Individual Support Planning

A Resource Guide to Assist with Developing, Implementing and Monitoring an Individual Supports Plan

Human Services
Persons with Developmental Disabilities
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Copies of this resource guide are available for download at the PDD Program website, http://humanservices.alberta.ca/disability-services/pdd.html
What is this Resource Guide?

The purpose of this guide is to help a Support Team prepare an Individual Support Plan (ISP). It offers suggestions on how to implement and monitor the ISP once it has been created.

This resource guide was created collaboratively by community service providers and Persons with Developmental Disabilities (PDD) in consultation with Dr. Robert Schalock and incorporates concepts from the Council on Quality and Leadership (CQL)\(^1\). The guide can be used as a step-by-step framework to follow, or simply to help focus the conversations of a Support Team.

Vision

Alberta’s Social Policy Framework\(^2\) identifies the overall direction for social policy in Alberta. The Social Policy Framework vision is: **In Alberta, everyone contributes to making our communities inclusive and welcoming. Everyone has opportunities to fulfill their potential and benefit from our thriving social, economic, and cultural life.**

The Persons with Developmental Disabilities (PDD) vision identifies the overall direction of the PDD

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\(^1\) CQL, an organization based in the United States, works with human service organizations and systems to continuously define, measure and improve the quality of life of all people.

\(^2\) Alberta’s Social Policy Framework website: http://socialpolicy.alberta.ca
program and describes what PDD is striving to achieve. The PDD vision is: \textit{An Alberta that honours and respects the dignity and equal worth of persons with developmental disabilities.}

\textbf{Anticipated Long-Term Outcomes}

Albertans are:

\begin{itemize}
  \item \textit{Safe} — Live free from fear of abuse and violence.
  \item \textit{Healthy} — Achieve the highest attainable standards of health and well-being.
  \item \textit{Secure & Resilient} — Support themselves and their households through safe work and career opportunities, with access to effective income supports when in financial need.
  \item \textit{Lifelong Learners} — Develop the knowledge, skills, and commitment to learning needed to participate in society and reach potential.
  \item \textit{Included} — Feel welcomed in the communities where they live, learn, and work.
  \item \textit{Active & Engaged} — Explore opportunities to participate in recreational activities and cultural experiences, and to engage in Albertan society.
\end{itemize}

\textbf{What is an Individual Support Plan (ISP)?}

An Individual Support Plan is a written tool that describes an Individual’s desired personal outcomes and how these outcomes will be achieved through the involvement of a variety of people, services and supports. It outlines goals and the steps to follow in order to meet those goals. It actively involves the Individual throughout the process and builds upon his or her strengths and natural supports. The ISP can be used to help motivate and inspire an Individual and his or her Support Team.
The ISP identifies:

⇒ Specific goals that are tied to the Quality of Life domains;
⇒ The actions or objectives needed to meet those goals;
⇒ The support strategies or resources required for the goals;
⇒ The outcomes and indicators that the goals have been met.

The terms goals, objectives, support strategies and outcomes are used throughout this guide. Definitions are available in the Glossary (Appendix 1) so that there is some consistent understanding of their usage in the guide.

An ISP should be based on a set of principles that reflects what is important to and for the Individual.

**Individual Support Plan Development Principles**

1. The Individual and the Individual’s natural supports (including but not limited to family members) are actively involved in the plan’s development and implementation.

2. The support team that develops the ISP includes people who know the Individual well and will be involved in the plan’s implementation.

3. Priority is given to those outcome areas that reflect the person’s goals, relevant major life activity areas, and exceptional medical and behavioral support needs.

4. A quality of life framework is used to show how supports and outcomes can affect many aspects of a person’s life.
5. Support objectives are about specific support strategies and how they are carried out.

6. The ISP is implemented by the Individual and his or her support team.

The ISP format should be user friendly and easy to communicate so as to facilitate effective implementation.

**What is a Support Team?**

A Support Team is a group of people who work together to create, implement and monitor the ISP.

The Support Team is composed of the Individual receiving supports and services, his/her parents or family members, the guardian when applicable, direct service staff who work with the Individual, PDD supports coordinator, other professionals and people who may be involved in planning with the Individual.

When creating an ISP, the responsibilities of the Support Team typically involve:

- Identifying what is important to and for an Individual
- Identifying what fits with the Individual’s strengths
- Ensuring that the ISP is meaningful to the Individual and his/her natural supports, such as family members or friends
- Ensuring that the ISP provides clear goals, objectives, support strategies and outcomes all based on the Quality of Life domains and fits with the Individual’s strengths
- Identifying which team member is responsible for implementing each support strategy

Once the ISP is created, the Support Team is responsible for both implementing and monitoring it. The ISP is based on the Quality of Life framework, which means that the goals and outcomes reflect specific Quality of Life domains.
What are the Quality of Life Domains?

Quality of Life domains are a way of measuring the degree to which a person enjoys the possibilities of his/her life given the person’s unique opportunities and limitations. The domains describe personal and environmental factors that influence quality of life. This guide describes eight Quality of Life domains. The full descriptions and examples of each domain can be found in Appendix 2 of this guide.

What will you find in this guide?

Eight best practice guidelines form the basis of this resource guide. These are:

1. Identify the Individual’s goals and strengths
2. Select support needs that are important to and for the Individual
3. Align support needs to outcome categories
4. Align support needs to specific support strategies
5. Identify a specific support objective for each support strategy
6. Use a Support Team to develop the Individual Support Plan (ISP)
7. Implement the Individual Support Plan using Support Team members
8. Monitor the status of support objectives

The guide can help the Support Team identify goals, objectives and strategies and link the goals to Quality of Life domain(s). This allows for the ISP to be continuously monitored and outcomes evaluated. Through this process, the Support Team will identify what an Individual can do and what the person is passionate about. From there, the Individual and the team will identify flexible, responsive supports the Individual needs to lead a good life in the community.
Guideline #1

Identify the Individual’s Goals and Strengths for the Individual Supports Plan

It is essential for the Support Team to fully understand the Individual’s personal goals. Identifying and understanding these goals is the most important step in the process since the value of the ISP will depend on the quality of the information gathered here.

In order to accurately identify the Individual’s goals, he or she must be central in the planning and included throughout the ISP process. Some strategies the Support Team can use to ensure the Individual is fully engaged in the discussion are:

⇒ Capability should always be assumed. Start with the knowledge that this person makes decisions every single day. Assess how he or she makes those decisions, and how he or she communicates those preferences. Let this knowledge guide you in providing the appropriate resources and experiences to aid in decision-making.³

⇒ Be actively involved in the interaction and discussion and pay close attention to the Individual’s responses.

⇒ Listen to what the Individual is saying and look for body language that may indicate whether her or she is engaged.
⇒ Observe how the Individual is communicating and include their responses in the discussion.
⇒ Be aware of your own personal judgments and opinions and do not let them influence the outcome of the discussion; what matters are the goals of the Individual.
⇒ Whenever possible, keep questions open-ended [questions that need more than one or two words as an answer and cannot be answered with “yes” or “no” alone]. Open-ended questions elicit more information, which can lead to a greater understanding of what the Individual is explaining.
⇒ Do not rush the conversation; make sure that the Individual has enough time to respond and to finish his/her thoughts.
⇒ Spend time learning about how the Individual prefers to communicate.

In order to identify goals that reflect a person’s interests, some questions that can be asked are:
⇒ How do you want to spend your day?
⇒ What do you want to learn?
⇒ Where do you want to live and work?
⇒ Who do you want to spend time with?
⇒ What would make you feel more safe and secure?

It is important to focus on the Individual’s personal strengths or assets, which include his or her attitudes, interests, skills, and natural supports.

An Individual’s strengths can fall in the areas of:
⇒ Conceptual skills such as language, reading and writing, self-direction, time awareness, and problem solving
⇒ Social skills such as interpersonal relations, responsibility, self-esteem, citizenship, manners, wariness, and social problem solving
⇒ Practical skills such as activities of daily living (personal care), occupational skills, use of money, safety, health care, travel/transportation, schedules/routines, and use of telephone
The Individual’s natural supports are those opportunities and support strategies provided by family members, friends, colleagues, peers, other members of a social network, generic agencies, and self-help groups.

Questions that help draw out these strengths and assets can include:

⇒ What are your goals?
⇒ What do you want life to be like in the future?
⇒ How do you want to live?
⇒ How do you want to spend your time (work, school, recreation)?
⇒ What supports do you already have (family, friends, other service organizations)?

Sometimes an Individual may not know how to describe his or her skills/strengths, so it can be useful to ask more focused questions such as:

⇒ Do you enjoy reading and writing?
⇒ Do you like to meet new people?
⇒ What are your hobbies and activities you do for fun?
⇒ What do other people like about you /tell you that you are good at?

It may also be important to talk to people outside of the Support Team who know the Individual well. The Support Team may not be made up of all of the people the Individual feels are important in his/her life, so having these additional conversations may increase the team’s knowledge and understanding of the Individual.

It is important to remember that since the ISP is based on the Individual’s personal goals and strengths, each ISP will look different. Like anyone’s goals, the Individual’s goals, objectives and outcomes will also change over time, so it is important to have ongoing conversations with the Individual to ensure that he or she has the opportunity to identify and explore new goals or move on from old goals.
Throughout this guide, two examples will be used at the end of each Guideline section to help clarify how these guidelines can be put into action. This example will follow one goal, recognizing that this is only one part of a bigger conversation and a bigger plan.

GUIDELINE #1 Example: Identify David’s Goals

“David” and his Support Team, which consists of David, agency staff, and his parents, have been talking about what is important to David. David tells everyone he would like to purchase a computer. As he talks more about this, it is apparent that David wants to buy this computer with his own money. The Support Team members ask David questions to help them understand why David wants a computer.

Team: “David what do you like best about using a computer?”

David responds with comments about meeting other people online through gaming, Facebook and other applications.

“How does this help you with your future goals?”

David says that it is easier for him to meet people on-line than it is meeting them in person.

Some of these strategies are adapted from the CQL website: http://www.thecouncil.org/base.aspx?id=1458
# David’s Individual Support Plan

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Goals</th>
<th>Assessed support needs</th>
<th>Support Strategies</th>
<th>Support Objectives</th>
<th>Who is responsible</th>
<th>Progress Review Time Lines Comments</th>
</tr>
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<tr>
<td></td>
<td>To buy a computer</td>
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<td></td>
<td>To buy the computer with his own money</td>
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Example 2: Identify Jane’s Goals

“Jane” and her Support Team have been talking about what is important to Jane. Jane requires high levels of support in all areas of her life as result Jane’s parents are speaking on Jane’s behalf. Her parents tell everyone they want Jane to be happy.

Team: “What does ‘happy’ mean to you?

Jane’s parents respond with comments about her spending time doing things she enjoys and with people she likes.

Jane’s Individual Support Plan

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<thead>
<tr>
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<th>Assessed support needs</th>
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Guideline #2

Select Support Needs that are Important to and for the Individual

It is crucial that an ISP includes details about what the Individual considers important to him or her. For instance, what does the Individual want to work on and achieve? These wishes need to be central to the plan so that the Individual clearly sees the ISP as his or her plan and is thus more motivated and committed to making the plan successful.

Sometimes the needs identified by an Individual are different from the needs seen by caregivers, families, friends or other professionals. The Supports Intensity Scale (SIS) focuses on life activity areas and exceptional medical and behavioural supports that the Individual may not always take into consideration.

In the process of identifying goals and needs with the Individual, it is possible to connect some of the SIS-related needs with the Individual’s goals. For example, if a goal is to find employment, a discussion could take place about how important it is to improve personal hygiene in order to find work. If the Individual agrees that this is important and that he or she needs support in this regard, the next step is identifying what that support will look like.
Example: With reminders, the Individual will begin a daily hygiene routine. This is a way of incorporating what is important for the Individual and to the Individual. The person wants a job, and the SIS information clearly identifies that the Individual requires support in the area of personal hygiene.

If one looks only at SIS-related numbers, then the holistic aspect of an Individual is not being considered. A strong ISP emerges from collective wisdom of the Support Team.

Important to the Individual (based on personal goals and preferences):

⇒ “How do I want to spend the day?”
⇒ “What do I want to learn?”
⇒ “Where do I want to live?”
⇒ “Where do I want to work?”
⇒ “Who do I want to spend time with?”

Important for the Individual (based on SIS-identified areas of support):

⇒ Home Living: Bathing and taking care of personal hygiene and grooming needs
⇒ Employment: Accessing work related supports
⇒ Health-Safety: Taking medications
⇒ Protection and Advocacy: Protecting self from exploitation
⇒ Medical: Example: Seizure management and control
Guideline 2 Example: Needed Supports Based on What Is Important To and For the Individual

David gradually identifies other elements to the primary goal of purchasing a computer.

The team asks for more details about his wish to pay for a computer with his own money. The team members and David discuss where he would like to work. All of this is important to David.

The team recognizes that it is important for David to know how he will manage money he receives and money he earns in order to make his goal come true. (This does not appear to be important to David, but it is clear that managing money will be important for David, so that he can reach the goals that he values.)

As well, the Support Team, with the help of SIS information, notes that David will need to protect himself from exploitation. The team recognizes that it must be aware of situations where David could be at risk, without letting this interfere with his eagerness to find work and to achieve his goal.

Some examples of what is important to David:

⇒ Open a bank account
⇒ Finding a good place to work
⇒ Increasing computer skills

Some examples of what is important for David (as identified by David’s Support Team):

⇒ Better money management skills
⇒ Safety in the community and online
## David’s Individual Support Plan

<table>
<thead>
<tr>
<th>Outcomes</th>
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<tr>
<td></td>
<td>To be safe in the community and online</td>
<td>Protection from being manipulated or harmed</td>
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</table>

Goals that are important to David

Goals that are important for David
Guideline 2 Example2: Needed Supports Based on What Is Important To and For the Individual

Jane’s parents gradually identifies other elements to the primary goals of being happy.

The team asks for more details about what activities or events does Jane enjoy. How does Jane communicate and show she is enjoying something or not enjoying something. They also ask for names of people Jane enjoys being with or who would have valuable information about Jane’s likes/dislikes, etc.

Discussion about Jane’s support needs reveals she will need help to ensure she is safe during the activities.

Some examples of what is important to Jane and her parents:

⇒ Find activities she enjoys
⇒ Spend time with people she likes

Some examples of what is important for Jane and her parents:

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<td>To do things and be with people that make me happy</td>
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Guideline #3

Align Support Needs to Outcome Categories

The Support Team needs to integrate all the information into an ISP that is relevant to the Individual, outcome-oriented and practical.

This information will include:

- The personal goals of the Individual, SIS information and other professional recommendations
- Objectives and support strategies
- Expected outcomes as they relate to the eight Quality of Life domains

Definitions of the terms “objectives”, “goals”, “support strategies” and “outcomes” can be found in the Glossary in Appendix 1 at the end of this document.

The development of an ISP can involve professional terminology and concepts. It is very important that the professional information does not remove the Individual from the centre of the planning process.

Support teams need to use a framework that aligns these three components as they develop an individualized plan. Although there are optional
formats that can be used to align these three components, the framework used in this Guideline is based on the eight Quality of Life domains found in Appendix 2.

Support teams need to understand how each Individual defines the result or benefit of supports for her/himself. Understanding the Individual’s point of view will help support teams align the support objectives and support strategies with the Quality of Life domains and measure if the personal outcome has been achieved.

An Individual may say he/she wants to move from where they currently live. Asking ‘why’ questions reveals that the Individual wants to move closer to a specific church or community activity they want to attend regularly. During further conversation the Support Team finds out the Individual wants to attend church without staff.

Reviewing the Quality of Life framework with this new knowledge will help the team identify the Quality of Life domain(s) that represent the Individual’s personal outcomes.

Guideline 3 Example: Aligning support needs to outcome categories

The Support Team meets with David and other people he wants to have at the meeting. They discuss his goals, which include buying a new computer and finding work. Everyone supports this and when the issue of money management is raised, David states that he can handle money well. The family members and his friends have had some experiences with David that contradict this statement. Everyone has agreed beforehand that it is important not to impose opinions on David, but it is also important to point out areas where David could use more support to achieve the desired outcomes.
With encouragement from the other team members, his family and friends point out some areas where he could use help. For example, his friends remind him that he sometimes doesn’t have enough money to buy something when they are out together. After some discussion, he agrees with them that some support here would help.

After the meeting is over, the team organizes the information from this discussion into a format that aligns his goals to Quality of Life domains and outcomes. They do this by referring to the Quality of Life Framework document and reading the description and indicators for each domain. This is done so that there is a consistent and accepted way to measure his progress and to ensure that supports and support needs identified will actually lead to improved Quality of Life.

Below is an outline of the Quality of Life domains.

<table>
<thead>
<tr>
<th>Quality of Life Domains</th>
<th>Exemplary Indicators</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Development</td>
<td>Educational status, personal competence, activities of daily living and instrumental activities of daily living</td>
<td>David has learned new skills with money management, using computers and is developing new social activities</td>
</tr>
<tr>
<td>Self-Determination</td>
<td>Choices, decision-making, autonomy, personal control, personal goals</td>
<td>David has more independence and expresses pride in the decisions that he is making, both in terms of finances, socialization and self-care</td>
</tr>
<tr>
<td>Interpersonal Relations</td>
<td>Social networks, family, friends, peers, social activities, relationships</td>
<td>David is satisfied with his social life and he is able to expand his social network</td>
</tr>
</tbody>
</table>

Continued on next page
<table>
<thead>
<tr>
<th>Quality of Life Domains</th>
<th>Exemplary Indicators</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Inclusion</td>
<td>Community integration/participation, community roles, volunteering, ability to participate in desired social and community activities</td>
<td>David is happy with new social activities at work and in other areas</td>
</tr>
<tr>
<td>Rights</td>
<td>Human rights: respect, dignity, equality, Legal rights: access and due process</td>
<td>David feels safe in his interactions and believes that his rights as an employee are respected</td>
</tr>
<tr>
<td>Emotional Well-Being</td>
<td>Positive experiences in an Individual’s life and life satisfaction</td>
<td>David’s self-esteem and his pride in work and in his social life</td>
</tr>
<tr>
<td>Physical Well-Being</td>
<td>Health status, nutritional status, recreation/physical, mobility, wellness</td>
<td>David is balancing work and time on the computer with other activities</td>
</tr>
<tr>
<td>Material Well-Being</td>
<td>Financial status, employment status, housing status, possessions, ownership</td>
<td>David’s able to purchase a computer and to maintain expenses, to keep a job and to manage his money</td>
</tr>
</tbody>
</table>

The quality of Life Framework is included as Appendix 2 in this document. The team also uses the SIS information and links it to the Quality of Life domains. On the next page is an example of how David’s team could take SIS support items and match them to the relevant Quality of Life domains. (The complete set of SIS Support items and the Quality of Life domain that relates to each of them can be found in Appendix 3.)
David’s Individual Support Plan

<table>
<thead>
<tr>
<th>Outcomes/Domains</th>
<th>Goals</th>
<th>Assessed support needs (What does David’s SIS assessment tell the support team about his support needs in the area of learning and using new skills?)</th>
<th>Support Strategies</th>
<th>Support Objectives</th>
<th>Who is responsible</th>
<th>Progress Review</th>
<th>Time-lines Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Material well-being (indicators are ownership, possessions)</td>
<td>To buy a computer</td>
<td>Shopping and purchasing goods</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Material well-being (indicators employment, financial status) and personal development (indicators personal competency)</td>
<td>To buy the computer with his own money.</td>
<td>Getting employment</td>
<td></td>
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<tr>
<td>Personal development (indicators, personal competency)</td>
<td>To have better money management skills</td>
<td>Learning and using money management skills</td>
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<tr>
<td>Emotional and physical well-being (indicators safety, positive experience)</td>
<td>To be safe in the community and online</td>
<td>Protection from being manipulated or harmed</td>
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Guideline 3 Example 2: Aligning support needs to outcome categories

The support teams meet to identify things Jane likes to do and people she likes to be with. Jane’s parents gave two examples, other support team members were unsure what Jane liked. There was further uncertainty on how Jane communicated her feelings.

Team: How would people in her life know Jane was enjoying something?

Jane’s parents said: She smiles and is quiet, calm.

They all agree Jane’s safety is a top priority in everything she does.

<table>
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<th>Progress Review Time-lines Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional well-being and Self-determination (indicators positive experiences, life satisfaction, choices, personal control, decision making)</td>
<td>To do things and be with people that make me happy</td>
<td>Maintaining emotional well-being and making choices and decisions.</td>
<td></td>
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<tr>
<td>Quality of Life Domains</td>
<td>SIS Support Items for David’s ISP</td>
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</table>
| Personal Development         | Interacting with others in learning activities (C 1)  
Participating in training/education decisions (C 2)  
Managing money and personal finances (P & A 2) |
| Self-Determination           | Belonging to/participating in self advocacy group (P & A 5)  
Making choices and decisions (P & A 7) |
| Interpersonal Relations      | Interacting with community members (B 7)  
Interacting with co-workers (D 3)  
Interacting with supervisors/job coaches (D 4)  
Participating in recreation/leisure activities with other people (F 2)  
Making and keeping friends (F 4) |
| Social Inclusion             | Transportation (B 1)  
Participation in recreation/leisure activities in the community (B 2) |
| Rights                       | Protecting self from exploitation (P & A 3)  
Exercising legal responsibilities (P & A 4) |
| Emotional Well-Being         | Learning self-management strategies (C 9)  
Maintaining emotional well-being (E 8) |
| Physical Well-Being          | Learning health and physical education skills (C 7)  
Maintaining physical health and fitness (E 7) |
| Material Well-Being          | Learning and using specific job skills (D 2)  
Completing work-related tasks with acceptable speed (D 5) and quality (D 6)  
Changing job assignments (D 7) |
Guideline #4

Align Support Needs to Specific Support Strategies

One of the most significant developments over the last decade has been the emergence of the concept of a “system of supports”. A system of supports is an approach to providing individualized supports. The system is based on having a method to assess individual support needs (such as those obtained from the SIS) and involves the implementation of individualized support strategies (see Appendix 4 for examples of support strategies). Through the development of an Individual Support Plan, the supports provided to an Individual are matched to the person’s assessed support needs, and this provides a structure for service providers to support individuals.

When a Support Team starts to develop an ISP, it is helpful to think about supports as a system. Every member of the team is working within the system of supports to address needs that the Individual considers important. A system will be better equipped to prevent old habits of “teaching skills” and “decreasing undesirable behaviours” because no member of the team works in isolation.

Support strategies are organized so that each team member’s input affects the system of supports and its outcomes. Support strategies make effective use of various resources (natural supports, skills and
knowledge, environmental accommodation, incentives, etc.)
that assist in addressing the needs of an Individual and
enhance his or her functioning. This is the “how” of the ISP.

Ideally, a supports framework aligns specific support
strategies to support needs by:

⇒ Organizing potential support strategies into a system
⇒ Providing a framework for obtaining and applying
  individualized supports across the sources of support
⇒ Providing a framework for evaluating the impact of
  individualized supports on the Individual’s
  functioning level and valued personal outcomes

For more information on the elements and components of a
System of Supports, please refer to Appendix 4.

Guideline 4 Example: Align David’s Support
Needs to Specific Strategies

Each support strategy on the next page affects, and is
affected by, the other support activities. The system of
supports will also keep in mind other needs, including
David’s expressed need to be more socially active and
connected.
### Guideline 4 Example: Align David’s Support Needs to Specific Strategies

**David’s Individual Support Plan**

<table>
<thead>
<tr>
<th>Outcomes/Domains</th>
<th>Goals</th>
<th>Assessed support needs</th>
<th>Support Strategies</th>
<th>Support Objectives</th>
<th>Who is responsible</th>
<th>Progress Review</th>
<th>Time-lines</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Material well-being</td>
<td>To buy a computer</td>
<td>Shopping and purchasing goods</td>
<td>Comparison shop for best option to meet David’s gaming needs and price.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Material well-being (personal development)</td>
<td>To buy the computer with his own money.</td>
<td>Getting employment</td>
<td>Application to employment supports services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal development (indicators, personal competency)</td>
<td>To have better money management skills</td>
<td>Learning and using money management skills</td>
<td>Develop step to step guide to use an ATM machine.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional and physical well-being</td>
<td>To be safe in the community and online</td>
<td>Protection from being manipulated or harmed</td>
<td>Educate David on safety practices. Install virus protection software</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Guideline 4 Example: Align Jane’s Support Needs to Specific Strategies

Jane’s Individual Support Plan

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Goals</th>
<th>Assessed support needs</th>
<th>Support Strategies</th>
<th>Support Objectives</th>
<th>Who is responsible</th>
<th>Progress Review Time-lines Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional well-being and Self-determination (indicators positive experiences, life satisfaction, choices, personal control, decision making)</td>
<td>To do things and be with people that make me happy</td>
<td>Maintaining emotional well-being and making choices and decisions.</td>
<td>Observe Jane’s responses and body language in different situations.</td>
<td>Talk to people involved in Jane’s life.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Take Jane to a variety of activities/events.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional well-being (indicators safety, life satisfaction)</td>
<td>To be safe while participating in activities</td>
<td>Protection from being manipulated or harmed</td>
<td>Develop risk assessment plan.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To do things and be with people that make me happy
Maintaining emotional well-being and making choices and decisions.
Observe Jane’s responses and body language in different situations.
Talk to people involved in Jane’s life.
Take Jane to a variety of activities/events.
Protection from being manipulated or harmed
Develop risk assessment plan.
Guideline #5

Identify a Specific Support Objective for each Support Strategy

Once a system of supports is implemented, best practices regarding the provision of supports requires the specification of support objectives for each selected support strategy. This is one of the ways to make it easier to measure progress.

If the support objectives are clearly stated and linked to the support strategy, it will be more positive and tied to observable activities. This is designed to eliminate the traditional habit of establishing behavioural objectives (e.g. “John will act appropriately 80% of the time”).

Support Objectives are defined as: The desired result of specific support strategies. They are concrete, tangible and can be measured or validated. These are tied to an Individual’s goals and are often steps along the way to reaching a goal. In David’s example, finding a suitable bank in his community is an objective tied to his goal of purchasing a computer with his own money and the Support Team’s goal of improving David’s ability to manage money.
Please note that action verbs are used in specifying a support strategy. Action verbs identify how specific support strategies are implemented through actions that involve using, providing, implementing, procuring, advocating for, developing, networking, expanding, encouraging, and accessing.
Guideline 5 Example: Develop a Specific Support Objective for each Support Strategy for David’s ISP

David’s Individual Support Plan

<table>
<thead>
<tr>
<th>Outcomes/Domains</th>
<th>Goals</th>
<th>Assessed support needs</th>
<th>Support Strategies</th>
<th>Support Objectives</th>
<th>Who is responsible</th>
<th>Progress Review Time-lines Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Material well-being</td>
<td>To buy a computer</td>
<td>Shopping and purchasing goods</td>
<td>Comparison shop for best option to meet David’s gaming needs and price.</td>
<td>To purchase the right computer for David’s gaming needs and budget.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Material well-being (personal development)</td>
<td>To buy the computer with his own money.</td>
<td>Getting employment</td>
<td>Application to employment supports services.</td>
<td>Have employment services help David find a job.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal development (indicators, personal competency)</td>
<td>To have better money management skills</td>
<td>Learning and using money management skills</td>
<td>Develop step by step guide to use an ATM machine.</td>
<td>Have a guide for David to follow.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional and physical well-being</td>
<td>To be safe in the community and online</td>
<td>Protection from being manipulated or harmed</td>
<td>Educate David on safety practices. Install virus protection software</td>
<td>David has tools, skills to increase personal safety.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Jane’s Individual Support Plan

<table>
<thead>
<tr>
<th>Outcomes/ Domains</th>
<th>Goals</th>
<th>Assessed support needs</th>
<th>Support Strategies</th>
<th>Support Objectives</th>
<th>Who is responsible</th>
<th>Progress Review Timelines Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional well-being and Self-determination (indicators positive experiences, life satisfaction, choices, personal control, decision making)</td>
<td>To do things and be with people that make me happy</td>
<td>Maintaining emotional well-being and making choices and decisions.</td>
<td>Observe Jane’s responses and body language in different situations. Talk to people involved in Jane’s life. Take Jane to a variety of activities/events.</td>
<td>To have a clear understanding of how Jane indicates her feelings (happiness, upset, etc.) To ensure everyone involved in Jane’s life knows how she communicates and what she enjoys.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional well-being (indicators safety, life satisfaction)</td>
<td>To be safe while participating in activities</td>
<td>Protection from being manipulated or harmed</td>
<td>Develop risk assessment plan.</td>
<td>To have supports to reduce risks.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Guideline 5 Example2: Develop a Specific Support Objective for each Support Strategy for David’s ISP
Guideline #6

Use a Support Team to Develop the Individual Support Plan (ISP)

The development of an ISP brings all of the planning steps together:

1. Identify the Individual’s primary support needs based on what is important to the Individual (his or her goals and preferences) and what is important for the Individual (other needs identified by the team, including professional recommendations). (Guideline #2)

2. Organize these support needs into the Quality of Life domains. (Guideline #3)

3. Align the needs with specific support strategies. (Guideline #4)

4. Specify a support objective for each support strategy. (Guideline #5)

5. Identify who is responsible for implementing each objective. (Guideline #7)

The Support Team should develop an ISP that has the following qualities:

⇒ Uses a person-centered philosophy and approach⁴;
⇒ Follows a logical and realistic sequence;
⇒ Aligns the SIS information, goals, the specific objectives, and the support strategies.

⁴The CQL website has excellent information about the person-centered approach. To learn more, go to http://www.thecouncil.org/pceguidedisability.aspx (Also see the glossary in Appendix 1)
The Support Team needs to:

- Understand SIS information and what it tells you about the Individual
- Understand the Individual’s personal goals and assets
- Apply ISP development principles
- Use an ISP template that is relevant, functional, and outcome oriented

**Understand SIS Information (‘My Support Profile’)**

The “My Support Profile” (SIS information results) has been developed to provide the Support Team with a detailed picture of the level of support the Individual needs to be successful in all areas of life. The support needs information described in the SIS should be explained to the team members so that they clearly understand:

- The life activity areas on the SIS, including exceptional medical and behavioral support needs.
- That the SIS is not used to identify what a person can or cannot do. Rather, the SIS looks at the pattern and intensity of supports a person requires to be more successful in life activity areas.
- That the higher scores represent more intense support needs.
- That the intent of the graph in the ‘My Supports Profile’ (page 6 of the report) is to provide a general overview of the pattern and intensity of support a person needs compared to other people in the province with developmental disabilities. Example: If the Individual is at the 25% mark in Home Living, this means that 75% of the population with developmental disabilities need more support in this area.
Understand the Individual’s Personal Goals and Assets

The most effective way to discover the strengths and desires of an Individual is in natural, informal conversations and interactions with the person and/or a trusted advocate for the person. It is helpful to remember that the Individual is the expert on his/her own life and whatever the person communicates is important and deserves attention. Try to notice all the ways that a person provides information. (Guideline 1)

Apply ISP Development Principles

An ISP should be developed based on a set of principles that reflects what is important to and for the Individual. The ISP should contain easy-to-understand support objectives that facilitate the plan’s successful implementation and monitoring.

Write the ISP (three examples of a template can be found in Appendix 5)

This Resource Guide does not prescribe a specific ISP format. However, the format used must include:

- Desired outcomes/goals
- Important or relevant assessed support needs
- Specific support strategies
- Measurable support objectives
- A responsible person/entity to implement the support strategies
- Timelines for review
Guideline 6 Example: Use a Support Team to Develop the Individual Support Plan (ISP)

See prior Guidelines for example of David’s and Jane’s individual support plan
Guideline #7

Implement the ISP Using Support Team Members

Once a plan is established it is very important that the versions are user-friendly.

⇒ *My Support Plan*: a 1-2 page ISP that lists the person’s goals, objectives, and support strategies and can be kept with the Individual.

⇒ *Family Role in the Support Plan*: a 1-2 page summary that provides parents/family members with a picture of the Individual’s goals and preferences and the specific support objectives for which they are responsible, if indicated.

⇒ *Support Team Action Plan*: a 1-2 page summary that gives the Support Team and direct support staff a description of the Individual’s goals and the support objectives for which they are responsible.

⇒ *PDD Regional Staff*: Are responsible for the monitoring of the ISP.

⇒ *Agency Staff*: Are responsible for the coordination and monitoring of the ISP.

The actual implementation of any ISP will look different for each individual. The first step for any implementation should be for members of the Support Team to commit to following up on their responsibilities and to ensure that they continue to connect with each other in keeping with the system of supports concept.
Guideline 7 Example: Implement Jane’s ISP Using Support Team Members

Jane will be given a one page ISP that would include his goal of purchasing a computer. The plan might look like this (plus other goals, objectives and strategies determined during the planning process):

Jane's Individual Support Plan

<table>
<thead>
<tr>
<th>Outcomes/Domains</th>
<th>Goals</th>
<th>Assessed support needs</th>
<th>Support Strategies</th>
<th>Support Objectives</th>
<th>Who is responsible</th>
<th>Progress Review Time-lines Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional well-being and Self-determination (indicators positive experiences, life satisfaction, choices, personal control, decision making)</td>
<td>To do things and be with people that make me happy</td>
<td>Maintaining emotional well-being and making choices and decisions.</td>
<td>Observe Jane’s responses and body language in different situations. Talk to people involved in Jane’s life. Take Jane to a variety of activities/events.</td>
<td>To have a clear understanding of how Jane indicates her feelings (happiness, upset, etc.) To ensure everyone involved in Jane’s life knows how she communicates.</td>
<td>Agency staff</td>
<td>Monthly review</td>
</tr>
<tr>
<td>Emotional well-being (indicators safety, life satisfaction)</td>
<td>To be safe while participating in activities</td>
<td>Protection from being manipulated or harmed</td>
<td>Develop risk assessment plan.</td>
<td>To have supports to reduce risks.</td>
<td>Jane’s parent and agency staff.</td>
<td>Monthly review</td>
</tr>
</tbody>
</table>
Guideline #8

Monitor the Status of Support Objectives

The most effective ISPs recognize that everyone’s needs change over time and support strategies often need to respond to changes in resources and the person’s own capabilities. It is important to frequently monitor progress towards support objectives so that the ISP continues to hold the interest of the person and the Support Team.

Monitoring the ISP involves determining the status of the support objective(s). Monitoring the ISP is a collective effort by the Support Team, including the Individual receiving the supports, and it involves assessing the impact of supports on the Individual’s personal outcomes.

This process will vary from person to person and Support Team to Support Team. Therefore, each team must identify how this will be accomplished (e.g., meetings, frequency of reviews, and how they will identify the status of each support objective).

The Monitoring Process

It is best practice to require that an ISP includes support objectives since the focus of an ISP is on the provision of individualized supports. Therefore, monitoring an ISP involves:

- Listing each support objective;
- Listing the person responsible for implementing the support objective;
⇒ Evaluating the status of each support objective.
   One of the approaches to evaluating the status of each support objective could be to apply a 3-point scale such as fully implemented (1), partially implemented (2), or not implemented (3).

**The Post-Monitoring Process**

This is an opportunity to celebrate success and to ask the person, “How’s this working for you? Have your personal goals been achieved?” The post-monitoring process is an opportunity to reinforce the contribution of Support Team members. The team can also determine whether changes are necessary in any part of the ISP, including new support objectives and support strategies.

The Support Team’s role is to look for continuous quality improvement. Questions the team might ask include:

⇒ If the objective has been fully implemented, does it need to remain and if so, at the same duration and intensity?

⇒ If the objective has been partially implemented, what is the reason for the partial implementation? Is the objective not clear, is the strategy/equipment not in place or inconsistently used/applied, are new strategies needed, or is staff training needed for full implementation?

⇒ If the objective has not been implemented, why? Is there confusion or lack of knowledge about what the objectives and strategies really entail, or is there confusion about who is really responsible for its implementation?

⇒ Is the Individual’s goal still relevant to the person? If not, what changes need to be made to the ISP to keep it current and meaningful?
Guideline 8 Example: Monitor the Status of Support Objectives

The team members stay in touch with each other on a regular basis. Monitoring timelines are determined based on individual situations; therefore, one person’s support plan may be monitored monthly while another person’s support plan is monitored quarterly.

The Support Team monitors the progress being made on David’s ISP support strategies and support objectives and identifies any unintended effects of the plan (e.g., David met a woman online but the relationship is causing him some stress) or any unexpected opportunities that have arisen (e.g., there is a new social support group meeting close to where David lives). David and his team discuss whether current support objectives and strategies need to be revised, and if support objectives and strategies are needed to assist him with his new relationship or to assist him joining the social group if this is what he wants to do.

The team ensures that David is part of these discussions. They could use a three-point scale (i.e. achieved, in progress, not achieved) to roughly measure the progress towards the goals and the success of the support objectives, including the team members’ self-evaluations of their respective contributions. The team highlights every step along the way.
APPENDICES

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5: Support Plan Templates .......................................................... 40
6: Why Measure Outcomes? ...................................................... 43
1 Glossary of Terms

**Goals:** Personal goals reflect how the Individual wants to spend the day, what he or she wants to learn, where to live and work, and with whom to spend time.

**Outcomes** are benefits for participants during or after their involvement with a program. They are influenced by a program's outputs. Outcomes may relate to knowledge, skills, attitudes, values, behavior, condition, or status. They are what participants know, think, or can do; or how they behave; or what their condition is, that is different following the program. Examples of outcomes include greater knowledge of nutritional needs, improved reading skills, more effective responses to conflict, getting a job and having greater financial stability.

**Person-centered philosophy:** This is an approach that keeps the focus on each person as the key decision-maker in his or her own life. As a person’s interests and priorities change, the planning process is revisited to ensure that both major and day-to-day decisions also change in response. Planning and funding are connected to outcomes and supports, not programs. For more information, refer to the CQL website:

http://www.thecouncil.org/pceguidedisability.aspx

**Natural Supports:** Those opportunities and supports provided by family members, friends, colleagues, peers, other members of a social network, self-help groups.

**Support Strategies:** The effective use of various resources that assist in addressing the needs of an Individual and enhance his or her functioning. This is the “how” of the ISP.

**Support Objectives:** The desired result of specific support strategies. They are concrete, tangible and can be measured or validated. These are tied to the goals of an Individual and are often steps along the way to reaching a goal. In David’s example, finding a suitable bank in his community is an objective tied to his goal of purchasing a computer with his own money and the Support Team’s goal of improving David’s ability to manage money.

**System of supports:** An approach to providing individualized supports. The system is based on having a method to assess individual support needs (such as obtained from the SIS) and involves the implementation of individualized support strategies (see Appendix 4 for examples of support strategies). Through the development of an ISP, the supports provided to an Individual are matched to the person’s assessed support needs and this provides a structure for service providers to increase an individual’s performance.
2 Quality of Life Framework

The *My Life: Personal Outcomes Index™* is one way for PDD to measure personal outcomes for the adults with developmental disabilities that PDD funds. It is a survey that profiles how individuals feel about their **quality of life** in eight different domains. The domains are grouped into three factors:

⇒ **Well-Being:** emotional, material, physical
⇒ **Independence:** personal development, self-determination
⇒ **Social Participation:** interpersonal relations, social inclusion, rights

**FACTORS and DOMAINS**

<table>
<thead>
<tr>
<th>Emotional Well-Being</th>
<th>Material Well-Being</th>
<th>Physical Well-Being</th>
<th>Personal Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Contentment</td>
<td>• Financial Status</td>
<td>• Health</td>
<td>• Education</td>
</tr>
<tr>
<td>• Self-Concept</td>
<td>• Housing</td>
<td>• Activities of Daily Living</td>
<td>• Personal Skill</td>
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<td></td>
<td>• Employment</td>
<td>• Leisure</td>
<td>• Competence</td>
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<td></td>
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<td></td>
<td>• Performance</td>
</tr>
<tr>
<td>Self-Determination</td>
<td>Interpersonal</td>
<td>Social Inclusion</td>
<td>Rights</td>
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<td>Relations</td>
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<td>• Human</td>
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<td>• Legal</td>
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<td>Interactions</td>
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<td>Relationships</td>
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<td>Supports</td>
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<td>Community</td>
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<td>Integration &amp;</td>
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<td>Participation</td>
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<td></td>
<td></td>
<td>Community Roles</td>
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<tr>
<td></td>
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<td>Social Supports</td>
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</tr>
</tbody>
</table>

Schalock, R.L. & Verdugo, M.A., 2002

**DOMAIN descriptions**

**Emotional well being:** happiness and safety, and how individuals feel about their lives

**Interpersonal relations:** type of support and help individuals get, relationships with family and friends, and the types of activities that individuals do with people in their life

**Social inclusion:** the activities and things individuals do and would like to do in the community, the people they do things with and places they go in their community

**Personal development:** the things that individuals are interested in learning and things that they enjoy and are important to them
**Self-determination:** the choices and decisions individuals make about areas that matter to them in their life

**Physical well-being:** energy levels, being able to get medical help, health and lifestyle

**Material well-being:** personal possessions that are important to individuals, how much individuals can use money for things they want or need

**Rights:** individuals’ right to privacy, how individuals are treated by people, how much they are listened to

# Quality of Life Domains And SIS Support Areas

<table>
<thead>
<tr>
<th>Quality of Life Domain</th>
<th>SIS Support Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal Relations</td>
<td>Going to visit family and friends (B 4)  Interacting with community members (B 7)  Interacting with co-workers (D 3)  Interacting with supervisors/job coaches (D 4)  Socializing within the household (F 1)  Participating in recreation/leisure activities w/others (F 2)  Socializing outside the household (F 3)  Making and keeping friends (F 4)  Communicating about personal needs (F 5)  Using appropriate social skills (F 6)  Engaging in loving and intimate relationships (F 7)</td>
</tr>
<tr>
<td>Quality of Life Domain</td>
<td>SIS Support Areas</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------</td>
</tr>
</tbody>
</table>
| **Self-Determination** | Learning self-determination skills (C 8)  
Advocating for self (P & A 1)  
Participating in self advocacy group (P & A 5)  
Making choices and decisions (P & A 7) |
| **Social Inclusion** | Transportation (B 1)  
Participation in recreation/leisure activities in the community (B 2)  
Using public services in the community (B 3)  
Participating-preferred community activities (B 5)  
Shopping and purchasing goods and services (B 6)  
Accessing public buildings/settings (B 8)  
Engaging in volunteer work (F 8) |
| **Rights** | Protecting self from exploitation (P & A 3)  
Exercising legal responsibilities (P & A 4)  
Obtaining legal services (P & A 6)  
Advocating for others (P & A 8) |
| **Emotional Well-Being** | Learning self-management strategies (C 9)  
Maintains emotional well-being (E 8)  
Exceptional behavioral support needs (Section 3 B) |
| **Physical Well-Being** | Learning health and physical education skills (C 7)  
Taking medications (E 1)  
Avoiding health and safety hazards (E 2)  
Obtaining health care services (E 3)  
Ambulating and moving about (E 4)  
Learning how to access emergency services (E 5)  
Maintaining a nutritious diet (E 6)  
Maintaining physical health and fitness (E 7)  
Exceptional medical support needs (Section 3 A) |
| **Material Well-Being** | Accessing/receiving job/task accommodation (D 1)  
Learning and using specific job skills (D 2)  
Completing work-related tasks with acceptable speed (D 5)  
Completing work-related tasks with acceptable quality (D 6)  
Changing job assignments (D 7)  
Seeking information and assistance from an employer (D 8) |
# System of Support Elements and Exemplary Support Strategies

<table>
<thead>
<tr>
<th>Element</th>
<th>Exemplary Support Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural Supports</td>
<td>Support networks (e.g. family, friends, colleagues, generic agencies), advocacy, befriending, community involvement, social engagement, and interactions</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Assistive and information technology (e.g. communication devices, cell phones, iPads, medication dispensing devices, med alert monitors, speech recognition devices)</td>
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<tr>
<td>Prosthetics</td>
<td>Sensory aides and mobility assistance devices</td>
</tr>
<tr>
<td>Skills and Knowledge</td>
<td>Task analysis (i.e. step-by-step guide to learning) applied behavior analysis, information availability, situational learning opportunities, education and training strategies such as Universal Design for Learning</td>
</tr>
<tr>
<td>Environmental Accommodation</td>
<td>Ramps, Braille, push buttons, modified counters and workspaces, modified transportation, secure and predictable environments, adapted texts and signs, environments that are conducive to learning, matching tasks to an individual’s relative strengths and interests</td>
</tr>
<tr>
<td>Incentives</td>
<td>Role status involvement, recognition, appreciation, money, personal goal setting, empowerment, self-directed ISP, community participation</td>
</tr>
<tr>
<td>Personal Assets</td>
<td>Attitudes, interests, adaptive strengths (conceptual, social, practical), and natural supports</td>
</tr>
<tr>
<td>Professional Services</td>
<td>Physical Therapy, Occupational Therapy, Speech Therapy, Medical, Psychological, Psychiatric, Nursing</td>
</tr>
<tr>
<td>Positive Behaviour Supports</td>
<td>Functional assessment of problem behavior and focusing on altering the environment before a problem behavior occurs and teaching appropriate behaviors</td>
</tr>
</tbody>
</table>
### Exemplary Support Strategies

<table>
<thead>
<tr>
<th>Element</th>
<th>Exemplary Support Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies and Practices (Organizational)</td>
<td>Aligning staff and professionals’ work, increasing staff involvement, providing needed transportation, reducing turnover and continual change of direct support staff, establishing a reference person for each client, partnering with universities and other research and training centers</td>
</tr>
<tr>
<td>Policies and Practices (Societal)</td>
<td>Resource allocation patterns, interagency networks, public relations campaigns, information services</td>
</tr>
</tbody>
</table>

### Examples of Assessed Support Needs Aligned to Specific Support Strategies

<table>
<thead>
<tr>
<th>Assessed Support Need</th>
<th>Specific Support Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing-personal hygiene</td>
<td>Incentive program</td>
</tr>
<tr>
<td>Learning functional skills</td>
<td>Universal design for learning</td>
</tr>
<tr>
<td>Learning self-determination skills</td>
<td>Opportunities for choice-decision making</td>
</tr>
<tr>
<td>Shopping and purchasing goods</td>
<td>Pictorial shopping guide</td>
</tr>
<tr>
<td>Making and keeping friends</td>
<td>Support network</td>
</tr>
<tr>
<td>Socializing within the household</td>
<td>Incentive program</td>
</tr>
<tr>
<td>Transportation</td>
<td>Modified transportation</td>
</tr>
<tr>
<td>Participation in recreation/leisure activities</td>
<td>Interests and motivation</td>
</tr>
<tr>
<td>Protecting self from exploitation</td>
<td>Cell phone app</td>
</tr>
<tr>
<td>Obtaining legal services</td>
<td>Transportation to access Legal Aid office</td>
</tr>
<tr>
<td>Learning self management strategies</td>
<td>Self management program</td>
</tr>
<tr>
<td>Prevention of non-aggressive but inappropriate sexual behavior</td>
<td>Applied behavior analysis</td>
</tr>
<tr>
<td>Taking medication</td>
<td>Medication dispensing device</td>
</tr>
<tr>
<td>Seizure management</td>
<td>Med alert device</td>
</tr>
<tr>
<td>Learning and using specific job skills</td>
<td>Supported employment</td>
</tr>
<tr>
<td>Completing work-related tasks with acceptable speed</td>
<td>Supported employment</td>
</tr>
</tbody>
</table>
Support Plan Templates

My Support Plan

Name:__________________________________________________
Signature Individual/Guardian:______________________________
Date:________________________
PDD Client ID #:________________

<table>
<thead>
<tr>
<th>What are my goals? What is important 'to' me and what is important 'for' me?</th>
<th>What Support Objectives (worker use to assist me?)</th>
<th>What Support Strategies (additional resources – natural/generic) will my support worker use to assist me?</th>
<th>How will achieving the outcome(s) benefit my Quality of Life? And which SIS activity area and item does it relate to?</th>
<th>Timelines for review</th>
<th>Progress review and comments.</th>
</tr>
</thead>
<tbody>
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**Quality of Life domains:** Personal Development; Self-Determination; Interpersonal Relations; Social Inclusion; Rights; Emotional Well-Being; Physical Well-Being; Material Well-Being.

**SIS Activity Areas:** Home Living; Community Living; Lifelong Learning; Employment; Health and Safety; Social

**SIS Items:** Refer to your SIS ‘My Supports Profile’ for listing of each item.

**Progress Review:** (1) Fully Implemented; (2) Partially Implemented; (3) Not Implemented

**Notes:**
**Tom Smith's SUPPORT PLAN**  
**PDD ID#: 0123-456**

**It is important to me to:**

1. Keep my job
2. Improve my physical fitness
3. Improve telling others about my needs or concerns

<table>
<thead>
<tr>
<th>What are my 'Support Needs'?</th>
<th>What 'Support Strategies' will Staff use to assist me?</th>
<th>How will this impact my Quality of Life?</th>
</tr>
</thead>
</table>
| Learning health and physical education skills | Your Facilitators will:  
- Provide information and insight into exercise options at Prospect and the YMCA  
- Prompt Tom to identify what he'd like to learn, and physical activities he enjoys | Learning health and physical education skills will increase my Self-Determination |
| Maintaining physical health and fitness | Your Facilitators will:  
- Provide Tom outdoor pursuits options to participate in  
- Provide Tom advice around healthy diet choices when applicable  
- Provide Tom with activities at Prospect and in the community that focus on physical fitness | Maintaining my physical health and fitness will increase my Physical Well-Being |
| Communicating with others about personal needs | Your Facilitators, Job Coach, and Case Manager will:  
- Ask Tom consistently if there are concerns in the workplace  
- Ask Tom to identify accomplishments in the workplace and community access  
- Prompt Tom to talk about his likes and dislikes and what programs he'd like to see and participate in  
- Encourage Tom to journal any concerns and show this to staff if he doesn't feel comfortable talking about it  
- Keep in contact with your supportive roommate to talk about any concerns or accomplishments | Communicating with others about personal needs will improve my Interpersonal Relations |
| Making choices and decisions | Your Facilitators, Job Coach, and Case Manager will:  
- Provide Tom with choices to help him make decisions. (Schedules, Diet/Food options, Exercise routines, etc.)  
- Help Tom make choices by explaining benefits to different options | Making choices and decisions will enhance my Self-Determination |

Tom and his supports have identified that he would like to work on improving his physical well-being, as well as communicating with others more effectively. Tom is enjoying his part-time employment with Home Depot and would like to continue his employment there. Tom and his supportive roommate also noted that he would like become more independent in making decisions.
My Support Plan
I am Ard and this is My Support Plan. In this is written down how I am doing, what my Wishes and Goals are, what is important for me in my life and what supports I need. Every three months we will take a look at how all this is doing. We means the support worker and I, together with my Personal Assistant. If you have a question, ask me or my Personal Assistant.

The name of my Personal Assistant is:

These are my Wishes and Goals
1. I wish to have more friends.
2. I want to be a member of the local Football Club.
3. I wish to be taken seriously. Therefore I want to be more able to express myself.
4. I wish to live on my own.
5. I wish to have a paid job.

Is this improving?
YES—NO

Date 1: ————

Date 2: ————

These are the supports that I need

Personal Development—Learning new things
- Give me an overview of available courses about writing, accounting, drawing, cooking. Let me choose the course I like.
- Ask me to assist you in housekeeping, cooking, gardening and so on...
- While assisting, explain to me what you do and tell me how I am doing. Be an example for me!

Self-determination—Make my own choices
- When a choice is needed, ask me. First let me try on my own. If it is to difficult for me, then explain to me what possible options there are to choose. Be patient and only decide for me when I ask you to do so.

Interpersonal Relations—Family and friends
- Create a birthday calendar for me.
- Support me in sending cards for special moments.
- Support me to invite people at home.

Social Inclusion—Be part of the community
- Support me in becoming a member of the local Football Club. Introduce me there. Especially in the beginning it is important for me that you also come to the training and the first matches.
- Take me out. Teach me what shops there are in my village and how I get there.

Rights—What I am allowed to do
- Support me in getting an overview of my money.
- Tell me, explain to me, what my rights are.

Emotional Well-Being—How I feel
- Talk with me about my day in the morning and evening.
- Tell me what I am good at.

Physical Well-Being—Being healthy
- Support me in preparing healthy meals.
- Let us eat together.
- Support me in exercising (e.g. cycling, walking to the shops).

Material Well-Being—Have money and goods
- Support me in getting a paid job. (Especially getting paid for the job I have now).
Why Measure Outcomes?

In growing numbers, service providers, governments, other funders, and the public are calling for clearer evidence that the resources they expend actually produce benefits for people. Consumers of services and volunteers who provide services want to know that programs to which they devote their time really make a difference. That is, that they want better accountability for the use of resources. Once clear and compelling answer to the question of “Why measure outcomes?” is:

**To see if programs really make a difference in the lives of people**

Although improved accountability has been a major force behind the move to outcome measurement, there is an even more important reason: To help programs improve services.

Outcome measurement provides a learning loop that feeds information back into programs on how well they are doing. It offers findings they can use to adapt, improve, and become more effective.

The dividend doesn’t take years to occur. It often starts appearing early in the process of setting up an outcome measurement system. Just the process of focusing on outcomes-on why the program is doing what it’s doing and how it thinks participants will be better off-gives program managers and staff a clearer picture of the purpose of their efforts. That clarification alone frequently leads to more focused and productive service delivery.

Results of outcome measurement show not only where services are being effective for participants, but also where outcomes are not as expected. Program managers can use outcome data to:

- Strengthen existing services.
- Target effective services for expansion.
- Identify staff and volunteer training needs.
- Develop and justify budgets.
- Prepare long-range plans.
- Focus board members’ attention on programmatic issues.

To increase its internal efficiency, a program needs to track its *inputs and outputs*. To assess compliance with service delivery standards, a program needs to monitor *activities and outputs*. But to improve its effectiveness in helping participants, to assure potential participants and funders that its programs produce results, and to show the general public that its programs produce results, and to show the general public that it produces benefits that merit support, an agency needs to measure its *outcomes*.
Resources dedicated to or consumed by the program

Money
Staff and time
Volunteers & volunteer time
Facilities
Equipment & supplies

Constraints on the program

Laws
Regulations
Funders’ requirements

What the program does with the inputs to fulfill its mission

Feed and shelter homeless families
Provide job training
Educate the public about signs of child abuse
Counsel pregnant women
Create mentoring relationships for youth

The direct products of program activities

Number of classes
Number of counseling sessions
Number of educational materials distributed
Number of hours of service delivered
Number of participants served

Benefits for participants during and after program activities

New knowledge
Increased skills
Changed attitudes or values
Modified behavior
Improved condition
Altered status
Glossary of Selected Outcome Measurement Terms

**Inputs** are resources a program uses to achieve program objectives. Examples are staff, volunteers, facilities, equipment, curricula, and money. A program uses inputs to support activities.

**Activities** are what a program does with its inputs – the services it provides – to fulfill its mission. Activities include the strategies, techniques, and types of treatment that comprise the program’s service methodology. For instance, sheltering homeless families, educating the public about signs of child abuse are program activities, as are training and counseling homeless adults to help them prepare for and find jobs. Program activities result in outputs.

**Outputs** are the direct products of program activities and usually are measured in terms of the volume of work accomplished – for example, the numbers of classes taught, counseling sessions conducted, educational materials distributed, and participants served. Outputs have little inherent value in themselves. They are important because they are intended to lead to a desired benefit for participants or target populations.

**Outcomes** are benefits for participants during or after their involvement with a program. They are influenced by a program’s outputs. Outcomes may relate to knowledge, skills, attitudes, values, behavior, condition, or status. They are what participants know, think, or can do; or how they behave; or what their condition is, that is different following the program. Examples of outcomes include greater knowledge of nutritional needs, improved reading skills, more effective responses to conflict, getting a job and having greater financial stability.

**Outcome indicators** are the specific items of information that track a program’s success on outcomes. They describe observable, measurable characteristics or changes that represent achievement of an outcome. For example, a program whose desired outcome is that participants purse a healthy lifestyle could define “healthy lifestyle” as not smoking; maintaining a recommended weight, blood pressure, and cholesterol level; getting at least two hours of exercise each week; and wearing seat belts consistently. The number and percent of program participants who demonstrate these behaviors then in an indicator of how well the program is doing with respect to the outcome.

**Outcome targets** are numerical objectives for a program’s level of achievement on its outcomes. After a program has had experience with measuring outcomes, it can use its findings to set targets for the number and percent of participants expected to achieve desired outcomes in the next reporting period. It also can set targets for the amount of change it expects participants to experience.

**Benchmarks** are performance data that are used for comparative purposes. A program can use its own data as a baseline benchmark against which to compare future performance. It also can use data from another program as a benchmark. In the latter case, the other program often is chosen because it is exemplary and its data are used as a target to strive for, rather than as a baseline.