



**LEGAL ADVOCACY FOR
DEVELOPMENTALLY DISABLED
PERSONS IN MINNESOTA**

**GUIDE TO
INDIVIDUALIZED
PROGRAMMING REVIEW**

- by -
Cathy Macdonald, M.A.
*Developmental Disability
Professional*

This survey form was developed by Cathy Macdonald, M.A., a member of the staff of Legal Advocacy for Developmentally Disabled Persons in Minnesota, 222 Grain Exchange Building, 323 Fourth Avenue South, Minneapolis, Minnesota 55415, for purposes of monitoring compliance with paragraph 63 and other related provisions of the Consent Decree dated September 15, 1980, in Welsch v. Noot. Comments or questions should be directed to her at that address or telephone (locally) (612) 338-0968; or toll-free at 1-800-292- 4150.

I. Guide to Individualized Programming Review
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INDIVIDUALIZED PROGRAMMING REVIEW COMPONENTS

I. Guide to Individualized Programming Review: Contains general information plus a list of the survey questions with an associated interpretation for each question.

II. Comments: Narrative comments made on an individual resident's program in relation to survey questions.

III. Summary Form: Includes prioritized summaries of evaluator's comments and space for responses from state institution staff and follow-up comments by the Court Monitor or evaluator.

A priority rating A, B, or C will be assigned for each issue raised to indicate the urgency with which it should be addressed. The priority ratings are defined as follows:

Priority A. Should be addressed immediately. Examples; issues raised that are life-threatening, do physical harm, etc.

Priority B. Should be addressed as soon as possible. Examples; issues raised that are crucial to function in less restrictive environments such as behavioral excess, communication skills, etc.

Priority C. Should be addressed. Examples; issues raised that interfere with an individual's potential to develop functional skills such as generalization of communication skills, use of age-appropriate materials when applicable, etc.

QUESTION: 1. Are the individual's needs and strengths indentified in the assessment process and presented at the team meeting for IPP development?

INTERPRETATION: In assessing needs and strengths, team members should consider the following:

a) Does the assessment process identify needs in terms of obstacles to function in the least restrictive environment?

b) Are assessments developmentally appropriate, providing information about what the client can do as well as what he cannot do for program development?

c) Whenever possible are assessments adapted for the individual's physical limitations to show a more accurate picture of his abilities?

Identification of individual needs and strengths is the basis for development of an appropriate IPP. This should be a "team" process in which each team member's contributions are combined and synthesized for team goal-writing. See also question number four's interpretation. A cross-disciplinary approach can result in goals formulated to meet more than one of a resident's needs making skills acquired even more functional (e.g., combination of mobility and social programming needs into a goal to increase mobility through social games). (ACMRDD Standards 1.2.7.2 and 1.2.7.3).

QUESTION: 2. Are the various assessments done at appropriate intervals for the resident?

INTERPRETATION: For standards of assessment intervals refer to Rule 34 (12 MCAR §2.034, c.2) and ACRDD Standards 1.2.12.3. It should be remembered that additional assessment may be warranted at any time due to changes in an individual's health or behavior.

QUESTION: 3. Are goals and objectives a result of a synthesis of assessment information?

INTERPRETATION: The team IPP meeting and subsequent documentation should include team interpretation and integration of assessment results gathered through formal testing and informal observation. As cited in ACMRDD Standards (1978 edition, p. 2-3):

"The problems associated with developmental disabilities do not fall within the purview of any one discipline, but require for their alleviation the knowledge and skills of many professions. Therefore, services to developmentally disabled individuals must be rendered in an interdisciplinary manner."

The interdisciplinary approach requires that a unified and integrated evaluation and individual program plan be developed by an appropriately constituted team for each individual served. Consequently, the interdisciplinary team process requires participants to share and discuss, on a face-to-face basis, all information and recommendations, so that decisions can be made by the team, rather than merely by the individual members of it.

Therefore, it follows that it is much more appropriate for each team member to contribute a list of the resident's needs and strengths based on their own assessment information than to come to the meeting with a preconceived set of proposed goals.

QUESTION: 4. Did the team set goals and priorities for objectives designed to provide the resident with skills needed to function in a less restrictive environment?

INTERPRETATION: When choosing goals and setting priorities team members should maintain focus on functional skills that allow the developmentally disabled person to be more independent in less restrictive settings. (The definition of a "functional" skill should include regular use of a skill in routine activities, preferably immediately.) Rationale for goal choices and priorities should be evident in IPP documentation. This facilitates the "team" thinking process and provides a permanent record of this important information for future decision-making.

QUESTION: 5. Is team rationale for choice of goals and objectives evident in documentation?

INTERPRETATION: Documentation of team rationale for choice of goals and objectives provides a permanent record of this important information for future decision-making.

QUESTION: 6. Are all relevant team members present when significant decisions are made regarding individualized programming (e.g., annual team meetings)?

INTERPRETATION: It is important that all relevant team members are included in making significant program decisions in order to maintain an interdisciplinary approach to programming and maximize the individual resident's potential.

QUESTION: 7. Are goals broken down into small enough steps (i.e., objectives) for the resident to make progress?

INTERPRETATION: An IPP should contain goals or general statements describing a program's proposed effect on the client's behavior. In addition, these goals should be broken down into objectives which specify observable, measurable steps toward goal mastery. Specific behavioral objectives help team members to see the resident's progress more clearly. (ACMRDD Standards 1.3.3 and 1.3.3.2.3).

A behavioral objective should include:
a) a target behavior for the individual (not staff) to perform; b) the conditions under which the behavior is to be performed (materials, environments, prompts, etc.); c) the number of opportunities (trials) that the individual will have to perform the behavior; and d) a criterion or level of success required (frequency, repetitions required, etc.).

The following example points out these components: When physically guided to a leisure activity cabinet (condition), the client chooses one object out of three for a leisure time activity (behavior). Definition of success: 10 consecutive trials (criterion), 2 trials given per day (number of opportunities).

QUESTION: 8. Are the behaviors described by the objective observable and measurable?

INTERPRETATION: In order to obtain accurate measures of progress, behavioral objectives must be stated in terms of a single behavioral outcome and written in behavioral terms that provide for a means for observing the behavior and measuring progress (or lack of it). (ACMRDD Standard 1.3.3.2.3).

QUESTION: 9. Do objectives focus on development of positive behaviors?

INTERPRETATION: Focus of programming on development of positive behaviors is most appropriate for the following reasons:

a) Developmentally disabled persons often have a limited repertoire of adaptive behaviors and with instruction to increase positive behaviors can learn to function more independently.

b) Recent instructional research suggests that an important way to reduce problem behaviors is through training for functional skill acquisition. The basis for this reasoning is that developmentally disabled persons typically have limited functional skills and that problem behaviors may provide an important source of social, escape, and intrinsic reinforcement. It has been proposed that attempting to extinguish behavior problems along with providing programs for positive replacement behaviors is the most efficient and permanent way to reduce problem behaviors and also provides the benefit of new useful skills.

c) Emphasis on decreasing undesirable behaviors is often detrimental to staff attitudes by lowering expectations for the client to acquire new skills and encouraging a view of the client as a list of problems. Example: It would be better to write a goal and associated objectives to attempt to "increase appropriate peer interaction skills" than to focus on "decreasing pushing behavior toward peers".

QUESTION: 10. Are written intervention plans in the resident's records for each behavioral objective?

INTERPRETATION: Each behavioral objective should have an associated intervention plan with task analysis of the behavior to be worked on, specific teaching strategies, and consideration for the resident's individual needs and preferences. Written intervention plans assure program consistency and improve chances for success.

QUESTION: 11. Are written objectives, intervention plans, and implementation procedures individualized to respond to the resident's individual habilitation needs?

INTERPRETATION: Habilitation programs developed should be planned around the client's individual needs and strengths in order to maximize potential to function in the least restrictive environment. During the development of intervention plans and procedures the following questions should be considered:

a) What teaching strategies does the resident respond to most positively? Important concerns include the determination of individual personal preferences for various program activities and reinforcers, better training results through a particular modality (e.g., visual, auditory or tactile input or various combinations), and individual differences in response to certain kinds of prompts (e.g., manual guidance, visual cues, models, etc.).

b) Is the habilitation program appropriate to the individual's developmental level? Habilitation efforts should be designed to focus on training new, more complex behaviors without requiring responses that are too complex for the resident to succeed. (ACMRDD accepts the developmental model as the basis for active treatment and habilitation for developmentally disabled persons.)

c) Is the habilitation program adapted for the individual with physical handicaps? Programs should be adapted to help an individual compensate for physical handicaps that may interfere with progress. Example: having the OT help design a special self-help skills program for a hemiplegic client.

d) Have special positioning needs of the non-ambulatory resident been identified and positioning procedures written?

Non-ambulatory individuals must be specially positioned throughout the day for both developmental programming and health needs.

e) Are intervention methods varied progressively to promote generalization? Developmentally disabled persons typically have difficulty transferring isolated skills learned to functional use in their living environment. Methods should be varied to include skill performance over differing natural settings, people, instructional materials, and language cues. An excellent way to promote generalization is to provide training in natural contexts whenever possible (rather than in isolated tasks) resulting in less need for generalization training.

QUESTION: 12. Do program plans provide for appropriate amounts of training time to reach objectives set?

INTERPRETATION: Program plans must designate the approximate amount of time to be spent for skill training. Inadequate concentration of training time (e.g., number of hours per week) interferes with rate of progress, while excessively long projected periods of training (e.g., target date in 1 year) lower staff expectations for progress.

QUESTION: 13. Are initiation, review, and target dates established for behavioral objectives?

QUESTION: 14. Are persons responsible for writing habilitation programs noted by name and title?

QUESTION: 15. Are persons responsible for implementation of habilitation programs noted by name and title?

QUESTION: 16. Have team recommendations been followed up with appropriate actions?

INTERPRETATION: Team recommendations for further special assessment, program materials, change in residential living area or day programming placement, etc., should be carried out within specified time limits or in the IPP or within a reasonable period of time.

QUESTION: 17. Is adequate focus placed on the development of positive behaviors in habilitation program implementation?

INTERPRETATION: Though reduction of behavioral excesses, health care, or other program areas may demand extra attention at times, program implementation should reflect an aim to focus on the development of new positive behaviors. Positive behaviors mastered move an individual closer to the goal of function in the least restrictive environment (by providing new adaptive behaviors as well as positive replacement behaviors for behavioral excesses).

QUESTION: 18. When program implementation is observed, does it match documentation available?

INTERPRETATION: Unless program modifications have been entered in the IPP record, program implementation should follow the original IPP as planned. In other words, the resident's daily activities should correspond to those set up by the IPP.

QUESTION: 19. Are habilitation program components (e.g., day and residential) coordinated as dictated by individual needs?

INTERPRETATION: For programming to be effective, all facets of a resident's program should be coordinated in relation to the individual's habilitation needs. The IPP and other program documentation must be readily available to all pertinent staff members. Interdisciplinary team members should be familiar with IPP goals, methods, and schedules. Regular channels of communication should be established to facilitate coordination of program components for each client.

Program coordination is especially crucial for adequate implementation of communication and behavioral programs. For example, total communication skills learned in daytime programming will not be meaningful and functional for an individual unless communication efforts are encouraged and reinforced in other settings such as the residential area. A resident's specific developmental programs should be integrated into his daily life routines whenever possible. (ACMRDD Standards 1.5.1 and 1.5.2).

QUESTION: 20. Is a schedule of the individual resident's daily activities available and implemented as written?

INTERPRETATION: For purposes of program coordination and personal health and safety, a schedule of each resident's daily activities should be placed in every location the resident visits regularly.

QUESTION: 21. Have the positioning needs of the non-ambulatory individual been identified and corresponding measures been taken to meet these needs?

INTERPRETATION: Non-ambulatory residents have special positioning needs related to health, safety, and developmental programming issues. Wheelchairs must be adapted to the individual's personal size and positioning needs. Direct care staff should be instructed by professional staff as to how often the resident's positioning must be changed and how much time he should spend out of his wheelchair. A 24-hour positioning schedule with a means to monitor its implementation is advisable. For multiply handicapped persons, when applicable to developmental programming, occupational and physical therapy staff members should instruct staff in positioning and handling techniques that promote development by facilitating voluntary movement. (Consent Decree, ¶64).

QUESTION: 22. Is staff trained in the specific skills required to implement particular programs?

INTERPRETATION: Staff members must be adequately trained to enable them to implement instructional programs effectively. When a habilitation plan is written by a professional on the team, it is that professional's responsibility to see to it that those implementing the instructional program understand its purpose, content, and procedures involved. Training for program plan implementation can increase the direct care staff member's interest in a successful outcome as well as provide the necessary skills for program implementation. (Rule 34, E.3.b.(1) and ACRDD Standard 4.6.1.4).

QUESTION: 23. Are appropriate habilitation program data systematically recorded and adequately interpreted by the team?

INTERPRETATION: Objective data on response to individualized programs must be recorded systematically, compiled, and submitted to the team for review. (ACMRDD Standard 1.3.7 recommends at least monthly review of habilitation program data). Habilitation program data should be available and accessible to all team members. Coordinated program data (e.g., day and residential setting data) should be combined and analyzed in total for accurate analysis. Important measurements include: baseline behaviors, ongoing program progress data, final performance upon termination of a program, and possibly graphed or maintenance data. Appropriate data procedures are crucial to provision of effective habilitation for each resident.

Thorough and accurate data recording can provide:

a) An informed basis for programming decisions. With the aid of data collected; the team can decide whether goals, objectives, and intervention techniques should be continued, modified, dropped, or replaced. If little progress is noted over time, the team should reevaluate the appropriateness of program methods. Possible reasons for lack of progress should be discussed as a team. A change in teaching strategies may improve resident performance. For example, a change from modelling cues to manual guidance may improve resident performance. If change in strategy is not successful or the team does not feel it will be helpful, a revision of the objective (or goal) itself may be in order. For instance, the team may determine that a

certain objective/goal is unrealistic or in conflict with functional skill acquisition. If little progress is noted upon team review, but no program changes are proposed, this could reflect inappropriately low team expectations for a resident. (ACMRDD Standard 1.3.8).

b) Increased accountability for programming results.

c) Reinforcement for staff for carrying out programs and reinforcement for clients for behavioral change.

QUESTION: 24. Have barriers to IPP progress (e.g., health, transportation, lack of resources, etc.) been identified and documented, and have attempts been made to overcome them?

INTERPRETATION: The team review process should include identification and documentation of barriers to IPP progress. Such barriers may be related to client factors such as behavior problems or medication side effects or other limiting factors such as lack of habilitation materials, staff shortages, and limited access to outside resources for problems the team has been unable to solve. Remedies for barriers to progress identified should be pursued by the team without delay.

QUESTION: 25. Has an annual community placement assessment been completed?

INTERPRETATION: Consent Decree, ¶21.

QUESTION: 26. Does the community placement assessment identify the type of community placement and the scope of services necessary in terms of need rather than availability?

INTERPRETATION: The community placement assessment should identify: a) the resident's service needs (e.g., type of residential and day programming, instructional needs in self-care, mobility, communication, etc., for all settings); and b) identification of specific professionals and level of service to be provided in order to meet service needs (e.g., indirect consultant services from an occupational therapist and direct speech and language therapy services).

QUESTION: 27. Is staff being in-serviced regularly with emphasis on proper care of the physically handicapped?

INTERPRETATION: Important issues in staff training as related to care of the physically handicapped include: mobility, positioning and handling techniques, feeding procedures, adaptations of assessment and programming methods for physical handicaps, and vulnerability. (Consent Decree, ¶60).

QUESTION: 28. Is staff being in-serviced regularly with emphasis on proper implementation of behavior modification programs?

INTERPRETATION: Important issues in staff training as related to implementation of behavior modification programs include: consistency and coordination of programs across settings, defining and identifying target behaviors, data keeping, limitations and regulations for the use of aversive procedures, and training of positive replacement behaviors. (Consent Decree, ¶60).

QUESTION: 29. Is staff being in-serviced regularly with emphasis on effective training methods for development of communication skills for severely/profoundly retarded individuals?

INTERPRETATION: Important issues in staff training as related to implementation of communication programs include: consistency and coordination of programs across settings, importance of teaching "functional" communication skills, alternatives to speech for non-verbal residents, and facilitating pre-communication behaviors. (Consent Decree, ¶60).

QUESTION: 30. Is staff being in-serviced regularly with emphasis on services provided to mentally retarded persons by residential and non-residential community service providers?

INTERPRETATION: Important issues in staff training as related to current trends in community residential and day services include: programs for behavioral excess, communication training, and habilitation of multiply handicapped individuals along with community living and vocational skills training. (Consent Decree, ¶60).