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Notes:

INTERVIEWER: Why is it important to you to be the one running the meeting?

ADAM: Um, that way, so when I'm running the meet, like if I like to, like if I like to have, when I run the meetings they just under, they listen to what I have to say. They know what I like to say, they like, like when I say it, they know, so they understand me, what I want, but it works.

INTERVIEWER: So, why is that important?

ADAM: Um, because um, if you, if I didn't speak up to em, or if I didn't say anything, or if I didn't talk to them about it, they would have, um, probably would have made a decision already without, um, me. It's like my sister made a decision without consulting me first on our mother, so basically it would be kinda like that and then, once I find out, I would, I would be angry, and you don't want me to be angry.

1.20 When a person and his guardian don't agree

When a person and his current guardian don't agree

Whenever possible, facilitate negotiations that can help make progress towards helping the person live the life he wants:

- Gather information about what is important to the person.
- Work with the guardian to find ways to keep the person in the center of planning.
- Problem solve to see what can be done to help balance a person's health and safety with her personal choices.



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1.21 Video



Adam talks about how to tell him if something he wants cannot be done right now.

*Select the Resources tab to read Adam's one page profile.
Select the Transcripts tab to read a transcription of this video.*

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Notes:

ADAM: Just tell me straight to my face. I'm not afraid of anything like that. If you want to tell me that it's not able to happen, cool. I don't really care. I'm fine, but if it's, but I mean, like, if they could, if it's able to be done, right on. Let's do it, let's get it done.

1.22 If guardianship may be needed – general proceedings

If guardianship may be needed – general proceedings

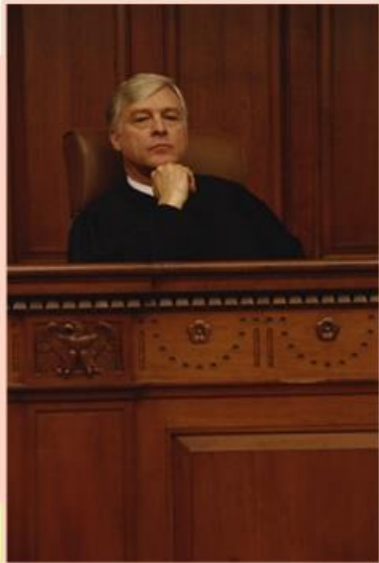


- A petition for guardianship is filed with the court.
- Notices and copies are provided to the person and close relatives.
- A “court visitor” is assigned by the court, who:
 - Meets with the parties involved to establish the need for guardianship.
 - Prepares a report for the court.

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1.23 Guardianship proceedings

Guardianship proceedings



- If the person wants to contest the guardianship, she can do so orally or in writing.
- The court holds a hearing to determine whether a guardian is needed.

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1.24 If guardianship is needed – your role

If guardianship is needed – your role

- You may be asked for your input on whether or not the person seems to be able to make informed decisions.
- Be aware that there is typically a significant financial cost in establishing guardianship.
- If needed, assist the person or family by providing information and resources about guardianship and alternatives.



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1.25 How long can guardianship last?

How long can guardianship last?

A guardianship ends upon the death, resignation or removal of the person's guardian or when the person passes away.



In some cases, a guardian may be removed when it is found to be in the person's best interest.

- A person's guardian can only be removed or replaced by the court.
- A judge may also end a guardianship if it is determined that the person has regained his capacity to make his own decisions.

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1.26 Your role when a person wants to reverse her guardianship

Your role when a person wants to reverse her guardianship

A person has the right to request a new guardian, or seek to reverse her guardianship from the courts.

- Your role is to reflect the person's perspective in her ISP and facilitate planning for action if applicable.
- Provide resources to help the person make informed choices.
- Ask your supervisor for help if you have any questions.



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1.27 What types of guardianships are there in Oregon?

What types of guardianships are there in Oregon?



In Oregon there are three types of guardianships for people who have been determined “incapacitated.”

- Standard
- Temporary
- Limited

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1.28 Standard Guardianship

Standard Guardianship

A Standard Guardianship is ongoing guardianship.

It often has long-term responsibilities of determining a person's residence, medical treatment, and consenting to the release of confidential information.

- Standard guardianship:
 - Takes longer to obtain
 - Extends for as long as the protected person needs to have someone else make decisions for him



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1.29 Temporary Guardianship

Temporary Guardianship

In an emergency, a Temporary Guardianship may be appointed.



- Temporary guardianship is typically sought when:
 - A person's welfare requires immediate action.
 - A person is incapacitated and in immediate danger which poses a substantial risk of death or serious physical harm to herself or to others.

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1.30 Scope of temporary guardianship

Scope of temporary guardianship

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
31	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31	1	2	3

July 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

August 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

September 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

- A temporary guardianship can last as little as 30 days, and can be extended, if the court agrees.
- Often, if there is an emergency, a person will seek appointment as a temporary guardian on an emergency basis, and will begin the process of seeking a standard guardianship at the same time.

1.31 Guardianship of minors

Guardianship of minors

In most cases, minors (under 18 years old) have at least one guardian.

- Know the names of all guardians as well as the type and scope of their guardianship in the child's life.
- Make sure you have current documentation.



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1.32 Additional information on Guardianship of minors

Additional information on Guardianship of minors

- Be aware that in some instances:
 - A child's guardian may not be a parent or a family member.
 - DHS Child Welfare may be the appointed guardian.
 - Some guardianships of minors may last until age 21.
 - A guardian may consent for adoption of a minor.



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1.33 Limited Guardianship

Limited Guardianship



Limited Guardianships are designed to give a guardian decision-making authority over a person's life in **specific, limited, or short-term** capacities.

- A person may be determined to be incapacitated only in some areas of life and is able to make her own decisions in other areas.

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1.34 Scope of limited guardianship

Scope of limited guardianship



- For example, someone who has a limited guardianship may have authority:
 - To make health care decisions for a person but not decisions about his living arrangements.
 - Over a person's living arrangements but not choice of her services or medical care.
- Limited guardianships are usually designed to expire in a short time, as decided by the courts.

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1.35 Alternatives to guardianship

Alternatives to guardianship

If a person needs help making decisions, guardianships are not the only solutions available.

- There are ways a person can be supported in decision making *without* having a guardian appointed.



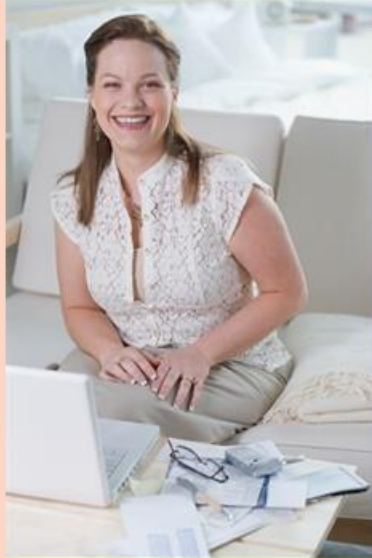
For more information on alternatives to guardianship see the resource tab.

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1.36 Alternatives to guardianship

Alternatives to guardianship

- For example:
 - **Representative payees** and **conservators** can help with managing a person's finances.
 - **Legal representatives** chosen by the person can make legal decisions with or for that person.



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1.37 Helping with finances - representative payees

Helping with finances - representative payees



A person's representative payee is chosen by the person and approved by the Social Security Administration to manage that person's benefits

- Duties of a representative payee include but are not limited to:
 - Regularly accounting to the benefit's administration on the use of the money (ex: sending in statements to Social Security).
 - Being liable to repay money if it is mismanaged.

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1.38 Representative payees

Representative payees



- A representative payee can be a person, such as a family member, or an organization.
- Make sure you know who has a representative payee and how these supports are set up for the person.

For more information on representative payees see the resource tab.

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1.39 Helping with finances - conservatorship

Helping with finances - conservatorship



A person may have a conservator instead of, or in addition to a guardian.

- Conservatorship is a formal method of managing and protecting the income and assets of a person.
 - Conservatorship may be specific or broad in scope.
 - A person may still have access to his funds, even if he has a conservator.
- A conservator is appointed and supervised by the courts.

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1.40 Helping with legal and other decisions - legal representatives

Helping with legal and other decisions - legal representatives

A person has a right to designate someone else to make legal decisions on his behalf.

A legal representative is empowered to make legal decisions, as long as the person wants.

- This can be done without having to go to court and can be revoked upon the person's request.
- Having a legal representative does not remove a person's rights to make his own decisions.



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1.41 Helping with medical care and wellness- health care representatives

Helping with medical care and wellness- health care representatives



Health care representatives can either be self-appointed or be appointed by members of a person's ISP team.

- Self-appointed health care representatives:
 - Are chosen by the person to make specific health care decisions on his behalf.
 - May make end-of life decisions for the person.

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1.42 ISP team-appointed health care representatives

ISP team-appointed health care representatives



- ISP team-appointed health care representatives are:
 - Designated to make specific health care decisions on behalf of the person.
 - Appointed by the ISP team for up to one year using a form provided by ODDS.
 - May NOT make end-of-life decisions for a person.

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1.43 What is Informed Consent?

What is Informed Consent?



“Informed consent is a person's agreement to allow something to happen, based on full disclosure of the facts needed to make the decision intelligently.”

- The Arc of Oregon

For more information on informed consent see the resource tab.

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1.44 Your role in obtaining informed consent

Your role in obtaining informed consent

Your role is to help a person who does not have a guardian make informed choices and to obtain his informed consent.

- Provide **resources** so the person has information with which to make decisions and provide informed consent.
- Help the person **actively participate** and provide input into his own decision making.



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1.45 Obtaining informed consent

Obtaining informed consent

- **Document** efforts to obtain the person's informed consent. Include:
 - What you did to provide options
 - Whether the person appears to understand the options
 - If you believe the person is making an informed decision



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1.46 Support a person to make decisions – options and consequences

Support a person to make decisions – options and consequences



Each person's ability to make decisions is unique and may also vary depending on the specifics of the decision that needs to be made.

- Provide and explain all options available to the person in a manner which she can understand.
- Ensure that she understands the consequences of those choices and can provide informed consent.

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1.47 Use professional judgment– does the person understand her options?

Use professional judgment– does the person understand her options?

When you are supporting a person to make decisions, you will need to use your professional judgment to decipher whether or not the person appears to understand her available options.



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1.48 What you can do to see if a person understands her options

What you can do to see if a person understands her options

It may be challenging to be certain that the person understands her available options and is able to provide informed consent.



If you are unsure:

- Explain options in detail, using terms the person is familiar with.
- Ask the person to repeat back her decision to you, using her own communication method.
- Ask the question in a different way to see if the person's answer remains consistent.

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1.49 Obtaining informed consent

Obtaining informed consent

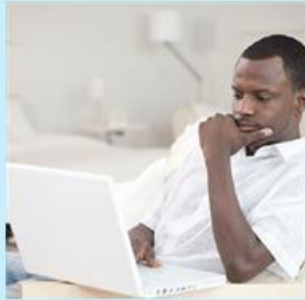


- Give the person time to process the information before giving an answer.
- Consider if there are others in the person's life who could help clarify whether or not the person understands her available options and is able to give informed consent.

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1.50 If you think a person needs help giving informed consent

If you think a person needs help giving informed consent



Before recommending guardianship, search for other alternatives.

- **Gather information:**

- Are there some decisions that the person is able to make?
- What specific decisions does the person need help with, and how?
- Are there others in the person's life who could help?
- Does the person really need a guardian and, if so, in what capacity?

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1.51 If you think a person might need a guardian

If you think a person might need a guardian



Familiarize yourself with resources and provide information on guardianship and alternatives to the person and/or his family.

If a legal process to adjudicate a person's ability to give consent has been started, you might be asked to help provide information.

Look under the Resource tab for links and other resources.

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1.52 What to do if a person is unable to give consent

What to do if a person is unable to give consent

If you believe a person is unable to give informed consent, facilitate a discussion with the person's ISP team.



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1.53 Options for medical decision making

Options for medical decision making

A person may be unable to provide informed consent regarding his medical needs, such as deciding on chemotherapy options or making end of life decisions.



If this is the case, options for assistance might include helping the person get connected with:

- A health care representative
 - Self-appointed
 - Appointed by the person's ISP team
- A family member or next of kin

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1.54 Informed consent may be waived temporarily in a medical emergency

Informed consent may be waived temporarily in a medical emergency

Be aware that medical professionals must legally obtain informed consent from all patients.

However, if a person needs **emergency treatment**, the medical professional may provide the needed care immediately, without informed consent.

- Obtain informed consent as soon as possible.
- Talk with your supervisor if you have any questions or concerns about someone's ability to provide informed consent.



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SC/PA 204: Balancing Risks and Choice

1. SCPA - Balancing choice and risks

1.1 Balancing Choice and Risks

Balancing Risks and Choice

Tier 2: Must be completed within 90 days of start date

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1.2 In this course we will cover

In this course...

- Your core responsibilities in addressing risk and where you might exercise judgment or creativity in providing options or recommending action.
- The importance of having a plan in place when a person is engaging in risky behavior.



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1.3 In this course we will cover

In this course...

- Explaining options and offering to connect the person with alternatives to risky behavior.
- Awareness of other agencies that offer services.



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1.4 Untitled Slide



At your organization

Talk with your supervisor and/or training team, to ensure that you:

- Understand your responsibilities in addressing known risks in the person's life and assisting the person in balancing choices and risks.
- Know what documentation you need to complete and who to talk to if you need assistance.

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1.5 Risk is a part of life

Risk is a part of life



From birth to death, life is a series of decisions.

All decisions include some degree of risk.

See the Resource tab for an article, *Thinking About Risk*.

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1.6 Dignity of risk

Dignity of risk

“Dignity of risk” means respecting each person’s autonomy and self-determination to make choices for himself.



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1.7 Taking risks help us grow

Taking risks help us grow



A person has the right to grow by making his own choices and taking risks with dignity.

However, there is no dignity in serious injury.

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1.8 Robert Perske

Robert Perske


Robert Perske is an award-winning author and passionate advocate for the rights of people experiencing disabilities.



See the Resource tab for more information on Robert Perske.

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1.9 VIDEO - Real World Risks



These are Robert Perske's words about risks in the real world, illustrated by OTAC.

Select the Transcripts tab to read a transcription of this video.

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Notes:

NARRATOR: Overprotection may appear, on the surface, to be kind, but it can be really evil; an oversupply can smother people emotionally, squeeze the life out of their hopes and expectations, and strip them of their dignity. Over protection can keep people from becoming all that they could become. Many of our best achievements came the hard way. We took risks, fell flat, suffered, picked ourselves up and tried again. Sometimes we made it and sometimes we did not. Even so, we were given the chance to try. Persons with special needs need these chances too. Of course, we are talking about prudent risks. People should not be expected to blindly face challenges that, without a doubt, will explode in their faces. Knowing what chances are prudent and which are not: this is a new skill that needs to be acquired. On the other hand, a risk is really only when it is not known beforehand whether a person really can succeed. The real world is not always safe, secure, and predictable; it does not always say please, excuse me, or I'm sorry. Every day we face the possibility of being thrown into situations where we will have to risk everything. In the past, we found clever ways to build avoidance of risk into the lives of people living with disabilities. Now we must work equally hard to help find the proper amount of risk people have the right to take. We have learned that there can be healthy development in risk taking and there can be crippling indignity in safety.

1.10 All people want control

All people want control

Everyone wants and needs control over some aspects of their life – this is what makes life richer.



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1.11 VIDEO - Meet Tracy



Tracy talks about why being able to take risks is so important to her, as well as asking for help when needed.

Select the Resources tab to read Tracy's one page profile.

Select the Transcripts tab to read a transcription of this video.

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Notes:

TRACY: How you gonna learn if you don't take risks? How you gonna learn? I mean, it's not smart, but how you gonna learn if you don't? It's, I think you should have the right to adventure and learn from the consequences if you do things that are dangerous and not so smart. I think that everybody should learn from some, some one dumb thing or the other. I mean, we're all gonna do it. Um, like I said, some people are scared to take chances because they're figuring, "oh, its gonna hurt me," well everybody ends up doing something that's going to get hurt. And people shouldn't, they shouldn't be afraid to ask for help. A lot of people are afraid to ask for help cuz they figure, "Oh, they don't, they won't, I don't, I won't get the help." Yes you will if you ask for help. Yes you will. So people that are stubborn and don't want help or don't know how to ask for help and I think asking for help is the most important, is the most important thing of all is asking for help.

1.12 Planning with the person for risk

Planning with the person for risk



All adults have the right to make their own choices about their health and care, even if care professionals believe these choices endanger the person's health or longevity.

Your role is in **planning** with the person and her team for those risks.

See the Resource tab for an article, Revisiting Choice.

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1.13 Your role in planning with the person

Your role in planning with the person

- ✓ Facilitate conversations to help the person stay healthy and safe in a way that works for her.
- ✓ Assist the person with understanding the possible consequences of taking specific risks.
- ✓ Help the person make informed choices, based on what is important to her and important for her.



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1.14 Know the rules

Know the rules

Federal and state guidelines require written plans to be in place to address known risks.



Be able to locate and make sure you understand rules and regulations regarding addressing risks.

Ask your supervisor for help.

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Notes:

1.15 Written plans address risks

Written plans address risks

Written plans that address known risks must be documented in the person's Individual Support Plan (ISP) as well as provider support documents, such as a Positive Behavior Support Plan.



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Notes:

1.16 Documenting risks

Documenting risks



Documentation must contain current and accurate information.

Risk information should be...

- Reviewed regularly
- Updated to remain relevant

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1.17 Get to know the person

Get to know the person

Supporting people to take real world risks requires person centered skills.

Get to know the person in order to plan for risks.



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1.18 Start with gathering information

Start with gathering information



Facilitate the gathering of person centered information, including:

- what is important **to** the person.
- what is important **for** her.

There is more information about person centered information and practices in other modules.

%crpage%

1.19 What is important TO someone

What is important TO someone

What is important TO a person includes those things in life which help the person to be satisfied, content, comforted, fulfilled, and happy – the person's own definition of quality of life.



Important To includes person centered concepts, principles and materials used with permission from The Learning Community for Person Centered Practices. Find out more at www.learningcommunity.us.

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1.20 The person's perspective

The person's perspective



Seek to understand the **person's perspective**.

What is important to a person includes only what she is communicating...

- With her words
- With her behavior

When words and behavior are in conflict, pay attention to the behavior.

Important To includes person centered concepts, principles and materials used with permission from The Learning Community for Person Centered Practices. Find out more at www.learningcommunity.us.

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1.21 What is important FOR someone

What is important FOR someone

What is important FOR a person primarily includes those things which help her be healthy, safe, and a valued member of her community.



Important For includes person centered concepts, principles and materials used with permission from The Learning Community for Person Centered Practices. Find out more at www.learningcommunity.us.

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1.22 What is important *FOR* someone includes...

What is important **FOR** someone includes...



Issues of health:

- Prevention and treatment of illness or medical conditions
- Promotion of wellness (e.g.: diet, exercise)

Issues of safety:

- The person's environment
- Physical and emotional well being, including freedom from fear

Important For includes person centered concepts, principles and materials used with permission from The Learning Community for Person Centered Practices. Find out more at www.learningcommunity.us.

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1.23 What is important FOR someone also includes...

What is important FOR someone also includes...



What others see as necessary to help the person:

- Be valued.
- Be a contributing member of his community.

Important For includes person centered concepts, principles and materials used with permission from The Learning Community for Person Centered Practices. Find out more at www.learningcommunity.us.

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1.24 Seek to understand

Seek to understand

When a person chooses to engage in activities that are risky or dangerous, it is your role to seek to understand why.



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1.25 Consider the person's perspective

Consider the person's perspective



Consider...

- What barriers may exist for the person?
- Is this issue really important for him?
- Are there other people who could help?

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1.26 Your role

Your role



- ✓ Provide the person with resources that can help him understand potential consequences of his options so he can make informed choices.
- ✓ Facilitate conversations to plan for risks in a way that works for the person.

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1.27 Planning for risks is a partnership

Planning for risks is a partnership

Gathering information and facilitating planning for risks should not be done in isolation.



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1.28 What you can do to

What you can do to facilitate partnerships



- ✓ Communicate with the person.
- ✓ With permission, involve others who know and care about the person, such as...
 - Providers
 - Friends
 - Family members
 - Others in the community

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1.29 Viable options are essential

Viable options are essential



Your role is to help a person make informed choices.

This can only happen if the person is offered viable options to choose from.

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1.30 How to tell if an option is viable

How to tell if an option is viable

In order to be viable, options offered should be relevant to what is **important** to the person.

This is the case, even if what the person wants to do involves a risk.



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1.31 For example

For example



If Shelly wants to work with animals but is allergic to cats:

- A choice between computer repair or data entry are not viable options for her.
- Rather, a job at the animal shelter walking dogs or starting her own dog walking business would offer her viable options.

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1.32 Another example

Another example

If Mark wants to get a driver's license but he can't read:

- A choice between learning about bus routes or how to call a cab will not work for him in the long run.
- Instead, getting creative about ways he could work towards his license, such as learning to recognize street signs or rules of the road would offer him viable options that can help him get closer to his goal.



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1.33 Explaining options

Explaining options



Provide information and options in a way that works best for the person.

- ✓ Use her preferred method of communication.
- ✓ Ask how she prefers to receive information (in person, over the phone, etc.)

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1.34 You don't have to know everything

You don't have to know everything

You don't have to know everything – the key is to be able to find information when it is needed.



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1.35 Connecting with resources

Connecting with resources



Familiarize yourself with resources in your area, such as community organizations, so you can help connect a person when needed.

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1.36 Asking for help

Asking for help



- ✓ Ask the person if she has experience with any area resources, so you have a better idea of how to help.
- ✓ Talk with your coworkers, as they have likely collected some useful information that can be shared.
- ✓ Ask your supervisor if your organization has a list or database of resources that can be helpful to you.

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1.37 Your core responsibilities

Your core responsibilities

Your core responsibilities regarding addressing risks include...

- Gathering information.
- Facilitating planning for risk.
- Offering choices to connect the person with resources and alternatives to risky behavior.
- Documenting conversations about addressing a risk.



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1.38 You may need to intervene

You may need to intervene



Depending on the situation, you may also have a responsibility to intervene.

Talk with your supervisor if you have any questions or concerns about a person or situation.

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1.39 What to do if the person is a danger to herself or others

What to do if the person is a danger to herself or others

Call the police if you think someone is in danger.

Familiarize yourself with local emergency resources and crisis line numbers, including where to find information.

- ✓ Provide information to the person, guardian, and/or family if applicable.
- ✓ Be ready to make the call for the person if needed.



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1.40 In an emergency

In an emergency



In an emergency, you may provide confidential information without a release.

- ✓ Contact the guardian if the person has one.
- ✓ Talk to your supervisor if you need help.
- ✓ Your agency may have additional policy and procedures regarding emergencies that you will want to familiarize yourself with.

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1.41 Using judgment and creativity

Using judgment and creativity

Use your judgment and creativity in figuring out *how* to plan for risks with a person (and guardian, family, or ISP team if applicable).



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1.42 Using judgment and creativity when planning for risks

Using judgment and creativity when planning for risks



Consider...

- What is important to the person and how can those things remain in the focus?
- What has been tried in the past that worked or didn't work?
- How should options be offered to the person?

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1.43 Offering alternatives to risks

Offering alternatives to risks

Consider what works best for the person.

Some people may readily share information with you at a meeting with a group, while others may be more comfortable meeting with you privately.



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1.44 Facilitating partnerships when offering alternatives to risks

Facilitating partnerships when offering alternatives to risks

It may take time for a person to feel comfortable enough to share information with you.

- With permission, engage others in the person's life who she may feel more comfortable with, to have those conversations.



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1.45 Ultimately, it's the person's decision

Ultimately, it's the person's decision



Your role includes offering options and, at times, recommending action to a person (and guardian, designated representative, and/or family if applicable).

However, you are not the decision maker in the person's life.

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1.46 Documentation is vital

Documentation is vital



Document...

- The person's perspective and decisions.
- Your actions.
- Agreements for follow-up.

Know your organizations requirements for documentation.

When in doubt, write it down!

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1.47 It doesn't have to be perfect...it's life

It doesn't have to be perfect ...it's life.

"Don't wait until everything is just right. It will never be perfect. There will always be challenges, obstacles and less than perfect conditions. So what. Get started now. With each step you take, you will grow stronger and stronger, more and more skilled, more and more self-confident and more and more successful."

- Mark Victor Hansen, the founder and co-creator of the "Chicken Soup for the Soul" book series.



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SC/PA 205: Monitoring, Follow Up, and Ensuring Honesty

1. SCPA Unit 12 Monitoring

1.1 Monitoring, Integrity, and Action when Providers are Not Meeting Requirements

Monitoring, Follow Up, and Ensuring Honesty

Tier 2: Must be completed within 90 days of start date

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1.2 In this course we will cover

In this course...

- Required monitoring of services.
- Identifying, communicating, documenting follow-up, and “closing the loop” on issues found during monitoring.
- Your role as it relates to licensing and regulatory oversight of licensed or certified providers.



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1.3 In this course we will cover

In this course...

- Medicaid fraud and your role when fraud or unethical behavior is suspected or observed.
- The importance of honesty and integrity in all of your tasks.



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1.4 At your organization



At your organization

Talk with your supervisor and/or training team, to ensure that you:

- Understand monitoring requirements specific to your job.

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1.5 At your organization



At your organization

- Understand and be able to explain your role as it relates to
 - Licensing and regulatory oversight.
 - Understanding and reporting Medicaid fraud and unethical behavior.
- Know what documentation you need to complete and who to talk to if you need assistance.

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1.6 Minimum monitoring requirements

Minimum monitoring requirements

The minimum requirements for contact with a person and monitoring of services a person is receiving are primarily governed by the funding sources of those services, such as...

- Community First Choice (K Plan) state plan.
- Home and Community Based Services (HCBS) waivers.



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1.7 Know the rules

Know the rules



Minimum monitoring requirements are written in Oregon Administrative Rules (OARs).

Familiarize yourself and be able to access all guidance provided by the Oregon Developmental Disabilities Services (ODDS).

See the Resource tab for a link to ODDS and OARs.

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1.8 Why monitor?

Why monitor?



One of the most important aspects of your job is assessing how things are going in a person's life, with regards to her services.

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1.9 Monitoring health, safety, and supports

Monitoring health, safety, and supports

Monitoring is done to review that the person's health and safety needs are being adequately addressed, and to ensure the effectiveness of supports being delivered.

There must be regular monitoring of a person's health, safety, and behavioral supports.



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1.10 Monitoring relates to the ISP

Monitoring relates to the ISP

Monitoring is done to review that...

- The person's services are being provided as described in his Individual Support Plan (ISP).
- The ISP outcomes remain relevant and are being implemented as planned.
- The services outlined in the ISP continue to meet what is important to and important for the person.

John Smith-24 Hour Residential-Sample

Desired Outcomes

Desired Outcome What is the desired result?	Key steps to work toward the outcome
John takes his annual trip to Hawaii.	John continues to save money, budget with staff, and get help from family.
John maintains his robust social life, doing the things he enjoys with people he has fun with and cares about.	John continues to get support from staff to contact friends and family as he requests. Staff will also support John with rides as needed. John will work on being more proactive with requesting rides and the supports he needs to maintain his relationships and doing his favorite activities.

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1.11 Reviewing how things are going

Reviewing how things are going



Monitoring is also done to review whether...

- Changes in the person's needs or availability of other resources might compel adjustments in how supports are set up.
- The preferences of the person (or guardian/designated representative if applicable) are addressed.

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1.12 Monitoring also helps protect rights

Monitoring also helps protect rights

Monitoring also provides a way to check in with the person, to make sure that...

- Her rights are protected.
- She has opportunities to exercise her rights.



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1.13 Reciprocal contact is necessary

Reciprocal contact is necessary



Every person who has an ISP must have reciprocal SC/PA contact at least every 3 months.

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1.14 Monitoring varies

Monitoring varies



How often you monitor will depend on the people you work with, the services they receive, the service setting, and relevant administrative rules.



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1.15 Monitoring of supports frequencies

Monitoring of supports frequencies



Monitoring must be provided at a frequency prescribed by administrative rules, to people who receive services in any of the following settings:

- 24 hour residential
- In home supports
- Child or adult foster care
- Supported living
- Employment or day support services

See the Resource tab for a link to related OARs.

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1.16 Risks in the ISP increase monitoring

Risks in the ISP increase monitoring

A person who has high risk health and safety issues identified in his ISP needs more frequent (often monthly) contact.



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1.17 Monitoring of personal finances

Monitoring of personal finances

There must also be regular monitoring and review of a person's access and utilization of personal funds for individuals enrolled in a 24 hour residential or adult foster home.



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1.18 How to monitor someone's

How to monitor someone's personal finances



Determine whether financial records, bank statements, and personal spending funds are correctly reconciled and accounted for.

Monitoring of finances must be provided to the person at a frequency prescribed by administrative rules.

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1.19 Misuse of funds must be reported

Misuse of funds must be reported



If you suspect that a person's funds may have been misused, you must report it.

- PAs, report to the Community Developmental Disability Program (CDDP) and ODDS.
- SCs, follow your CDDP's guidelines for reporting.

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1.20 Monitoring frequencies may change

Monitoring frequencies may change

A person's needs or events in her life may change the frequency at which you need to monitor her services.



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1.21 For example...

For example...



Changes in the person's life or needs which can affect how often you must monitor might include but are not limited to...

- Significant change in the person's support needs.
- A serious event.
- An abuse investigation.
- Presence of high risk medical issues.
- Request of ISP team.

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1.22 Additional monitoring requirements

Additional monitoring requirements

- ✓ Monitor a person's progress toward a path to employment when the person is receiving employment or day support services.
- ✓ Review reports of serious or unusual incidents.



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1.23 Case management only

Case management only contact requirement



A person receiving case management only (not receiving any other funded services) must receive reciprocal contact at least annually, to assess if there are any changes in circumstances and support needs.

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1.24 Follow up

Follow up

When monitoring a service or a plan, you may observe a situation that requires follow-up.

Be sure all necessary **follow-up** occurs and is **documented**.



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1.25 Document all follow up

Document all follow up



- ✓ Document all follow up, including:
 - Who is accountable to do what needs to be done and by when.
 - When and how you will know that it was completed.

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1.26 Make sure follow up is completed

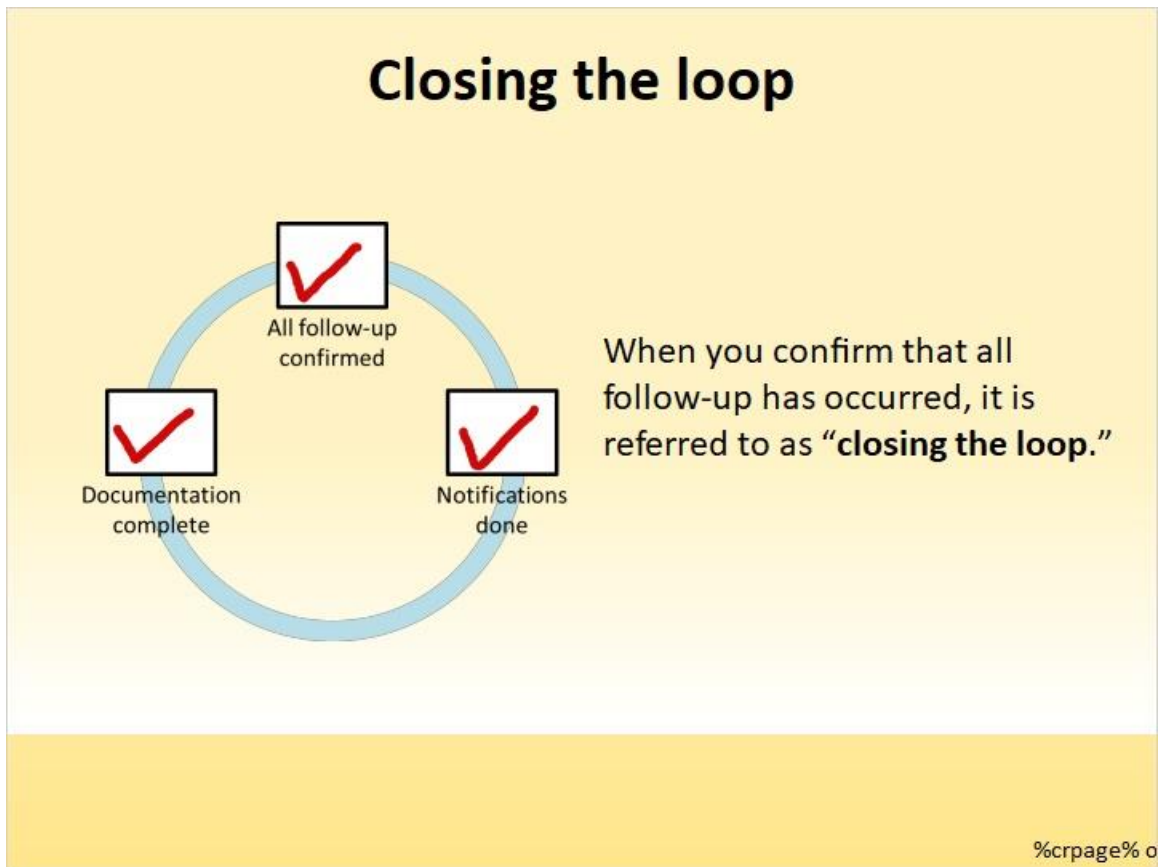
Make sure follow up is completed

- ✓ Ensure that all follow up was completed.
- ✓ Notify others such as your supervisor, licensing, or protective services if necessary.



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1.27 Closing the loop



1.28 Monitoring tools and documentation

Monitoring tools and documentation

Familiarize yourself with various tools and/or methods for monitoring and documenting.

- In most instances, progress notes can be used to document monitoring.
- ODDS provides guidance on monitoring documentation requirements and tools.



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1.29 Know what is required

Know what is required



Talk with your supervisor and/or training team to know if a specific tool needs to be used and how documentation needs to occur.

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1.30 Licensing and regulatory oversight

Licensing and regulatory oversight

Your role regarding licensing and regulatory oversight might vary, depending on whether you are a Services Coordinator or a Personal Agent.

- ✓ Have knowledge of licensing, certification and other qualification requirements in various services.
- ✓ Understand how to get information about services.



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1.31 Communicating with your supervisor

Communicating with your supervisor



Know what is expected of you in your role, and ask your supervisor for help when you need it.

It is a good idea to notify your supervisor when issues arise related to licensing and regulatory oversight, even if you feel like you know what you are supposed to do.

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1.32 Services and variances

Services and variances

Familiarize yourself with what services each person receives.

Maintain awareness of any variance, sanctions or limitations in place for a person, such as...

- A variance for someone's apartment because there are not enough fire exits.
- Barriers in the home (having a locked kitchen).



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1.33 Providers must be qualified

Providers must be qualified

Make sure proper qualifications are in place before referring a person to a provider.

You can find this information by checking with licensing.



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1.34 Reviewing incidents for licensing and regulatory oversight issues

Reviewing incidents for licensing and regulatory oversight issues



Review incident reports or complaints, and note if there is an indication of a provider qualification issue.

For example, if...

- Staff was not trained.
- A provider is no longer qualified.

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1.35 Participating in follow up

Participating in follow up



Participate in reviews and site visits as appropriate.

Organize yourself, so you can follow up as needed.

- It is a good idea to keep a “tickler system,” if there is a need to track any qualification pieces.



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1.36 Communicating issues

Communicating issues

Observe, inform and communicate regarding issues with:

- Licensors
- People who receive services (and guardian/designated representative if applicable)
- Coworkers and your supervisor



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1.37 Being observant during visits

Being observant during visits



When making a site visit to a provider, be aware of any licensing violations and follow up as needed.

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1.38 Following up

Following up on provider licensing citations

Follow up on incident reports, licensing, and certification issues.

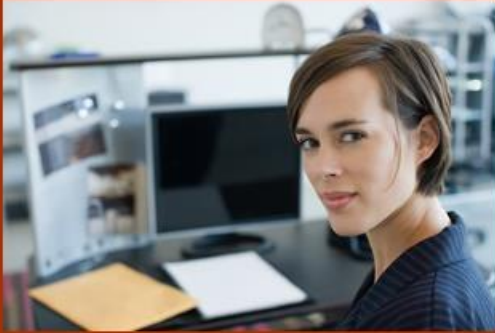
- ✓ Check to see if licensing violations have been corrected, and document the correction.
- ✓ Be aware of what issues require your follow up.
- ✓ Communicate with the licensor, and notify ODDS Licensing of issues as needed.



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1.39 Your role in improvement and

Your role in improvement and resolution of concerns



- ✓ Collaborate with licensors or certifiers to improve or resolve issues.
- ✓ Identify needs of providers who support the person and provide technical assistance as needed.
- ✓ Document everything and “close the loop.”

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1.40 Ongoing concerns

Ongoing concerns

Document all of your efforts to improve or resolve any issues with providers.

If you are not able to improve or resolve any issues with providers, talk with your supervisor to develop a plan of action.



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1.41 What to do when there are

What to do when there are ongoing concerns



- ✓ Determine if there are health and safety issues.
- ✓ Determine if the issue needs to be forwarded to ODDS Licensing.
- ✓ Know what next steps are needed to resolve the issue.

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1.42 Contacting the Office of Licensing and Regulatory Oversight

Contacting ODDS Licensing



ODDS Licensing must be contacted if a provider is observed providing a service that is outside of, or not in compliance, with its license or certification. For example:

A foster provider is serving six people when the home is only licensed to provide support to five.

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1.43 Contacting the Office of Licensing and Regulatory Oversight

Contacting ODDS Licensing

ODDS Licensing must also be contacted when:

- The provider is not making progress toward resolving ongoing issues related to licensing or certification.
- There are ongoing concerns regarding the physical maintenance of a licensed or certified residence.



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1.44 Understanding what constitutes fraud

Understanding what constitutes fraud



It is important that you know what the Centers for Medicare and Medicaid Services (CMS) considers fraud, so you can help prevent it.

See the Resource tab for more information on CMS fraud and abuse.

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1.45 CMS defines “fraud” as...

CMS defines “fraud” as...

- The **intentional deception** or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.
- It includes any act that constitutes fraud under applicable Federal or State laws.



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1.46 CMS defines “abuse” as...

CMS defines “abuse” as...



- Provider practices that are **inconsistent** with sound fiscal, business, or medical practices, and result in an **unnecessary cost** to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
- It also includes recipient practices that result in unnecessary costs to the Medicaid program.

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1.47 For example

For example

Examples of Medicaid fraud include but are not limited to...

- Intentionally giving information that is not true or leaving out information for the purpose of getting benefits.



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1.48 For example

For example

Examples of Medicaid fraud include but are not limited to...



- Inaccurate billing, such as:
 - Billing for services that were not provided.
 - Billing 50 minutes for a service that took 10 minutes.
 - Billing twice for the same service.
 - Billing for services that someone else provided.
 - For example, someone's sister provided the service but mom billed for it.

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1.49 For example

For example

Examples of Medicaid fraud include but are not limited to...

Giving an item provided for a person to someone else

- For example, a bus pass.



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1.50 Unintentional fraud

Unintentional fraud



Fraud can be a result of not knowing the rules.

Some providers, especially family members who provide care, may not be aware of all of the requirements, especially when it comes to documenting.

Not knowing the rules is not an excuse. It is still fraud.

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1.51 Help people understand the rules

Help people understand the rules

- ✓ Explain the rules and their responsibility to follow the rules in a respectful way.
- ✓ Connect people with resources that can help.
- ✓ Explain that monies may have to be repaid to Medicaid, if an audit happens and problems are found with inadequate or faulty documentation.



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1.52 Honesty and integrity

Honesty and integrity



Honesty is the quality of being fair and truthful – doing what is right at all times, no matter what the consequences.

Integrity is doing what is right, even when no one is watching.

- This is done by demonstrating consistency of actions, values, methods and principles.

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1.53 Demonstrating professionalism

Demonstrating professionalism



SC/PAs should possess the qualities of both honesty and integrity while demonstrating professionalism by adhering to the best standards, methods, behaviors, and personal characteristics.

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1.54 Help people avoid unintentional fraud

Help people avoid unintentional fraud

Inform family members and providers of the rules, so they can avoid unintentionally committing fraud.

Maintaining honesty and integrity (and avoiding fraud) is everyone's job.



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1.55 Be ready to assist if needed

Be ready to assist if needed



Being up-front about the rules is important.

Some providers may need your assistance to understand the requirements, such as...

- Family members who are care givers.
- Independent contractors or personal support workers.

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1.56 Report suspected fraud

Report suspected fraud

Report suspected falsehood in reports or documentation from others, such as in provider time sheets and progress notes, etc.



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1.57 What you can do

What you can do



- ✓ Work with providers to help improve their systems.
- ✓ Follow established policies and procedures.
- ✓ Don't try to manipulate the system to get a desired outcome.

Remember, it's everyone's responsibility to help the person receive good supports.

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1.58 Maintain good stewardship

Maintain good stewardship

It is your role to maintain good stewardship of tax-payer funds.



There is more on stewardship in another module.

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1.59 Help avoid billing issues

Help avoid billing issues



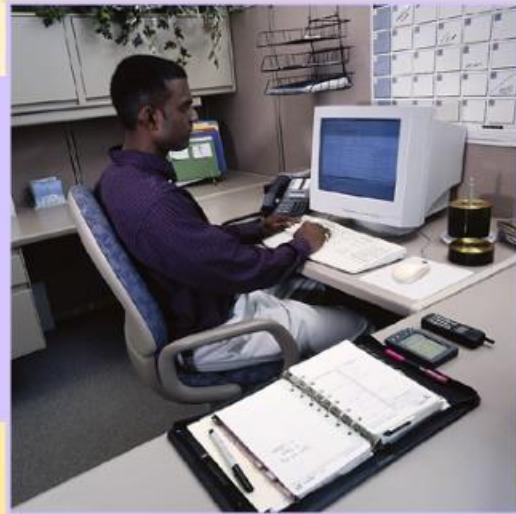
- ✓ Be aware of what services people receive to ensure that services are not overlapping and creating a problem for billing.
 - This is sometimes referred to as “double dipping.”
- ✓ Make sure that everything is documented.

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1.60 Truthfulness in documentation

Truthfulness in documentation

Demonstrate truthfulness in all reporting, such as assessments, progress notes, time sheets, and expense claims.



*There is more about professional documentation
and confidentiality in other modules.*

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1.61 When documenting...

When documenting...



- ✓ Don't leave out important information in an attempt to achieve a better outcome.
- ✓ Be clear, accurate, and precise in documentation.
- ✓ Use quotes when reflecting what others said.
- ✓ Use people's first and last names, as well as their role in the situation or person's life, while assuring that HIPAA confidentiality requirements are followed.

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1.62 Resources

Resources

You can find valuable information on the DHS website, such as...



- OARs related to your job, such as the I/DD Case Management Rule (OAR 411-415)
- Training materials.
- Manuals and Technical Guides.
- Program tools and resources.

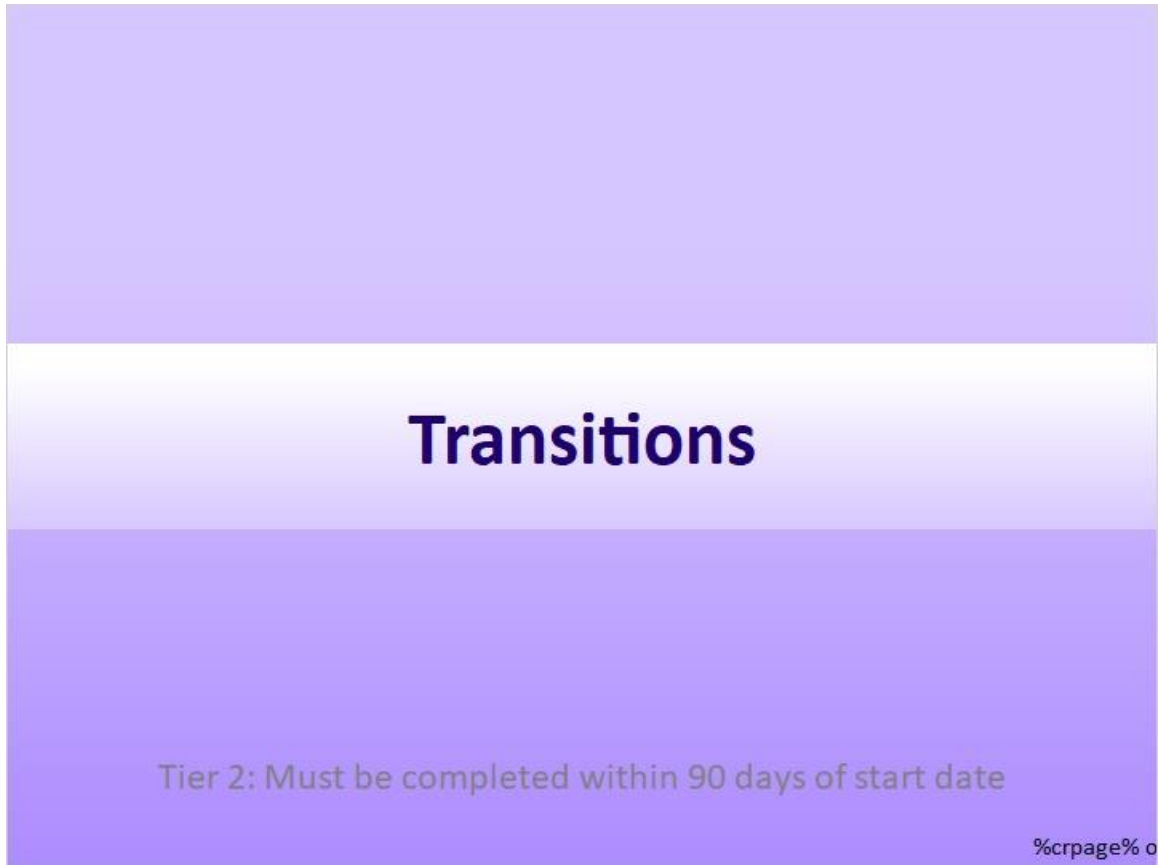
See the Resource tab for a link to DHS resources.

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SC/PA 206: Transitions

1. SCPA Transitions

1.1 Transitions



1.2 In this course

In this course...

- Continuity of care
- Your role in assisting people and families with a wide variety of transitions



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1.3 At your organization



At your organization

Talk with your supervisor and/or training team to ensure that you understand your responsibilities regarding assisting people with transitions.

Know...

- What documentation you need to complete and who to talk to if you need assistance.

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1.4 At your organization



At your organization

- Specific timelines and requirements of your organization in facilitating and documenting transitions.
- What training is required and/or offered at your organization.

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1.5 The DHS website

The DHS website



The Office of Developmental Disabilities Services (ODDS) has resources available on the DHS website to help Services Coordinators (SCs) and Personal Agents (PAs) ensure that no critical detail is overlooked.

See the Resource tab for a link to the DHS Staff Tools webpage.

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1.6 Be able to access ODDS resources

Be able to access ODDS resources

Familiarize yourself with resources so you are able to access them when you need to.

Helpful resources include:

- Transition planning forms and checklists.
- Technical Guide.
- Oregon Administrative Rules (OARs) related to transitions.



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1.7 Seamless transitions

Seamless transitions

There are many types of transitions a person may encounter.



It is your role to assist the person and/or her family, to assure that transitions are as seamless as possible and the person's services are uninterrupted.

Ask your supervisor if you have any questions or need help.

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1.8 Continuity of care during transitions

Continuity of care during transitions

“Continuity of care” means that information and services crucial to the person’s well being remain intact.

It is your role to help ensure continuity of care for a person when he is making a transition.



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1.9 Your role in ensuring continuity of care

Your role in ensuring continuity of care



- ✓ Line up funding and supports, so that the person's services continue throughout the transition.

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1.10 What you can do to ensure

What you can do to ensure continuity of care

As requested by the person and/or her guardian, if applicable...

- ✓ Coordinate and participate in transition meetings and planning.
- ✓ Provide resources to assist the person with making informed decisions.



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1.11 Person centered information

Person centered information



- ✓ Gather information about the person's needs, preferences, and supports necessary to meet those needs.
- ✓ Document in progress notes additional information that may not be included in needs assessments or the person's Individual Support Plan (ISP).

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1.12 Updating the ISP

Updating the ISP

- ✓ Ensure the person's ISP is updated to reflect current information about transitions in their life as well as chosen services and other supports.



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1.13 Transitions can be challenging

Transitions can be challenging times for the person and her family.



As they leave behind one system of supports and services and enter another, your assistance is crucial to ensuring a successful transition.

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1.14 Consider the person's experiences

Consider the person's experiences

Consider that the transition you are assisting with might be the very first time the person and/or her family accesses services, and the terminology and process is new for them.

Even if they are already receiving services, they will likely need you to provide them information about the transition process.



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1.15 Provide resources and information

Provide resources and information



- ✓ Familiarize yourself with available resources in the person's community.
- ✓ Provide information and resources that are relevant to the person.
- ✓ Be ready to assist the person to navigate systems that may be confusing or hard to access.

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1.16 Understanding a child's supports

Understanding a child's supports

Keep in mind...

- Children who are starting school for the first time may already be receiving case management services from the Community Developmental Disabilities Program (CDDP).
- Some children will also already be receiving an array of educational, medical and clinical supports.



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1.17 Get to know educational systems

Get to know educational systems

- Be aware that schools have their own eligibility, testing and planning rules, criteria and practices.
- In some cases, there will be existing assessments and records to aid in this process, while in other instances, new or additional testing and assessments may be needed.



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1.18 DHS Child Welfare

DHS Child Welfare involvement can impact transition, especially if the person is in school.



- ✓ Find out whether DHS Child Welfare is involved with anyone for whom you provide case management services.
- ✓ Be sure you know who can receive information about the person.
- ✓ Ask your supervisor for help or if you have any questions.

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1.19 Your role in assisting a child to start school

Your role in assisting a child to start school

- ✓ Help the family and/or guardian understand that each child is entitled to have an Individualized Educational Plan (IEP) developed and implemented by the school.
- ✓ Provide resources that can help the family to understand the child's school system.



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1.20 Family to Family Networks

Family to Family Networks and other Resources



- ✓ Provide resources to help navigate I/DD services and system processes.

Referral to a Family to Family Network can often provide families with valuable resources from those with knowledge and experience in school services.

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1.21 Preparing for employment

Preparing for employment begins in childhood

Planning for a person's future career and/or employment should begin as early as possible to help ensure that the person has the most opportunities and options as an adult.



While transition planning to adulthood technically begins at age 16, preparation and discussion should begin in earnest by age 14.



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1.22 Thinking about the future with

Thinking about the future with children and families



Encourage active participation by the child and his family and/or guardian(s) in all aspects of planning and service delivery.

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1.23 Conversations about the future

Conversations about the future



- ✓ Ask the child what he wants to be when he grows up.
- ✓ Guide conversations that help the family think about their hopes and dreams for the child's future.
- ✓ Record gathered information and use it in facilitating the development of the person's ISP.

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1.24 Your role in assisting a person to prepare for future employment

Your role in assisting a person to prepare for future employment

- ✓ Gather person centered information and use it to assist the person in planning for and accessing Discovery for employment.
- ✓ Provide choice advising and offer access to a wide variety of service options to help the person and her family make informed decisions.



There will be more on choice advising and employment in other modules.

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1.25 Good documentation is important

Good documentation is important



- ✓ Keep accurate and timely documentation to ensure that important details that have implications for the person's future are maintained and updated...
 - Annually with the person's ISP development.
 - As circumstances in the person's life change.

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1.26 Leaving school and

Leaving school and preparing for adult services

Students who experience I/DD are eligible to receive school services through their 21st year.

However, **planning** for the transition into adult services begins at age 16.



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1.27 What you can do to help someone prepare for adulthood

What you can do to help someone prepare for adulthood



- ✓ Familiarize yourself with diploma options and resources to help the person understand her options.
- ✓ Participate in transition planning by attending IEP or other transition planning meetings to discuss the person's future living and work options.
 - If the person and/or his guardian requests that you do not attend these meetings, respect and document the choice.

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1.28 Changing providers

Changing providers

A person may choose to change providers for various reasons.

Keep in mind...

- The person is not required to give a reason for choosing to change providers.
- The person has the right to choose her provider from among all available options.



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1.29 Why would someone want to

Why would someone want to change providers?



Reasons why a person may choose to change providers can include but are not limited to...

- Personal preferences
- Needs are not being met with current provider
- Changing support needs
- Loss of provider availability
- Changes in eligibility and funding

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1.30 What you can do to help a person to change providers

What you can do to help a person to change providers

Explain options, processes and timelines, so the person knows:

- **What** to expect
- **When** to expect it to happen

Be able to explain what will be different with a new provider and what will remain the same, so the person can make informed decisions.



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1.31 Case management provider options

Case management provider options



SCs provide case management services through a CDDP to:

- Children
- Adults:
 - who receive 24-hour supports outside of their homes.
 - In supported living in their own home.

Other adults may choose between a CDDP (SCs) and Support Services Brokerages (PAs) serving their geographical area.

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1.32 Changing case management providers

Changing case management providers

A person has the right to request a different SC/PA if desired or needed.



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1.33 Assist the person in understanding case management options

Be ready to discuss some key points when someone is **changing** or **choosing** a case management provider.



- ✓ CDDP or brokerage office locations
- ✓ Hours of operation
- ✓ Array of support and administrative services available at the CDDP or brokerage

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1.34 Assist the person in understanding case management options



- ✓ How many people each SC/PA provides case management services to
- ✓ Language and cultural knowledge of SC/PAs
- ✓ Customer service practices and expectations

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1.35 Visits can help someone decide

Visits can help someone decide

- ✓ Arrange for opportunities to visit agencies and interview staff, whenever possible and desired by the person.

This can help the person make a more informed choice.



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1.36 Know your role

Know your role

CDDPs and Support Services Brokerages coordinate transitions for people changing case management services.

- ✓ Familiarize yourself with OARs, ODDS policies, and your organization's policies and procedures.



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1.37 Keeping documents up to date

Keeping documents up to date



- ✓ Participate in transition planning and update the person's ISP to help him make a successful transition.

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1.38 Moving within Oregon

Moving within Oregon

Case management service organization options are available to a person based on her geographic location.

While CDDPs are often run by individual counties, in other cases they are run by groups of counties, or by agencies contracting with a county or the state.



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Notes:

Minor formatting change. Shelly

1.39 Re-determination may be needed

Re-determination may be needed



When a person moves to an area served by a different CDDP, she maintains her I/DD eligibility as determined by the previous CDDP.

- However, the receiving CDDP may have to conduct a re-determination if more or updated information about the person is needed.

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1.40 Your role in assisting a person to

Your role in assisting a person to move within Oregon

Provide choice advising regarding case management and other service options to a person who is moving from one county to another within Oregon.

- This must be done within the required timeframe as stipulated in OARs.



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1.41 Know the rules and ask for help

Know the rules and ask for help

- ✓ Familiarize yourself with OARs, transmittals, forms, and checklists to guide transfers within Oregon.
- ✓ Ask your supervisor if you need help or have any questions about assisting a person to move within Oregon.



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1.42 Retirement

Retirement



As a person ages, she may seek to...

- Retire from employment.
- Have different day activities.
- Make changes in her living situation.

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1.43 Planning ahead

Planning ahead



Early planning and discussion can help ensure that a person's needs and preferences are met.

Be able to explain how retirement will affect a person's income and benefits, as well as access to living and social situations.

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1.44 Services for senior citizens

Services for senior citizens

The person may be able to access some services for senior citizens.

- ✓ Assist the person to choose between senior and I/DD services if he is eligible.
- ✓ Coordinate with other agencies to help meet all of the person's needs and preferences.



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1.45 What you can do to

What you can do to help someone retire



- ✓ Familiarize yourself with senior services eligibility requirements, as well as community resources.
- ✓ Provide information to the person, family and/or guardian to help make informed choices about retirement and future planning.

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SC/PA 207: Cultural Sensitivity

1. SCPA Cultural Sensitivity

1.1 *Cultural Sensitivity*



1.2 In this course

In this course...

- Becoming aware that case management interacts with a diverse population



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1.3 At your organization



At your organization

Talk with your supervisor and/or training team to ensure that you understand your responsibilities regarding providing case management services with cultural sensitivity.

- Know what training is required and/or offered at your organization.

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1.4 DHS mission statement

DHS mission statement



The Oregon Department of Human Services (DHS) mission statement is:

“To help Oregonians in their own communities achieve wellbeing and independence through opportunities that protect, empower, respect choice and preserve dignity.”

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1.5 Diverse interactions

Diverse interactions

People of various cultural and ethnic backgrounds use Oregon Developmental Disabilities Services (ODDS).

As a Services Coordinator (SC) or Personal Agent (PA), your job requires you to interact with people who have a wide range of cultures.



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1.6 Keep in mind

Keep in mind



- ✓ Use sensitivity and respect when interacting with people.
- ✓ Be mindful when visiting a person's home, and remove your shoes if requested.
- ✓ Ask your supervisor for help or if you have any questions about respecting a person's culture.

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1.7 What is culture?

What is culture?

Culture represents the values, norms, and traditions that affect how individuals of a particular group perceive, think, interact, behave, and make judgments about their world.



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1.8 Examples of cultural differences...

Examples of cultural differences...



Language

Communication

Education

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1.9 Examples of cultural differences...

Examples of cultural differences...

Family units



Raising children



Rules in the home



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1.10 Examples of cultural differences...

Examples of cultural differences...



Community involvement

Food and meals

Giving of gifts

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1.11 Examples of cultural differences...

Examples of cultural differences...

Religion



Spirituality



Observance of holidays



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1.12 Examples of cultural differences...

Examples of cultural differences...



Medical treatments

Ability to access
services and
information

View of governmental
institutions

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1.13 Meet people where they are at

Meet people where they are at



In order to provide culturally sensitive case management services, consider where the person or family is in their lives.

- Listen to the person and family with an open mind.
- Choice advising conversations can be a good place to start building relationships.

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1.14 When meeting with

When meeting with a person or family

You need to build trust first.

- The person or family may not be ready to have a conversation with you that involves sharing private information.



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1.15 Some options may be stressful

Some options may be stressful



It may be too soon to offer options that would mean a big change for the person or the family's life.

- For example, don't start a conversation by offering attendant care or out of home services to a family who has been caring for their loved one, as this can be upsetting or frightening to them.

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1.16 Timing may not be right for a conversation

Timing may not be right for a conversation



- There may be more pressing issues going on in their lives at that moment.
- Be flexible to have conversations when it works for the person.

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1.17 Consider the person's bilingual needs

Consider the person's bilingual needs

The person or family may need bilingual assistance to understand service options and requirements.



- Eligibility
- Funding
- Choices
 - What is available to the person
 - Making informed choices
- Access to services
- Service delivery
 - Having someone come to their home, documentation, and monitoring

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1.18 Interpretation

Interpretation

- If the person does not understand English or uses sign language to communicate, it is required to offer interpretation.



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1.19 Interpretation resources

Interpretation resources



Familiarize yourself with local resources and how to access interpreters in your area.

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1.20 Consider the person's culture

Consider the person's culture

The person or family may have drastically different customs than your own.



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1.21 Eye contact

Eye contact

When you are interacting with the person and/or family, consider:



- Eye contact
 - Do you know what is appropriate?
 - Are you being respectful?

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1.22 Communicating with respect

Communicating with respect

When you are interacting with the person and/or family, consider:

- Your choice in words when communicating
 - Are you sensitive to the person and/or family's language barriers, educational background, or reading abilities?



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1.23 The person's access to information

The person's access to information

When you are interacting with the person and/or family, consider:



- The person's access to information and communication
 - Is he able to use a computer, phone, or mail?

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1.24 Concept of time

Concept of time

When you are interacting with the person and/or family, consider:

- Timelines and timeliness
 - What is considered “on time?”
 - Does the person and/or family need more time to process and understand the information you are providing?



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1.25 Gifts and food

Gifts and food

When you are interacting with the person and/or family, consider:



- Gifts or food offered by the person and/or family
 - What is more harmful, accepting or refusing a gift or food?
 - Know your organization's policies regarding receiving gifts or food.

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1.26 Gender roles

Gender roles

When you are interacting with the person and/or family, consider:

- Gender roles
 - Are you sensitive when offering services, or discussing support preferences?



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1.27 Avoid assumptions

Avoid assumptions



Just because a person has a name that you think is of a different ethnicity, do not assume that you know her culture, or that she does not speak English.

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1.28 Get to know people

Get to know people

- ✓ Get to know the person and the family, so you can provide services in a culturally competent and sensitive manner.
- ✓ Ask in a respectful manner if you are not sure if a person needs assistance due to a language barrier.



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1.29 Get to know the community

Get to know the community



Familiarize yourself with community resources in your area, and provide them to the person and/or family.

Resources of interest might include:

- Activities and community events,
- Organizations, and
- Opportunities to network with others.

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1.30 Ask for help

Ask for help

Always ask your supervisor,
the person, family, or your
coworkers for help if you need
it.



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