

Who is on First? Lessons in Team Process

Strategies to address the challenge
of building a strong community
team to support the development
and successful execution of a
Person Centered Plan

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The student will learn basic principles of Team process including:

1. Which Team players to draft;
2. Gathering information to achieve a better understanding of the person;
3. Analysis of information to generate organizational support;
4. Development of a meaningful plan that focuses on the person's present, as well as their future, daily life;
5. Successful plan implementation requires on-going Team oversight and adjustment as the person's needs/desires change;
6. Team oversight + good Team communication = An Effective Team Process;
7. The measure of an effective Team is defined by Positive Outcomes;
8. Positive Outcomes or Indicator's of a person's quality community life include: Competence, Choice and Control, Presence and Participation, Relationships, Respect and Dignity, and Rights

Team Players

- Team is composed of the individual and others- friends, family, service providers, nonprofessional and professionals, who possess knowledge to accurately identify the comprehensive array of support needs
- There is no correct # of team members
- Was Team expertise sufficient to meet needs of the individual ?
- Input from all sources (employer, health care provider, dentist, etc.)

Gathering Information

- Meeting schedules facilitate participation
- Within 30 days, new, revised, or updated assessments accurately identify functional abilities and preferences. (W210)
- “Accurate” assessment data are current, relevant, & valid & skills, abilities, needs identified correspond to the individual’s actual status.
- Teams prepare pre-assessment questions. In the presence of a diagnosis (medical or other) evaluation data must be available to support diagnosis.
- Assessments interpret significance of the results in terms of individual’s functional daily needs

Assessment Analysis

- Physical Health and specialists
- Nutritional: diet, intake, skills associated with eating (chewing & swallowing)
- Sensorimotor: Muscular, neuromuscular, physical skills, corrective/orthotic supports
- Emotional: Interests, attitudes, emotions
- Communication: verbal/nonverbal, receptive/expressive, interventions, AT
- Auditory: ability to hear/aids desensitization
- Vision: acuity, ocular health (cataracts)
- Social: self-help, leisure, adaptive behavior skills
- Independent living, work interests/experiences

Plan Development

- Plan content reflects assessment results
- Goals provide overall direction
- Behaviorally stated objectives with target date for accomplishment support goals
- Methods define actions to accomplish objectives and person responsible
- Data is defined/ used to measure progress
- Service actions to support outcomes

Plan Implementation

- Person Centered Planning and ICF/MR requirements for “Active Treatment” (AT) can co-exist. (Investigative Procedures, Revised 2005)
- Principle focus of the CMS survey is on outcome of the facility’s implementation of AT by measuring what actually happens to the individuals:
 - Needed Services and interventions provided?
 - Freedom from abuse/neglect/mistreatment/injury
 - Individual/guardian identifies and selects service
 - Active Treatment support positive outcomes.

Plan Implementation

- Opportunities for greater independence, integration and productivity.
- All health needs are met.
- Support persons interact competently and effectively and know the individual
- Record reviews are completed AFTER observations and interviews to verify choice, control, relationships, inclusion

Active Treatment Information

■ W196

Standard:

Active Treatment

483.440 (a) (1) PROBES

How does the facility address the active treatment needs of individuals along their full life span?

- Is the activity scheduled or planned?
- Are materials present to implement the activity?
- Are they used?
- Are all individuals present involved or engaged in activity?
- Are the activity and materials age-appropriate, adaptive and functional?
- Are new skills and behaviors being taught or reinforced?
- Are all individuals reinforced and prompted frequently?
- Are all staff verbally and physically involved?
- Are there sufficient staff for the activity?
- Are interactions characterized by a “mentor/friend” tone?
- Does the activity related directly to specific objectives and needs?
- Do staff demonstrate the skills necessary to train or reinforce training on the IPP objectives?
- Are individuals observed to engage in aggression, self-injurious behavior or self-stimulatory behavior?
- If so, do staff intervene as per ISP/IPP?

* Information taken from Center for Medicare & Medicaid Services (CMS) ICF/MR Field Resource Guide, September 2003

Team Oversight

- Team meets (face to face, electronic, or teleconference) to review relevance of plan and address any change in status, progress, lack of progress, injury, illness, abuse or neglect.
- Case manager and/or QMRP document and file meeting agenda, discussion, interventions planned with date for accomplishment.
- Interventions detailed in ISP/IPP address each existing and any new Risk factor.
- Discipline with expertise in Risk area provides additional oversight, shares documents/files info.
- An effective Team is a Team that communicates

Positive Outcomes

- Quality community life is measured by positive outcomes:
- Plan content addresses quality indicators:
 - Good Health: Safeguards for Risk are in place.
 - Opportunities are provided to increase competence, choice and control
 - Relationships are built via community connections
 - Respect and dignity is enhanced through valued contributions at home, school, work, leisure, church, and community.
 - Rights are protected with safeguards and exercised through consent, assembly, voting, speech (self advocacy)

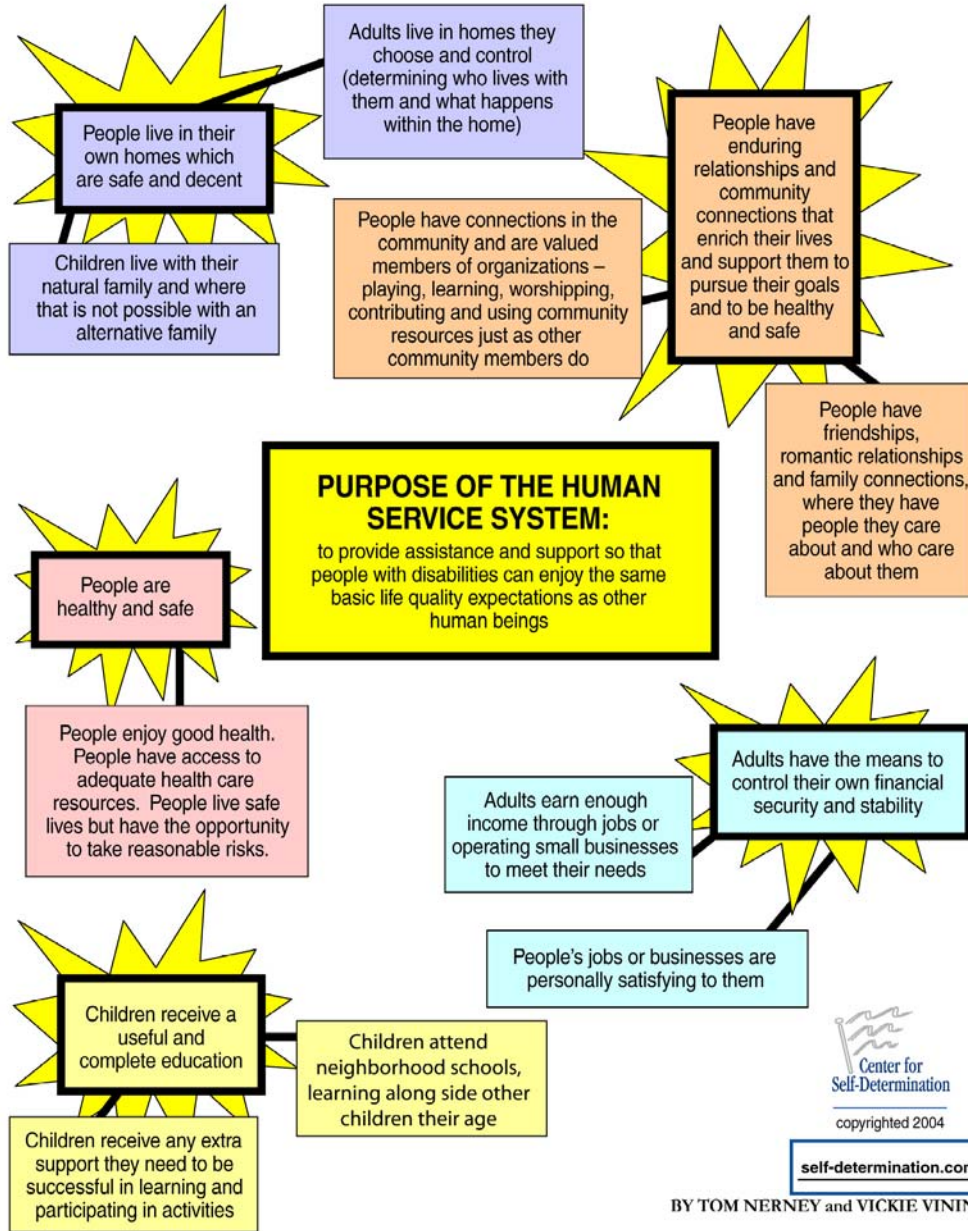
Factors Contributing to Quality

- Real choices in all aspects of daily life
- Functional skills
- Interaction with a variety of people
- Use of “generic” services
- Access to community resources
- Age appropriateness
- Use of a range of community environments
- Living in typical neighborhood
- Meaningful daily activity
- Nonaversive interventions
- Relationships with friends
- Relationships with family
- Respect
- Skill development
- Typical daily routine
- Active participation
- Adult relationships supported
- Personal appearance
- Relationships with neighbors
- Safety within the home
- Working in integrated worksite
- Access to medical care
- Client input in program decisions
- Coherent planning process
- Personal sense of competence
- Freedom of movement
- Good health
- Individualization
- Personal responsibility fostered

Self-Determination

- Changes lives, dreams, and the future for all people
- Not a program, a home, or a budget
- Is about “getting a life”, living in houses and homes
- Is about having abilities and needs, not labels
- Ultimate Goal: public dollars should be used to enable individuals with disabilities to craft meaningful life in the community, engage in long-term relationships, and overcome the consequences of enforced poverty

PURPOSE OF THE HUMAN SERVICE SYSTEM




Center for
Self-Determination
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BY TOM NERNEY and VICKIE VINING

Positive Behavior Support Practices (PBS)

- One of the biggest challenges of training service providers in PBS practices is changing their attitudes about the individual with challenging behaviors from “person as a problem” to “person who has something legitimate to say, but no socially acceptable way to effectively communicate the message.”
- This attitude change is in addition to the need to change current intervention strategies that are all too often reactive and punitive in nature while learning strategies that are proactive, positive and geared toward self-determination rather than external control.

Values Driving PBS Practices

- Self-determination
- Assumption of competence
- Inclusion
- Improvements in qualities of life
- Team process
 - Families, friends, professionals, co-workers, and/or classmates

Antecedent Analysis

Systematic review of possible variables which might be responsible for or contributing to the onset of a behavior, sign or symptom. Antecedent variables generally fall under categories such as :

- (1) time and place,
- (2) immediate, and
- (3) distant.

Antecedents

- Time and place: the time of day, days of the week, and physical location.
- Immediate antecedents: the activity at the time, people present, social and interpersonal events or statements, covert activity such as what the person may have been thinking or imagining (generally obtained by questioning the person or listening carefully to self-talk), and affect or emotion such as frowns, muscle tension, etc.
- Distant antecedents or non-immediate events: a stress event such as the person's family member not keeping an appointment the day before, hunger due to missing a meal, discomfort from an illness or medical condition.

PBS Components

- Functional assessment of behavior and the contexts in which it occurs
- Analysis of assessment information and development of hypotheses regarding the function of the behavior
- Designing hypothesis driven multi-component support plans that are proactive, educative, and functional
- Implementing the support plan which will require skills in instruction, program and environmental modifications, facilitating social interactions and lifestyle enhancement
- Integrating PBS with other life enhancing interventions
- Evaluating the impact of intervention and making informed adjustments to improve and /or expand the effect