



# Student Resource Guide

## 2. Person-Centered Planning

# Person-Centered Planning

## OUTCOMES

When you finish this session, you will be able to:

- List the things you can learn about an individual when using person-centered planning.
- Describe tips for communicating with family members about the individual's preferences.
- Get ready for a person-centered planning team meeting.
- Support an individual's goals and objectives.
- Describe your role as a team member.
- Determine if an individual is making progress on goals and objectives.

## KEY WORDS

Key Word	Meaning	In My Own Words
<b>Goals</b>	A list of things that are important to the individual and that he or she want to do or accomplish in the future. Goals reflect the individual's needs and preferences.	
<b>Individual Program Plan (IPP)</b>	An agreement required by the Lanterman Act, between the individual and the regional center that lists the individual's goals, objectives, and the services and supports needed to reach those goals. The IPP is developed by the planning team based upon the individual's needs and preferences.	
<b>Objectives</b>	What an individual wants to accomplish. Objectives must be specific, time-limited, stated in measurable terms, and related to the individual's goals and needs.	
<b>Person-Centered</b>	The individual with the developmental disability is the most important person in both planning for and providing services.	

**KEY WORDS (CONT.)**

Key Word	Meaning	In My Own Words
<b>Person-Centered Planning</b>	A process for learning about things that are important to the individual and reflect the individual's needs and preferences (goals). This includes the type of services and support needed to help the person reach his or her goals. The individual, his or her family, friends, and people who know and care about the person (including DSPs), work together to identify things the individual likes to do (preferences), things he or she does well (strengths and capabilities), things he or she wants to do (hopes and dreams), and things that get in the way (barriers).	
<b>Planning Team</b>	A group of people, including the individual with disabilities, the regional center service coordinator, and others who know and care about the individual, who come together to plan and support the needs and preferences of the individual.	
<b>Regional Center</b>	A group of 21 centers throughout California, created by the Lanterman Act, that help individuals with intellectual/developmental disabilities and their families find and access services. Regional centers purchase necessary services included in the Individual Program Plan.	
<b>Review Date</b>	A pre-determined time period when a goal or a plan will be looked at to see if progress has been made and if anything needs to change.	

## KEY WORDS (CONT.)

Key Word	Meaning	In My Own Words
<b>Service Coordinator</b>	An individual from the regional center who works with individuals and families to find and coordinate needed services and supports.	
<b>Services and Supports</b>	Assistance necessary for the individual to lead the most independent and productive life possible, based on the individual's wants, needs, and desires.	

**A C T I V I T Y**

**What Do You Want to Know?**

**Directions:** *Think about the topic of this training session. Answer the first two questions in the space provided below. You will come back to this page at the end of the session to answer the last question.*

.....  
What do you **already know** about Person-Centered Planning?

.....  
What do you **want to know** about Person-Centered Planning?

.....  
To be answered at the end of the session, during review:  
What **have you learned** about Person-Centered Planning?

## The Person-Centered Planning Process

### What is Person-Centered Planning?

The Lanterman Developmental Disabilities Services Act says that regional centers must use person-centered planning to support the different ways that people choose to live. **Person-Centered Planning** is a way to learn about things that the individual:

- Wants to do in the future (hopes and dreams)
- Likes to do (preferences)
- Does well (strengths and capabilities)
- Chooses to do in the next year or so (goals)
- Will need help with to get from here to there (services and supports)
- May think will get in the way (barriers)

“Person-Centered Planning provides strategies to increase the likelihood that people with disabilities will develop relationships, be part of community life, increase their control over their lives, acquire increasingly positive roles in community life, and develop competencies to help them accomplish these goals. Person-Centered Planning helps to clarify and implement these ideals one person at a time.”

Adapted from *Its Never Too Early, Its Never Too Late*, by Beth Mount and Kay Zwernik

The **planning team**, including the individual, family members, friends, the regional center service coordinator, and other people who know and care about the person (including DSPs), works to learn about the individual’s hopes and dreams, preferences, strengths and capabilities, goals, barriers, and needs for services. The team then develops a plan with the individual.

The Lanterman Act requires that an **Individual Program Plan (IPP)** be developed for every individual. The IPP is based upon the results of the person-centered planning process. It is an agreement between the individual and the regional center that lists the individual’s goals and objectives, and the services and supports needed to reach those objectives. The IPP includes goals, objectives, and plans.

- **Goals** are results that are important to the individual and reflect the individual’s needs and preferences. For example:

*I want to spend time with my boyfriend, Richard.*

- **Objectives** are specific, time-limited, stated in measurable terms, and related to the individual’s goals. For example:

*Once a week I will spend two to three hours with Richard at his or my home, or someplace that we want to go together.*

- **Services and Supports** are ways to assist and help the individual to lead the most independent and productive life possible, based on the individual’s wants, needs, and desires. For example:

*Shirley, a DSP at my home, will help me arrange time with Richard and will provide transportation and other support I may need.*

## The Person-Centered Planning Process (cont.)

The IPP protects the individual's right to make choices. According to the Lanterman Act, the individual has a right to make choices about:

- Where to live and with whom.
- How to spend time each day; for example, day program, at work, or for fun.
- With whom to spend time; for example, visiting friends and family.

- Hopes and dreams for the future; for example, to have a job or save up for a special vacation.

Person-centered planning helps support the choices that people make about their lives. We will next discuss ways DSPs may participate in this important process.

## The Person-Centered Planning Team

It takes a team working together to do person-centered planning. By law, team members must include the individual with a developmental disability; family members if someone is younger than 18 years old; a guardian or conservator if the person has one; and the regional center service coordinator or someone else from the regional center. The individual might invite other people to participate in the team meeting such as family members, DSPs, a doctor, psychologist, nurse, or speech therapist.

Everyone on the team should know the individual. As a DSP, you may be asked to be a member of a person-centered planning team. It's important to remember these five responsibilities of the planning team:

- Get to know the individual
- Find out what's important to him or her
- Support the individual's choices
- Figure out ways to make those choices a part of everyday life
- Identify services to support those choices

One of the first steps to get ready for the planning team meeting is to be an active listener. Talk with the individual about their goals, desires, and needs, ask questions, and listen to them to learn more about what is important to them.



### ACTIVITY

#### Getting Ready for a Person-Centered Planning Meeting

**Directions:** Break into small groups. On the flip chart paper provided, write down the answers to the following questions.

**How can I learn more about an individual's goals, desires, and needs?**

**What are some questions I could ask to learn more about what is important to the individual?**

## The Role of the Direct Support Professional in Person-Centered Planning

Getting to know the individual is at the core of person-centered planning. The best way to get to know someone is to spend time together. You can talk, listen, and observe to learn what is important to the individual. The DSP is often in the best position to get this information.

When an individual cannot speak for him or herself, it's important for the DSP to spend more time observing activities in the home; for example, meal time, outings, and free time. The DSP should also observe how people respond to them. Do they use smiles, frowns, shrugs, and eagerness? This will help you learn what people like and do not like as well as with whom they like to spend time.

If someone is new to the home or it's difficult to figure out an individual's preferences from the beginning, it's important to write down preferred items and activities; for example, foods at meal time or free time activities.

You will also want to ask others. If family, friends, or day program staff are available, remember to ask them questions about preferences; for example, "When does he seem to be the happiest?" or, "Where are her favorite places to go?"

Finally, you may find additional information about preferences in the individual's record. If the record includes a summary of a person-centered planning session, you should find a list of likes, dislikes, and preferences.



As you learn about an individual's preferences, it's important to communicate these findings to other staff and to the person-centered planning team. You might do this at staff meetings, team meetings, on a staff log, or in progress notes. This helps create more opportunities for favorite activities and other relevant items to be included in daily routines. It also helps the team develop more person-centered services and supports.

## What Can Be Learned From Behavior?

How would someone's behavior tell you that he or she wanted something? When you offer a choice of foods for dinner, he or she might point to a preferred food. Or, if you mention that you are going to the park and someone gets into the van, that would tell you that the person likes something about the activity, such as riding in the car or playing Frisbee in the park.

Sometimes it's easier to figure out what a person doesn't like. For example, someone might spit out food or push away a staff person who is trying to help. Imagine that you don't have words to describe your feelings.

What are some other ways that you would let someone know that something was making you unhappy?

## Teamwork and Working with Families

Teamwork and working with families is a very important part of person-centered planning and is a key to success for individuals with intellectual/developmental disabilities. In addition to the individual, the planning team will likely include family members, consultants, health professionals, regional center staff, and support staff. Since you may participate on a planning team for someone you work with and support, it's important to know some basics about teams and how they work best.

Below are some facts about teams:

- Teams include co-workers, families, the regional center, and other community agencies.
- Trust is the basic element for success.

Teamwork is about sharing, cooperating, and helping each other. An effective team values everyone's contributions and works toward a common goal. When people work together as a team, they usually get better results.

Many experts say trust is basic to successful teamwork. Trust takes time. It is dependent upon people getting to know each other to see if they say what they mean and do what they say, and if they contribute to the work of the team in a positive way.

Besides trust, other values that support teamwork are:

- Open, honest communication
- Equal access to information
- Focus on a goal

## Team Members' Roles

Everyone has an important role to play on the person-centered planning team. Individuals with intellectual/developmental disabilities and their families, of course, have a big part to play. As team members, they talk about their choices, hopes, and dreams and what services and supports they need to be successful.

DSPs may help individuals talk about their choices, hopes, and dreams and provide information to the team about what they have seen and heard. Most importantly, DSPs provide services and supports that help individuals work toward their goals. Regional center service coordinators help write the person-centered IPP and locate services and supports when needed.

## Communication with Families

Families communicate valuable information to the DSP and the team about the preferences, likes, and dislikes of an individual. Following are useful tips to encourage successful communication with families.

- **Regular Contact**

It's important to encourage contact with family members whenever possible.

- **Communicate First and Often**

Early and ongoing communication is important to building a good relationship with family members. Often, the first contact between a DSP and a family member involves a problem. This is a frustrating way for a family member to start a relationship with a relative's caregiver.

- **Be Positive**

The relationship between families and DSPs should be positive. It should be seen as a chance to work together to serve the best interests of the individual.

- **Use Different Methods to Communicate**

Speaking with family members and writing them notes are just two methods of communicating with families. Be creative and practical!

- **Be Honest**

Honesty in your interaction with families is very important. Sometimes this can be very difficult, especially when the information may be difficult for the family to accept. Learn how to best approach family members.

- **Be an Advocate**

DSPs have a dual role. Not only are you responsible for the day-to-day care of the individuals you serve, you are also their advocate. This is probably one of your most important functions because it involves serving the best interest of those with whom you work. At times, being an advocate involves working together with family members on behalf of the individual. At other times, it involves advocating on behalf of the individual in matters on which the family might disagree.

- **Share What You Learn**

When family members share important information, make sure to share it with other DSPs. Remember, you all work together to support the individual.

- **Show You Care**

Your genuine concern for the individual, as well as for their family members, will serve you well. Sharing observations with family members and asking for their input will go a long way in maintaining positive communication.

- **Be Sensitive**

Be sensitive to the individuals you support even if you may not be enthusiastic about the involvement of their families. Adults who do not have a guardian or conservator have a right to decide how much family involvement they want. This may be something you can help with.

*Source: Terri Niland, a DSP from Maryland.*

## The Role of the Direct Support Professional in Implementing IPPs

Let's examine an IPP and find ways to be supportive team members. The role of the DSP is to review the information in each individual's IPP and to be aware of what should or should not be done to best support each individual's needs and goals.

**Most importantly, the DSP is responsible for implementing the IPP.** Often, the services and supports that an individual needs to reach their goals are provided by the DSP. For this reason, you

must be familiar with the IPPs for each person in the home, and know what their goals and objectives are and what your responsibilities are to assist the individual in achieving them. The IPP should tell you who is to do what by when.

You must know where each individual's record is kept, read and be familiar with the IPP, and work with the administrator and other DSPs in the home to provide necessary services and supports identified in the IPP.

### Sample IPP

*Read this partial IPP. What is the goal? What is the objective? What is the plan? Who will do what and by when for the individual? What does the DSP do to support the goal?*

**The following is an example of an IPP for Eric.**

Eric wants to see his friend play baseball. The DSP will help him by finding out when and where the games are scheduled and at least once a week, and provide for or arrange transportation for Eric to go to the game with him.

**Goal:**

I want to watch my friend, John, play on the local baseball team.

**Objective:**

Helen and I will go to John's baseball game once a week throughout the season (April to July).

**Service and Support Plan:**

Everett, a DSP in the home where I live, will check the weekly schedule to make sure we go at the right time, provide or arrange for transportation, and accompany me to the game.

## A C T I V I T Y

### Implementing an IPP

**Directions:** Look at Kwan's IPP in Appendix 2-B on pages S-18 through S-28. Split into small groups. Each group will be assigned an objective to review and answer the following questions:

1. What is the goal?
2. What are the plans?
3. Who is responsible?
4. What should the DSP do?
5. When should the DSP do it?

## The DSP's Role In Assessing Progress on the IPP

Each IPP has a review date, a pre-determined time period when a goal or a plan is looked at to see if progress has been made and if any changes are needed. Often, the IPP will require that the DSP (or responsible person) write down observations or keep a record of what was done to implement the plan. This information should be shared with other staff and be reviewed by the regional center service coordinator, the individual's planning team, and others involved in the individual's health, safety, and quality of life.

Sometimes the IPP objectives or plans aren't helping the individual achieve his or her goal. Sometimes the original plan needs to be changed and you are in a good position to identify when there are problems. If you see that something in the plan is not working, it is your responsibility to let others know.

## The DSP's Job in Assessing the Quality of Services

A form entitled, "Looking at Service Quality" may be found in Appendix 2-C. It was adapted from a tool that the Department of Developmental Services offers to service providers as a way to look at services and identify opportunities for improvement. The tool assists you in asking questions, such as the quality of a person's life in the areas of choice, relationships, lifestyle, health and well-being, rights, and satisfaction:

*Do I know the hopes and dreams of each person I support?*

*Do I know the goals in each person's IPP?*

*Have the individuals I support made progress in reaching a goal in the past year?*

*Do I provide opportunities for individuals to have choices in their daily life?*

*Does each person in the home have opportunities to spend time with their friends?*

*Does each person have someone to talk to in their primary language?*

*Does each person get to do activities in the community?*

*Does each person have access to needed health services?*

*Does each person know his or her rights?*

*Do I and others treat people with dignity and respect?*

These are just a few questions that you might ask to assess the quality of services that you and others in the home provide. You and others will want to review the answers to these questions as a way to assess the quality of services you provide. Remember, a better quality of life for people with developmental disabilities will likely lead to a more rewarding professional life for you!

**PRACTICE AND  
SHARE**

When you return to the home in which you work, ask yourself the questions on page S-11 for just one individual that you support. Be ready to share the answers at the beginning of the next class.

### Person-Centered Planning

- 1. What can the DSP learn about the individual during the person-centered planning process?**
  - A) The individual's life goals
  - B) What the individual learned in school
  - C) The individual's social life
  - D) What is the individual's favorite color
- 2. How should the DSP get ready for a person-centered planning meeting?**
  - A) By reviewing the individual's medical record
  - B) By making decisions for the individual
  - C) By asking the individual about their goals
  - D) By asking the family about their goals for the individual
- 3. What is the DSP's role as a person-centered planning team member?**
  - A) to write up what goes on in the meeting
  - B) to support an individual's goals, desires, and needs
  - C) to run the meeting
  - D) to decide what is best for the individual
- 4. What are some tips for communicating with family members about the individual's preferences?**
  - A) Ask them what they enjoy doing
  - B) Be an honest advocate for the individual
  - C) Use only non-verbal communication
  - D) Have limited contact with the family
- 5. How can the DSP support an individual's goals and objectives?**
  - A) Know what their responsibilities are
  - B) Know about each individual's behavior problems
  - C) Speak with an administrator about the individual
  - D) Be familiar with the family of each person in the home
- 6. How can the DSP help to assess an individual's progress in meeting their IPP goals and objectives?**
  - A) Decide if the IPP goals and objectives are working
  - B) Change the goals and objectives if they are not working
  - C) Get family members to change the individual's goals and objectives
  - D) Write down observations or keep a record of what is done to implement the IPP
- 7. Ethics, Observation, and Decision Making are skills included in the:**
  - A) IPP team
  - B) Title 17 regulations
  - C) DSP toolbox
  - D) Lanterman Act
- 8. What may the DSP's do to assess the quality of services received by an individual?**
  - A) Teach the individual to be independent
  - B) Ask questions about the individual's quality of life
  - C) Learn about the individual's future goals
  - D) Learn to provide new services

## Session 2 Quiz (cont.)

- 9. The objectives of an individual must be:**
- A) Written in a legal document
  - B) Specific and related to goals
  - C) Long term and unclear
  - D) Difficult to measure
- 10. Which is the responsibility of the service coordinator?**
- A) Teach the individual to support themselves
  - B) Help individuals take their medications regularly
  - C) Help individuals find needed services and supports
  - D) Teach the DSP about the needs of the individual



## Appendices



## Everyone's Regional Center (ERC) Individual Program Plan (IPP)

Date of IPP Meeting: 4/1/016

### IDENTIFYING INFORMATION

Kwan Louise Wang                      F                      4/18/58  
Name                                      Gender                      Date of Birth

1421 High View Street, Roseland, CA 90375                      (405) 677-9535  
Current Address    Phone

English                                      Community Care Facility, Service Level 4  
Primary Language                                      Residence Type

Betsy Helpful                      (405) 546-9203  
Service Coordinator                                      Phone

### IPP MEETING PARTICIPANTS

- Kwan Wang, Phone (405) 677-9535
- Judy Wang, mother and conservator, Home phone: (405) 391-2537, Cell :(405) 636-2452
- John Wang, brother, Home phone: (310) 372-3610
- Martha Green, administrator of the Green home, Phone: (405) 677-9436
- Mimi Rosales, direct support staff at the home, Phone: (405) 677-9535
- Armand Garcia, Hillside Day Program counselor, Phone: (405) 638-4423
- Betsy Helpful, ERC service coordinator, Phone: (405) 546-9203

### FAMILY INFORMATION

#### Family Members

- Judy Wang (Mother and Conservator) 76711 S. San Pedro St., Roseland, CA 90375  
Home phone: (405) 391-2537, Cell:(405) 636-2452
- John Wang (Brother) 525 Avenida Esplendida, Ripart, CA 90275  
Home phone: (310) 372-3610

#### Consumer/Family Concerns and Priorities

Kwan has a boyfriend, Robert, with whom she enjoys spending time with. She would like support to be able to spend good, quality time with Robert. Kwan enjoys animals and has a pet bird. Someday, she would like to have more than one bird. In the meantime, Kwan would like to find more ways to be around animals, especially birds. She would also like a job since she wants to save money for her dream trip to Disneyland and to buy more clothes and CDs. Kwan also enjoys spending time with her mother and brother. She and her mother get together once a week for shopping and other activities. She doesn't see her brother as often, since he lives 50 miles away.

Kwan's mom wants Kwan to be happy in her new home. She is concerned that Kwan's fairly complicated medical needs are taken care of properly. She wants to continue to take a very active part in Kwan's life. She loves her daughter very much and wants to do what is best for her. Kwan's brother is concerned that Kwan's wheelchair needs to be replaced and wants to see Kwan get a new one as soon as possible. He also wonders if there isn't something that could help Kwan communicate more effectively as it is very hard to understand her.

### **MEDICAL INFORMATION**

Health Insurance: Medi-Cal: 4679635738; Medicare: 467963573 (Father deceased)

#### **Medications**

- Tegretol - 200mg QID (four times a day, 7:00 A.M, 12:00 P.M., 5:00 P.M., 10:00 P.M.) with food for seizures
- Colace - 250mg q AM (every morning) with a large glass of water for constipation
- Milk of Magnesia - 30cc q 3rd day (every third day) with no bowel movement
- OsCAL - 1500mg qd (every day) for prevention of osteoporosis
- Lotensin - 20mg q AM, (every morning) for hypertension
- Fluorigard - 15cc mouthwash after toothbrushing AM and PM for oral health
- SPF 35 sunguard and lip balm to protect from sunburn to be applied if Kwan is to be in the sun for more than 15 minutes

#### **Health Providers**

##### **Primary Care Physician**

Dr. Ubeewell, 7922 Spirit St., Pleasantville, CA 90375 Phone: (405) 391-8511

##### **Neurologist**

Dr. Nicely, 12 Fair Oaks Dr., Suite 3, Roseland, CA 90375 Phone: (405) 333-7272

##### **Gynecologist**

Dr. Young, 12 Fair Oaks Dr., Suite 14, Roseland, CA 90375 Phone: (405)333-6789

##### **Dentist**

Dr. Y. Nocaries, 12 Whitten Way, Pleasantville, CA 90375 Phone: (405) 696-3372

##### **Audiologist**

Dr. Hearless, 1434 Hayes Way, Suite 200, Pleasantville, CA 90375 Phone: (405) 333- 4536

##### **Health Status**

Height: 5 feet

Weight: 120 pounds

**Eligible Diagnosis:** Spastic Quadriplegia Cerebral Palsy, Severe ID, Mixed Seizure Disorder

## Appendices 2-B (cont.)

**Chronic medical conditions/special health issues:** Kwan had a right hip fracture with pinning in 1998. She currently has a seizure disorder, hypertension (diagnosed in 2003), chronic constipation, and moderate hearing loss in the left ear (diagnosed in 2002). She has doctor's orders for a therapeutic diet (high fiber for constipation and no coffee or added salt for hypertension). In addition she cannot eat tomatoes or tomato products.

**Allergies:** Kwan is allergic to tomatoes and tomato products. They give her hives. She is also sensitive to the sun and sunburns easily.

**Equipment:** Wheelchair, shower chair, adaptive spoon

**Hospitalizations:** No hospitalizations in the past year.

**Mental Health Issues:** N/A

**Immunizations:** Kwan had a flu shot and pneumovax in September, 2015.

### NATURAL SUPPORTS

Kwan's mother and brother are both very close to Kwan and want to do as much to support her as they are able. Her mother visits Kwan once a week. Every fourth week she takes her shopping at the local mall. She goes with Kwan as often as she can to doctor visits. Kwan spends Thanksgiving and Christmas holidays with her mother and family. Kwan's boyfriend, Robert, is also an important source of support and fun.

### WHAT PEOPLE NEED TO KNOW ABOUT KWAN

Kwan is a friendly and happy person who gets along well with others. She has a good sense of humor and likes to be with people and do fun things. Kwan enjoys her close relationship with her mother and brother. Kwan likes birds, especially her yellow parakeet Pete. She also loves having her nails polished and going shopping with her mom. Kwan likes watching TV, especially the Disney Channel. Kwan is able to express some of her needs verbally; however, when she is very excited, her speech is very difficult to understand. She hears best with her right ear. Kwan uses a wheelchair and needs assistance with most things. Kwan has very fair skin and is sensitive to sun.

### HOPES AND DREAMS

Kwan enjoys spending time with Robert, and would like more opportunities to be with him. Kwan loves her bird. She would like to someday work in a pet shop or somewhere where there are lots of birds. She likes the water and would like to learn to swim. The thing that would make her happiest in the world would be to go to Disneyland with Robert.

### CONSUMER/FAMILY SATISFACTION WITH SERVICES

Kwan likes her new home. The staff are nice and she likes spending time with them, but she would like to have more friends and to spend more time with Robert. Kwan's mother, who is also her conservator, is happy with Kwan's new home as well.

### FINANCIAL SITUATION

Benefits: Kwan receives SSI in the amount of \$670 a month with an additional \$90.00 for personal and incidentals (P&I). In addition, Kwan receives SSA in the amount of \$270 a month. Her mother is her representative payee. She also maintains a bank account for Kwan. Kwan uses her P&I to purchase personal items, clothes, pet supplies for Pete, and for weekly activities as needed.

### LEGAL STATUS

Kwan's mother is her limited conservator and as such is authorized to sign for Kwan's medical care, handle her finances, and make decisions about where she lives.

### INDIVIDUAL PROGRAM PLAN AREAS

#### HOME

**Current Status:** On January 6th this year (2012), Kwan moved to her new home, a level 4 owner-operated CCF. Martha Green is the owner and administrator. Kwan had to move because her previous service provider became seriously ill. Kwan likes her new home, and particularly likes Mimi Rosales, one of the staff. It also helped that her previous roommate moved with her. There is one staff for every three people in the home at all times. In the morning and evening there is one additional staff. Kwan's mom was worried about the move, but is now satisfied that the new home is working for Kwan. Being able to keep her bird was one of the reasons she and her mom chose the Green home.

#### Goal

Kwan will live in a safe, comfortable, home that meets her needs and supports her choices and preferences.

#### Objectives

1. Kwan will continue to live in the Green home through 8/30/17.
2. Kwan's staff will receive yearly Red Cross training in First Aid, CPR, and proper transfer and lifting procedures for Kwan.

#### Plans

- 1) Green home staff will provide services and supports for Kwan as described in Kwan's IPP and with consideration for Kwan's unique needs and preferences.
- 2) Martha Green, Administrator, will prepare a quarterly summary of activities and outcomes related to implementation of individual IPP objectives for which the facility is responsible.

- 3) ERC will continue to provide monthly payment at the Level 4 rate (minus the SSI and SSA amount) to the Green home for Kwan. Kwan's ERC service coordinator will visit Kwan once every three months (August, November, February, May) or more frequently as needed to monitor the implementation of Kwan's IPP and Kwan and her mother's continued satisfaction with the services being provided. Kwan's service coordinator will invite Kwan's mother to participate in these visits.
- 4) As representative payee, Kwan's mom will continue to provide monthly payment for Kwan to the Green home for the total amount of the SSI and SSA payments.

### PERSONAL CARE

**Current Status:** Kwan likes to wear nice clothes, make-up, and have her nails polished. Kwan uses an adaptive spoon to eat, but otherwise needs to be assisted with all her needs. She enjoys long showers. Kwan is unable to stand and pivot to transfer from her wheelchair. Kwan's wheelchair needs replacement. It is 8 years old and the upholstery is ragged and the frame wobbly. The brakes were recently repaired.

#### Goal

Kwan will maintain good oral health, healthy skin, will eat as independently as possible, and will be dressed and groomed appropriately for the occasion and the season through 4/30/17.

#### Objectives

- 1) Home staff will provide complete assistance to Kwan with bathing, dental care, dressing, toileting, grooming (including makeup) with concern for her privacy and dignity and provide Kwan with opportunities for choice throughout her daily routine. Staff will schedule extra time for Kwan's shower.
- 2) Home staff will floss Kwan's teeth once a day and brush with an electric toothbrush twice a day. They will assist Kwan in using Flourigard as prescribed after each brushing.
- 3) Home and day program staff will assist Kwan to shift position in her wheelchair once every 2 hours. Home staff will assist Kwan to transfer from her wheelchair to a beanbag for an hour each night at home while she is watching her favorite TV program or listening to music.
- 4) Home and day program staff will ensure that Kwan has her adaptive spoon when eating and will provide partial assistance and verbal prompts to guide Kwan to eat as independently as possible.

- 5) Home and day program staff will coordinate Kwan's toileting schedule.
- 6) Both home and day program staff will assist Kwan to apply sunscreen, lip balm, and a hat each time she is in the sun for any extended length of time (more than 15 minutes).
- 7) By 6/1/17, Kwan's service coordinator will arrange for Jacquie Ohanesian, CRT, at First Care Equipment (405-696-4651) to assess Kwan's wheelchair. ERC will fund the assessment.
- 8) Within 2 weeks of the completed assessment, the service coordinator will schedule a meeting with Kwan, her mom and Martha Green to discuss the results of the evaluation and write an IPP addendum including a plan with a target date for the purchase of necessary equipment. If Medi-Cal will not approve the purchase of the recommended wheelchair and lift, ERC will authorize.

### COMMUNICATION

**Current Status:** Kwan is a friendly and happy person. She has a good sense of humor and likes to be with people. Kwan is able to express some of her needs verbally; however, at times when she is very excited, her speech is very difficult to understand. An audiogram done in 2002 revealed a moderate left hearing loss. No hearing aid was recommended. Kwan hears best when people direct their speech directly at her or toward her left ear. Her brother is concerned that there may be some way to assist her to communicate more effectively.

#### Goal

Kwan will be able to communicate as effectively as possible.

#### Objectives

- 1) By 10/1/16, Kwan's service coordinator will arrange for Liz Speakeasy, Speech Therapist, to assess Kwan for use of augmentative communication. By 1/30/17, the speech therapist will have completed the assessment. The speech therapist will assess Kwan in different environments and situations. Medi-Cal will fund the assessment.
- 2) Within 2 weeks of the completed assessment, the service coordinator will schedule a meeting with Kwan, her mom, and Martha Green to discuss the results of the evaluation and write an IPP addendum including a plan with a target date for the purchase of any necessary augmentative communication device.

- 3) Home staff will schedule 30 minutes a day of one-to-one time to talk to Kwan about things she likes to talk about. Whenever possible, Kwan's favorite staff person, Mimi Rosales, will be scheduled to participate in this activity. Kwan's speech is very slow and often difficult to understand, so this will be focused time with her. Home staff will talk to Kwan while assisting with personal care and at other times when they are supporting her.

### **FAMILY, FRIENDS and FUN**

**Current Status:** Kwan lives with three other women close to her age. Kwan likes visiting with her mother and brother, especially during the holidays. Her mother and brother visit her often. Kwan has told Mimi Rosales that she wants to spend more time with her new friend, Robert. Her life's dream would be to go to Disneyland with Robert. She also loves having her nails polished and going shopping with her mom. Kwan especially enjoys shopping for clothes, make up and jewelry. Kwan likes watching TV, especially the Disney Channel. In February, Kwan attended a Valentine's Day Party. She is very proud of the picture taken of her at the party that shows how pretty she looked in her red dress. Her mom framed it.

#### **Goals**

Kwan will maintain her strong relationship with her family, and Robert, make more friends, participate more in community activities, and explore a job or volunteer work.

#### **Objectives**

- 1) Martha and her staff will provide support for Kwan's to participate in fun activities of her choice in her local community at least once a week.
- 2) Kwan's mom, home staff and Loi will help Kwan plan a trip to Disneyland.

#### **Plans**

- 1) Martha will help Kwan to arrange for weekly visits with Robert, and, at Kwan's request, will help coordinate additional visits.
- 2) By October 1, 2016, Kwan's mom will work with Kwan to develop a budget and savings plan for the Disneyland trip.
- 3) Mimi Rosales pointed out that the National Self-Advocacy Conference is being held in Anaheim in September, 2017, and that Kwan's boyfriend Robert is planning to go. Mimi volunteered to talk more with Kwan about whether she would like to go to the conference AND Disneyland at the same time. Mimi also volunteered to help Loi and Kwan plan the trip to Disneyland. By October 1, 2016, the plan for going to Disneyland will be developed.

- 4) As prearranged with Kwan's mom, home staff will arrange for Dial-A-Ride to take Kwan to and from the mall to meet her mother for shopping.
- 5) As prearranged with Robert and Kwan, home staff will arrange for Dial-A-Ride to take Kwan to and from Robert's home.

### HEALTH

**Current Status:** In late January of 2003, Kwan was diagnosed with high blood pressure. Medication has brought her blood pressure down to 132/86. The doctor ordered a diet with no coffee or added salt. Kwan continues on her high fiber diet. She is allergic to tomatoes and tomato products. Although she is on stool softeners and laxatives she continues to experience chronic constipation. Kwan's gums bleed easily as a result of the gingivitis. Seizure frequency is reduced to about 5-6 grand mal seizures per year. Seizures last 1-2 minutes. Seizures sometimes are noted to be in association with episodes of severe constipation.

Kwan's last visit to her primary care physician, Dr. Ubeewell was 5/14/16. Her blood pressure was within normal range. Kwan is to return every three months or more frequently as needed. Kwan's last visit to her neurologist, Dr. Nicely was 7/12/16. Her serum blood level for Tegretol and TSH was normal. She is to return yearly or more frequently as needed. Lab work needs to be done prior to visit (call doctor for order). Kwan last saw her gynecologist, Dr. Young, on 1/30/16. Dr. Young works with the Adult Special Disabilities Clinic at University Hospital and Kwan feels very comfortable. She has an examining table which makes transfer from her wheelchair easy. She had a breast exam and pap smear on the same date, and a mammogram on 3/22/16. Findings were normal for both. Kwan is to return for a yearly breast exam, pap smear and mammogram (Bay Area Breast Center). Kwan went to her dentist, Dr. Y. Nocarries, on 2/28/16. She had 2 small cavities that were filled and her teeth cleaned. She is to return two times a year. She saw Dr. Hearless, her audiologist, on 2/15/16. Dr. Hearless diagnosed moderate hearing loss in left ear. She is to return once a year for follow-up audiogram.

#### Goal

Kwan will be supported to have the best possible health.

#### Goal

Kwan will receive ongoing medical and dental care and age and gender appropriate health screenings.

### Objectives

- 1) Martha Green will make all necessary medical/dental care appointments.  
Martha will make appointments on the following schedule:  
Primary Care Physician: Dr. Ubeewell; last visit 5/14/16; return quarterly or more frequently as needed.  
Neurologist: Dr. Nicely, last visit 7/12/16; return yearly or more frequently as needed; and, call doctor for lab order prior to yearly visit.  
Gynecologist: Dr. Young, last visit 1/30/16; last pap smear 1/30/16 and last mammogram 3/22/16, return for yearly pap smear and mammogram.  
Dentist: Dr. Nocaries, last visit 2/28/16; return two times a year.  
Audiologist: Dr. Hearless, last visit 2/15/16; return once a year for follow-up audiogram.
- 2) Kwan's mother wants to accompany her to her yearly neurologist appointment, her twice-yearly dental appointments and her yearly audiogram appointment.
- 3) On a quarterly basis, Kwan's ERC service coordinator will review Kwan's ongoing notes, seizure log, bowel log, medication and other health records for any changes or special incidents and take appropriate action.
- 4) Martha or a home staff member will accompany Kwan to all medical and dental appointments, provide necessary information, document all visits and the outcome in Kwan's notes, and follow doctor's recommendations. Martha will notify Kwan's mother of any scheduled appointments, as well as any changes in Kwan's health, e.g., illness, injury and any hospitalization or ER visit.
  - a) In consultation with the Green home's dietician, Kwan, her mother, and home staff will develop and follow a menu plan for Kwan's therapeutic diet. To help prevent constipation and maintain good health, staff at Kwan's home and day program will offer Kwan water throughout the day.
  - b) Martha Green and both home and day program staff will keep and share a record of Kwan's seizures. Home and day program staff will assist Kwan to take prescribed medications following doctor's orders.
  - c) Martha Green will provide the day program with pharmacy prepared and labeled bottle of Tegretol for Kwan's midday dose. Armand Garcia will ensure that day program staff who assist Kwan with her medication are trained to safely assist her and that they document each dose.

### Plans

- 1) Martha Green will coordinate menu planning with Kwan's day program. As ordered by her primary care physician, Kwan will be encouraged to eat foods high in fiber and will not eat (or drink) coffee, salt or tomatoes.
- 2) Martha Green will ensure that home staff keep a daily record of Kwan's bowel movements. She will work with the day program director in sharing this record. On every third day without a bowel movement, home staff will assist her to take the prescribed dose of Milk of Magnesia and document Kwan's medication log. If she has no bowel movement on the next day, home staff will call Dr. Ubeewell.
- 3) If frequency or duration of seizures increase, Martha Green will call Dr. Nicely.
- 4) Martha Green will ensure that home staff has been trained to safely assist Kwan and that when providing assistance, staff follow the Five Rights for assisting with medications and document each dose on a Medication Log.

### EDUCATION/WORK/DAY ACTIVITY

**Current Status:** Since her move to the Green home, Kwan has attended Hillside Day Program, 73468 Southside Lane, Roseland CA 90375, telephone (405) 696-1173. The program has a one to three staff ratio to support people who use wheelchairs, like Kwan. Kwan's activities include music appreciation, artwork and a class on current events. Kwan has a longer lunchtime so that she doesn't have to hurry. She also gets additional assistance to help her while she is eating. She has made several friends at Hillside, and has a special new boyfriend Robert. She enjoys the half hour bus trip to the Center since Robert is on the bus and they sit together. Kwan likes water and has expressed a desire to swim in a pool. Kwan likes birds, and has expressed a desire to work in a pet shop someday where there are lots of birds.

### Goal

Kwan will expand her daytime activities to include swimming and more community activities.

### Objectives

- 1) By 10/15/16, Martha Green will make an appointment for Kwan with Dr. Ubeewell to discuss her desire to swim. Martha Green will notify Kwan's mom of the time as she wants to go to talk to the doctor as well.
- 2) Kwan's service coordinator will provide any specific orders to the day program staff regarding the doctor's instructions for swimming.

## Appendices 2-B (cont.)

- 3) Following instructions from Kwan's doctor, day program staff will make arrangements for and support Kwan to swim at least 3 times a week in a pool, preferably a warm indoor pool.
- 4) Day program staff will look for community groups with an interest in birds and support Kwan in becoming involved. Martha Green and home staff will also provide support for evening and weekend activities of whatever group Kwan chooses to join.
- 5) Day program staff will take Kwan on weekly visits to a local pet store, bird aviary and other places where Kwan can share her interest in birds.
- 6) Kwan will continue to attend Hillside Day Program. ERC will fund Hillside Day Program for Kwan through 11/1/17.
- 7) Dave Chauncey at New Horizon Bus Services 5567 Studebaker Circle, Roseland (405) 333-2056 will provide transportation to and from the day program five days a week. Dave will ensure that all drivers are trained in First Aid and correct "tie-down" procedures for wheelchairs. ERC will fund the transportation service.
- 8) Kwan's ERC service coordinator will visit Kwan at the day program at least once every six months or more frequently as needed to review Kwan's IPP with Kwan and her mother and their satisfaction with her services.

### Plans

Martha will collaborate with Kwan's day program to ensure she is supported by home staff to swim and engage in more community activities.

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Signature of ERC Representative Title Date

I certify that I have participated in the development of the IPP and give permission for the plan to be carried out. I further understand that, if changes occur before the scheduled Annual Review of this plan, I may contact the regional center to discuss any needed modifications to the plan.

The Everyone's Regional Center Complaint and Appeal Process have been explained to me. I have been informed that I will receive a copy of this plan.

I approve the continuation of my current service coordinator.

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Signature Relationship Date

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Signature Relationship Date

## Appendices 2-C

### Looking at Service Quality

*Adapted from Department of Developmental Services (1999)*

*As you read each of the following statements, think about the services for people who live in the home where you work. What do you think about those services and supports most of the time?*

<b>CHOICE</b>	Yes	Could Be Improved	No
We know each person's likes, dislikes, and needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual choices and preferences are a part of each person's daily life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If individuals cannot communicate, there is someone who helps speak for that person such as a family member or advocate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We all know the goals in each person's Individual Program Plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Each individual has opportunities for making choices everyday; for example, when to get up, what to wear, and what to eat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Each individual has opportunities for making major life decisions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Training and support in choice and decision making is provided for individuals as needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>RELATIONSHIPS</b>			
Individuals make contact with family, friends, and community members on a regular basis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individuals have opportunities to meet new friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People have a choice of who to spend time with and where.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People have the support they need for having contacts with family, friends, and community members.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People have the support they need to make new friends and to develop caring relationships.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Someone is available and willing if an individual wants to talk about relationship issues; for example, problems with boyfriends or girlfriends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Appendices 2-C (cont.)

<b>LIFESTYLE</b>	<b>Yes</b>	<b>Could Be Improved</b>	<b>No</b>
Each individual has a method of communication and someone to talk to (in their same language).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Each person has adaptive devices or equipment as needed; for example, a communication device, wheelchair, special eating utensils.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Each individual has opportunities for learning things that lead to greater independence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Each person has opportunities for completing everyday life activities on his or her own or with support.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We know the religious or cultural preferences of each person and honor those preferences.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Each individual participates in everyday community activities with other community members.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
 <b>HEALTH and WELL-BEING</b>			
The home is accessible and safe for each person who lives there.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Each person has opportunities to exercise.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individuals are provided with health care to meet their needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We all know about the medications (and side effects) used by each individual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information about safe sex, drugs, and/or alcohol abuse is provided if needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Each person knows what to do in an emergency or there is someone to help him or her in an emergency.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
 <b>RIGHTS</b>			
Each individual is safe from abuse, neglect, or exploitation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Each person knows his or her rights and responsibilities and is supported in learning about them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individuals speak up for themselves or receive training or support in speaking up for themselves.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individuals have training or support on what to do if harmed by someone else.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individuals are treated with respect by those who work with them and by others in the community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Appendices 2-C (cont.)

<b>SATISFACTION</b>	<b>Yes</b>	<b>Could Be Improved</b>	<b>No</b>
Individuals are satisfied with the services and supports they receive in the home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friends and family of the individual are satisfied with the services and supports we provide.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The individuals we support have opportunities to tell us if they are not satisfied.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We are satisfied with the services and supports we provide.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In general, the people we support are happy with their lives.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Looking at Service Quality

As a group, figure out the number of **Yes**, **Could Be Improved**, or **No** responses for each section (for example, CHOICE).

<b>CHOICE</b>	_____	_____	_____
<b>RELATIONSHIPS</b>	_____	_____	_____
<b>LIFESTYLE</b>	_____	_____	_____
<b>HEALTH and WELL-BEING</b>	_____	_____	_____
<b>RIGHTS</b>	_____	_____	_____
<b>SATISFACTION</b>	_____	_____	_____

*Now, below, write the three areas with the highest **Yes** numbers:*

*Next, write down the area with the highest **Could Be Improved** and **No** numbers:*

*What are some ways you can think of to improve services in that area?*