Delaware Health and Social Services

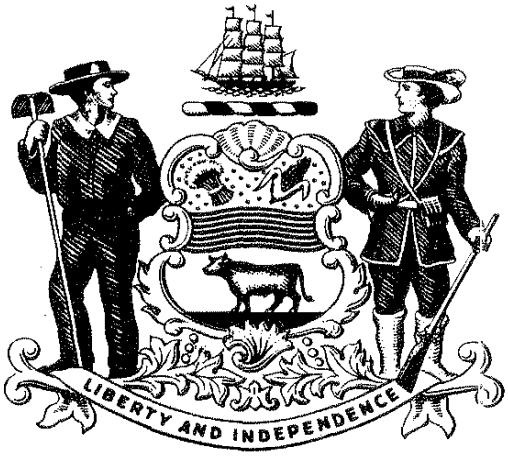
Division of Developmental Disabilities Services

Essential Lifestyle Planning (ELP) User's Manual

Fourth Edition
(April 2014)

Delaware

Division of Developmental Disabilities Services



Essential Lifestyle Planning Users Manual

April 2014 – Fourth Edition

INDEX

SECTION 1

INTRODUCTION

This Users Manual is for people who are involved in developing ELP's. The Essential Lifestyle Planning Process is a process that is constantly changing to meet the needs of the person. The same is true for this Users Manual – Third Edition. As this is an ongoing process, everyone's input is important as to how we can improve, so the manual and ELP plans can be the best they can be.

The Essential Lifestyle Planning Process was originally developed by Michael Smull and Susan Burke-Harrison. Also, much of the material included in this manual was developed by; Michael Smull, Bill Allen, Susan Burke-Harrison and Helen Sanderson. Finally, the information on learning was largely developed by Dana Henning. The materials are used with permission of the Authors.

However, Delaware's ELP Process has truly been adapted by Delaware for Delaware. We encourage your input so that you, too, can be part of this process and make it work for all of us.

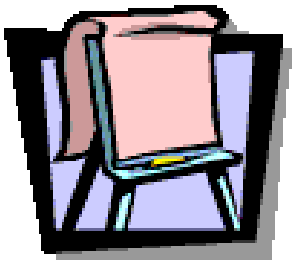
Remember:
A Plan is Not an Outcome
Helping People Get the Lives They Want is the Outcome

LOOKING AT ESSENTIAL LIFESTYLE PLANS

Essential Lifestyle Planning is a way of listening to people, recording what was heard, and developing a support plan that is as unique as each individual and addresses how the person wants to live. In an Essential Lifestyle Plan, efforts are made to learn what is important to the person in everyday life and to determine what we can do to help the person have more of what is important to them. The plan can be seen as a series of questions and answers. Please note that the answer to the central question "What is important to the person with whom we are planning?" is not found by asking the question directly but by spending time with the person and talking to those people who know and care about the person.

ELP GENERAL LANGUAGE GUIDELINES

Words/phrases that shouldn't be in an ELP	Suggested Alternatives
• Let	• John will do it himself
• Allow	• John will tell you when he wants to
• Permit	• John goes to _____ twice a week
• Feed	• Help eating
• Toileting	• Help in the bathroom
• Model/Modeling	• Show, tell (what's the best way)
• Ambulate	• Walk, uses a cane to get around, etc.
• Client	• Person receiving services, name, etc.
• Verbal	• Talk, speak, tell
• Verbal praise	• Compliment (what works best)
• Redirect	• Change the subject (what works best)
• Monitor	• Keep an eye on (how, why)
• Wheelchair bound / Wheelchair person	• Person who uses a wheelchair
• High/low functioning	• Has the ability



ELP General Ground Rules

1. Be Respectful

It's possible to have fun and to have a respectful process. Remember that people need honest feedback, not harsh criticism or condescending remarks. Gentle frankness is helpful.

2. No Obsessing

In a preliminary plan it is much more important that everything gets said than it is to have it said perfectly. Encourage brief discussion about unresolved issues then suggest the issue be revisited after there is time to think about it. Try using the "5 minute rule". No more than 5 minutes spent on any decision about how to say something or where it should go.

3. No jargon, no disempowering language

Help each other remember to use every day language. Help people to rephrase things using empowering language (for example, we don't "allow" someone to go for a walk, we "support" them by learning what to do and what to expect when they want to go for a walk). Try to use words like help, assist or support rather than supervise, allow or monitor. Remember not to use "jargon" words that only people working in our system would understand. Anyone should be able to read and understand an ELP.

4. No fixing

People are not broken and we are not trying to "fix" them. The focus of ELP is to help people to live the lives THEY want to live. We can't do that all at once, so listen to the person and try to resolve the most critical issues first with respect to how the person wants to live.

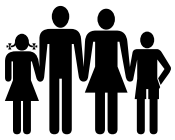
5. Don't discuss sensitive or private issues in a large group

Only people identified by the focus person or staff actively involved with a particular sensitive issue need to discuss it. This is a way of attempting to make the person as comfortable as possible when sensitive issues are addressed. Make sure sensitive issues are dealt with on a "need to know" basis in order to maintain the focus person's dignity and privacy.

6. Not complete until it is signed off by the individual

7. Not to be created at the day of the annual meeting; the annual meeting is a time to review.

SECTION 2



GETTING STARTED

Much of the material in this section is adapted from Helping People Leave Institutions: A Blueprint for Essential Lifestyle Planning, by Michael Smull and Bill Allen, 1997 and other materials by Michael Smull. The originals can be obtained from the Allen, Shea & Associates web site at: http://www.allenshea.com

FIRST STEP: TALK TO THE PERSON

(this should occur at least two months before a finished plan is required)

Explain the ELP Process to the person. Spend time with the person. Review the planning process and the reasons for doing the plan with them. **Do this regardless of your perception of whether or not the person will understand.** If there is a question about how well the person understands the process, have someone sit in who knows them well and cares for them. They can help you determine how best to proceed.

After you go over the process with the person (giving them a copy of "Looking at Essential Lifestyle Planning" might help), decide with the person:

- Who do they want to be involved
- Do they want someone to advocate for them through the process
- How the focus person wants to be involved or informed about these conversations
- What topics or issues are "off limits" for particular people, and what topics need to be dealt with in a particular way.

When what the person wants will create a problem in developing a good first plan (e.g. the person has challenging behaviors and does not want to talk with anyone about them), negotiate an acceptable compromise. With the person, decide on the smallest number of people who should be involved, at least one or two people the person trusts. Explain that the plan won't be complete without addressing these issues. The compromise should be acceptable to the person and should work in developing the plan. Working with the person to compromise on issues promotes a feeling of mutual respect and often has very positive results.

LISTENING TO PEOPLE WHO DO NOT USE WORDS TO TALK

Many people do not use words to talk, or use very few words. Even if someone you are planning with does not use words to talk, you should involve them in all the conversations unless they choose not to be involved. Involving the person in all of the conversations you have can give you information about the person's non-verbal communication. If you are planning with someone who does not use words to talk, refer to the "Communication Section" to develop a plan so that the "voice" of the person is represented.

SECOND STEP: TALK TO PEOPLE WHO KNOW AND CARE ABOUT THE PERSON

Who Should We Talk To?

Besides the focus person, remember that the most important people to talk with are the people the person chooses, people who spend time with the focus person, people who care about the focus person and like being with them, and people who provide services to the person, such as the Nurse or BA/PA. Keep in mind that the more people you talk to, the richer the ELP is likely to be.

Where Should We Talk?

You should talk in a place that is comfortable for the person, preferably in a place they choose. You may talk in their home, in the park, at a restaurant or anywhere people feel comfortable and there is enough privacy to honestly share thoughts, feelings and concerns about the focus person.

You can also talk to people over the phone, but remember the information you get may not be as rich as that obtained from a face-to-face conversation. People communicate in a variety of ways, not just with words, and if you are speaking to someone over the phone, you may miss things like seeing the speaker's eyes light up when they talk about the person.

When There Are More People to Talk to Than There is Time:

One good way to gather information from people you are unable to meet with is to ask them to complete an ELP Personal Profile. Blank copies of the ELP Personal Profile are included in this Manual. Face-to-face conversations are always preferred because they will help you gather the best information.

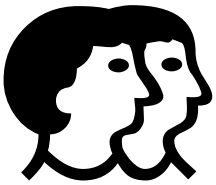
CONVERSATIONS vs. INTERVIEWS

Think about how you are going to have a conversation with each person. If you have an interview (asking a set of prepared questions), you will learn only what you expect to learn. If you have a conversation (asking questions, listening carefully, asking more questions based on the answers), you will learn things that are important and that weren't suggested in advance. In conversation, you want to avoid:

- Closed Ended Questions – Questions that must be answered "yes" or "no" and questions that must be answer with one or the other (e.g. Do you like this or that?). You should only use these types of questions to clarify information you have already.

- Leading Questions – Questions that, when asked, seem to suggest the preferred answer (e.g. "You want this, don't you?" or "You'd like to live in that house, wouldn't you?") You should avoid using these types of questions whenever possible. If you hear yourself (or someone else) asking these kinds of questions, stop, think, and rephrase the question.

It is almost impossible to avoid these kinds of questions entirely, but there are some ways you can avoid "interviewing" someone, and simply have a conversation with them.



GATHERING INFORMATION

(At least 2 months before the Annual Meeting)

At least once in the information gathering process, you should talk with as many people as you can who know the person. This will give you a chance to "bounce things" off each other and make sure information is accurate.

Before you begin to talk with people who know and care about the focus person, you should have some idea about what you need to learn. For everyone, you should know:

Who and What is Important to the Person –

- In relationships with others
- When interacting with others
- Things to do
- Things to have
- Rhythm or pace of activities
- Routines or positive rituals

What Others Need to Know and Do -

- In helping the person get what is important to them
- When addressing issues of health and safety within the context of how the person wants to live.

Make sure to include those things that should be absent from a person's life as well as those things that should be present. When we are confronted with things that we prefer absent from our lives, we leave the situation. We may change where we live, with whom we live, what we do. The focus person might express their distress with words or actions, but will probably need our support to get the changes they need in their lives.

How Much Do We Need to Know?

The more physical assistance a person requires, the more you need to focus on the details, especially Individual Protection and Outcome Plan (IPOP). Explore how much help is needed or wanted, the sequence of events the person prefers, how the help is provided, and how the person lets you know if its being done the right way, or the wrong way, and how the person will let you know when they want to change the way its done.

For many individuals with challenging behavioral issues there are, or have been, people in their lives whose support has resulted in fewer instances (or even absence) of the challenging behavior. Explore what it is about those people that had this positive effect in the person's life. Is it the way they talk to the person, they way they offer help, their mannerisms, their attitude? Answering these questions can often begin to shed light on what is important in how the focus person is treated and the characteristics of people who should be present (or absent) in their lives.

For individuals with challenging health issues, explore what others need to know, and to do, to help the person stay healthy. The Nurse will be actively involved. Learn as much as you can about the way others should help, the setting, the time, and special things that should happen before or after. Describe, as clearly as possible, the order things should happen in, what explanation, if any, does the person prefer along with what is happening.

HELPFUL HINTS

Much of the information in the following sections is adapted from The Council on Quality and Leadership in Supports for People With Disabilities (The Council) and the Outcome Based Performance Measures. More information about The Council can be found on their web page: http://www.thecouncil.org

Sometimes the most difficult thing about having a conversation with someone is getting started. Whether you are talking with the focus person, a family member or others who know and care for the person, here are some suggestions that might help:

- **Ask the person you will be talking with *where* and *when* they would like to talk**. Do not show up at someone's home and begin having a conversation with them. Be respectful - make an appointment to sit down and talk. When you arrive, ask if there is a specific location (the bedroom, the living room, the porch) where the person would like to talk with you. Try not to schedule time to talk immediately after someone arrives home. Most of us need some time to relax when we get home.

- **Ask the person if they need any accommodations**. If they want to talk with you somewhere other than their home, ask if they will need wheelchair accessibility, special equipment, help arranging transportation, an interpreter, etc.

- **Before you begin, explain to the person the purpose of your conversation** (it may have slipped their mind since you set up the appointment).

- **Ask the person if they would like anyone else to sit with you while you talk.** Many people will feel more comfortable if they are able to have a friend, family member or familiar support staff present.

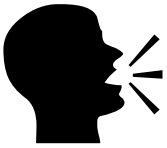
- **Ask the person if they would like anything to make them more comfortable while you talk** – maybe a soda or a cup of coffee or tea, or a pillow for their feet.

- **Explain to the person that you will be taking notes while you talk, and that others may also** so you can remember the things you'll be talking about. Explain to them that your notes are to help you remember the things they tell you. Ask them if they would like something to take notes on too.

- **Let the person know that it is OK for *them* to set limits too**.
  - Let them know that when they get tired, its OK to call for a break or end the conversation – perhaps you can make an appointment to come back another time.
  - If there are issues they do not want to discuss, ask if they would be willing to discuss them in a different setting, or on another day, or in different company.
  - If the person ends the conversation, but you still need more information, ask them if its OK for you to talk with other people (family, support staff).

- **Direct <u>ALL</u> of your questions to the person from whom you are seeking information <u>*even if they do not use words to talk*</u>**. Explain to support staff and family members that you will be addressing questions directly to the person, and request that they give the person time to answer. Ask them to check with the person before answering for them ("is it OK if I help you answer that question?"). This promotes an atmosphere of respect for the person.

- **Don't interrupt usual routines**. It is not respectful for us to try to have a conversation with someone when it's time for something else important to happen. For example, do not interrupt snack time to have a conversation. If you happen to be having a conversation, and snack time rolls around, ask the person if they would like to talk while they snack, or if they would like you to come back later, or another day.



BEGINNING THE CONVERSATION

Remember, a good way to begin is to "walk through time" with the person. Start by asking questions about what happens in the morning, what time the person gets up and what makes a good morning or a bad morning, and then proceed through the day. Although you should not approach a conversation with a prepared set of questions, here are some suggested questions that might help to get you started. <u>*These questions are only*</u>

When you are gathering information from someone other than the person, remember 5 very important words: <u>***HOW DO YOU KNOW THAT?***</u>

When someone gives you information about the person, and the person is not able to confirm this for you, ask those 5 words to verify that the information is correct. If you ask someone "how do you know that" and they are able to tell you, the information might be correct. If you ask someone "how do you know that" and their answer is "because someone else told me", you should check to make sure that information is accurate.

When talking to others who know and care:

- What is your relationship to the person?
- How long have you known the person?
- How much time did/do you spend with the person?
- What do you like most about the person?
- What is your favorite story about the person?

When talking to people who don't use words to talk:

- Use the ELP Communication Table if you have one (see section 6 of the ELP Users Manual)
- What important information do we need to know about how you communicate with us?
- What can we do to help with communication?
- Do you have a picture system or adaptive device?

When talking about home:

- How did you choose to live here?
- Where else have you lived?
- If you could live anywhere, where would you live?
- Would you like to show me your room?
- Would you like to show me some of your favorite things?
- How do you like to spend your free time at home?

When talking about work or day service:

- How did you choose this as your job/day service?
- What other jobs/day services have you tried?
- If you could have any job/day service, describe what it would be like
- What kind of things do you do at work/day service?
- When do you get breaks and lunch?
- What do you like to have to eat or drink during breaks and lunch?
- How would you arrange your schedule if you could have it any way you want?

When talking about important routines:

- What time do you wake up in the morning?
- How do you wake up? (alarm clock, wake up by myself, etc.)
- What time do you eat breakfast?
- What do you like to eat for breakfast?
- Do you eat before or after you get dressed?
- What time do you leave the house on a "typical" day?
- What time do you come home?
- What do you like to do when you get home?
- What time do you go to sleep?
- When do you shower or bathe?

When talking about important people:

- Who are the people you like to spend time with?
- What kinds of things do you like to do when spending time with those people?
- Where do you like to spend time with them?
- How do you keep in touch with the important people in your life?
- What kind of help do you need to keep in touch with them?
- Are there important people in your life you don't get to see or talk to?

When talking about favorite things to do:

- What are your favorite things to do?
- Where do you do them?
- Are there special times or days you like to do them?
- Are there special people you prefer to do these things with?
- How do you make arrangements to do these things?
- What kind of help do you need to do these things?

When talking about physical health:

- How are you feeling?
- Is there something about your physical health making you feel bad?
- How do you deal with your physical health issues?
- What help do you need/want to deal with these issues?
- What medicines do you take?
- What help do you want/need to take your medicine?
- What medical equipment do you use?
- What help do you need/want using or maintaining your medical equipment?
- Who helps you take care of your physical health issues? (Doctor, nurse, etc.)

When talking about Mental Health:

- What mental health issues are you dealing with?
- Who supports you with mental health issues? (Psychiatrist, Psychologist, etc.)
- If you have a counselor, how often do you see them?
- How can we help?
- Are there things that make it better? Worse? What are they?
- What happens when you get upset?
- How can we help when you're upset?

When talking about behavioral issues:

- What behavioral issues are you dealing with?
- Who supports you to deal with these issues? (B.A., Psychological Assistant, etc.)
- Are there things you do that you would like to stop doing?
- How can we help you stop?
- Are there things you do that you would like to do differently or change?
- How can we help you do them differently or change the way you do them?
- How do you let us know you are happy, sad, mad, upset?
- Are there special people who really know how to help you? Who are they?

When talking about goals, accomplishments, hopes and dreams:

- What things have you accomplished in the past year that made <u>you</u> feel good?
- How did you accomplish them?
- What help did you need to do it?
- Is there anything that you want to do, but can't?
- If there are things that you can't do, why not?
- What kinds of things would you like to do in the future?
- Are there things you would like to learn?
- Are there things you want to try, but haven't? Why not?

DEVELOPING A FIRST PLAN

INTRODUCTION

Once you have gathered information through conversations with the focus person and others that know and care for them, you will need to begin putting this information into the ELP format. You should start with the required headings, and place relevant information under each heading. For now, don't worry about what language you use, the order of items, or whether you need additional headings. The first step is just to get it all written down.

When your first draft is done, review it for the following:

Language – make sure you don't use "jargon" or disempowering language. Your plan should be written in "every day" language and should include the terms that the focus person uses every day. For example, if the focus person refers to their quad-cane as "my walking stick", this is how you should refer to the quad-cane in the plan (don't forget to include an explanation of what "my walking stick" means for anyone who doesn't already know the person).

Location – make sure information is located under the correct heading (see Required Headings for Delaware). If you find information that doesn't seem to fit under any of the required headings, you may need to add subheadings or arrange items differently. Some items will need to be included in more than one section.

Relationship - organize items under each heading that go together and relate to each other. Try to organize the information in "natural" groupings. For example, if there are several things about getting up in the morning that are important to the person, you might want to try groupings like "In the Morning" or "Getting Started for the Day". Think of a phrase that describes the items in a group and develop your own subheadings. Some examples of subheadings:

- Things John Must Have in His Life
- Things Jane Needs Before Going to Work
- Before Going Home For a Visit, John Must …
- Regarding Jane's Family …

Good plans take time and patience!

UPDATING & REVISING

An Essential Lifestyle Plan will never be "finished". As people try and learn new things and have new experiences, they often discover even more new things they'd like to try. As people begin to live the kind of lives they want to live, they may need or want to be supported in different ways. So when do you add information to the ELP you have already helped the person develop, and when do you need to begin work on a new version? Each person will have different needs. Some people may want to change their ELP often, as they may be trying and learning lots of new things! Other people will not need or want to change their ELP as often, because they prefer to have new experiences more slowly. Following are some simple guidelines to help you decide when to update and when to rewrite.

When to UPDATE & REVISE (add information to the existing ELP)

- ALL THE TIME!
- When someone has a new experience they want to have again
- When someone has a new experience they NEVER want to have again
- When someone tries something new, and they want to try it again
- When someone tries something new and they NEVER want to try it again
- When you try something new with the person, and it works!
- When you try something new with the person and it doesn't work
- When the person tells you something new about how they want to live

When to EDIT (change)

- When a person changes services (finds a new doctor, a new Case Manager, etc.)
- When the person gets a new job, or changes jobs
- Before each Annual Meeting (after team members have reviewed it with the person)
- When the person's support needs change significantly
- When the person is dealing with a new major health issue
- When the person is dealing with a significant new behavioral /psychiatric issue
- When the person moves to a new home (at the 30 day conference) and as often as necessary thereafter, to capture new things being learned about someone.

ESSENTIAL LIFESTYLE PLANNING:
HEADINGS FOR DELAWARE

ELP Heading	Purpose of Heading	Required / Optional
◆ Cover Sheet	Identifies the person, date of plan, place, time and date of team meetings, relationship of contributors to the person, others who contributed to the plan, the purpose of the plan	R
◆ What ____ Must/Must Not Have in His/Her Life –OR- People and Things Most Important to ____	Identifies what is most important to the person to have (or NOT have) in their life; what they love or hate [Note – Things should be listed, even if the person doesn't currently have what is important to them]	**R**
◆ What ____ Likes/Dislikes	Identifies what is second in importance to a person(Non –verbal only)	**R**
◆ Desired Outcomes	Identifies personal goals ... Make sure the person understands what a "dream" or "personal goal" is	**R**
◆ Things to Try or Learn	Identify opportunities that the person may be interested in (new things, learning something, motivation, achieving a personal goal, etc.)	**R**
◆ Issues to be Resolved	Identifies issues that currently do not make sense in a person's life, but that the support team is unable to change or work on this year. Example – the person loves to swim, but is unable to do so currently because of doctor's orders relating to a particular health condition. This is not something the support team can resolve, but it is still important information to know in supporting the person, and may one day be resolved if/when the particular health condition improves.	**O**
◆ Outcomes	Identifies outcomes and necessary supports for a person.	**R**
◆ ELP Signature Page	Signed by everyone who supports the person, stating that they have read, and agree to contribute to, the ELP	**R**

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
STOCKLEY CENTER
Georgetown, Delaware

Required Heading for Essential Lifestyle Plans

_____

_____

What People Like and Admire About _____(Remove)

What _____ Must or Must Not Have in His/Her Life

The Likes and Dislikes Section is for individuals who are non-verbal.
What _____ Likes

- In General
- Favorite Activities
- Favorite Places to Go
- Favorite Foods/Beverages

What _____ Dislikes

- In General
- Favorite Activities
- Favorite Places to Go
- Favorite Foods/Beverages

Desired Outcomes

Things to Try or Learn

Issues to be Resolved

Outcomes

ELP Signature Page

* note – items in **BOLD** type indicate required headings. Headings not in bold type are used only if they apply to the person with whom you are planning.

SECTION 3

The Cover Page

The cover page of the ELP should contain the following information:

- The person's name
- The date the plan was completed (usually in a header at the top of the page)
- The reason for the ELP (annual meeting, converting a record, moving to a new home, etc.)
- The date(s) of meeting(s) that were held to gather information
- The location of the meeting(s)
- The names of individuals who attended the meeting(s)
- The relationship of the individuals to the focus person
- The names of other people who contributed information for the ELP (but who were not able to attend the meeting)
- The page number (usually in a header or a footer on the page)
- The Index (only needed for long ELP's – may be put on a separate page if necessary)
- **For Stockley Center ONLY** – Signature of the ELP - Individual's case number and living area

Reminders:

If several meetings are held to gather information, make sure you put them on the cover page. You should include the location, time, date and people who attended for each meeting.

Remember to involve the people who know the person best, such as family, friends, etc.

Personalize it! You can use graphics and pictures on the cover page of the ELP to help make it more personal. You can also help the person pick out special stationary on which to print the final draft, or ask them what else they would like to add to make it "their" ELP.

(For tips on using graphics and pictures, see the section "Computer Tips for Composing ELP's" in this Manual.)

SECTION 4

SECTION 5

What the Person MUST or MUST NOT have in their life
OR
People and Things MOST IMPORTANT to the Person

These are the most important things in a person's life. The things or people that the person needs to have in order to be reasonably happy. Without these things, the person would be unhappy, and this may lead to the person withdrawing, or developing challenging support needs. These things may not seem important at first, but they are VERY important to the person in having the kind of life they want to have.

This section should include ALL things that the person believes are absolutely necessary for their happiness, even if they do not have them in their lives right now. If the person does not have some of these things in their life, but believes they are essential to happiness, then you would address how this is being handled through Desired Outcomes or supported in the IPOP.

Some examples of "Things the Person Must / Must Not Have in Their Life"

(Desired Outcomes)- Important TO:

- Something the person wants, and how we will support them to obtain it. Short and/or Long term goals

John must have his Cigarettes

- Does not have enough for the month= Goal (budgeting plan or specific number of cigarettes a day)
    - Example: John will budget $50.00 a month from his personal spending for his cigarettes.

(IPOP)- something identified but is naturally supported)

- John must have his Coffee in the morning = IPOP
    - John must have his coffee at breakfast time with cream and sugar.

If there is something in the person's life that they believe they must have, but which is not possible for them, we need to explain how we help the person understand and deal with this.
For example – John says he MUST live with his parents. However, John's parents are not able to provide a home for him. So, In Order to Support John, we should:

- Listen when he talks about wanting to live with his parents
- Help him to visit his parents as often as he can
- Encourage John to call his parents when he is unable to visit
- Help John find a home closer to his parents
- Help John understand why his parents can't provide a home for him by making time to talk about it

Special Considerations

For people who have Legal Guardians or family involved in the planning process– make sure what you include in this section is **ONLY what the PERSON wants!** You can address things the Guardian and/or family think are important under a sub-heading, such as "What ___'s Guardian/Family Thinks ____ Must Have" and add this under "What _____ Must Have" in the ELP.

(Service Plans): Important For:

- Nursing Care plans
- Safety plans

You can also use the sub-heading "What the Support Team Thinks _____ Must Have" if there are things that members of the support team believe are important for the person.

Things to Make Sure You Include in this Section:

- Who is important to the person and what is the contact like?
  - John needs to visit his mom every Sunday
  - Jane needs to call her dad every other Thursday
- What is important to the person when they interact with others
  - John prefers people who "talk softly"
  - Jane needs to be around people who talk loudly because she has a hard time hearing them
- What health issues are important to the person
  - I need to take my medicine on time or else I might have seizures and I hate when I have seizures
- What things are important to the person to do or have
  - I need a job where my hands can be busy all the time
  - I need to watch my favorite TV show on Tuesday nights
- Is there a pace important to the person?
  - Jane doesn't like to be rushed in the morning
  - John needs some time to relax and do nothing when he gets home from work
  - Jane needs to have a consistent routine

What the Person Likes / Dislikes

Things that should be included in this section are things the person would not consider to be essential to the person's happiness. These are things the person might like to have or do, but would not make life intolerable if they didn't have or do them.

The person may have a long list of things they like or dislike. You should group items together to make them more easily understood by someone reading the plan.

This section is very important for individuals who may have difficulty expressing their wants and wishes or uses a communication table. We use this section to get to know a person if we list these things, so include as many as you learn about!

- John's favorite food
- Things Jane likes to do in her spare time
- Things I like when I'm at work
- What I like to wear
- Things John likes to buy or collect

Remember:
When a number of these things don't happen or aren't present in the person's life, it can start to affect the quality of life, even though each thing individually might not be significant.

SECTION 6

THE DESIRED OUTCOMES SECTION OF THE ELP

Every individual should have the opportunity not only to dream, but to take active positive steps in pursuit of their dream. One of the most important steps in helping people to develop Essential Lifestyle Plans is to find out what their dreams are, and make sure that the supports provided also support their dreams, or at least do not stand in the way.

The "Desired Outcomes" section of the ELP should come immediately before "Things to Try and Learn".

HOW DO WE FIND OUT WHAT THE PERSON'S DESIRED OUTCOMES ARE?

Very simply – just ask! Whatever the person tells you their dream is, that is what you put in the "Desired Outcomes" section of the ELP. This may be a **short or long range goals.** Some questions you might ask the person with whom you are planning are:

- How do you want your life to be in the future?
- What is important to you to accomplish or learn?
- If you were in charge of the whole world, what would you change about your life, or add to it?
- If you could have or be anything you want, what would that be?

If the person is not able to tell you directly what their dreams are (perhaps they do not know what a "hope" or a "dream" is), then its necessary to spend time talking with them. Listen for them to say things like:

- Some day I want to …
- I wish I could …
- I have always wanted to …

These statements can be indicators of what the person's desired outcomes for their future might be. If you hear someone say things like this, explore them further … maybe you can help the person discover their dream.

WHAT IF THE PERSON DOES NOT KNOW WHAT THEIR DESIRED OUTCOMES ARE?

People who have had limited opportunities to examine their communities often can not answer the question, "What are your desired outcomes?" We develop these over a lifetime. We see, try and learn about different things, and from all those experiences, we formulate our dreams. For

some of us, the dream is to graduate from an educational program, for others, it is to achieve certain things in life – being part of a family, getting married, getting a car, owning a house, etc.

People who have had limited life experiences may have trouble identifying a dream for themselves. They may not be aware of what's possible in their lives.

For those people, it is important to have support staff who will help them explore their community, and their world, to have different experiences that will enable them to decide on outcomes for themselves. We can't guarantee that anyone will ever achieve their dreams, but we can guarantee they will have the opportunity to pursue them. The same opportunity we all have.

If the person is unable to tell you what their dreams are, then in the "Desired Outcomes" section of the ELP, you should document what efforts are being made to assist the person to learn about their world and their community. The entry in the "Desired Outcomes" section of the ELP might look something like this:

"John is not able to tell us what his Desired Outcomes are; However, he has expressed an interest in music, so we will begin to explore this with him in hopes of discovering a desired outcome. The way we will explore this with John is to_____ _____(list all of the things the team will support John to do in exploring his interest in music – this information might also be included in the "Things to Try or Learn" section of John's ELP)_____".

WHAT IF THE PERSON DOESN'T USE WORDS TO TALK?

If the person is not able to talk with words, the team should be able to make a best guess at what the person's desired outcomes might be.

If the person is not able to communicate to us their desired outcomes, it is a fair assumption to make that one of their desired outcomes might be to find a way to be able to communicate with us. If the team is not able to determine what the person's desired outcomes are, and the team is not able to make a "best guess" based on what they know about the person, then the team should be working to find a reliable, understandable way for the person to communicate so that their desired outcomes can become known and then supported. These efforts to find a reliable way of communicating should be addressed in the "Desired Outcomes" section of the ELP.

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All our dreams can come true - if we have the courage to pursue them.
Walt Disney

SECTION 7

The Communication Section

The Communication Section can be one of the most important sections in the ELP document. Using a well-developed communication section can help us understand what someone is saying, even if they aren't saying it with words. It can also be useful for people who say things with words, but aren't always able to express what they really mean.

Developing a Communication Table

First - talk to the people who know the person and spend time with him or her (support staff, day service staff, family, friends, anyone who knows them well) and ask them questions about how the person communicates.

> Remember – 5 very important words to use are: "**How Do You Know That**?"
> If someone can't tell you, or give you an example, they might be mistaken or might be repeating something they have been told that might not be accurate. If that happens, you should double check with the person or others that know the person well to confirm that the information is correct.

Some Suggested Questions for Gathering Information:

- Does the person speak a language other than English, and do they require an interpreter?
- How do you know when the person is mad?
- What does that look like? What are their facial expressions like?
- What should you do, if anything, when you see that they are getting mad?
- How do you know when the person is sad?
- What does that look like? What are their facial expressions like?
- What should you do, if anything, when you see that they are sad?
- How do you know when the person is happy?
- What does that look like? What are their facial expressions like?
- What should you do, if anything, to help them stay happy?
- How do you know if the person likes something?
- How do you know when they don't like something?
- How do you know if the person is tired?
- How do you know if the person wants something?
- How do you know if the person doesn't want something?

Remember to be sure and ask if they have different reactions in different settings (for example, if someone is mad at home, do they act differently than when they are mad at work? Do they act differently if they are out in the community and they get mad?)

Once you have all your information (write it all down, even if it seems silly or like people should already know that - you can sort through it later) then make a table and enter the information. Remember to group items into logical groups. For example, one section might be "When Jane is Home". Another section might be "When Jane is at Work". Still another section might be "Anytime" or "All the Time".

The Communication Table Layout

Your table should have 4 columns and the headings should be:

1) In this situation ...

2) When The Person (use the person's name here) does this ...

3) We think it means ...

4) You should ...

Some examples:

In This Situation …	When Jane …	We Think it Means …	You Should …
At Home	Walks back and forth and mumbles softly to herself	She wants someone to talk to her	Stop what you're doing and talk for a few minutes
At Work	Walks back and forth and mumbles softly to herself	She is finished with her work	Check to see if she'd like a break, or something else to do
When Shopping	Walks back and forth and mumbles softly to herself	She has picked out something she'd like to buy	Help her choose the item she wants and purchase it
Anytime	Walks back and forth and mumbles LOUDLY to herself	She is upset	Find out what's bothering her and help her figure out what to do about it
Anytime	Smiles and pats you on the back	Jane is happy with you	Be happy too!
Visiting her Parents	Begins to pace back and forth by the door	Jane is ready to go home	Take Jane home
Going to the Doctor	Begins to pace back and forth by the door	Jane is nervous about her appointment	Ask Jane to sit with you and explain to her what she can expect during her appointment

SECTION 8

"Things to Try or Learn"

INTRODUCTION

* note – for Stockley Center, refer to the approved plan writing format guidelines- remove

As a part of the "gathering information" stage of the Essential Lifestyle Planning Process, we come up with ideas of things for the person to try and/or to learn. All of the ideas that the person is interested in go under this new heading. Below is a list of the types of things that would go under this heading:

- Any new opportunities that the person may be interested in trying
- skills to learn
- learning about something/knowledge (i.e. history)
- to work toward, and achieve, a personal goal in life
- motivation to do something - to encourage people to try things when they have expressed an interest, but have been reluctant to actually do it (i.e. when the time comes to really do it)
- motivation to do something - to help a person become healthier or safer - when it is our idea and not their idea. They would still need to agree to it. (What if they don't agree? See the information on motivation later on in this section.)

The "Things to Try or Learn" heading is supposed to be a list of ALL the possible opportunities, and the ones the person will be working on in the coming year should be separated out and designated as such. The things the person will be working on in the coming year will also be listed as outcomes on the ELP "Action Plan".

How Do We Come Up With Ideas for the "Things to Try or learn" heading?

There are many ways to come up with ideas. There are no "right" or "wrong" ones. However, these should be things that the person wants to try (even if we came up with the idea). Also, the person must agree to it. (If the person doesn't speak with words, then we will do our best to come up with ideas we believe they may enjoy based on the things we already know about the person. Remember that the person should always be involved. Their body language should tell you whether suggestions are on the right track or not. People who don't speak can still tell us yes or no when we ask them a question.)

- Person says he wants to – This is probably the easiest way. Ask the person what he or she would like to learn or try.
- Ask friends, family, and staff (who know the person well) - Ask these folks which things seem to interest the person, when is it that this person seems most tuned in, eager to participate, etc.

- Perhaps the person would enjoy learning something new so that he or she could participate in an activity that his family members or friends do. The person doesn't have to learn the entire activity in order to participate.
- Try to build on other interests. For example, if a person loves to sit and rip pictures of boats out of magazines, perhaps he or she would be interested in going boating, or fishing, or building boat models, or having tropical fish. So you may get some ideas for activities by looking at other things the person likes to do.
- The person needs to learn something in order to do a job or to participate in an activity of his or her own choosing. The person may want to have a job making pizza boxes but doesn't know how to make pizza boxes.
- Teaching other ways of "saying" something or handling a situation. Perhaps the person hits his or her roommate as a way of saying "leave me alone". A goal for this person may be to learn how to tell people "leave me alone" or how to get away from others without hitting them. These things help people cope in a way that doesn't make them stand out in a crowd.
- A Person's best friend does it! Many of us develop interests in order to share experiences with those we care about. There are those who go to football games with loved ones but don't fully understand the game. Yet they enjoy themselves. People may want to learn to participate, even if not fully, in activities merely because their friend/family does it.
- Sometimes we do things because we have to do them for our own personal health or safety. Many of us do aerobics. Some of us even enjoy them. A woman may be living on her own and need to develop a system to remind herself to lock all the windows and doors before she goes to bed at night, or how to check that she knows a person before opening the door.
- Reminders of a time gone by – Many people have warm and fond memories of things they have done with their families before they moved. Support people so that they can re-gain the ethnic, religious, and family traditions.
- Have the person go out and try to new things or go new places. Find out what they think about what they tried. Do they want to do it again?
- Use staff as resources for new ideas. See if there is a staff person who plays a musical instrument, decorates cakes, loves to cook, collects stamps, makes things out of wood.
- Try some things in their neighborhood. An added bonus of doing things near your homes is that you are likely to build relationships with people who live nearby.

See If An Idea Can Pass These Tests:

◊ Does the person really want to do it? (If not, try motivation, try something else or figure out another way that the person agrees to.) If the person doesn't speak with words, review ideas with them and see if their body language tells you whether they think it is a good idea. Some people who don't speak can still "tell" us yes or no in some other way.

◊ If the idea has to do with learning something new, see if there is a way that this person could get the benefit without having to learn to do it? (ex.: Could the person use velcro sneakers rather than having to lace and tie his shoes? Could the person get a "talking clock" instead of learning to tell time?)

◊ Is there a material that could be adapted to avoid spending time on teaching something? (ex. Could the person carry a card that says "Is this the Downtown bus?" rather than

needing to learn to recognize the proper bus? In this example, if the person would rather learn to recognize the proper bus, then that is what we'd do.)

- ◊ Is there a way that the environment could be adapted to avoid spending time teaching something? (ex. If the person leaves the water dripping because she can't grip the faucet handle tight enough, could the sink be changed to have blade faucet handles that she can effectively use to turn the water all of the way off?)
- ◊ Can the person indicate that he wants to stop doing something? Will a person let you know they are not enjoying something by their body language? **It is very important for staff to know when, and how, a person is telling us to stop .** The person decides when to discontinue a plan (to try something).
- ◊ Are there any safety or health related issues that could involve trying something new? Does the person need any medical or other type of "clearance" to try something? (When you have worked through these issues, you would use the Supplemental Plan to document your efforts. This would go under "Preparation needed" in the Supplemental Plan)
- ◊ When motivation (regarding something that is vital to a person's health and/or safety) is being considered, **first ask: does the person REALLY need to do this**? (More about motivation later in this section.)

The Action Plan: Making Ideas Happen

Once you have the ideas listed under the "Things to Try or Learn" Heading, then talk with the person about which ideas they want to work on in the coming year. As long as it is possible to do, then all of the things the person wants to try this year get listed on the Action Plan. If some ideas will take a little work/preparation or we are not sure how to make something happen, then we will have to negotiate with the person. If the person wants to try more than staff can reasonably support, then you also need to negotiate this with the person. In other words, decide how many ideas we have the ability to help with. These are ideas that the person has selected or agreed to.

If the person doesn't speak with words, then try to figure out what the person may like to try, based on discussions with people who know and care about the person. The person should always be involved in these discussions! Body language can often tell us whether our guesses are right or wrong.

It is quite possible that not all of the things listed under the "Things to Try or Learn" heading will happen before the next ELP revision. The "Things to Try or Learn" heading is supposed to be a "laundry list" of ALL the opportunities the person can think of. The things that are planned to happen during the coming year will be designated in the "Things to Try or Learn" section and will be listed as an outcome on the "Action Plan".

Developing a Supplemental Plan

*At the Annual Conference (with discussions in advance), the outcomes for the year will be finalized and go into the ELP "Action Plan" section.

*A Supplemental Plan is used to outline the detailed plan of action that will enable us to work with the person to accomplish an outcome listed in the ELP "Action Plan".

*A Supplemental Plan is ONLY needed when an identified outcome involves more than simply doing it! For example, when specific instructions (of how to support the person or how to help the person learn something) or detailed preparations/plans are needed to help ensure success, then a Supplemental Plan would be needed. (If a plan is not needed, then we assist the person with the outcome and document how it went in the ELP Monthly Progress report.)

*The Supplemental Plan would be developed after the Annual Conference by the people who will help carry out the plan. **Copies of each type of Supplemental Plan, as well as instructions for completing each plan, are included at the back of this section.**

*Try out your plan before actually writing it! Have the person work on this plan with you. Ask the person for their ideas and get their reactions to yours. If they don't speak, then explain what you are going to do and ask them to sit with you while you do it. Then continue to explain your ideas and to read their body language.

*Types of Supplemental Plans:

- New Opportunities
- Learning
- Motivation (the person's idea)
- Motivation (vital to the person's health and/or safety - our idea)
- To Achieve a Personal Goal

Regarding the Motivation to do something

Motivation is involved when any of us need extra effort/encouragement to get started doing something. There are 2 circumstances where an idea under "Things to Try or Learn" may involve motivation:

1. The person says they want to do something, but they are reluctant (or refuse) when it's time to do it. For example: Sally says she loves to go shopping. However, whenever we ask if she wants to go, she says no.
2. Doing a particular thing is absolutely vital to the person's health, their safety, or other's safety. However, they don't want to do it (or hate to do it). **In these situations, make sure the person REALLY, REALLY has to do this thing!** (In other words, is there a way around it or does it really have to be done at all?)
   For example: Jackie needs to wear a splint on her hand. If she doesn't wear it, she will eventually develop a lot of pain in her hand. She hates to wear the splint. It is always a struggle to get her to wear it. Another example: James can do and undo his seat belt, but he won't do it up when he gets into the van. When staff do it up, he'll often undo it

What can you do when motivation is involved?

1. When a person says they want to do something, but they are reluctant**, find out why they are reluctant to do it**. There's probably a reason!
   *For example: The people who work with Sally (from example #1 above) talked to her to try to figure out why she always refused to go shopping, but says she loves to shop. When they asked her, she explained that one time she "had an accident" when she was shopping and it REALLY embarrassed her! It was more important for her not to be embarrassed again than it was to go shopping. So, they figured out what needed to be done to address her incontinence that would make her feel comfortable going out. Now she goes out all the time!!! They asked her why she never told them that before and she said, "You never asked me!!!"
2. When the person can do something, but won't, **first find out why they won't do it.** They may be willing to do it, IF you make a few changes. If that doesn't work, look at providing information (i.e. on the importance of doing something) by bringing in an "expert" on that topic.
   *For example: The people who support James, brought in a speaker from the DE Public Safety Commission who did a presentation (for everyone at the center) on the importance of seat belts. He showed a video and talked about what happens when you don't wear your seatbelt and you get into an accident. This was just what James needed to convince him (or give him the motivation) to wear a seat belt, even though it isn't particularly comfortable for him. The staff used to nag him about his seat belts. He didn't need nagging, he needed to hear the information from someone he saw as an expert. (The staff also do everything they can to make that seatbelt as comfortable as possible.)

   *Another example: Jackie hates to wear her splint and it is usually a struggle to get (and keep) it on. Jackie does understand why she is supposed to wear the splint, but she still fights it. When asked why she hates the splint, Jackie said that the splint gets very hot and gets really uncomfortable after wearing it for awhile. Several staff (who support Jackie) had things they did that seemed to make the splint more comfortable. One staff put baby powder on her hand before she put the splint on. Another staff massaged her hand whenever she put the splint on or off. Also, since it gets hot, staff are checking with Jackie's therapists to see if the splint could come off a couple of times a day for 15 minutes or so. In other words, her team is trying to address every issue that Jackie has around wearing the splint. This has provided Jackie with the encouragement that she needed. The "In Order to Support" section in her ELP is being updated to explain to all staff what we can do to help make the splint easier for Jackie to wear.

What if they won't agree to try something and it involves health and safety?

If you have tried motivation, and it didn't work, **contact the ELP Coordinator for additional technical assistance**. After that assistance if a motivational strategy still didn't work, then it becomes an "Issue to be Resolved" (and should be listed under that heading). When this happens, **you would also explain the LEAST NOXIOUS way (for the person) of seeing that the health/safety thing does get done. This explanation would go in the "In Order to Support" section.** Again, find out from the person and staff what they do to make it easier, more comfortable, less frustrating, etc.

Identifying A Person's Learning Style:

** see "Identifying a Person's Learning Style" at the end of this section*

What are learning styles? Learning styles include: verbal, visual and tactile. Most people gain information for new skills best from one or more of those methods. See if you can figure out what kind of learner you are, this will help you see it in others. Once you know someone's learning style, this is what you use as a guide when you are helping someone learn. Most of the time, the person's learning style will remain the same across different types of activities. Remember, the person can have more than one type of learning style. If that is the case, then you would use both styles.

There are also other things that effect learning (noise, light, etc.). You want to try to figure out these "other things" as well, by completing the ***"Identifying a Person's Learning Style" form***. This form will guide you through a look at possible things that affect a person's learning. As with the entire ELP process, you start by asking the person and those people who know them well

Here is some additional information to assist you in identifying a person's learning style:

a) The Verbal Learner: Here are some of the possible ways to help someone who is a verbal learner:

- ◊ explain to me what I am going to do, talk to me, don't show me
- ◊ tell me step by step what to do rather than giving me an overall picture of the task
- ◊ give each material or piece of equipment that we use a name and refer to it by name as you teach me
- ◊ don't insist that I look at what I am doing if I can do it without focusing on it
- ◊ give me a tape recording of what to do; have me follow it step by step or, sometimes it helps me to just let me hear it over and over again in the background
- ◊ let me tell you back how to do the task or let me explain it to someone else
- ◊ let's carry on a conversation about this task at break time or whenever

* If the person learns better with any of the ways above, then they are a verbal learner.

b) The Visual Learner tends to learn best in several different ways:

- ◊ when you have the materials for the task laid out in front of them in the order in which they need to use them
- ◊ when you show them how to do something-preferably when you don't talk at that time
- ◊ when they watch other people do the task
- ◊ with picture cues, color codes, physical models of how something looks

* If the person learns better with any of these ways, then they are visual learners.

c) The Tactile or Kinesthetic learners:

Tactile or kinesthetic learners also have their own style:

- ◊ Let me do it myself; I don't want to watch you, let me....

- ◊ I don't want to look at it, it confuses me
- ◊ I may not give you eye contact when you talk,
- ◊ Although almost everyone learns best when with someone they like, tactile learners *really* learn best from favorite people
- ◊ If I get stuck in the middle of a task or an assembly, I will need to go back to the beginning, it just doesn't feel right to continue once I am interrupted
- ◊ A calm, relaxed environment helps me
- ◊ Textures will help cue me more than colors or directions
- ◊ Let me feel all the materials before I begin and/or as I go on the task
- ◊ Some tactile/kinesthetic learners might need to smell objects or rub them on their faces, etc. in order to really 'connect' and to the task
- ◊ I will do this at my own pace --- don't rush me!

Assisting the person with an opportunity

- If things don't go well, don't give up after the first time.
- Keep in mind that people often need to try something a couple of times before they are comfortable with it and/or decide it is not what they want to do. Many things are more frightening than fun the first time we do it.
- If a person is not enjoying the experience, then try to figure out what it is that the person is not enjoying. For example, one gentleman said he wanted to try dishwashing. He tried it in one place and hated it. It turns out that he liked washing dishes, but he hates noise and chaotic settings. Fortunately, his staff didn't give up after the first try. They tried to figure out what went wrong and then found a different place where these things were not present. Another guy went to an amusement park and really didn't like it. A year later they asked him if he wanted to go again and he said yes. This time he had a great time. He just needed to get used to the amusement park "hustle and bustle".

Documentation/Follow-up

- Each time someone helps the person with an outcome identified on the "Action Plan", document what happened.
- The summary of progress would be written in the ELP Progress Notes, **with the individual's input**. This summary would be based on the notes written each time we supported the person with a particular outcome.
- When the new experience has been completed/achieved, then the date is noted on the "Action Plan". At that point, you want to make sure that the person can let you know when they want to do the opportunity again. If it is something new they learned, then they would use the new learning on a regular basis, when it is a natural time to do it.
- The other reason you would discontinue an Action Plan item is when the person tells us (via words or actions) that they do NOT want to keep trying this new thing. You should, though, try to figure out what about that experience the person did not like. You should also try the new experience several times, if possible.

IDENTIFYING A PERSON'S LEARNING STYLE

FOR: _____

Completed by/Date: _____

I learn best when:

[Note: This should be completed with the person and possibly someone else of their choosing.]

	Comments
A. Sound ☐ Quiet place ☐ Somewhat noisy place ☐ Noisy place ☐ It helps when you talk as I am learning the skill ☐ Please be quiet when I am learning the skill	
B. Light ☐ Bright ☐ Dim	
C. Crowds ☐ Many others around ☐ One or two others around ☐ When I am alone with "instructor" ☐ Alone	
D. Location ☐ I prefer to practice the skill at home before I try it for real ☐ I prefer to try it out for the first time wherever I really need to do the skill ☐ I like to do a "dry run" practice when there are few others in the real environment	
E. Help ☐ Help me to figure out how to ask others for help, if I need it ☐ Point out environmental cues that may help me learn ☐ I don't want anyone else to know you are helping me when we are in public ☐ I would prefer it if I could learn from watching others rather than having staff with me	

I learn best when:
[Note: This should be completed with the person and possibly someone else of their choosing.]

	Comments
F. I learn best when: (check all that apply) ☐ You correct me before I make a mistake ☐ I make a mistake and figure out for myself how to fix it ☐ I make a mistake and you help me figure out my mistake and how to correct it ☐ I do it alone and ask for help if I need it ☐ You show me how to do the task before I try it on my own ☐ You show me how to do the whole task first and then show me how to do each step ☐ You show me how to do only one step of the task at a time rather than overwhelm me by showing me the whole thing first ☐ You explain/show me how to do the whole skill before I begin and then leave me alone to do it ☐ You explain/show me how to do only one step of the task at a time rather than overwhelm me by showing me the whole thing first ☐ You put your hands over mine to help me do the whole skill until I feel comfortable trying it on my own ☐ You do all of the task then put hands over mine to help me do one step at a time until I feel comfortable trying it on my own ☐ You give me a cassette recording of how to do the task step by step and I can use my walkman to listen. (This way no one will know that I am getting help. ☐ I can use picture/written directions ☐ There are not people with disabilities around me.	

I learn best when:
[Note: This should be completed with the person and possibly someone else of their choosing.]

	Comments
G. Is now a good time for me to learn something new: ☐ Right now I need a break; I would prefer to put any learning on hold for a while ☐ I think that my medications might be getting in the way of my learning; please check it ☐ I need a little time to explore what is out there to learn before I commit myself to wanting to learn things more than once? ☐ Right now there are too many things going on in my life; I would prefer to put any learning on hold for awhile	
H. Miscellaneous Information ☐ I can read well enough to get the information I need ☐ I can read. Giving me written directions is helpful ☐ I think I can read and I would sure like to try ☐ I can read only a few key words but I think it would be helpful to check out what they are so we can use that information ☐ My family and friends speak another language. It is _____ ☐ I can understand/speak some _____ ☐ I am a morning person/learner ☐ I learn best in late afternoon/nighttime.	
I. Based on responses, this is how we think _____ learns best: _____ _____ _____ _____ _____ _____ _____ _____ _____ (This information should go in the "Things To Try or Learn" ELP heading.)	

How To Write A Supplemental Plan To
Help Someone Learn A New Skill

Learning Plans are used when we need to do more than identify someone's learning style and then show them how to do what they want to learn. (A lot of people learn by this simple method.)

Heading	Explanation	Required/Optional
"Person"	The name of the person.	R
"Date"	The date that the plan was written.	R
"Type of Plan"	"Learning"	R
"Developed by"	List the person or people who developed the plan. To the greatest extent possible, the person receiving services should be involved in developing this plan and should also be listed here. It is expected that the Learning Plan will be developed by those who will actually be helping the person learn.	R
"Target date for completion"	This date would be the goal that has been set...When is it anticipated that the plan will be successfully completed?	R
" _____ learns best"	You are describing what we know about the person's learning style –or- what can help/get in the way of a person learning.	R
" _____ wants to learn"	Describe what it is the person wants to learn, in enough detail so that we will be able to tell when they have learned it. Remember that people may just be learning to do part of a skill (with others doing the rest for now). This varies from person to person.	R
"Why we will help _____ learn"	Explain the reason that we are helping a person learn the identified skill. Remember, it should be their idea or they should agree to one of our ideas.	R
"How we will help _____ learn" - "Preparation Needed"	Describe what needs to be done before the plan can be carried out. Does anything need to be purchased? Do any arrangements need to be made? Are there risk factors that need to be addressed ahead of time? Do we need any information?	O

"How we will help _____ learn" - "Who will help?"	List who will be helping the person learn. You can also list the staff who will act as a "back up" to carry out the plan.	R
"How we will help _____ learn" - "Where will learning happen?"	Explain where the learning will occur. This could be in their home, at the center, at the Christiana Mall, the grocery store, etc. It can also be more than one place.	R
"How we will help _____ learn" - "What needs to be done?"	Clearly explain what needs to be done to carry out this plan (e.g. the steps). Be as specific as necessary.	R
"Issues in making this happen"	If there are any issues around carrying out this plan, explain them here. For example, John might hate it when the general public can tell that we are explaining something to him. In this example, you would explain what staff should do about help so that the public won't realize it.	O
"How will we know that the plan is working"	We used to call this "Measure of Success". If you have *very specifically* identified what someone is going to learn, then the measure of success will be the point at which they have learned to consistently do the skill, in the way it was described under "_____ wants to learn". Describe how we can tell the Learning Plan has worked.	R

How To Write A Supplemental Plan To Support a New Opportunity

You would develop this Supplemental Plan if you needed to do more than simply go and try new opportunity with the person. In other words, if you needed some detail, or explanation, of what staff need to do to make an opportunity happen or an explanation of the preparation , then you would write this type of Supplemental Plan.

Heading	Explanation	Required/ Optional
"Person"	The name of the person	R
"Date"	The date that the plan was written.	R
"Type of Plan"	"New Opportunity"	R
"Developed by"	List the person or people who developed the plan. To the greatest extent possible, the person receiving services should be involved in developing this plan and should also be listed here. . It is expected that the Learning Plan will be developed by those who will actually be helping the person learn.	R
"Target date for completion"	This date would be the goal that has been set...When is it anticipated that the plan will be successfully completed?	R
"What are we trying to help _____ to do?"	Clearly describe the opportunity that the plan is going to support.	R
"Why"	Briefly explain why this new opportunity is important. Explain the reason that we are helping a person learn the identified skill. Remember, it should be their idea or they should agree to one of our ideas.	R
"Preparation Needed"	Describe what needs to be done before the plan can be carried out. Does anything need to be purchased? Do any arrangements need to be made? Are there risk factors that need to be addressed ahead of time? Do we need any information?	O
"Strategy: What needs to be done -"	Clearly explain what needs to happen to carry out this plan. Be a specific as possible.	R
"Strategy: Who -"	List who will be helping the person learn. You can also list the staff who will act as a "back up" to carry out the plan.	R

"Strategy: Where -"	Explain where the opportunity will take place. This could be in their home, the grocery store, etc. It can also be more than one place.	R
"Issues in making this happen"	If there are any issues around carrying out this plan, explain them here. For example, John might hate to be in large crowds. In this example, you would explain his hate of large crowds. You would also explain that if you get somewhere and it is crowded, you ask the person if they would like to try another day. In other words, you want to also explain what staff should do about it.	O
"How will we know if it's working?"	We used to call this "Measure of Success". Since you have *specifically* explained what the new opportunity is, then the measure of success will be the point at which they have had a chance to try out this new thing at least several times. So, just describe how we can tell when we have completed the plan.	R

How To Write A Supplemental Plan That Will Encourage or Motivate Someone

This sheet explains what to include for each heading in the 2 "Motivational Plans". Motivational Plans are used when we want to encourage someone to try or do something. There are two types of Motivational Plans: 1). To provide encouragement to do something that a person wants to do, but is reluctant to do it (i.e. to lose weight); and 2). To provide encouragement to do something that is vital to the person's health and/or safety.

Heading	Explanation	Required/ Optional
"Person"	The name of the person.	R
"Date"	The date that the plan was written.	R
"Type of Plan"	"Motivational (the person's idea)" –or- "Motivational (vital to the person's health and/or safety – our idea)"	R
"Developed by"	List the person or people who developed the plan. To the greatest extent possible, the person receiving services should be involved in developing this plan and should also be listed here. It is expected that the Motivation Plan will be developed by those who will actually be helping the person learn.	R
"Target date for completion"	This date would be the goal that has been set...When is it anticipated that the plan will be successfully completed?	R
"What are we trying to help _____ to do?"	Clearly describe what we are going to encourage the person to do. Remember that our goal is to help them develop the **internal** desire/motivation to do something.	R
"What is the issue? Why is motivation needed?"	Explain what we know about why the person is reluctant to do something or what we understand about it. Also explain the reason we are doing this plan (i.e. they are asking for it, it is something that is critical for their safety, etc.)	R
"What have we already tried?"	Describe anything that we have tried before to encourage the person to do something. Also explain why it didn't work.	O
"Preparation	Describe what needs to be done before the	O

needed"	plan can be carried out. Does anything need to be purchased? Do any arrangements need to be made? Are there risk factors that need to be addressed ahead of time?	
"What are we going to try? Strategy: What needs to be done -"	Clearly explain what needs to happen to carry out this plan. Be a specific as possible.	R
"What are we going to try? Strategy: Who will help"	List who will be working with the person on encouragement/motivation to do what has been identified. It should be someone that the person either chooses or is very comfortable with. You can also list the staff who will act as a "back up" to carry out the plan.	R
"What are we going to try? Strategy: Where -"	Explain where the plan will be carried out. This could be in their home or it can be more than one place.	R
"Measure of Success"	We used to call this "Measure of Success". Since you have *specifically* explained what we are trying to encourage the person to do, then the measure of success will be the point at which the encouragement is consistently helping the person to do something. So, just describe how we can tell when we have completed the plan. Once the plan has been completed, you would add the strategy (that is working) into the "In Order to Support" section.	R

How to write a Plan to Help Someone Achieve a Personal Goal

This sheet explains what to include for each heading in the "Achieving a Personal Goal" Plan. Plans to help a person achieve a goal are used when there is a fairly detailed strategy that needs to be followed to achieve a goal. If what needs to be done to achieve the goal is fairly simple, then a supplemental plan may not be needed.

Heading	Explanation	Required/ Optional
"Person"	The name of the person.	R
"Date"	The date that the plan was written	R
"Type of Plan"	"Achieving a Personal Goal"	R
"Developed by"	List the person or people who developed the plan. To the greatest extent possible, the person receiving services should be involved in developing this plan and should also be listed here. It is expected that this plan will be developed by those who will actually be helping the person learn.	R
"Target date for completion"	This date would be the goal that has been set...When is it anticipated that the plan will be successfully completed?	R
"What is _____'s Personal Goal?"	Clearly describe the goal that the person wants to achieve. Make sure that it is written so that we can tell when the goal has been achieved.	R
"Why is this important to _____?"	Explain why this is something the person wants to achieve or why is it important to them.	R
"Steps…: What needs to be done "	Clearly explain what needs to happen to carry out this plan. Be as specific as possible. List all steps needed to accomplish this goal. Include what each step is, who is going to help accomplish each step, where is it going to be done, and by when.	R
"Steps… : Are there any steps the person does not want to do? Are there other ways to do it?"	List any steps that the person does not want to do, is reluctant to do, or is not interested in doing.	O

"Steps… : After seeing what is involved, is the person still interested in their goal -"	Sometimes, when a person sees all of the things that they have to do to achieve a goal, then that person decides they really don't want to try it. So, after listing all of the steps, make sure the person is still interested in working toward this goal.	O
"Preparation Needed"	If applicable, describe what needs to be done before the plan can be carried out. Does anything need to be purchased? Do any arrangements need to be made? Are there risk factors that need to be addressed ahead of time? Do we need any information about a particular event?	O
"Issues"	If there are any issues around carrying out this plan, explain them here. For example, John might hate to be in large crowds, yet one of the steps in achieving his goal may involve crowds. You'd figure out what to do to make this step as easy as possible. This often involves specific tips to staff about what to do.	O
"Measure of Success"	We used to call this "Measure of Success". Since you have *specifically* explained what the personal goal is, then the measure of success will be the point at which the goal is reached. So, just describe how we can tell when we have completed the plan..	R

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

SUPPLEMENTAL PLAN

Person:_____ Date:_____

Type of Plan:_____**Learning**_____ Target date for completion:__

Developed By:_____

_____learns best:

_____wants to learn:
(circle one: It was our idea. It was his/her idea. Since the person doesn't speak, it was our "best guess", based upon interviews.)

Why we will help _____learn:

How we will help _____learn:

Preparation needed:

Who will help:

Where will the learning happen:

What needs to be done:

Issues in making this happen:

How will we know that the plan is working:

****THE SUPPLEMENTAL PLAN GOES DIRECTLY BEHIND THE ELP IN THE COR****

To document:

- Each time staff assists the person, document what happened. Documentation should be: legible (easy to read), readily available; done on one sheet for each Supplemental Plan; and kept secure/confidential.
- For the ELP Progress Report: The summary of progress should be written with the individual's input. The information in the ELP Progress Report should be a summary, based upon the documentation from each time the plan was carried out.

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

SUPPLEMENTAL PLAN

Person:_____ Date:_____

Type of Plan: Motivational (the person's idea) Target date for completion:__

Developed By:_____

What are we trying to help_____to do:

What is the issue?/Why is motivation needed?:

What have we already tried?:

What are we going to try/Strategy?:

What needs to be done -

Who will help -

Where -

How will we know it is working:

****THE SUPPLEMENTAL PLAN GOES DIRECTLY BEHIND THE ELP IN THE COR****

To document:

- Each time staff assists the person, document what happened. Documentation should be: legible (easy to read), readily available; done on one sheet for each Supplemental Plan; and kept secure/confidential.
- For the ELP Progress Report: The summary of progress should be written with the individual's input. The information in the ELP Progress Report should be a summary, based upon the documentation from each time the plan was carried out.

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

SUPPLEMENTAL PLAN

Person:_____ Date:_____

Type of Plan: Motivational (our idea) Target date for completion:__

Developed By:_____

What are we trying to help_____to do:

What is the issue?/Why is motivation needed?:

What have we already tried?:

What are we going to try/Strategy:

What needs to be done -

Who will help -

Where -

How will we know it is working?:

****THE SUPPLEMENTAL PLAN GOES DIRECTLY BEHIND THE ELP IN THE COR****

To document:

- Each time staff assists the person, document what happened. Documentation should be: legible (easy to read), readily available; done on one sheet for each Supplemental Plan; and kept secure/confidential.
- For the ELP Progress Report: The summary of progress should be written with the individual's input. The information in the ELP Progress Report should be a summary, based upon the documentation from each time the plan was carried out.

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

SUPPLEMENTAL PLAN

Person:_____ Date:_____

Type of Plan: New Opportunity Target date for completion:__

Developed By:_____

What are we trying to help to do:

Why:

Preparation needed:

What are we going to try?/Strategy:

What needs to be done -

Who will help -

Where -

Issues in making this happen::

How will we know if it's working:

****THE SUPPLEMENTAL PLAN GOES DIRECTLY BEHIND THE ELP IN THE COR****

To document:

- Each time staff assists the person, document what happened. Documentation should be: legible (easy to read), readily available; done on one sheet for each Supplemental Plan; and kept secure/confidential.
- For the ELP Progress Report: The summary of progress should be written with the individual's input. The information in the ELP Progress Report should be a summary, based upon the documentation from each time the plan was carried out.

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

SUPPLEMENTAL PLAN

Person:_____ Date:_____

Type of Plan: Achieving a Personal Goal Target date for completion:__

Developed By:_____

What is 's Personal Goal:

Why is this important to :

Steps in Achieving this Goal:

What needs to be done (who, what, where, when)?-

Are there steps the person does not want to do? Are there other ways to do it? -

After seeing what is involved, is the person still interested in their goal? -

Issues in making this happen:

How will we know it's working:

****THE SUPPLEMENTAL PLAN GOES DIRECTLY BEHIND THE ELP IN THE COR****

To document:

- Each time staff assists the person, document what happened. Documentation should be: legible (easy to read), readily available; done on one sheet for each Supplemental Plan; and kept secure/confidential.
- For the ELP Progress Report: The summary of progress should be written with the individual's input. The information in the ELP Progress Report should be a summary, based upon the documentation from each time the plan was carried out.

SECTION 9

The Action Plan

The Action Plan section of the ELP helps to identify and track the outcomes a person wants in their life and the supports necessary to get them. The Action Plan also helps determine who is accountable for making sure things get done. If you have grouped related items together in the body of the ELP, you should group them that way on the action plan.

What Must be Addressed in the Action Plan:

- **Things in the Must/Must Not Have section**. (if it is something the person does not currently have, then the way we support the person should be listed instead. For example, if Joe wants to live with his parents, but that's not possible due to their health, in the MUST HAVE section of Joe's ELP, we would include "Live with his parents", but the way we support Joe might be to get him counseling to understand why this isn't possible right now. In this case, "counseling to understand why he can't live with his parents" might be listed on the Action Plan, rather than "Live with his parents".)

- **Things currently happening in the person's life that we need to ensure continue** (Doctors the person sees, medical treatments, behavioral supports, health and safety precautions, etc.).

- **Relationships to maintain and what support, if any, the person needs to maintain them**.

- **Things that need to be acquired or maintained** (Medical Equipment, Assitive Technology, Services, Referrals).

- **New opportunities the person wants to try, or new things they would like to learn**.

- **Supports needed to manage finances**. (if any)

- **Where the person lives or supports needed for making other living arrangements.**

- **What the person does during the day (work or day service) or supports needed for changing what the person does during the day.**

- **Things in "In Order to Support" that are vital or problematic.** (You don't need to include standard routine activities, like brushing one's teeth three times a day, unless an issue arises, such as, the person begins to have problems with bleeding gums and must pay special attention to tooth brushing)

- **Issues listed on the Annual Conference Summary that have been identified as concerns.** (These items should be addressed in "In Order to Support" as well as on the Action Plan.)

* note – items listed on the Action Plan should match any "objectives" listed on any written plans (i.e., if John's plan objective is "John will not have any side effects from his medication", that is how it should be listed on the Action Plan)

The Action Plan Section:

(A blank Action Plan follows this section)

Outcome:
In this column, list the things that we, as support staff, need to do or to accomplish in order to help the person, or things that the person does on his/her own that we need to make sure are able to continue. Also include the things that need to be done or maintained in order to help the person to have the kind of life they want (all these issues should be addressed elsewhere in the ELP in addition to being included in the Action Plan).
Some examples might be:

- A newspaper to read at breakfast every morning
- A specific medical treatment every day
- Telephone calls, visiting with family and/or friends
- Wheelchair in good repair
- See the following Doctors as recommended (LIST all the Doctors the person sees)
- Referral for an Adaptive Technology Assessment
- Join a club, group, or organization
- Learn to cook gourmet meals
- Work on safety skills (so he can spend time in the community without paid staff)
- $5.00 every day to take to work
- Open and manage a bank account with a MAC card
- Live where s/he currently lives (s/he likes it here and wants to stay)
- Find a new place to live (s/he wants to live with a best friend in an apartment)
- Go to Hudson Center every day (s/he really likes going)
- Go to Edgemoor until s/he can find a "good-paying" job (s/he wants to work in the community)
- Make a referral for Supported Employment
- Help with Personal Care

These are just some examples that might appear on an Action Plan. They are the Outcomes someone might like to have in their life.

Items will be specific for each person and unique to each individual.

Person Responsible:
If the person responsible is listed on the Team Flow Sheet in the front of the COR, you can list the job title of the person responsible. If the person responsible is NOT listed on the Team Flow Sheet in the front of the COR, or if your agency or facility does not use the Team Flow Sheet, enter the NAME of the person responsible for making sure this happens. If this person changes, remember to update the NAME on the ELP.

Depending on the Outcome, this may be a House Manager, Program Coordinator, Case Manager, Nurse, Behavior Analyst, Psychological Assistant, etc. It is not necessary to list the names of all the direct support staff who will help with this, just the name of the person who is accountable for making sure each Outcome happens or is supported.

Paperwork Required:
Check off which kind of paperwork is required for each outcome.

It is possible that some Outcomes will require more than one frequency of paperwork. For example, for some medical issues, like seeing Doctors as recommended, house staff may report monthly, but Nurses may have to report on this information quarterly. In this instance, you would check BOTH Monthly and Quarterly, and put this initials or the name of the person who reports under the appropriate box. For example:

Outcome (result)	Person Responsible (name & title)	Paperwork Required (frequency)		
		Monthly	Quarterly	As Needed
See Doctors as recommended: Dr. Smith Dr. Jones Dr. Roberts Dr. Allen	House Manager DDDS Nurse	☒ House Manager	☒ DDDS Nurse	☐

The "As Needed" box will usually be used for things that will occur one time, will occur sporadically, or will be completed, and will not require on-going reporting. For example, if someone wanted to open a bank account, the Action Plan might look like this:

Outcome (result)	Person Responsible (name & title)	Paperwork Required (frequency)		
		Monthly	Quarterly	As Needed
Open a new bank account	House Manager	☐	☐	☒

- **Please note:** These are <u>examples only</u> and are not intended to outline reporting requirements for specific support team members. Reporting requirements for all support team members are outlined in the Division of Developmental Disabilities Services Policy and Procedure Manual.

Target / Review Date
This column is used to establish the date by which something is expected to be completed, the Target Date. And also the date the team and the person will review the Outcome to determine if it should continue to be included on the Action Plan as it is, or if it needs to be changed or discontinued, the Review Date.

For example, for someone who attends Hudson Center Day Program and who likes going there and wants to continue going there, it might look like this:

Outcome (result)	Person Responsible (name & title)	Paperwork Required (frequency)			Target /Review Date
		Monthly	Quarterly	As Needed	
Attend Hudson Center Day Program	DDDS Case Manager House Manager Hudson Center Staff	☒ HM	☒ DDDS/CM Hudson Staff	☐	11/30/01

If the Case Manager is required to visit the person at the Day Program Quarterly, and report on that, then "Quarterly" paperwork is checked. The Review Date is the date by which the team will sit down with the person and discuss with the person if they want to continue attending Hudson Center Day program. A review of services being received must be completed with each person at least annually, so the Review Date will be set for one year from the last Annual Meeting.

Another example, for someone who wants to get a job and needs to be referred for supported employment services, it might look like this:

Outcome (result)	Person Responsible (name & title)	Paperwork Required (frequency)			Target /Review Date
		Monthly	Quarterly	As Needed	
Supported Employment Referral	DDDS Case Manager	☐	☐	☒	11/30/00

The date by which the Case Manager is expected to complete the Referral for Supported Employment is November 30, 2000, so the Target Date for this Outcome to be completed is November 30th. When the referral is actually completed, the Case Manager will use the next column, the "Completion Date".

Completion Date:
The Completion Date is used when an Outcome on the Action Plan is "finished". It is filled in when something has been accomplished or something no longer needs attention. However, a Completion Date may require that another Outcome to be added to the Action Plan and further action be taken. Using the example above:

Outcome (result)	Person Responsible (name & title)	Paperwork Required (frequency)			Target /Review Date	Completion Date (only for items that will be "finished")
		Monthly	Quarterly	As Needed		
Supported Employment Referral	DDDS Case Manager	☐	☐	☒	11/30/00	11/15/00

You might then need to add:

Outcome (result)	Person Responsible (name & title)	Paperwork Required (frequency)			Target /Review Date	Completion Date (only for items that will be "finished")
		Monthly	Quarterly	As Needed		
Find a satisfying challenging job in the community	Supported Employment Specialist	☒	☐	☐	12/31/00	

This shows that the Supported Employment Referral was successful, and that now the person, with the help of the Supported Employment Specialist, will begin looking for a job and hopes to have one by the new Target Date of 12/31/00.

When the person gets a new job, the Action Plan might be amended as follows:

Outcome (result)	Person Responsible (name & title)	Paperwork Required (frequency)			Target /Review Date	Completion Date (only for items that will be "finished")
		Monthly	Quarterly	As Needed		
Find a satisfying challenging job in the community	Supported Employment Specialist	☒	☐	☐	12/31/01	12/21/00
Work at Knott's Berry Farm	DDDS Case Manager Supported Employment Specialist	☒ Sup. Emp. Spec.	☒ DDDS Case Mgr.	☐	11/30/01	

Measure:
This final column on the Action Plan is used to describe how we will know if the Outcome is successfully being supported. The measurement for each Outcome will be different. It is not necessary to have a "formal" measure of each Outcome, as long as there is a way to make sure it is happening. Some examples follow:

Using the example from above, this is what the Measure column might look like:

Outcome (result)	Person Responsible (name & title)	Paperwork Required (frequency)			Target /Review Date	Completion Date (only for items that will be "finished")	Measure (How will we know if the outcome is happening)
		Monthly	Quarterly	As Needed			
Find a satisfying challenging job in the community	Supported Employment Specialist	☒	☐	☐	12/31/01	12/21/00	Make an ID note when a job is found and he is hired
Work at Knott's Berry Farm	DDDS Case Manager Supported Employment Specialist	☒ Sup. Emp. Spec.	☒ DDDS Case Mgr.	☐	11/30/01		Check with him – make sure he is still satisfied with his job, make an ID note if there are problems

The Bridge to Reporting

Each Outcome on the Action Plan that requires follow up should be transferred onto a blank ELP Progress Report. Each individual listed as responsible on the Action Plan will have their own ELP Progress Report. These progress reports should be compiled by the ELP Facilitator, and distributed to support team members as necessary. Items from the Action Plan should be copied and pasted into the progress report for each support team member that is required to report.

*Note – some members of the support team have their own reporting form and do not use the ELP Progress Report (i.e., Nursing Support staff may have a different monthly or quarterly reporting form). These progress reporting forms are for Community Services ONLY. Stockley Center staff will complete a "Qualified Mental Retardation Professional Monthly Review" according to facility guidelines and procedures. A sample of this form follows this section.

A Blank ELP Progress report looks like this:

****

ELP PROGRESS REPORT FOR _____

Person Responsible:_____ Paperwork Required:_____ Reporting Period:_____	**Status:** (+) Indicates the Outcome is successful in supporting the individual. (-) Indicates special concerns, problems, roadblocks, or follow-up is needed for this action. A comment must be written to explain why the action/outcome is not successful and what action will be taken.

Outcome	Status :	 -	Comments
	☐	☐	
	☐	☐	

Monthly Summary/Significant Events:

Individual's Response:

_____ _____

Person Responsible Date Person receiving services Date

Working from the example used above in defining sections of the Action Plan:

This is what the Action Plan looked like in the example for someone in the process of looking for a new job:

Outcome (result)	Person Responsible (name & title)	Paperwork Required (frequency)			Target /Review Date	Completion Date(only for items that will be "finished")	Measure (How will we know if the outcome is happening)
		Monthly	Quarterly	As Needed			
Supported Employment Referral	DDDS Case Manager	☐	☐	☒	11/30/00	11/15/00	Make and ID note when its done
Find a satisfying challenging job in the community	Supported Employment Specialist	☒	☐	☐	12/31/01	12/21/00	Make an ID note when a job is found and he is hired
Work at Knott's Berry Farm	DDDS Case Manager Supported Employment Specialist	☒ Sup. Emp. Spec.	☒ DDDS Case Mgr.	☐	11/30/01		Check with him – make sure he is still satisfied with his job, make an ID note if there are problems

The DDDS Case Manager was responsible for making the Supported Employment Referral. Once that was done, the Supported Employment Specialist was responsible for helping the person find a job. When the person was hired, it became the shared responsibility of the Supported Employment Specialist and the DDDS Case Manager to ensure that the person likes the job and wants to continue working there. The Supported Employment Specialist must report on this Outcome Monthly, while the DDDS Case Manager is required to report on this Outcome Quarterly. Examples of the separate Progress Reports for the DDDS Case Manager and the Supported Employment Specialist follow.

Each person responsible will have their own Monthly Progress Report to complete. The Progress Report for the DDDS Case Manager, when it is completed, will look like this:

ELP PROGRESS REPORT FOR **Peter Person**

Person Responsible**:** DDDS Case Manager Paperwork Required: Quarterly Reporting Period:10/1/00 – 12/30/00	**Status:** **(+)** Indicates the Outcome is successful in supporting the individual. **(-)** Indicates special concerns, problems, roadblocks, or follow-up is needed for this action. A comment must be written to explain why the action/outcome is not successful and what action will be taken.

Outcome	Status : -		Comments
Supported Employment Referral (this item was cut and pasted from the Action Plan)	:	☐	*Peter's referral was completed and he was assigned a supported employment specialist*
Work at Knott's Berry Farm	:	☐	*Hired on 12/21/00*

Monthly Summary/Significant Events:

Supported Employment Referral was completed and submitted to the agency on 11/30/00. He was contacted the within a week and met his new Supported Employment Specialist. Peter was hired at Knott's Berry Farm on 12/21/00.

Individual's Response:

Peter is very excited about starting work at Knott's Berry Farm. He said its just the kind of job he's been looking for.

Joe Jones/DDDS 11/30/00 _____ Person Responsible Date

Peter Person 11/30/00 _____ Person receiving services Date

You should note that the person receiving services is asked to sign (or otherwise mark) their progress reports if they are able. This serves to involve the person in their planning and reporting as well as making sure they have an opportunity to address any concerns they might have *every time the Outcome is reported on*.

The ELP Progress Report for the Supported Employment Specialist might look like this:

ELP PROGRESS REPORT FOR **Peter Person**

Person Responsible**:** Supported Employment Specialist Paperwork Required: MONTHLY Reporting Period:12/1/00 – 12/31/00	**Status:** (+) Indicates the Outcome is successful in supporting the individual. (-) Indicates special concerns, problems, roadblocks, or follow-up is needed for this action. A comment must be written to explain why the action/outcome is not successful and what action will be taken.

Outcome	Status :	 -	Comments
Find a satisfying challenging job in the community (this was taken from the Action Plan in the example above)	:	☐	Found a job and started training 12/21/00
Work at Knott's Berry Farm (this was also taken from the Action Plan in the example above)	:	☐	Began training on the job 12/21, and so far he likes it and is doing well learning his new responsibilities. (see attached task analysis and report)

Monthly Summary/Significant Events:

Peter went on several interviews (see Employment Interview Record) and he decided he really wanted the job at Knott's Berry Farm. He was offered a job there and accepted it. He started his training program on 12/21/00.

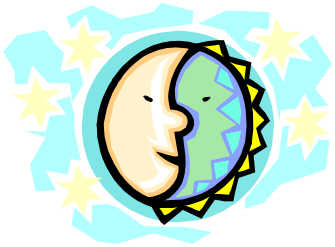
Individual's Response:

Peter has been enjoying his training program and talks about it all the time. He was especially proud to tell his family about it. He said he would like to learn more about farming. We added this to the "Things to Try or Learn" section of his ELP and he will be going to the library next week to check out some books on farming.

Sally Specialist 12/31/00 ***Peter Person 12/31/00***

Person Responsible Date Person receiving services Date

THE ANNUAL CONFERENCE



At least annually (and more often if necessary), the entire support team must review the services and supports that a person is receiving to ensure that they are meeting the person's needs and expectations.

Each year, as the Annual Conference approaches, the ELP Facilitator should consult with the person to determine whom the person would like in attendance at the Annual Conference, and how the person would like to participate. Although it is always preferable for the entire support team to meet and share ideas, the decision about who attends the Annual Conference should be made by the PERSON, with assistance from the ELP Facilitator.

Regardless of who actually attends the Annual Conference, each member of the support team must have a chance to review the person's ELP and attached plans and documents prior to the Annual Conference and provide recommendations, make updates, etc.
*note – please see the Division of Developmental Disabilities Services Policy and Procedure Manual for the definition of a "Support Team".

At the Annual Conference, the Annual Conference Summary will be completed by the ELP Facilitator. The Annual Conference Summary is documentation of issues that were discussed at the meeting, and helps support teams to make sure they are reviewing all areas of support for the person, to determine if support efforts should continue as they are, be modified to better meet the person's needs and expectations, or should be discontinued.

*** note – This Annual Conference Summary is used in Community Services ONLY. Stockley staff should follow facility guidelines for reporting on the Annual Conference.**

* The Annual ELP Conference Summary follows this section:

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
ANNUAL CONFERENCE SUMMARY

PERSON:_____ MCI NUMBER:_____

ANNUAL CONFERENCE DATE:_____ BIRTHDATE: _____

DATE OF LAST ANNUAL CONFERENCE: _____
PREPARED BY: _____ DATE: _____

The person receiving services and the I.D. Team reviewed the following and determined if further evaluation or action is needed at this time (beyond that which is already occurring). (Note: If "yes" is checked under "Further Action Required", there must be a comment)

	Received Currently?		**Further Action Required?**		**COMMENTS**
	YES	**NO**	**YES**	**NO**	
Case Management Services	☐	☐	☐	☐	
Clinical Services (Nursing, Behavior Support)	☐	☐	☐	☐	
Residential Services	☐	☐	☐	☐	
Respite Services	☐	☐	☐	☐	
Day Program or Employment Services	☐	☐	☐	☐	
Adaptive Assessment/Review	☐	☐	☐	☐	
Speech Therapy	☐	☐	☐	☐	
Occupational Therapy	☐	☐	☐	☐	
Physical Therapy	☐	☐	☐	☐	
Sexuality Education / Training	☐	☐	☐	☐	
Unsupervised Time	☐	☐	☐	☐	
Guardianship / Consent Issues	☐	☐	☐	☐	
Assistive Technology	☐	☐	☐	☐	
Nutritional Evaluation	☐	☐	☐	☐	
Vocational Evaluation	☐	☐	☐	☐	
Hearing Evaluation	☐	☐	☐	☐	
Physical	☐	☐	☐	☐	
Dental	☐	☐	☐	☐	
Self Advocacy Education / Training	☐	☐	☐	☐	
Academic Services / Supports	☐	☐	☐	☐	
Immunizations (up to date)	☐	☐	☐	☐	
PERSONAL GROWTH:					
Self Care	☐	☐	☐	☐	
Financial Management	☐	☐	☐	☐	
Home Maintenance Skills	☐	☐	☐	☐	
Safety / Emergency Procedures	☐	☐	☐	☐	
Medical/Physical Supports for Appointments	☐	☐	☐	☐	
Getting Around the Community	☐	☐	☐	☐	
Decision Making	☐	☐	☐	☐	
Social & Interpersonal Responsibility	☐	☐	☐	☐	
Responsibilities in Their Own Health Care	☐	☐	☐	☐	
Voter Registration / Election Activities	☐	☐	☐	☐	

Other_____ ☐ ☐ ☐ ☐ _____

SIGNIFICANT EVENTS AND ACCOMPLISHMENTS OF PAST YEAR:

Address things the person did this past year that they feel good about, personal accomplishments, etc.

SUMMARY OF ANNUAL MEETING:

Address how the person participated in scheduling their annual meeting, how the person participated in the meeting, any significant issues that arose during the meeting and plans for follow-up of issues discussed at the meeting

Signature of those Attending	***Please PRINT name***	***Relationship to Person***
Name:_____	_____	_____
Name:_____	_____	_____
Name:_____	_____	_____
Name:_____	_____	_____
Name:_____	_____	_____
Name:_____	_____	_____
Name:_____	_____	_____
Name:_____	_____	_____
Name:_____	_____	_____
Name:_____	_____	_____
Name:_____	_____	_____
Name:_____	_____	_____

Note: Also see ELP Cover Sheet for others who have contributed.

PARC Approved:02/04/04
03/COR

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
STOCKLEY CENTER

QUALIFIED MENTAL RETARDATION PROFESSIONAL MONTHLY REVIEW

Name: _____ Date: _____

MCI Number: _____ Area: _____

Review Period: _____

REVIEW OF BEHAVIORAL OBJECTIVES:

Objective Number	Data	Comments	Yes	No

REVIEW OF SERVICE OBJECTIVES:

Objective Number	Comments

Name: _____ Date: _____

Record Review	Completed	Follow-up Needed	Follow-up Completed	Comments
Supports:				
Communication				
Relationships				
Health				
Safety				
Other				
Personal Care				
Activity Schedule				
Target Dates				
Health and Data				
Physician Orders				
Lab Work				
Activities/Trips				
ID Notes				
Consultation Reports				
Adaptive Equipment				
Drug Reviews				
Program Materials				
Incident Reviews				

FURTHER EXPLANATION/ADDITIONAL COMMENTS

_____

Qualified Mental Retardation Professional Signature

241/65-SC(8-00)

SECTION 10

Your ROLE in the ELP Process

There are certain responsibilities that must be assumed regardless of position or relationship to an individual focus person. These responsibilities should be central to everyone involved with supporting the person, from direct support staff to Agency Directors and everyone in between. There are some responsibilities that must be shared in supporting a person to get the life they want.

CORE RESPONSIBILITIES (for everyone involved with focus people)

- LISTEN to the person
- Address ALL issues within the context of "helping people get the lives they want" at every level of the organization
- See the person as the "expert" on themselves
- Help people have as much positive control of their lives as they want
- Ensure that the ELP process is always respectful
- ALWAYS include the person in decision making and problem solving
- Share what you learn with the appropriate people
- Effectively use public resources to help the person get the life they want
- Work as a team to problem solve
- Acknowledge what is important to the person and be realistic about the things that are possible now without inappropriately raising expectations
- Be clear about what can be accomplished in the future while making sure things that are important to the person are made known to everyone involved with supporting them
- Help the person to understand that we don't do things *for* them, but rather, we help them to reach their own goals

In addition to these core responsibilities, there are some specific responsibilities that people must assume depending on their position within the organization and/or their relationship to the focus person. These responsibilities are listed in the following section.

Team Member's Roles in the ELP Process

Sometimes people developing ELP's will assume a dual role in the process. For example, when someone lives in a Neighborhood Home, there is an agency Case Manager who assumes the role of "Support Coordinator". However, when someone lives in a Foster Home, it is the DDDS Case Manager who assumes the role as both ELP Facilitator *and* Support Coordinator.

Focus Person

- Participate as much as possible in the ELP process
- Exercise as much positive control over your life as you can
- Help us understand the supports you need or want
- Negotiate solutions through compromise

Advocate

(Chosen by the focus person to help with conversations and provide support during the process. Can be the focus person or someone they trust.)

- Help the person through the ELP process
- Make sure ELP ground rules are honored
- Make sure the person is heard
- Help decide who will make decisions when the person is not able to directly select things
- Make sure concerns are addressed and questions are answered respectfully
- Help the person negotiate where compromise is necessary
- Make sure the plan reflects the person and how they want to live

Family & Friends

- Make sure the person is heard
- Help decide who will make decisions when the person is not able to directly select things
- Make sure concerns are addressed and questions are answered respectfully
- Help the person negotiate where compromise is necessary
- Make sure the plan reflects the person and how they want to live
- Share pertinent, valuable information about the person and how they want to live
- Respect the person's wishes/choices regarding how they want to live their lives

ELP Facilitator

- Begin planning 1 – 4 months before a "finished" plan is expected
- Let team members know which part of the ELP they will be responsible for
- Have conversations with the focus person and people who know and care
- Help decide who will make decisions when the person is not able to directly select things
- Help the person to negotiate where compromise is necessary
- Make sure the plan reflects the person and how they want to live
- Pull the plan together
- Explain expectations to key people (support staff & others)
- Write the ELP in the approved ELP format
- Make sure the ELP is reviewed and returned to the Support Coordinator
- Using the Action Plan, generate ELP Progress Reports for the support team members who are listed on the Action Plan and who do not have their own reporting format. (excludes Stockley Center as they use their own progress reporting forms)
- Recognize that learning about what is important to the person and how to support them is a continuous process
- Chair the Annual Meeting

Support Coordinator (DDDS Case Manager / Agency Program Coordinator/QMRP)

- Ensure that core responsibilities are met by all involved with the focus person
- Make sure supports make sense for the person
- Ensure that all support needs are addressed
- Schedule annual conference and notify appropriate parties of date and time
- Work with the person to set the "direction" for the person's life (relationships to pursue, opportunities to try, etc.)
- Let team members know which part of the ELP they are responsible for
- Distribute copies of the finished ELP to team members
- Chair the annual conference (unless this will be done by the ELP Facilitator)
- Make sure the ELP is put in the COR or Program Book and that the original is sent to Health Information Management (H.I.M.)
- Make sure the structure and process for on-going learning is in place
- Begin the active learning process with support staff (encourage them to write down what they learn on the ELP!)

ELP Reviewer * (see end of this sections for details)

- Assure that the ELP process remains person centered
- Attend information gathering meetings as necessary or as requested
- Provide technical assistance to teams developing ELP's
- Review finished ELP's for required information and format
- Evaluate finished ELP's for clarity and content

- Help the team decide what issues might need to be expanded in the next draft and provide ideas
- Help the team problem solve to overcome roadblocks
- Provide feedback to the ELP Coordinator regarding issues that may arise

Managers / Supervisors

- Demonstrate the importance of respect by supporting staff through the ELP process
- Make expectations clear as to what is expected of staff involved in the ELP process
    - everyone listens
    - everyone contributes
    - learning and implementation are accomplished by everyone
- Ensure teams have the necessary equipment to do the job
- Take an active role in the ELP process by developing and implementing an ELP
- Become and remain knowledgeable about the ELP process in Delaware
- Ensure individuals and teams have creative freedom to problem solve
- Help teams to work through road blocks
- Recognize and praise good work (people learning new things, positive outcomes)
- Accept that sometimes what people want in their lives involves risk, and support individuals and teams to help develop supports that minimize risk
- Help individuals and teams determine "reasonable risk"
- Recognize individual strengths and preferences and, wherever possible, match individuals with compatible staff
- Deal effectively with people who are not supportive of the ELP process

Direct Support Staff

- Contribute to the ELP
- Implement and carry out the ELP
- Record what's been tried, what's working and what's not working on the ELP
- Help the person have more positive control over their lives
- Help the person try new things
- LISTEN to the person
- Make sure we're "helping the person do" and not "doing to" the person

Nursing Staff / Support Services (OT, PT, ST, etc.)
(specific information about Nursing responsibilities can be found in the Nursing Section of this manual)

- Help the person understand how to live a "healthy lifestyle"
- Help the person problem solve regarding health issues
- Help the person understand their health issues within the context of how they want to live
- Educate the person and support staff about health issues the person may be dealing with

Behavioral / Psychological Staff

(specific information about Behavioral Supports can be found in the B.A./P.A. section of this manual)

- Help the person problem solve regarding their behavioral / psychological issues
- Help the person understand their behavioral / psychological issues and stay safe within the context of how they want to live
- Educate the person and support staff about behavioral / psychological issues the person may be dealing with

***** Criteria for participation as an ELP Mentor/Reviewer

- Must be designated as a Reviewer by the ELP Coordinator
- Must have successfully completed the ELP Facilitator's Training
- Must regularly attend scheduled ELP Reviewer meetings

The Behavior Analyst / Psychological Assistant Role in ELP

The BA/PA is responsible for helping the person in all areas of behavioral services. The BA/PA will:

- Help the person understand his or her support needs to the best of his or her ability (e.g.: diagnosis, symptoms, why he acts as he does)
- Help the person to meet and manage their own needs by taking an active part in the planning process
- Help other people who support the individual understand the person and their unique support needs by writing supports in the ELP in a very easy to understand way
- Help others who support the person to know how to provide support on a day-to-day basis as well as how to respond in crisis situations

The level of BA/PA involvement in the ELP process will depend on the person's support needs. For people having significant support needs there will be active, ongoing BA/PA involvement and monitoring. For other people who have more basic support needs, the BA/PA may initially be involved in helping to develop support guidelines but will not remain actively involved in the planning process and will not be required to monitor the ELP. For persons who do not have support needs the BA/PA will not be actively involved but will continue to be available for consults. This is explained in details as follows:

BA/PA Involvement & Expectations

<u>SIGNIFICANT SUPPORT NEEDS – the BA/PA is actively involved</u>

The ELP will contain a sub-section within the "In Order to Support" section. The sub-section will have its own title, such as "Regarding Joe's Mental Health" or "Helping Joe Keep Control". Pertinent information from this sub-section will also be blended throughout the ELP as appropriate. This sub-section must include:

- The diagnosis, symptoms (if there is a diagnosis), other targets - all defined in layman's terms (you can include past & present frequency/intensity here or discuss in the Significant Environmental Considerations section along with triggers, functions, etc)
- Name of psychiatrist, address, phone number
- Name of BA/PA, office location, phone number
- Communication information will be reviewed and added to as appropriate (remember, people communicate with words and actions and some folks have a hard time telling the difference between accurate and inaccurate statements so make sure it contains specific information for people who talk with words or their behavior)

- Significant Environmental considerations (e.g.: slow triggers, fast triggers, functions, and predictability (DO NOT USE JARGON. Example - "Jane will strike out at others, especially her housemates, and we think it is her way of saying 'leave me alone' or 'I don't want to do this'. It is most likely to happen when she is tired or has had a busy or stressful week. In the past it would happen several times a day but now happens only about once every 6 months. Efforts to teach her another way of saying "leave me alone" have not been very successful. The best thing to do is to pay attention to when she has had a busy week or seems to be tired and ask her if she wants to relax in a quiet area).
- Day-to-day proactive support procedures
- Teaching strategies/alternative skill development (may need a learning Plan too)
- Response to symptoms/targets
- What constitutes an emergency (include when, how & who should be contacted)
- What/how to record data, monitoring

<u>ELP Process for Significant Support needs:</u>

- Draft the sub-section by reviewing the current Service/Support Plan, talking to the individual, and talking to key support staff.
- Submit the draft to supervisor for input/corrections (before it goes to the Facilitator)
- Get it back from supervisor and make corrections (if needed)
- Resubmit to supervisor (if requested by supervisor)
- Submit to ELP Facilitator **(at least 1 month PRIOR to the Annual Meeting)**

<u>Ongoing monitoring for Significant Support Needs</u>:

The Action Plan will note which outcomes the BA/PA is responsible for and which must be reported on Quarterly. The ELP Quarterly Reporting Form will include, at a minimum, the following:

- Significant events over the past quarter (dates of psychiatric appointments, etc.)
- Changes in diagnosis or medications
- Psychiatric admissions
- Problematic or positive incidents and why it occurred if known
- Changes in Residential or Day Services and/or future plans if known
- Anything we've learned about the person's support needs
- Anything we still need to learn
- Other pertinent information.

BASIC SUPPORT NEEDS – No Ongoing Involvement by BA/PA

The BA/PA will provide information on support needs, suggestions, and basic guidelines. The information will be given to the Facilitator at least 1 month prior to the Annual Meeting. The information will be blended throughout the ELP. There will be no separate sub-section.

ELP Process for basic support needs:

- Draft the suggestions, guidelines, or supports
- Submit to supervisor for input/corrections
- Make corrections
- Resubmit to supervisor (if requested by supervisor)
- Submit to ELP Facilitator at least **1 month PRIOR to the Annual Meeting**

Ongoing monitoring for Basic Support Needs: No ongoing monitoring is required.

CONSULTS

The BA/PA will be available to the team on an as needed basis. The Case Manager will submit a referral for BA/PA to the Director of Behavioral Services for consultation. Future BA/PA involvement will depend upon the nature of the referral and the outcome of the functional assessment process.

OTHER DOCUMENTATION/PAPERWORK
Documents to be filed as noted on the COR Index

Adaptive Assessment – File in the Data Base section behind the Psychological Evaluations.

Annual Adaptive Review/Update or Deferral – File in the Data Base section behind the original Adaptive Assessment.

Assessment of Ability to Handle Unsupervised Time (completed as needed) - File in the Data Base section after the Behavior Consult.

Behavior Analyst Consult Reports (abbreviated Functional Assessment) - File in the Data Base section after Functional Assessment.

Functional Assessment Report – File in the Data Base section after Progress Reviews

Progress Reviews - File behind the Risk/Benefit Analysis and Titration Plan

Psychological Evaluation (Original) – File first in the Data Base section

Quarterly Reports - File in their own sub-section under the ELP Progress Note section.

Request for Review of Behavioral Intervention Strategies (BIS packet, PROBIS/HRC packet) – File in the Data Base section behind the Adaptive Assessments.

Risk/Benefit Analysis – File in the Data Base section after the PROBIS/HRC packet.

Titration Plan – Include on the same page as the Risk/Benefit Analysis under its own heading OR as a titration statement following the Risk/Benefit Analysis in a separate paragraph.

SYNOPSIS of COR filing Index

Data Base:
Psychological Evaluation
Adaptive Assessment
Adaptive Updates/Reviews/Deferrals
Request for Review of Behavioral Intervention Strategies packet (PROBIS & HRC)
Risk/Benefit Analysis
Titration Plan
Progress Reviews
Functional Assessment
Behavior Analyst Consult
Assessment of Ability to Handle Unsupervised Time

ELP Progress Note Section:
Quarterly report

ONGOING BA/PA RESPONSIBILITIES

* Talk to and spending time with the person
* Talk to support staff, encourage them to note suggestions on the ELP (what works, what doesn't work)
* Visit the home/day program
* Be the liaison to psychiatrist etc
* Let staff know when they are doing a good job, and offer constructive feedback when mistakes are made.

The Case Management Role in ELP

* note – this information applies to individuals working in Community Services programs only. Stockley staff should refer to facility guidelines in determining the role of the Case Manager on the support team.

- Make sure the ELP gives a true picture of the person.
- Coordinate and facilitate on going learning, listening, and growth for the person and their support folks.
- Make sure the Action Plan is respected, followed through, and added to so that it works for the person.

CASE MANGERS ROLE IN THE ELP PROCESS

- Each focus person has an individual assigned in this role. However, the assigned individual might have a different title depending on whether an agency has this responsibility or if DDDS has assigned a Sr. Social Worker/Case Manger. They may also play different rolls in the process such as ELP Facilitator or Support Coordinator and in some instances an advocate if a focus person wants them involved in their ELP in that role.

Please refer to details of role found in The ELP manual "YOUR ROLE in the ELP PROCESS" and "READY, SET, GO….".

ELP PAPERWORK

- Annual ELP Conference Summary – the form is taken to the annual meeting. After the meeting all team members should review and sign. Accomplishments of the past year should be noted before the meeting and added to throughout the meeting as things came up.
- In foster homes – a monthly ELP reporting form should be filled out, talked over and signed, in addition to the monthly ID Note during the monthly visit to the provider home. It's also a good time to review the ELP to see updates and changes. Quarterly Case Manager forms are filled out by the Support Coordinator to summarize what has been going on for the person and any changes in the ELP.

Other documentation is as usual (refer to "Community Services COR Index")

- Social Assessment Update
- Financial Responsibility Affidavit
- Assessment of Ability to Handle Unsupervised Time.
- Medicaid Waiver Recertification.
- Statement of Rights
- HRC Packet and Consents

ONGOING CASE MANAGER RESPONSIBILITIES

- Spend time talking, listening and learning with the person.
- Talk to support staff, family and friends encouraging them to note suggestions on the ELP about what works, does not work, and what they have learned.
- Let support staff know when they are doing a good job and offer constructive feedback when needed.

The Nursing Role in ELP

* note – this information applies to individuals working in Community Services programs only. Stockley staff should refer to facility guidelines in determining the role of the Nurse Consultant on the support team.

- Oversee the persons' medical care – helping the person understand how to live a healthy life, doing as much as they can for themselves.

- When the person needs supports with their medical care, write those supports in the ELP Nursing Assessment and trains support staff if it's needed.

- Encourages the person to speak for themselves about their own health concerns and be an advocate for them when they aren't able.

THE RN'S ROLE IN DEVELOPING THE ELP

Every person has a Nurse Consultant who is responsible for completing the annual ELP Nursing Assessment (*a copy of the ELP Nursing Assessment follows this section*). When putting this information together, remember:

- No medical jargon – like *TID; BID; PRN; B/P*.

- Diagnosis should be written but then broken down to explain the basics of what it means for that individual.

- Organize it so that it's easy to follow and subject matter is grouped together.

- Important things should stand out by being in **BOLD** or Underlined.

- If you know that there could be changes in a certain area, leave room for updated information to be written in.

Remember to include the following information on the ELP Nursing Assessment:

Special Procedures or treatments

- who can do them
- if special training is needed, those procedures are not included in the ELP

Medical Equipment

- where they get it
- who to call if it breaks or needs replacing (include phone number)
- if any special training is needed, those procedures should not be included in the ELP
-

Special things you know about going to Doctor's appointments, dentists, getting blood work done, etc.

EXAMPLE:
John has a real hard time when he has to get blood work done, so the best way for him/her has been

- don't tell him until just before you go
- either _____ or _____ should take him
- Call Med Lab and ask for _____, he'll set up a time for you to bring him. John likes _____ and doesn't have any problem as long as he can get in and out.
- Don't forget that he goes where he wants afterwards for a treat

Safety issues – should stand out or be underlined to bring attention

EXAMPLE:
MUST HAVE SUNSCREEN ON -- *#30 or more if he's out in direct sunlight for over ten minutes*

NEVER LEAVE POISONOUS LIQUIDS anywhere around _____ because he will drink anything around him.

Other Areas In The ELP The RN Would Help With:

Communication Section

How the person tells you they are not feeling well/sick?

Special ways the person tells you things at the doctor's office visit

Personal Care

Make sure any special treatments are covered and detail is there as to how to do it and what to do if there's a problem ….

EXAMPLE:
Jane wear Attends – always clean well with wet wipes and check for any reddened areas. As soon as you notice a reddened area, put on Sno-balm. If it continues more then two days, call and let RN know.

Specialized Equipment/ OT/PT/Speech/Hearing

Work with Case Managers in making sure all details are addressed

EXAMPLE:

Companion Pump – rental paid by Medicare. If it doesn't work, call and they will replace it.

RN DOCUMENTATION/PAPER WORK

Action Plan – make sure ALL Medical issues are listed on the Action Plan

Re: -track seizures
-weigh every week if needed
-take Blood Pressure daily
-see his/her Dr. as (s)he needs to:
Dr. _____
Dr. _____
Dr. _____

COR – refer to the Community Services COR index as to where these documents should be filed. All other department requirements remain the same.

ONGOING NURSING RESPONSIBILITIES

Take the time to talk to the person to see how they are feeling and if they have any health concerns.

Go on trips to the doctor's office with them if it is needed and/or wanted

Teach the person about their on-going health concerns and encourage them to know and do as much as they can for themselves.

Teach support staff treatments and procedures. Let support staff know when they are doing a good job and offer constructive feedback when necessary.

Listen to support people and encourage them to write what they know (i.e., what's working and what's not working) in the ELP working copy

DIVISION OF DEVELOPMENTAL DISABILITY SERVICES
ELP NURSING ASSESSMENT
DATE: _____

NAME: _____ CASE NUMBER: _____

D.O.B. _____ ALLERGIES: _____ **(Bold This Information)**

DIET & SPECIAL MEALTIME INSTRUCTIONS: _____

_____

CURRENT WEIGHT: _____

INDIVIDUAL'S HEALTH HISTORY:

CURRENT MEDICATIONS	WHAT IT'S USED FOR…

* See MAR or Pharmacy Drug Profile for more information, including side effects and dosages

Takes Medication Without Help _____ Takes Medication With Help _____

Pharmacy _____

Physical Exam: Completed _____ _____

ELP Nursing Assessment

_____
Name

Doctor, Address, Phone & Fax Number Specialty	Medication Ordered	Frequency of Visits

IMMUNIZATIONS	DATE GIVEN	DATE DUE
Tetanus Toxoid		
PPD (TB Test)		
Influenza Vaccine		
Hepatitis B Vaccine		
Pneumonia Vaccine		
Other		

Significant medical conditions:

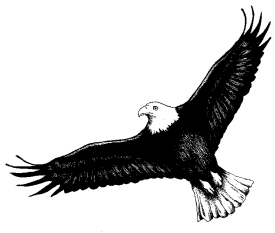
Name

Significant medical conditions: (continued)

DDDS Nurse Consultant

Phone: Ext:

DDDS On-Call Pager
(302) XXX - XXXX



The QUALITY ASSURANCE ROLE IN ELP

To make sure the ELP Process is working; the person should be learning and growing in his/her personal life.

QA does this by:

- Completing reviews and surveys with the person and/or the people who support him or her and know them the best.

- Reviewing the ELP to make sure what's written is happening by:

  - talking with the person, family, friends and support staff
  - watching what's going on in all aspects of the person's day
  - reviewing the documentation
  - reading the working copy of the ELP and writing their ideas or things they have found
  - asking questions

- Completing the ELP Reviewer Sheet.

SECTION 11

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

Community C.O.R. Index

SECTION	DOCUMENT	RETENTION PERIOD
Front of C.O.R.	• Copy of ELP C.O.R. Index • ELP Conversion Letter • Sign-Out Card • Client Fact Sheet • Client Identification Sheet • Photograph • Copy of Birth Certificate and Social Security Card • Copy of Health Insurance Cards • Team Flow Sheet • Service Flow Sheet • Guardianship Information	• Maintain until updated • Until otherwise notified • Until filled (then discard) • Update as needed (review and initial yearly) • Update as needed (review and initial yearly) • Update every three years • Maintain • Maintain as long as valid • Until filled (old one to H.I.M. - Health Information Management) • Maintain as long as valid (old to non-current)
ELP	• Completed, reviewed ELP Behind ELP Packet(if applicable) • Supplemental Plans • I.E.P. • Therapy Plans • Behavioral Support Plans • HRC/PROBIS Packets, Risk Benefit Analysis, progress reviews	• Maintain until updated (original to H.I.M – old one to non-current – over 1 year send to H.I.M.) • Maintain until updated (old one to non-current – over 1 year send to H.I.M.)
ELP Progress Notes Section	• Monthly / Quarterly Reports • Home Visit Checklist (FTH) • BA/PA Quarterly Report • RN Quarterly Report (FTH) • Day Service / Work Monthly / Quarterly Reports • School Report Cards (if applicable) • Active Therapy Reports (OT, PT, ST, etc.)	• Maintain 1 year (old ones to H.I.M.) ↓
Interdisciplinary Notes Section (ID Notes)	• Interdisciplinary notes • Nursing Monthly Med. Review notes (NGH, Apt.) CM ID notes (NGH, FTH)	• Maintain 1 year in Foster Homes, 3 months for Staffed Apartment and Neighborhood Home, plus 9 months on site, then to H.I.M.

Physicians Orders	• Standing Medical Orders • Medical Appointment Information Records (MAIR's) • Dental Date Base • Dental Service Sheets	• Maintain 2 years (old ones to H.I.M) • Maintain 1 year • Maintain until filled (old one to H.I.M.) • Maintain 1 year
Flow Sheets & Graphs	• Clothing and Personal Property Inventory • Medicaid Utilization Review (Medicaid Waiver only) • Blood Pressure Chart • Height/Weight Chart • Immunization Record • Medical Assistance Record (if applicable) • Seizure Description • Seizure Record Graph • Family contacts/visits (NGH)	• Maintain until filled (NGH) Maintain in Provider Record (FTH) • Maintain until filled (old one to H.I.M.) • Maintain 1 year • Maintain 1 year • DO NOT REMOVE • Maintain 3 months (1 year on site – old ones to H.I.M. • 3 Months in COR, 9 months on site • Maintain 1 year • Maintain 1 year
Data Base	• Waiver Recertification (CPDS & LOC Recert) • Initial Waiver Packet *may include the following: MAP-5 SSBG Eval. Of Client Needs Agreement for Participation CPDS NH-10 (Review & Approval) MAP-16 (Social Eval.) MAP-25 (Comp. Medical) LOC Recommendation • TPC/TSC Summary • Service Agreement with Provider • Annual ELP Conference Summary • Statement of Rights, Rights Review / Individuals (client's) Exercise of Rights • Physical (lab tests not to be attached)	• Original to HIM, copy in COR - Maintain 1 year – old one to non-current • DO NOT REMOVE • Maintain until replaced • Maintain until replaced • Maintain until replaced • Maintain 1 year – old one to non-current – more than 1 year – to H.I.M. • Maintain most current (both pages) • Maintain most current

Data Base (continued)	• Medical Summary / Medical Data Base • Nursing Assessment • Nursing Assessment Update • Social Assessment / Social History • Social Assessment Update • Unsupervised Time Assessment • Psychological Evaluation • Adaptive Assessment updates, reviews, referrals • Consents • Work/Day Assessment • Initial Assessments (OT, PT, ST, etc.)	• DO NOT REMOVE • Maintain until filled (old one to H.I.M.) • DO NOT REMOVE • Maintain until updated • DO NOT REMOVE • Maintain until updated – old one to H.I.M. • Maintain most current - old one to H.I.M. ↓ • DO NOT REMOVE
Lab / X-ray Reports	• Laboratory Test Results • X-Ray reports • Electrocardiogram • Electroencephalogram • Other diagnostic Reports	• Maintain at least 2 years (replace as updated) – old ones to H.I.M.
Consults/Referrals	(Maintain in alphabetical order by consult) • AIMS Scale • Audiology • Behavioral Consult (CS – BA/PA form) • Breast Exam/Mammogram • Cardiac • Dermatology • Endocrine • Ear, Nose, Throat • Genetic • Gynecology/Pap Smear • Nutrition • Occupational Therapy • Physical Therapy • Podiatry • Psychiatric • Speech Therapy • Neurology • Other	• Maintain until replaced (maintain minimum of 1 year) – old ones to H.I.M. • Maintain one year in COR after therapy is discontinued or until replaced) – old ones to H.I.M. ↓
Non Current	• Previous ELP material • As listed above	• Maintain 1 year – old ones to H.I.M.

ELP Reviewer's Checklist
ELP Focus Person _____

	Y	N	N/A		Y	N	N/A
COVER SHEET				* Pharmacy name & phone			
* Person's Name				* Medications (name, reason taken) and supports for taking medicine			
* Date/Place of meeting(s)				* Medical conditions listed – what to watch for, what to do			
* Purpose (Annual/TSC/Update)				* Positioning / Safety issues			
* Facilitator's Name				* Medical Assistive tech (where its fixed, etc.)			
* Who contributed – relationship to the person				* Special mealtime or eating instructions with detailed supports listed			
* Name, date, page number on every page							
WHAT PEOPLE LIKE AND ADMIRE				* BA/PA name & phone			
* Person's positive characteristics				* Supports clearly written in layman's terms			
Clinical or disability language NOT used				* Counselors listed (name, phone, frequency of visits, who schedules)			
WHAT _____ MUST/MUST NOT HAVE IN THEIR LIFE				* Medications (list prescribing physician, phone, diagnosis, frequency of visits, who schedules)			
* Includes <u>only</u> what the PERSON says is important				* List things that should be reported to BA/PA and how to record data			
First/third person used appropriately				* Clear emergency instructions			
Items appropriately listed in this section							
Clinical or disability language NOT used				* Case Manager name, phone, office address			
LIKES / DISLIKES				* Family, friends, Guardian listed, how to contact, phone number			
Items appropriately grouped				* Non-medical Assistive tech (where its fixed, replaced, etc.)			
HOPES & DREAMS				* Financial supports addressed			
THINGS TO TRY OR LEARN				* Personal Care section (if needed)			
* New things to try or learn				**ACTION PLAN**			
* Supplemental Plans (if necessary)				* All Must/Must Not Have addressed			
IN ORDER TO SUPPORT				* All Doctors listed			
Communication Table				* Medical issues addressed			
* All Must / Must Not Have listed with support details				* BA Supports addressed			
Required Headings used appropriately				* Where the person lives			
Daytime activity & necessary support listed				* What the person does during the day			
Where they live & necessary support listed				* Assistive tech (upkeep, etc.)			
				* Financial issues addressed			
* Allergies in BOLD				* Person responsible – must have NAME of responsible person			
* Nurse Consultant name & phone				* Target date listed (no "ongoing")			
* Doctors – name, phone number, frequency of visits, medication prescribed				* Required documentation checked (monthly, quarterly, etc.)			
				ISSUES TO BE RESOLVED			
Items designated with a (*) <u>MUST</u> be included in order to convert the record to ELP format.				Include issues to be resolved that will Not be addressed in current ELP			

DELAWARE DIVISION OF DEVELOPMENTAL DISABILITIES

ELP Personal Profile

This document is meant to provide a clear, easy-to-understand picture of a person and their supports. Please complete each section about the person to the best of your knowledge.

NAME: _____

PERSON COMPLETING PROFILE: _____

OTHERS CONTRIBUTING INFORMATION: _____

COMPLETION DATE: _____

NOTE: This ELP PERSONAL PROFILE should be completed by anyone who knows the person and who has information about how the person wants to live or wants to be supported. This profile is especially useful for getting information from people who are unable to attend the annual meeting or otherwise meet with the facilitator.

Section 1: What people like and admire about _____

Section 2: Describe what is important to _____ in Day Services.

A. Places that _____ likes to go:

B. Activities/Hobbies that _____ enjoys doing:

C. Work/Volunteering/Help that _____enjoys doing:

D. People that are important to _____at the Center:

Section 3: Describe what is important for _____'s success on a job.

*Does _____ like his/her current job? _____

*Did _____ choose his/her job? _____

A. Places that _____ would like to work:
[including business names and town/location]

B. Hours/Days that would be most desirable:

C. Working alone or in groups...does it matter?

D. Types of work that _____ is interested in:

E. Types of work that _____ dislikes:

F. Things that _____ MUST HAVE that might affect work:

Section 4: Describe what is important to _____ at home.

A. Places that _____ likes to go:

B. Things that _____ enjoys doing:

1. At home:

2. While we are out:

C. Chores/responsibilities, around the house, that _____ enjoys doing:

D. People at home that are important to _____:

E. Things that _____ really dislikes:

F. _____'s HOPES and DREAMS:

G. Important routines such as:

1. Morning

2. During transition

3. Coming home

4. Holidays/Celebrations

5. Other

H. Things that can ruin _____'s day.

I. Things that can make a great day for _____.

J. Other things important to the person:

Section 5: Describe the best way(s) to help _____ learn.
(Use "Identifying a Person's Learning Style" to complete this section.)

Section 6: Things to try or learn

A. Things they tried and enjoyed this past year:

B. Ideas for this year:

Section 7: Communication: (**Must be completed if a person does not talk**.)

A. How do you know _____ likes something?

B. How do you know _____ dislikes something?

C. Other important information regarding how _____communicates:

D. Other important information regarding how we communicate with _____.

E. Communication Table

In this situation:	When does this:	We think it means this:	You should do this:

Section 8: Progress and Significant Events of the past year:

Section 9: In Order to Support _____, we must:

A. During Meals:

1. At home:

2. When we are out:

B. Doing Chores around the house:

C. Helping in the bathroom:

D. Medical/Health Related/Safety Supports:
(include medications and what assistance they need to take them)

E. Supports for _____ when they get mad or upset:

F. Special Devices/Assistive Technology:

G. Helping _____when we go out:

H. Barriers that _____ faces and ways to support:

I. Transportation Supports for _____:

J. Supporting _____ with their appearance:

k. Supporting _____ with their money

l. Other supports that we need to know about:

Section 10: Issues to be resolved/concerns.
(List what doesn't make sense in the person's life right now.)

Section 11: Outcomes for the ELP Action Plan:

COMPUTER TIPS FOR COMPOSING ESSENTIAL LIFESTYLE PLANS

Portrait vs. Landscape

Before you begin typing your ELP draft, you will need to decide if the finished copy will be in Portrait (top to bottom on an 8.5 x 11 inch page) or Landscape (side to side on an 8.5 x 11 inch page).

Click on the File option in the main menu at the top of your screen.
Click on Page Setup
Then click on the Paper Size tab. You will see a big letter "A" and the two options (portrait or landscape) beside it. Click the circle next to the option you choose, and then click OK.
* note – many of the ELP forms you will need have already been formatted for you and are available on the F: drive of your local network.

Using Headers and Footers

Headers and Footers allow you to automatically insert an individuals name, the date of the ELP, and the page number on every page of the ELP.

To use a header:
On the menu at the top of your screen, click on View
Then click on Header and Footer
You will get a pop up box on your screen

To use a Header - type in the information that you wish to appear in the Header (this will appear at the top of each page)
To use a Footer - click on the small icon that looks like a piece of paper with 2 yellow bars on it (information in the footer will appear at the bottom of each page)

Some other options in the pop up box include:

Insert Auto Text – experiment with this! These options allow you to create and edit text inside the Header or Footer.

Insert Page Number – this option will automatically insert the page number at the top of each page

Insert Number of Pages – this option automatically inserts the number of pages in a document (for example, a header using this option might have "page 1 of 5"). This lets the reader know how many pages should be in the complete document.

Format Page Number – this option allows you to choose how you want your pages numbered (for example 1, 2, 3 … or A, B, C …)

Once your Header and Footer are formatted, click on the Close box. This will close the Header and Footer pop up box and allow you to continue working with your document. Header and Footer information will appear light gray at the top of your page, but will print in the same tone as the rest of your document.

Creating a Table

In the ELP, it is often useful to condense information into an easy-to-read table format. To use tables in your ELP document:

Click on **Table** in the main menu at the top of the page
Click on **Insert Table**
You will see a **pop up box** asking you the number of columns, the number of rows, and the column width.
Enter the number of columns and rows you want (in this example, 5 columns, 2 rows), leave the column width option at "auto" and click OK. The table will automatically be inserted into your document and will appear as it does below:

Click on the first box at the top (your cursor will flash), and type in whatever the column name will be, for example:

When John Does This				

Column width can be adjusted by holding your cursor over a vertical line until it turns into a double arrow (it will look something like this: ←||→). When the cursor turns into the double arrow, hold down your left mouse button, and drag the line to the width you want. The result will be something like this:

When John Does This				

Remember, your paper is only so wide. Be careful not to make your columns so wide they exceed the size of your page. Not sure how it will look? Want to see?

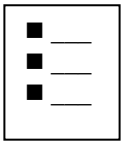
Click on **File** from the main menu on top of the page
Click on **Print Preview**. This will show you what your page will look like when it prints.
When finished viewing the print preview, click **Close** to return to your document, and make adjustments as necessary.

Text in the table can be edited just like other text.
- To make the contents of a box bold, highlight it by dragging your mouse over it, and click **B** (for **BOLD**) on the toolbar at the top of the page.
- To show the contents of a box in italics, highlight it by dragging your mouse over it, and click ***I*** (for ***Italics***) on the toolbar at the top of the page.
- To underline the contents of a box, highlight it by dragging your mouse over it, and click **U** (for **Underline**) on the toolbar at the top of the page.

Other Formatting Options

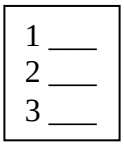
Bullets – its often useful to bullet information so people reading your document will be able to clearly see what the important points are.

To use bullets: Place your cursor where you want your bullets to begin. Click on the **Bullets** icon on your toolbar.



When you click on the Bullets icon, bullets will automatically be inserted at the beginning of each new line after hitting the <ENTER> key.

Numbering – it can sometimes be helpful to number items within the ELP document. To create a numbered list, click on the Numbering icon on your toolbar.



When you click on the Numbering icon, numbers will automatically be inserted at the beginning of each new line after hitting the <ENTER> key.

Graphics

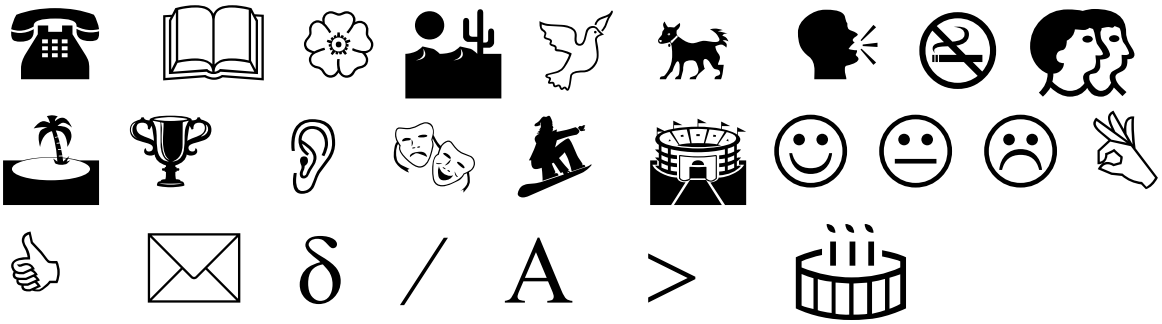
Adding graphics to an ELP can do lots of things. First, it can help to personalize the ELP by showing some of the things that are important to the person in picture form. It can help demonstrate a theme that the person thinks is important. It can help "jazz up" the ELP and it can be just plain FUN! **(* note – you should follow agency and/or facility guidelines for the use of graphics on ELP documents).**

To add graphics to your document:

Click on **Insert** from your main menu at the top of the page.

- To insert a symbol, click on **Symbol.** There are several menus of symbols to choose from. Once you insert the symbol, make it bigger or smaller by highlighting it and changing the font size.

Some examples -



- To insert clip art, click on **Picture** and then click on **Clip Art.** There are lots of options to choose from here!

Some examples –

- To insert word art (whatever you want to say can be said in an interesting way!), click on **Picture**, and then click on **Word Art.** Click on the format you want to use, and then click **OK.** You will get a pop up box. Type in the words you want to appear in Word Art, and choose your font type, font size, bold or italic.

An example –

Another example –

ESSENTIAL LIFESTYLE PLAN
Person's Name

Purpose of the ELP

Date of meeting(s):
Place of meeting(s):
People in attendance and relationship to the person:

Other people contributing*:*

WHAT PEOPLE LIKE AND ADMIRE ABOUT (Person's Name) :	*What other things have people said they like and admire about the person?*

WHAT (Person's Name) MUST/MUST NOT HAVE IN HIS(HER) LIFE: -or- **PEOPLE AND THINGS MOST IMPORTANT TO (Person's Name):**	*What other things have you learned that the person MUST/MUST NOT have in their life, or what other things have you learned are MOST IMPORTANT to the person?*

WHAT (Person's Name) LIKES/DISLIKES:	*What other things have you learned that the person likes or dislikes?*

_____'s HOPES AND DREAMS	*What other things has the person said or indicated the might dream of someday?*

THINGS TO TRY OR LEARN:	*What other things has the person said or indicated they would like to try or learn?*

Communication Section:

When This is Happening	And _____ Does....	We Think It Means …	Then We Should …

IN ORDER TO SUPPORT (Person's Name), WE MUST:	
The completed ELP Nursing Assessment should be inserted into this section of the ELP	

Contact Numbers: **At Home:** **At Work:** **Other:**	

Regarding Money:	

Supporting _____ with Personal Care:	

ISSUES TO BE RESOLVED	*What other things are happening in the person's life that don't make sense for the person right now?*

Essential Lifestyle Plan
Action Plan Section

Outcome (result)	**Person Responsible** (name)	Paperwork Required			**Review / Target Date**	**Completion Date** (if applicable)	**Measurement** (explain how the "results" will be measured)
		Monthly (initials)	**Quarterly** (initials)	**As Needed** (initials)			
CLINICAL OUTCOMES							
SEE DOCTORS AS RECOMMENDED		☐	☐	☐			
ASSIST WITH MEDICATIONS AS PRESCRIBED		☐	☐	☐			
SUPPORT TO MAINTAIN BEST POSSIBLE HEALTH		☐	☐	☐			
ASSISTANCE WITH MANAGING FINANCES AS NEEDED		☐	☐	☐			
SUPPORT WITH BEHAVIORAL ISSUES (OPTIONAL)		☐	☐	☐			
Other clinical outcomes as needed for each individual		☐	☐	☐			
		☐	☐	☐			
		☐	☐	☐			

Outcome (result)	**Person Responsible** (name)	**Paperwork Required**			**Review / Target Date**	**Completion Date** (if applicable)	**Measurement** (explain how the "results" will be measured)
		Monthly (initials)	**Quarterly** (initials)	**As Needed** (initials)			
INDIVIDUAL OUTCOMES							
Outcomes from "Hopes and Dreams" and "Things to Try or Learn" and ALL the person's "MUST HAVE"'s		☐	☐	☐			
		☐	☐	☐			
		☐	☐	☐			
		☐	☐	☐			
		☐	☐	☐			
		☐	☐	☐			
		☐	☐	☐			
		☐	☐	☐			

SECTION 12

Delaware Health and Social Services
Division of Developmental Disabilities Services
Dover, Delaware

Title: Essential Lifestyle Planning Policy **Approved By:** _____
Division Director

Written/Revised By: DDDS Policy Committee **Date of Origin: July 2002**

Revision Date: February 2004

I. PURPOSE

To establish the process and guidelines for the development and implementation of Essential Lifestyle Plans (ELPs) for people receiving services from the Division of Developmental Disabilities Services (DDDS).

II. POLICY

It is the policy of the DDDS that all people receiving support services from the Division will be assisted to develop a written plan of support that reflects their specific needs and lifestyle choices.

III. APPLICATION

Division of Developmental Disabilities Services (DDDS) Staff
Contractors

IV. DEFINITIONS

Residential Living Placement	A residential placement (community placement and Stockley Center) where an individual(s), under contract with or employed by the DDDS, provides necessary supports to people receiving services.
Essential Lifestyle Plan (ELP)	A person centered plan, developed with the person receiving services, his/her family or guardian and other individuals providing support, that outlines in detail the individual's preferences, individual support needs, and lifestyle choices.

IV. DEFINITIONS (continued)

ELP User's Manual for Delaware	Guidelines for the development and implementation of Essential Lifestyle Plans in Delaware as developed by the Division of Developmental Disabilities Services.
ELP Facilitator	An individual who has successfully completed the ELP Facilitator Training offered by DDDS, and who is responsible for putting information learned about a person receiving services into the ELP format.
ELP Reviewer	An individual designated by DDDS and meeting the requirements established in the ELP Users Manual for Delaware, to review plans for technical compliance.
Case Manager/Support Coordinator	An individual assigned to a person receiving services who is responsible for monitoring the overall implementation of the ELP. *(Note - For individuals in Foster Care, the DDDS Case Manager shall serve as the Case Manager/Support Coordinator. For individuals in residential placements operated by contractors, the contracted agency Program Coordinator, Case Manager, or designee shall serve as the Case Manager/Support Coordinator. For individuals who live at Stockley Center, the Case Manager/Support Coordinator shall be a QMRP.)*
ELP Oversight & Curriculum Committee	A committee chaired by the Statewide ELP Coordinator and charged with the responsibility of reviewing/developing/revising the ELP User's Manual at least every six (6) months. They shall also be the central depository of questions and recommendations relative to the ELP.
Support Team Members	Residential and Day Services staff, Nursing, behavioral and Case Management staff, other staff providing services and support, friends and family/guardian of the consumer.

V. STANDARDS

A. Each individual receiving residential services from the DDDS will be assisted to develop and implement an Essential Lifestyle Plan according to the guidelines established in the ELP User's Manual for Delaware and DDDS Policy and Procedure Manual.

B. An ELP Personal Profile shall be completed for individuals who receive only day services from the DDDS. The Center Director shall be responsible for coordinating the initial and annual updates for this planning document.

C. In the case of an emergency admission to residential services, the individual(s) will be assisted to develop an ELP within 30 days of their original admission date into residential services.

D. A designated ELP Facilitator shall assist each individual to develop their person centered plan.

E. Essential Lifestyle Plans shall minimally reflect what people like and admire about the person (the individual's strengths or assets), what the person says he/she must have in his/her life (preferences), and specific support details needed to support the person in their life activities (needs, current learning plans and individual lifestyle choices), as well as a plan of action for ensuring that the implementation of the ELP is monitored.

F. All applicable support team members shall be involved in the development of the ELP.

G. Essential Lifestyle Plans shall be updated, minimally within 365 days of the previous Annual Conference.

H. The person receiving services, with the ELP Facilitator, shall determine who attends the ELP meetings, when and where it shall be held. All support team members or their designee shall be requested to attend the Annual ELP meeting unless otherwise requested by the individual receiving services.

I. Issues that the person does not wish to discuss at the Annual ELP Meeting, shall be discussed with appropriate team members and outlined in the final draft of the ELP.

J. ALL members of the support team shall have input and shall review the Essential Lifestyle Plan prior to implementation. The Case Manager/Support Coordinator shall communicate changes/modifications to the ELP document to primary holders of the person centered plan (i.e., provider, day program, COR).

V. STANDARDS (continued)

K. The initial ELP (including Signature Sheet, Annual Conference Summary and subsequent updates) shall be submitted to the Health Information Management Department (HIM) within 30 calendar days of the meeting.

L. The ELP User's Manual for Delaware shall be the resource with the most current Division approved information relative to the development and implementation of ELP's. All staff and contractors shall comply with the guidelines set forth in this manual.

M. The ELP Oversight and Curriculum committee shall be responsible for the development and revision of the ELP User's Manual for Delaware. This committee shall review (and revise as necessary) the ELP User's Manual, at least every six (6) months.

N. Only one (1) version of the ELP shall be maintained at any given time. The working copy of the ELP shall be maintained in the COR for Community Services and Special Populations and in the Program Book at Stockley Center. The original ELP document is maintained by the H.I.M. Department.

O. The H.I.M. Department shall track the date of the most current ELP and the date that such document was received by H.I.M.

VI. PROCEDURES

Responsibility	Action
ELP Facilitator	1. Conducts meeting with the person receiving services, and others who know and care about the person, in addition to those currently providing support services, to determine what is important to the person. 2. Assists the person receiving services to develop an Essential Lifestyle Plan, using information gathered from the person and others providing support according to guidelines as established in the ELP Users Manual for Delaware. 3. Assures that the ELP is reviewed as necessary.

VI. PROCEDURES (continued)

For Individuals Moving into Community Residential Services or between Residential Settings Transferring Case Manager/Support Coordinator	4. Assures that the ELP is reviewed and developed with all members of the support team (both sending and receiving teams) prior to transfer to a new residential services setting. 5. Conducts the Transfer Summary Conference with both sending and receiving support team members to review the ELP and address any issues prior to the person's transfer to a new residential services setting.
Receiving Case Manager/Support Coordinator	6. Attends the Transfer Summary Conference and reviews current support needs as listed in the ELP with the ELP Facilitator, the person receiving services, and other team members. 7. Assures that arrangements for continuity of supports have been made as necessary prior to the person's date of transfer into a new residential services setting. 8. Assures that support staff are familiarized with the ELP and the person's support needs prior to transfer to the new residential placement. Assures that the support staff sign the ELP signature sheet. 9. Schedules and facilitates a 30-day post placement conference no later than 30 days following the person's transfer to a new residential services setting and updates the ELP to reflect any changes, or any new things learned about the person in the first 30 days post-transfer. 10. Assures the updated ELP is placed in the person's record no more than 60 days following the transfer to residential services. 11. Assures that the ELP is continually updated throughout the year by the person and/or support staff as the person learns new things, achieves goals, expresses new interests, and makes different lifestyle choices.

VI. PROCEDURES (continued)

	12. Schedules the Annual Conference. 13. Prepares an updated draft of the ELP and distributes it to all support team members at least 2 weeks (10 business days) prior to the Annual Conference. 14. Assures that all applicable support team members have a chance to review the updated ELP, and have input into the ELP, prior to attending the meeting.
Support Team Members	15. For individuals requiring behavioral support plans, health plans, learning plans or as required by applicable standards/regulations, support team members provide updated information (assessments) to the Case Manager/Support Coordinator within 30-45 days prior to the date of the Annual Conference.
Support Coordinator	16. Assures that the input of the person, as well as the input of <u>all</u> support team members, is included in the annual draft of the ELP. 17. Assures that all plans the person is currently working with, including day service plans, behavior support plans, health maintenance plans, etc. are either incorporated into the ELP, or are referenced in the ELP and attached as appropriate. 18. Assures that the Action Plan of the ELP reflects: • Services being provided and monitored, as well as lifestyle choices made by the individual across all settings. • Names of the person responsible for each item. • Reporting requirements for each individual responsible. • An explanation of the measurement of each outcome or service objective according to guidelines established in the ELP User's Manual for Delaware.

VI. PROCEDURES (continued)

	19. Completes the Annual ELP Conference documentation according to guidelines established in the ELP User's Manual for Delaware. Details relative to the use of respite services shall be documented accordingly on the Annual ELP Conference form. Files the ELP in the COR (for Community Services and Special Populations) or the Program Book (for Stockley Center) within 10 working days of the Annual Conference. 20. **Community Services Programs:** Places a finalized copy of the annual ELP documents in the COR and forwards a copy to the day service provider and foster home, if applicable. **Stockley Center:** Stockley Center shall place a final copy of the annual ELP documents in the program book. 21. Submits original initial ELP documents and subsequent updates to the Health Information Management Department (HIM) within 30 calendar days (for Community Services and Special Populations) and within 12 working days (for Stockley Center) of the meeting. 22. Generates the appropriate progress reports for each support team member (according to the ELP User's Manual for Delaware).
H.I.M. Department	23. Maintains a computerized tracking system to monitor the date of the most current ELP and the date that such document was received by H.I.M. 24. Distributes monthly reports to the Executive Director of Stockley Center, Director of Community Services, Director of Special Populations and designated Community Services Managers.
ELP Oversight and Curriculum Committee (chaired by the Statewide ELP Coordinator)	25. Updates the ELP User's Manual as needed. 26. Distributes updates to the ELP User's Manual to each contracted agency designee, Stockley Center designee, Quality Assurance Director, Director of Training and Professional Development, Community Services regional designees, Special Populations designee and the Director's Office.

VI. PROCEDURES (continued)

Recipients of ELP Manual updates	27. Disseminates ELP Manual updates to area manual holders.

VII. REFERENCES

ELP User's Manual for Delaware

VIII. EXHIBITS

ELP Personal Profile