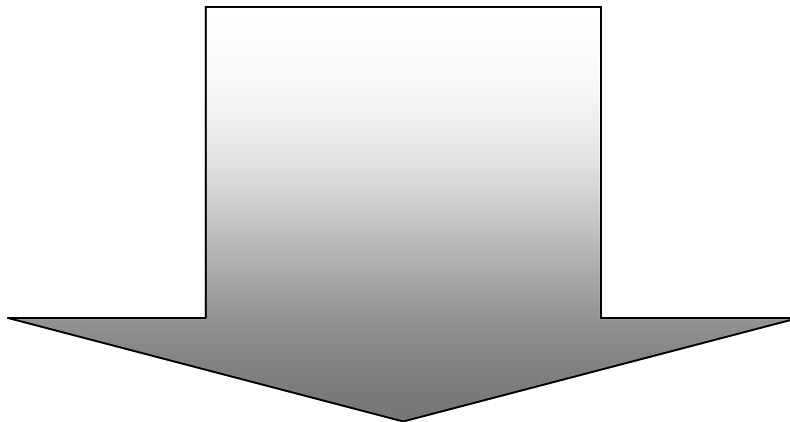
THE GRO TREE

A Decision Guide to Enhancing Supports for People at Risk

Including suggested strategies for problem-solving

July 1, 2010

Version 2



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DHS – Seniors and People with Disabilities

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INTRODUCTION

What is the GRO Tree?

The GRO Tree is a quality assurance tool which outlines a process for examining support documents already in place such as the Personal Focus Worksheet, Individual Support Plan, functional assessment and/or behavior support plan, as well as other supports provided by the organization serving an individual who engages in behaviors that put him or her at risk of losing a placement or services. In addition to providing a structure for examining these supports, this tool is a platform for brainstorming sessions, as it assists users to contribute to the process of adding, enhancing, or developing new supports by prompting them to:

- ask questions in order to understand the comprehensive support needs of a person who engages in challenging behavior;
- identify areas for further inquiry;
- identify deficits or conflicts of existing supports;
- bring information forward for discussion; and
- develop a “to-do” list of next steps toward resolving each issue.

The instructions and questions provided in the GRO Tree essentially comprise a checklist of best practices. The goal of this tool is to either prevent the person whose supports are being assessed from going into crisis – or to end the cycle of crisis the person has been experiencing for some time – by affecting positive change in the person’s life.

Who should use this tool?

Those whose responsibilities include:

- developing and/or providing behavior supports;
- managing staff;
- assisting programs to meet requirements; and
- improving quality of life for individuals served, especially those who frequently access our crisis system or have had recent or ongoing crisis behaviors.

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The GRO Tree can be used by anyone familiar with the person's documents of support and current support system, including but not limited to: lead staff, program manager, services coordinator, residential specialist, provider organization executive director, and behavior specialist. It is recommended that the user of this guide be someone who has been trained on person-centered values, is familiar with the Individual Support Plan process, and understands the basics of functional behavioral assessment and positive behavior support planning.

Contents of the GRO Tree:

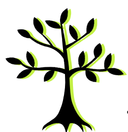
The GRO Tree consists of a **flow chart** which guides you through the support assessment process, **workbook pages** for planning, and **"Decision Process Guides"** for each section. Each Decision Process Guide contains questions that will help the user determine when to move forward in the assessment process, and when to use the workbook to plan steps for researching and/or resolving issues identified by answering the questions provided.

Where it starts…

A care provider, service coordinator, licensing specialist, protective services investigator or other entity observes or becomes aware that a person served engages in behaviors that may place him/her or others at risk of injury, or jeopardizes his/her placement or services. The individual's ISP team is notified and discussion about the risk of behavior begins. A member of the team can use the GRO Tree to guide the conversation and determine actions taken.

Using the GRO Tree:

Start at the beginning. The flow chart provides the user with a series of "yes" or "no" questions to answer.



This icon cues the user to follow the instructions and answer the questions provided in the Decision Process Guide section following each segment

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of the flow chart. The Decision Process Guide instructs the user to research the items listed by:

- observing the individual in multiple settings;
- examining data;
- conducting interviews with the person and people who know the person best.

The user can use the “Notes & Comments” section of the workbook pages to document findings. If the answer to a flow chart question is found to be “no”, the team is prompted to use the workbook for planning next steps toward resolving the issue. The “Follow Up” space in each workbook page can be used to document where to find additional information regarding actions taken as “Next Steps” are completed.

If the user answers “yes” to a question set on the flow chart, the flow chart instructs the user to move on to the next set of questions.

The information in The GRO Tree is provided by behavior specialists with many years of experience supporting individuals with intellectual disabilities and complex needs. This is the second edition of the GRO Tree: your input and suggestions are welcomed as we work to make this a useful tool. Please send all suggestions to OTAC, Community Supports and Crisis Intervention Project Manager, maseaton@otac.org.

**Note to users of this tool: Because best practices and regulations change over time, consider the recommendations below in the current context of your work and the organizations and people with whom you form a service plan team. Oregon Technical Assistance Corporation assumes no liability, implied or in fact, for use of this document. Use good judgment, thoughtful research, and knowledge of current standards and practices as your guide.*

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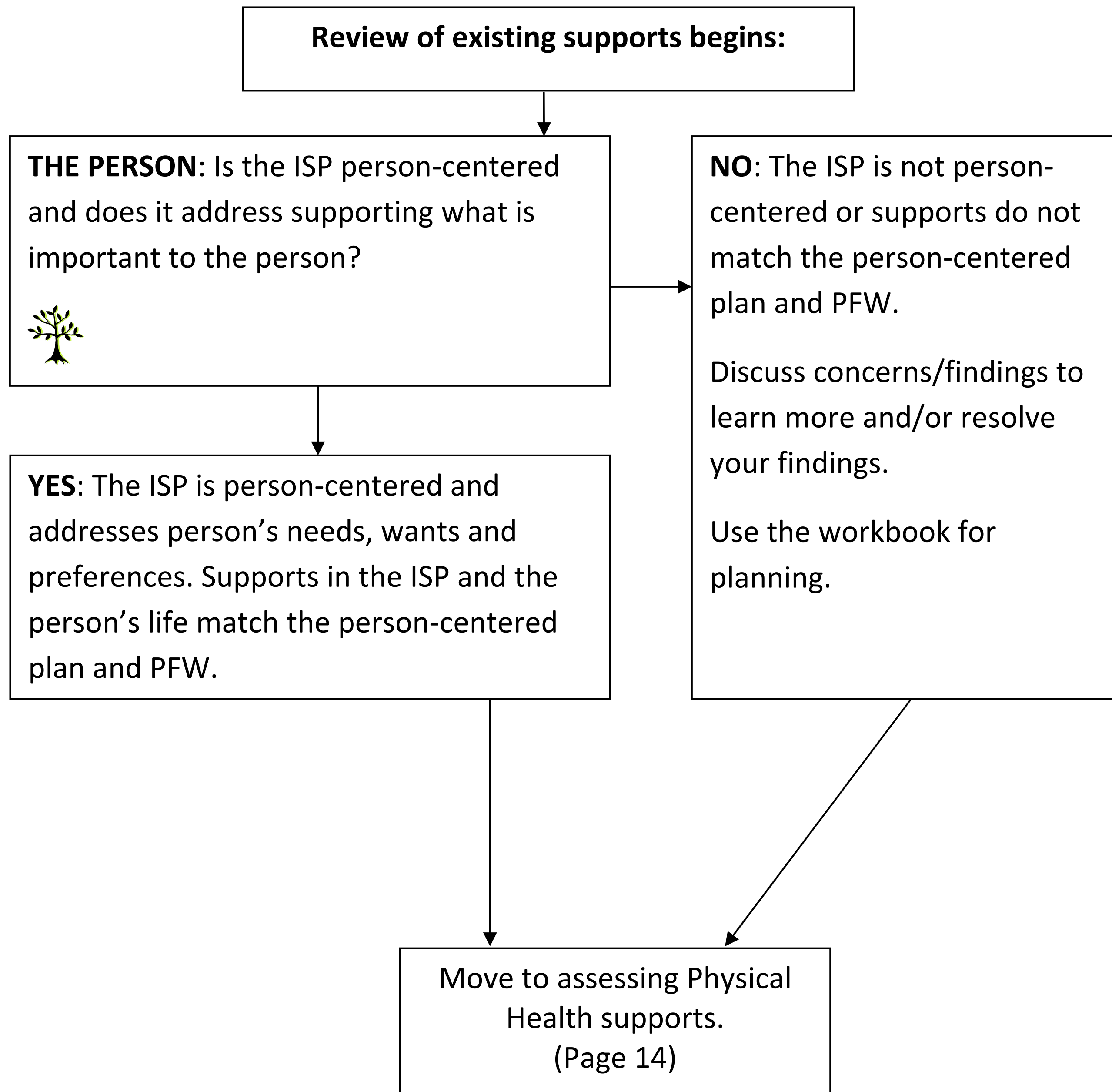
THE GRO TREE



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WORK BOOK:

Notes & Comments:

Next Steps: What needs to be accomplished, by whom, and by what date?			
Issue:	Desired outcome:	Measurable steps:	By whom/date:
Follow-up			

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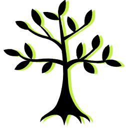

Decision Process Guide: The Person

Check if completed or assessed	1. If a person-centered plan has been completed for the person, read it. If not, it is highly recommended that one is completed for the person and that everyone the person would like to have participate is invited to the meeting to contribute.
	✓ If a person-centered plan has been completed, determine the following:
	a. Did the "next steps" happen?
	b. Are new action steps still being added and completed? (Is the plan current?)
	c. If the person is moving to a new home, starting a new job, had lots of staff turnover, experienced another life changing event, does a new PCP make sense at this time in the person's life?
	d. Is the person-centered plan over two years old? (Is it relevant in the current setting or situation?)
	e. Were supports developed with consideration to what works and does not work for the person?

Check if completed or assessed	*2.* Read the Personal Focus Worksheet. *The PFW is designed to provide information needed in order to assess and develop person-centered supports. Reading the PFW is the first step in gathering information that will be relevant for developing positive behavior supports that have a good chance of being successful.*
	✓ Determine whether the following statements are true:
	a. The information in the PFW compliments the person-centered plan and paints a vivid picture of what is needed in order to increase the person's quality of life.
	b. Section I of the PFW provides the following information *from the person's own perspective*:
	PFW #1: Who is most important to the person
	• Who this person likes to spend time with
	• Who the person wants to form relationships with or where they would like to meet them
	• Who the person wants to continue relationships with
	• Whether the person is lonely
	PFW #2: What things, activities, people, places, types of interactions, circumstances or routines, and types of environments the person enjoys
	PFW #3: What things, activities, people, places, types of interactions, circumstances and types of environments the person *dislikes*
	PFW #4: What the person's goals (for work, for living situation, for fun, etc.) and dreams are
	PFW# 5: What is most important to the person…
	• On a good day
	• On a bad day
	• What is happening that needs to continue, what is happening that needs to stop, and what is not happening that needs to begin happening or happen more often
	c. Section II of the PFW provides the following information from the perspective of people who know the person:
	PFW #6: A list of the person's strengths, gifts and capacities

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	PFW #7: What kinds of interactions work best with this person
	• How the person interacts with people they know
	• How the person interacts with people they don't know
	• What the person would benefit from learning regarding social interaction
	PFW #8: The person's *current* religious, spiritual or cultural preferences and needs
	PFW #9: The person's current living arrangements
	• What aspects of their living arrangement they like
	• What aspects they dislike
	• What would improve their living situation
	PFW #10: The person's current employment/ATE or school program
	• What aspects of the environment they like and/or dislike (about the schedule, about the work itself, of their co-workers and/or staff)
	• What outcomes of the program they like or dislike (e.g. paychecks, pay periods, status in the community, relationships with co-workers or other people they come into contact with)
	• What would improve this situation
	PFW #11: How the person communicates and what support the person needs with communication
	• Types of communication/types of information the person understands
	• Types of communication the person uses/types of information the person expresses
	• Descriptions of current communication supports
	• Support that if added, would enhance the person's communication (e.g. visual strategies)
	• Specific ways the person could learn to communicate information that could potentially replace a behavior that serves a communicative function?
	d. Section III of the PFW describes:
	PFW #12: What support the person needs in order to be safe…
	1. At home, at work/ATE/school, in the community
	2. During awake times, while sleeping
	3. Including any of the following that apply:
	❖ Environmental supports needed for safety
	❖ Medical supports, medications and protocols
	❖ Dietary support
	❖ Mobility support
	❖ Safety plans or protocols
	PFW #13: What support the person needs in order to do things he or she likes, including any of the following that apply:
	• Any type of physical support
	• Communicative support
	❖ Types of communication/types of information the person understands
	❖ Types of communication the person uses/types of information the person expresses
	❖ Description of current communication support

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	❖ List of supports that if added would enhance the person's communication style
	❖ Identification if risky behaviors may serve a communicative function and supports that could replace the current behavior to communicate the same need
	• Calming exercises or routines
	• Advance information (e.g. social stories, routines, schedules)
	e. Section IV of the PFW describes:
	PFW #14: (Questions 14-19) What the person could learn or use that would improve their quality of life (This information should be consistent with information in the rest of the document and the person-centered plan. Supports identified should be described clearly.)
	f. Section V provides information that can help determine whether "important to's" can somehow lead to challenging behavior with regard to the following:
	• The person's relationships
	• What the person enjoys or dislikes
	• The person's goals and/or dreams
	• A conflict between what is important to the person and what is important for his or her safety
	• How the person interacts socially
	• The person's religious, spiritual or cultural considerations
	• What the person wants and needs in a living situation
	• What the person wants and needs at their job/ATE/school program

Check if completed or assessed	3. Review who contributed to the PFW and consider the following:
	a. Were involved friends and family of the person asked to contribute?
	b. Did more than one staff contribute to the PFW? Staff with various points of view?
	c. How confident is the team that the information is accurate?

Check if completed or assessed	4. If the PFW changes, the agenda items for the ISP will change, and another meeting should be held.

Check if completed or assessed	5. Review the ISP agenda items found in the PFW.
	✓ Determine whether supports that would enhance the person's life are clearly identified.

Check if completed or assessed	6. Read the Individual Support Plan.
	✓ Determine or consider the following:
	a. Do action plans match what is important to the person according to the person-centered plan and PFW?
	b. Do action plans clearly lay out what it will take to ensure the person's access to the supports identified in the PFW agenda items?
	c. Are action plans being followed?

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	• How is this being monitored?
	• Are steps in action plans happening soon or often enough?
	• Have the tools needed in order to implement action plans been identified and listed?
	❖ Do the staff have access to the tools they need and is there a way to ensure supplies are where they need to be at all times?
	d. When supports have not been determined or agreed upon, are ideas for support explored in discussion records in the ISP?
	• Do discussion records identify the conflict with or barrier(s) to providing the support, as well as what has been tried, and what has or has not worked?
	e. Who wrote this document and participated in the ISP meeting?
	• Are the ISP author and meeting participants aware of what this person's life looks like, the abilities of their staff, and the workings of the program?
	• What was the person's level of involvement in this process?
	• How confident are the people who contributed to the PFW and ISP planning that they know what is important to the person and what their goals are?

Check if completed or assessed	7. Read the person's safety plan and other protocols.
	✓ Determine the following:
	a. What aspects of these plans conflict with what is important to the person?
	b. How is this addressed in the ISP?

Check if completed or assessed	8. Read incident reports about the person.
	✓ Determine the following:
	a. Is there any additional information about what is important to or for the person that has not been identified in any of the previously examined documents above?
	b. Do the incident reports give any clues about how exactly "important to's" should be delivered?

Check if completed or assessed	9. Interview the person, their friends and family, and staff.
	✓ Determine if there is hope on the horizon for the person by considering the following:
	a. Does the person really understand what is going on in their life?
	b. Does the person need more support to understand their plan?
	c. Does the person get to do the things they like with a significant other, friend, staff, or others who are also interested and get enjoyment from the same activity?
	d. How are options presented, and is that working?
	e. Does the person have access to a schedule of activities that is both fun and interesting to them?

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	f. Are there non-contingent, fun activities available to and scheduled for the person?
	g. Does the person have the opportunity to access the community at least daily?
	h. Does the person have opportunities to enjoy activities in the community and/or give back to the community?

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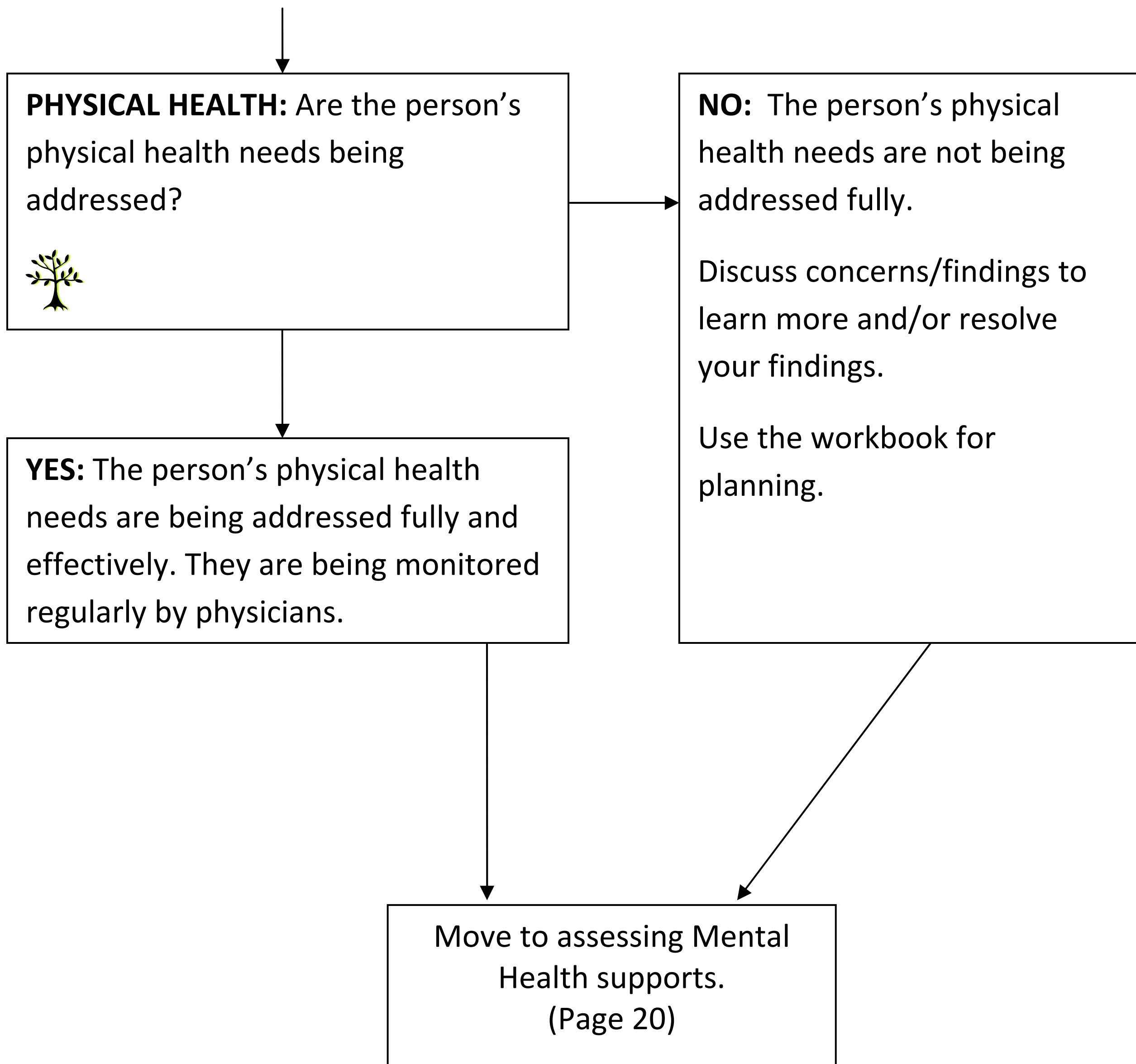

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Decision Process Guide: Physical Health

If the support provider reports the behavior(s) occur all the time and it appears the behaviors are occurring across settings, it is possible the function of the behavior has to do with the person's physical health.

(For more information, see "Common 'Problem' Behaviors and Speculations About Their Causes" handout by Ruth Myers, MD; James Salbenblatt, MD; and Melodie Blackridge, MD at http://dimagine.com/page66.html.)

Check if completed or assessed	1. Read/review RTR medical risks section (Questions 1-39) and answer the following questions.
	a. Are there medical conditions listed that could have an effect on the person's behavior?
	• Do medical issues such as allergies, pain, or GERD trigger challenging behaviors?
	b. Does the person have difficulty reporting pain? If so, this could be a clue about the person's behavior.
	c. Is there mention of sensory issues?
	• Has this been considered by the team or the person's doctor(s) as a possible cause for behaviors of concern?
	• Do we understand how the person processes sensory input/stimulation?
	• Is the person seeking out or avoiding specific sensory stimulation?
	• If a sensory issue is believed to be influencing behavior, has an Occupational Therapist evaluated this?
	• Has the team reviewed past OT evaluations and have the recommendations been tried, or is more information on how to carry out recommendations needed?
	d. Is the person at risk of not receiving medical care?
	• Is this due to behavior, unreported pain, or both?

Check if completed or assessed	2. Read/review the person's medical protocols.
	a. Do protocols give clear information for indicating how to recognize the person is experiencing symptoms, sick, or in pain?

Check if completed or assessed	3. Read/review medications and PRNs listed in the MARs.
	a. Are there spikes in challenging behavior that coincide with medical issues or PRNs being administered?
	• Does the person take PRN medication to address medical issues that may be causing behaviors of concern?
	• Do the medications alleviate symptoms and therefore decrease the behavior?

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	b. Have the person's medications been reviewed for contraindications via pharmacy, physician or even online drug interaction checkers?
	• Are we aware of possible side effects and is the person experiencing them?
	• How are we monitoring and measuring therapeutic effects?

Check if completed or assessed	4. Read/review the person's medical progress notes and any incident reports related to health/medical issues or doctors' appointments.
	a. Is the information objective and detailed regarding the person's health or health-related issues?
	b. Can you see a relationship between health-related issues or diet and the person's behavior?

Check if completed or assessed	5. Read/review physician's visit order forms from the last year.
	a. Determine whether the person is seeing a physician regularly. If the person will not go to the doctor or hospital…
	• Does the person have any predictability about receiving treatment?
	• Have necessary procedures been explained to the person in a way that they understand?
	• Have we systematically tried ways to reduce anxiety and increase predictability (e.g. driving into the parking lot and walking around the building one day, meeting the doctor outside another, then going in and getting a tour of the office another day, then meeting with the doctor in the office without having any procedures done, etc.)?
	• Does the person have any choices with regard to how the treatment is carried out (e.g. with whom, where, etc.)?
	• Does the person truly understand risks of the treatment versus risk of no treatment?
	• Does the health care provider need instructions on how to interact with the person? Has been tried in the past? What can we try? (e.g. Can we call ahead to ensure there is no wait time? Can the person have something fun to do while in the office?)
	• Can the doctor come to the house? What would this look like?
	b. Has a physician been asked to rule out the specific concern that might be related to the behavior?
	• Has the physician resisted diagnosing physical issues because the person does not report pain?
	c. Does the person have orders/recommendations by a physician or physical therapist that are not being followed?
	• How do we ensure these happen?
	• Do we need clarification on how to do this?
	d. Is there one person coordinating the health care?
	• Is the person (or people) assisting the person to access health care services effective in advocating for additional supports and/or treatments if necessary?
	• Do they follow up and communicate with the physician regarding new orders?
	• Is this person facilitating discussions between the person's various physicians?

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	• Is this person effectively informing other staff as well as organization management of new orders and/or treatments?

Check if completed or assessed	6. Review MAR and other documents of support regarding the person's diet, if applicable.
	a. Have diet issues been ruled out as part of the underlying causes of a challenging behavior?
	• If not, does the person complain of constipation, bloating, heartburn, etc.?
	b. Is the person on a specialized diet, and does this person have options?
	• Are staff trained in or knowledgeable about different ways to prepare the food?
	• Is the person involved in preparing his or her own food? Do they want to be? What would it take to make that happen?

Check if completed or assessed	7. Interview staff:
	a. When the person is routinely making poor health care decisions, do staff share this information with management?
	• How?
	• Do staff need more information about what is important to report?

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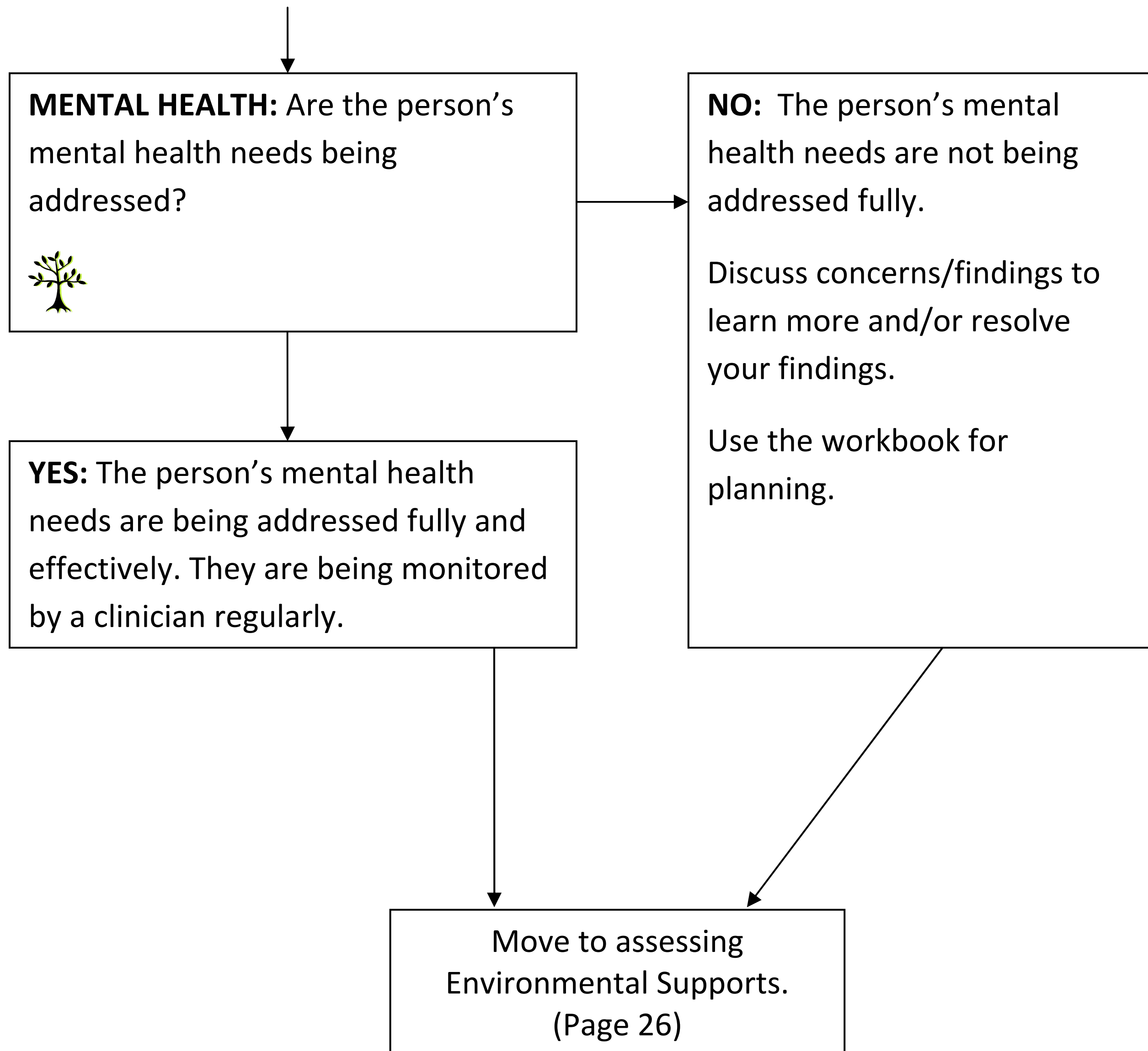
MENTAL HEALTH: Are the person's mental health needs being addressed?
NO: The person's mental health needs are not being addressed fully.
Discuss concerns/findings to learn more and/or resolve your findings.
Use the workbook for planning.
YES: The person's mental health needs are being addressed fully and effectively. They are being monitored by a clinician regularly.
Move to assessing Environmental Supports. (Page 26)

WORK BOOK:

Notes & Comments:

Next Steps: What needs to be accomplished, by whom, and by what date?			
Issue:	Desired outcome:	Measurable steps:	By whom/date:
Follow-up:			

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Decision Process Guide: Mental Health

If the support provider reports the behavior(s) occur all the time and it appears the behaviors are occurring across settings, it is possible that a piece of the function of the behavior has to do with the person's mental health status.

RTR mental health section (Questions 50-67), identify diagnoses, psychiatric evaluations, treatment history, MARs, medical progress notes,

Check if completed or assessed	1. Read/review RTR behavior/mental health section (Questions 50-67) and any psychiatric evaluations and/or treatment plans for the person and answer the following questions.
	a. Does the person have a mental health diagnosis?
	• If so, do we understand how it impacts the way they see and interact with the world?
	• Do we need more information about how the person's mental health diagnosis affects them (training)?
	b. Are there behaviors listed that could be tied to a mental health diagnosis?
	• Do mental health symptoms sometimes or often trigger challenging behavior?
	c. Is the person able to talk about his or her mental health? If so, are they seeing a therapist or counselor?
	d. If the person refuses to see a mental health professional…
	• Does the person have any predictability about these visits?
	• Has the treatment plan been explained to the person in a way that they understand?
	• Have we systematically tried ways to reduce anxiety and increase predictability about visits?
	• Does the person have any choices with regard to how the treatment is carried out (e.g. with whom, where, etc.)?
	• Does the person truly understand risks of the treatment versus risk of no treatment?
	• Does the mental health provider need instructions on how to interact with the person?
	• Was there ever a time the person willingly participated in their mental health treatment? If so, what did the treatment plan look like at that time, and can the current one be shaped to resemble it? If not, what's been tried that hasn't worked? (Be specific, name steps that were taken.)
	• Can the provider come to the house? What would this look like?
	e. If the person has a mental health treatment plan, how was this plan decided upon?
	• What are the goals of this support?
	• Are goals appropriate given the current skill level of the person?
	• What does the person need to learn in order to better understand and participate in reaching these goals?
	• Were all current medical and environmental issues considered?
	• Is there only one treatment option being considered right now? Has the

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	team gotten a second opinion?
	• If the issue is anxiety, how can we make aspects of life that stress the person out more predictable? If the issue is depression, how can we engage this person more and increase prediction and control?

Check if completed or assessed	2. Read/review the psychiatric medications listed in the MAR and answer the following.
	a. Is the person taking medications that address symptoms related to their diagnosis?
	• If so, are they working? (Are they the right meds?)
	• How is this being measured?
	• If they are not working, are we titrating off these meds before starting new ones or just adding more medications on?
	• Do the medications alleviate symptoms and therefore decrease the behavior?
	• Is progress toward these goals being documented and if so, consistently? Where?
	b. Have the person's medications been reviewed for contraindications via pharmacy, physician or even online drug interaction checkers?
	• Are we aware of possible side effects and is the person experiencing them?

Check if completed or assessed	8. Read/review the person's medical progress notes and any incident reports related to mental health issues or appointments.
	a. Is a data tool being used to track specific mental health concerns?
	• Is the information in IRs and data collection objective and detailed regarding the person's mental health-related issues?
	• Can you see a relationship between the person's mental health diagnosis and the person's behavior?

Check if completed or assessed	9. Read/review physician's visit order forms from the last year.
	a. Is the person seeing a qualified mental health professional (counselor, therapist, psychiatrist, psychologist or psychiatric nurse practitioner) regularly?
	b. Is the team experiencing difficulty with locating a qualified mental health professional?
	• If so, try contacting your county Mental Health Department for a list of mental health professionals in your community.
	• If the person has a mental health diagnosis, has the team contacted their local mental health agency to see if they take OHP (Oregon Health Plan)? Has the team contacted their County Health or Mental Health Departments to find out where to obtain mental health services with OHP?
	• Does the team have contact information for their Mental Health Organization (MHO)? (MHP Care Coordinators can help make referrals to appropriate programs for mental health treatment.)
	c. Has a physician been asked address the specific concern(s) that might be related to the behavior?
	• Has the physician resisted diagnosing mental health issues because the person has a developmental disability?

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	• If the person has had a provisional diagnosis ("rule out" diagnosis), what is the process to rule it in or out? (How long before a definite diagnosis is made?)
	d. Does the person have orders/recommendations/treatment plan by a mental health provider that are not being followed?
	• Are specific objectives or ways to measure the success of the psychiatric medications outlined in the physician's visit order forms or treatment plan(s)?
	• How do we ensure these happen?
	• Do we need clarification on how to do this?
	e. Is there one person coordinating mental health care/treatment?
	• Is the person (or people) assisting the person to access mental health care services effective in advocating for additional supports and/or treatments if necessary?
	• Do they follow up and communicate with the mental health provider regarding new orders?
	• Is this person facilitating discussions between the person's mental health care providers and other physicians?
	• Is this person effectively informing other staff as well as organization management of new orders and/or treatments?

Check if completed or assessed	10. Interview staff:
	a. When the person is exhibits behaviors that are not consistent with his or her personality, do staff share this information with management?
	• How?
	• Do staff need more information about what is important to report?
	b. Do staff understand the role stress plays in increasing mental health issues?
	• Do they understand what specific stressors to monitor and how to proactively and reactively decrease stress?
	• Is there an issue occurring wherein the staff blame the mental health diagnosis as opposed to understanding behavioral and environmental supports that can be addressed to support and decrease symptoms?
	• Can staff demonstrate how to use designated data forms for tracking mental health concerns?

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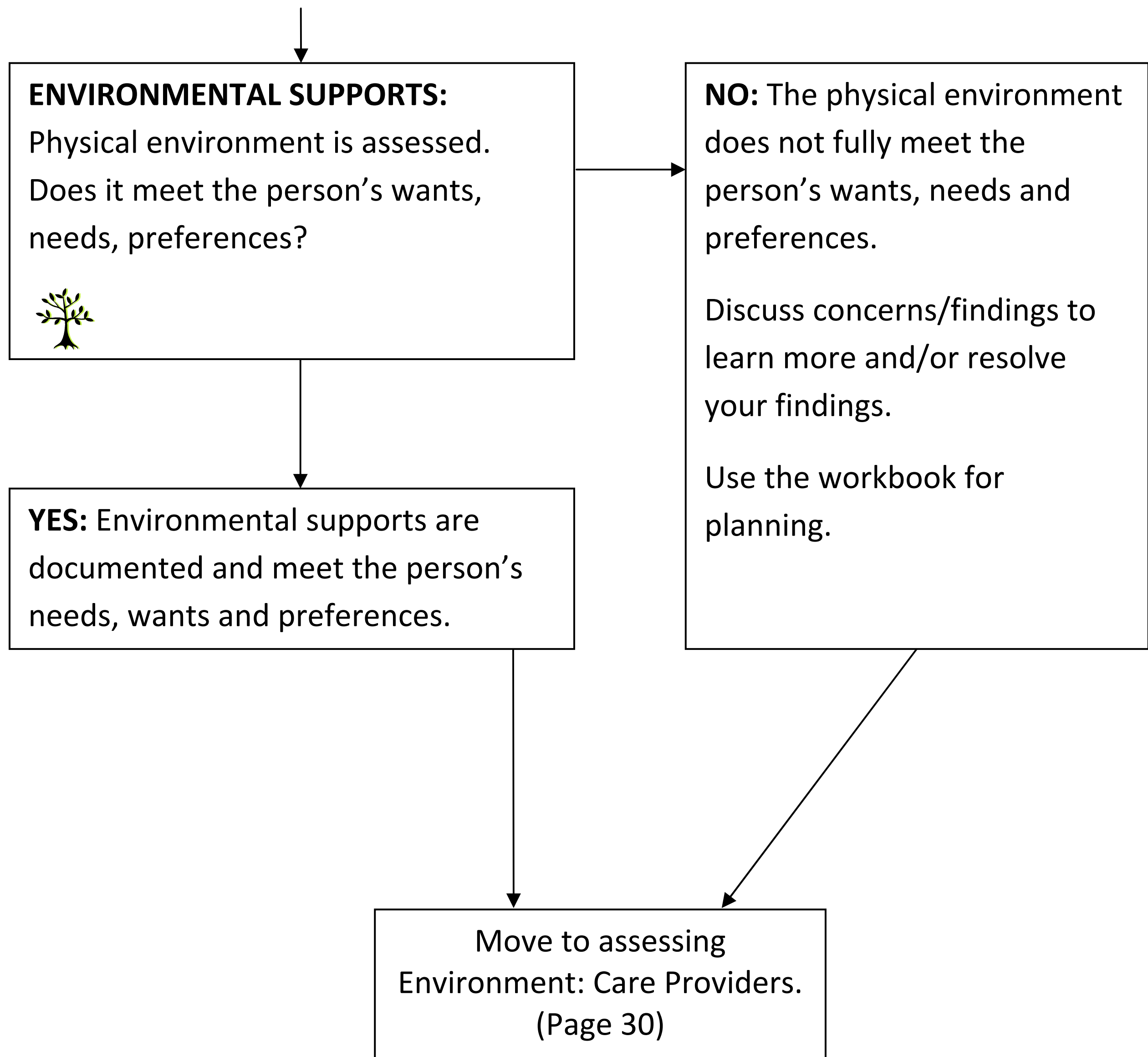

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Follow-up:			

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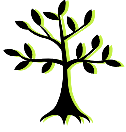

Decision Process Guide: Environmental Supports

Check if completed or assessed	1. Review the risk tracking record, personal focus worksheet, and ISP.
	a. Identify what is missing that the person needs in order to be both happy and safe.
	b. Review "important to" and "important for" conflicts that have been identified.
	• Are there at least small changes that can be made while the bigger steps are being discussed and planned?
	c. Identify which parts of the person's day are working.
	• Is there a way to bring elements of that to other parts of the day?
	d. Review questions 40-49 in the RTR (regarding safety and finances) and corresponding supports in the ISP.
	• Is any of this conflicting with what is important to the person?

Check if completed or assessed	2. Review incident reports and data collection forms.
	a. Determine whether information included in reports is clear, detailed and accurate.
	• Is the behavior clearly described?
	• Is staff's response clearly described?
	• Is the description of how the incident ended clear?
	• Are antecedents and outcomes – not explanations – clearly described?
	• Do staff need training on doing behavior documentation?
	b. Identify what is present or missing from the environment that is contributing to the challenging behavior(s).
	• How can these be addressed or avoided?

Check if completed or assessed	3. Observe the person in the environment where the behavior is occurring.
	a. Observe the person on a "good day" as well as on a "bad day" and note the things in the environment that were different or the same.
	• Number of peers and/or support providers present
	• Who exactly is present
	• Type of interactions (demands, requests, choices, social interaction, "casual supervision", etc.)
	• Type of activities
	• Transitions from one activity to another (preferred or non-preferred)
	• Time of day
	• Location
	• Atmosphere (quiet or chaotic)
	b. Consider the following questions:
	• Does the person get along with others in their environment?
	• Does the person have a way to receive and express information?
	• Does the person like the way others present information or make requests?

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	• Does the person like what they are doing? (Is it interesting, challenging, do they feel successful?)
	• Does the person understand what they are doing or what is expected of them?
	• Does the person need help with transitions and do you know what that should look like?
	• Are there particular times of day the person is more receptive to interaction and information than others? What are they? What's different about them from other times of day?
	• Does the person have privacy, and access to quiet, safe places when they want it? Access to people for interaction when they want it? Do they enjoy being in their bedroom because it is a nice place or because it is away from everyone else?
	• Does the environment match the person's preferences (e.g. for quiet or "fast-paced")?
	• Does what you see match what you have read in behavior documentation?

Check if completed or assessed	4. Review the ISP with the team.
	a. Revisit action plans and discussion records as a team.
	• Has the team truly addressed the issue of altering the environment, living situation, work demands, etc. to meet the person's needs or are historical support programs interfering? (For example, the "we have always done it this way" or "there is no other bed open right now" phenomenon.)
	• What are the natural supports this person has in the community? How can these supports be created or enhanced?

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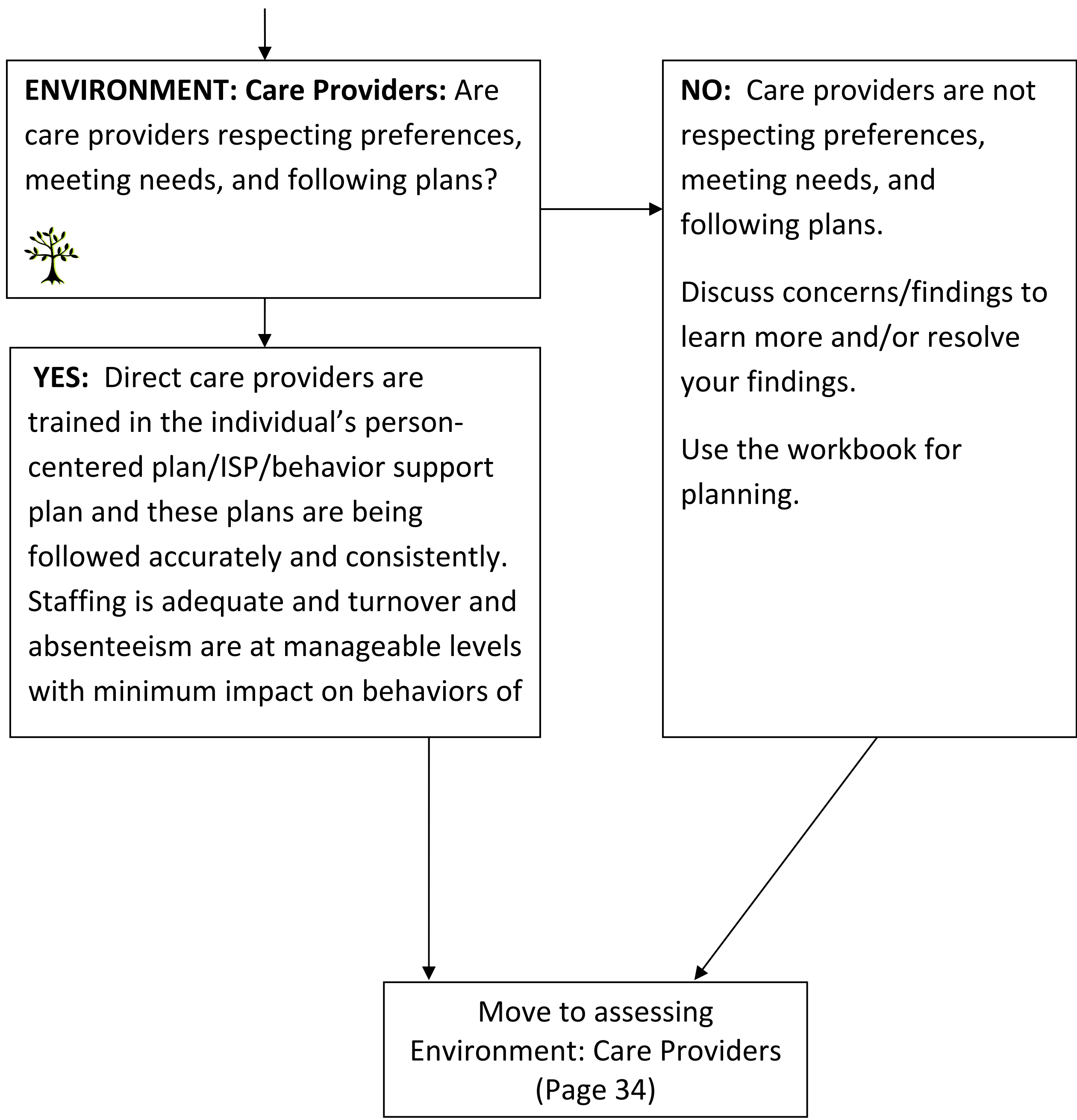

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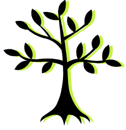

Decision Process Guide: Environment/Care Providers

Check if completed or assessed	1. Interview staff.
	a. Determine whether staff feel valued as being a resource for information about the person.
	• To what extent are they involved in brainstorming and identifying support needs?
	• Have they participated in person-centered planning, completed PFWs, and contributed to the functional assessment?
	• Is their information and input sought on a daily basis?
	• Do support providers have a sense of ownership and responsibility to communicate with managers and upper management and make changes immediately when necessary?
	• Are there regular staff meetings to address concerns?
	• How are concerns typically responded to? Is there prompt, sufficient follow up?
	• How do we ensure staff feel safe in voicing concerns while keeping the environment positive?

Check if completed or assessed	2. Interview the person and care provider and observe the person with care providers.
	a. Determine whether care provider(s) is a good match for the person.
	• Are interactions comfortable between care provider and person?
	• Do they understand one another?
	• Does the care provider respect the person's wishes for personal space and/or privacy while understanding and doing what is required to keep him or her safe?
	• Do the care provider's values for caring for someone or helping them to be independent match the person's needs or goals for independence?
	• Does the person like spending time with the care provider?
	• Does the care provider like spending time with the person?
	• Is the care provider able to read the person's body language and respond in ways that prevent escalation?
	• Is the care provider successful in helping the person to calm down when needed?
	• If you answered "no" to many of the questions above, is this a training issue? Or, can shift responsibilities/assignments be rearranged?
	b. If it is a staff training issue, determine what the challenge is and what steps can be taken to resolve it.
	• Have care providers been trained? On what? How were they trained?
	• Are care providers trained in providing positive behavior supports?
	• Do they know how to access all the things they need in order to support the person as planned?

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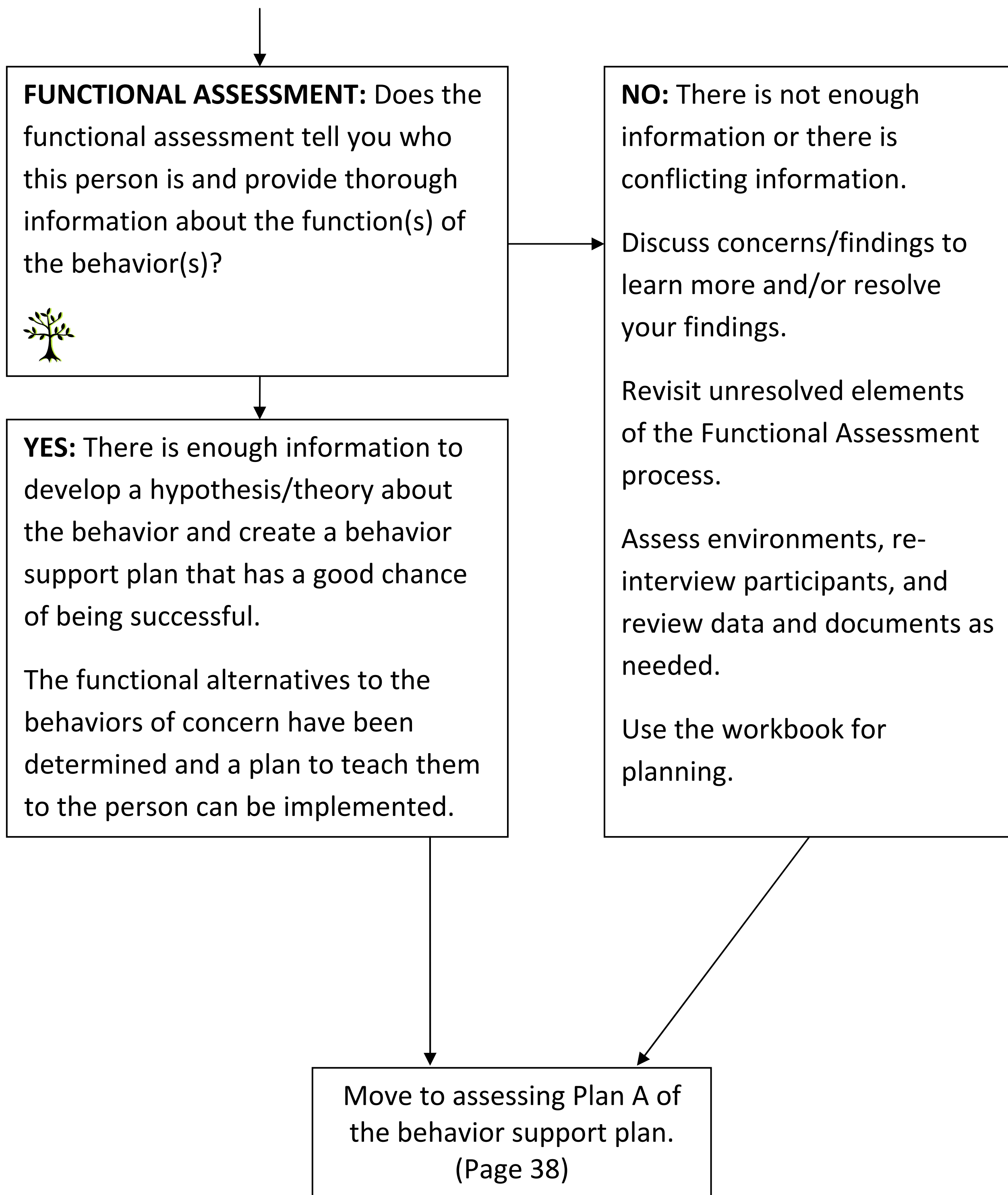
	• Is there a teaching difficulty of some kind? How can we address differences in staff learning styles?
	• Do care providers have relevant skills and confidence in their ability to make good decisions about preventing and responding to behavior? (How do you know?)
	• Can new or struggling staff shadow more experienced or successful staff?
	• Are IR follow ups consistent and appropriate? What actions are taken in the follow up piece? Are they always the same or do they differ depending on the situation?
	c. Determine the following regarding care providers' skills in following the ISP:
	• Have they had training on what an ISP and its components are? Do they need it?
	• Have they been trained on the person's ISP?
	• Do they understand their role in following the ISP?
	• Do they need training on how to implement the action plans in the person's ISP?
	• Have they been trained to the documents as well as how to incorporate the "important to"?

Check if completed or assessed	3. Observe several shift changes and transitions such as the person coming to work or home from work.
	a. Determine the following:
	• What does shift change look like? What do people do?
	• Is it chaotic or done very methodically?
	• Are care providers communicating with each other about what is happening in the person's life?
	• How does the flow of communication between the home and work environments look? What's the system?



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Decision Process Guide: The Functional Assessment

Complete the following "functional assessment checklist".

Item	Yes	No
1. Person-centered information matches the person-centered plan and PFW. (The document describes the person's strengths, gifts, capacities, interests and goals/dreams. It is clear what is important to the person, what is important for their safety, any conflicts in these, and what's working and not working.)		
2. The person's current communication skills and methods are clearly described.		
3. The person was interviewed and/or observed.		
4. Observation occurred in various settings, where the behavior occurred and did not.		
5. The person's friends and family were interviewed during the assessment process.		
6. Care providers who interact with or support the person regularly were interviewed.		
7. People who supported the person in past placements or programs interviewed if possible.		
8. Mental health professionals and/or prescribing physician(s) involved in the person's treatment were interviewed.		
9. The person's history is included in the FA document.		
10. Medical records (including MARs and progress notes) were reviewed.		
11. Psychiatric evaluations were reviewed.		
12. Behavior data (incident reports, progress notes, and behavior data tracking) were reviewed.		
13. How the person builds and maintains friendships is identified.		
14. Whether the person has relationships with people who are not paid support providers is identified, as well as how often and where the person sees these people.		
15. Targeted behaviors of concern are clearly described. – Specific actions – Frequency – Range of durations – Range of intensity (how much energy the person uses, judged by their post-crisis depletion behavior) – Range of severity (physical impact on the person or their environment)		
16. The way the person sees and interacts with their world is identified.		
17. The effect the person's disability has on them and their behavior and support needs is clearly described. – Executive functioning – Processing issues		
18. The effects the person's life experiences have or may have had on their		

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behavior is described. – Family dynamics – Past abuse or neglect – Past placements, multiple placements, separation from family, etc.		
19. Medical functions of the behavior are described. – Sensory – Pain		
20. Medical "underlying causes", setting events and triggers are identified.		
21. Mental health functions of behavior are identified. – Family history of developmental or mental health disorders		
22. Communicative functions the behavior serves are clearly described.		
23. Underlying communicative causes, setting events and triggers are described.		
24. The effect(s) the environment has on the person's behavior is described. – People, noise, personal space, ratios of support, lighting, temperature, etc. – Types of interactions		
25. Most and least likely conditions under which the behavior occurs are identified (what works and doesn't work): – People/personalities – Places – Activities/situations – Locations – Times of day – Other patterns		
26. Outcomes of the behavior are described (what the person gets or avoids).		
27. "What you see" or what the person looks like/does… – in baseline – in early escalation phase (early warning signs) – in crisis – in de-escalation (when calming down) – in post-crisis depletion – in stabilization		
28. The document includes summary statement(s) of the behavior(s).		
29. The functional assessment document has been updated within the last year. – Target behaviors and descriptions, frequency, duration, intensity and/or severity are current. (FA matches RTR for behavioral risks.)		

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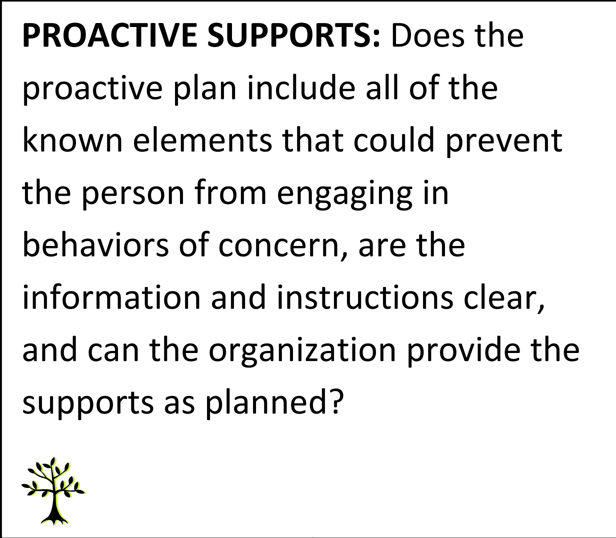
ASSESSING THE BEHAVIOR SUPPORT PLAN

PROACTIVE SUPPORTS: Does the proactive plan include all of the known elements that could prevent the person from engaging in behaviors of concern, are the information and instructions clear, and can the organization provide the supports as planned?



NO: The proactive plan of the BSP does not include all of the elements necessary;

~OR~

The organization or care providers cannot provide the supports as planned.

Clearly identify what information is missing from the support plan document *OR* what cannot be supported. Discuss with the ISP team.

YES: The strategies and instructions are clear, they work for the person, and the organization can provide the supports as planned.

Move to assessing Plan B of the behavior support plan. (Page 42)

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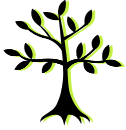

Decision Process Guide: The Behavior Support Plan, Plan "A"

Complete the following "Plan 'A' checklist".

Item	Yes	No
1. Proactive plan meets OAR requirements.		
2. Person's friends, family and care providers were consulted for strategy/support ideas.		
3. A clear description of how the person looks and acts in baseline is included.		
4. Important "to(s)" match the PCP and PFW.		
5. Important for's match PCP, PFW and RTR.		
6. Who it is important for the person to keep in contact with is included.		
7. Supports are based on information in the PCP, PFW, RTR and FA and include:		
a. How to communicate with the person in a way they understand		
b. How to interact with the person (what works best), including personal space considerations		
c. A summary of the function(s) of the behavior(s) to promote a better understanding of the supports in the plan		
d. Clearly identified functional alternatives to behaviors of concern		
e. Functional alternative behavior(s) that meets the same needs or outcomes as the behavior(s) of concern, that the person has the capacity to learn at this time		
f. How to teach the new behavior(s) and other skills		
g. How to recognize and minimize setting events		
h. Specific environmental supports: what they do and how to use them		
i. How to keep the person safe within the home or work program		
j. Supports that provide predictability to the person		
k. Supports that provide more control (i.e. ways to offer and support choices)		
l. Supports that provide physical, emotional and social outlets		
m. How to support the person to make connections in their community		
n. How to keep the person safe in the community		
8. Descriptions of any tools or processes care providers would need to access or know are included.		
9. Proactive plan is largest section of the BSP.		

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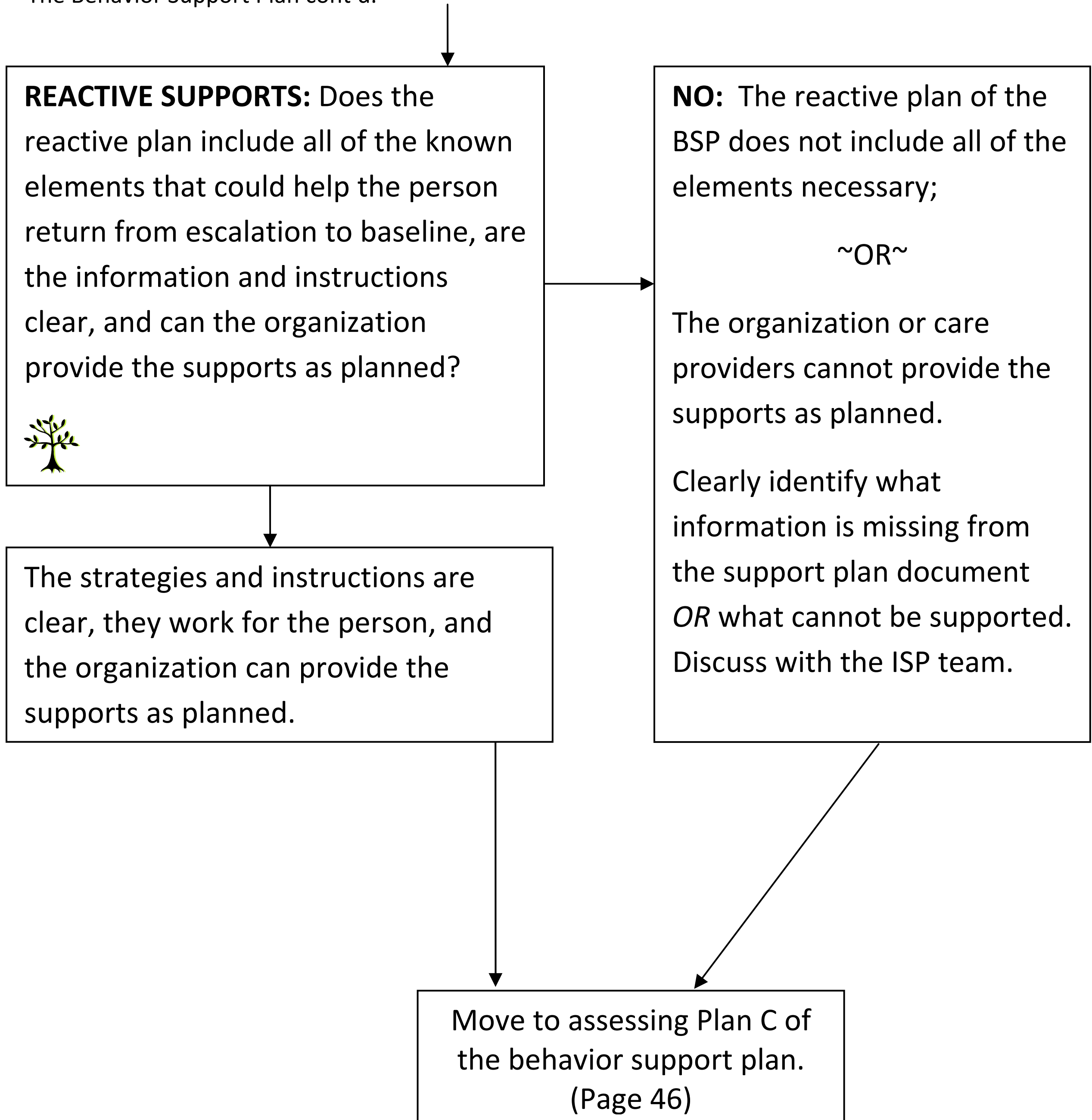

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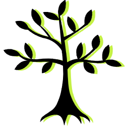

Decision Process Guide: The Behavior Support Plan, Plan "B"

Complete the following "Plan 'B' checklist".

Item	Yes	No
1. Reactive plan meets OAR requirements.		
2. Person's friends, family and care providers were consulted for strategy/support ideas.		
3. A clear description of how the person looks and acts just before or during escalation is included ("early warning signs of escalation").		
4. Supports are based on the FA and PCP and include:		
a. Setting events and triggers		
b. How to respond to early warning signs of escalation		
c. How to communicate with the person when they are escalating, including personal space considerations		
d. How to make it easy for the person to use the functional alternative behavior they are learning		
e. How to adjust the environment in order to help them calm down		
f. How to provide them with what is needed to help them calm down		
g. What to address and what to let go in the moment		
h. How to respond in various settings (home, work, community, etc.)		

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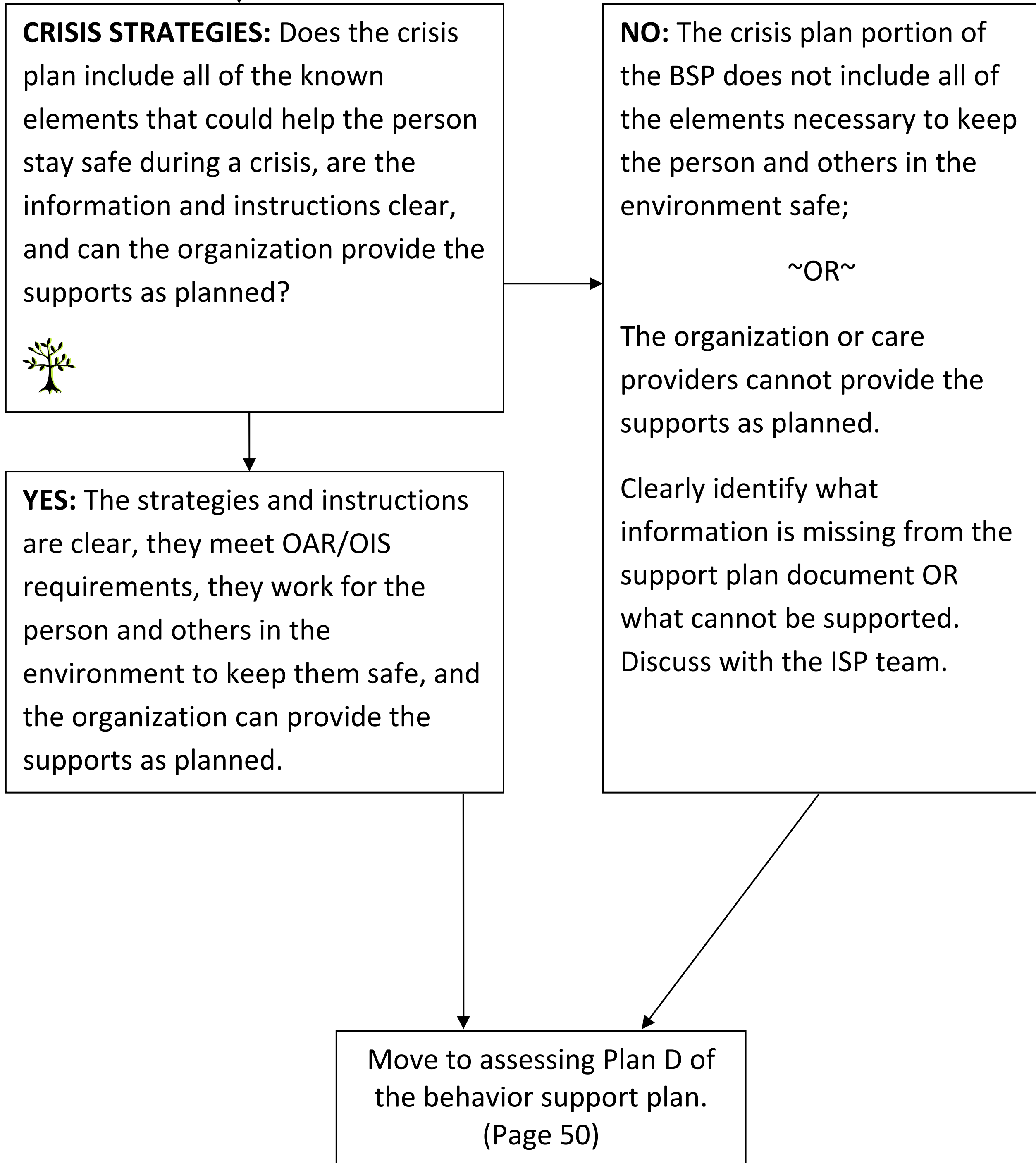

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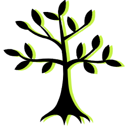

Decision Process Guide: The Behavior Support Plan, Plan "C"

Complete the following "Plan 'C' checklist".

Item	Yes	No
1. Crisis plan meets OAR requirements and follows OIS standards.		
2. Person's friends, family and care providers were consulted for strategy/support ideas.		
3. A clear description of how the person looks and acts when they are considered to be in crisis is included.		
4. Supports are based on the FA and PCP and include:		
a. Who should communicate with the person when they are in crisis		
b. How to communicate with the person when they are in crisis, including personal space considerations		
c. How to keep the person safe in the environment they are in (e.g. home, work, community, etc.)		
d. How to keep others in the environment safe, if applicable		
e. What *exactly* to do if the safety of the person or others in the environment is at risk		

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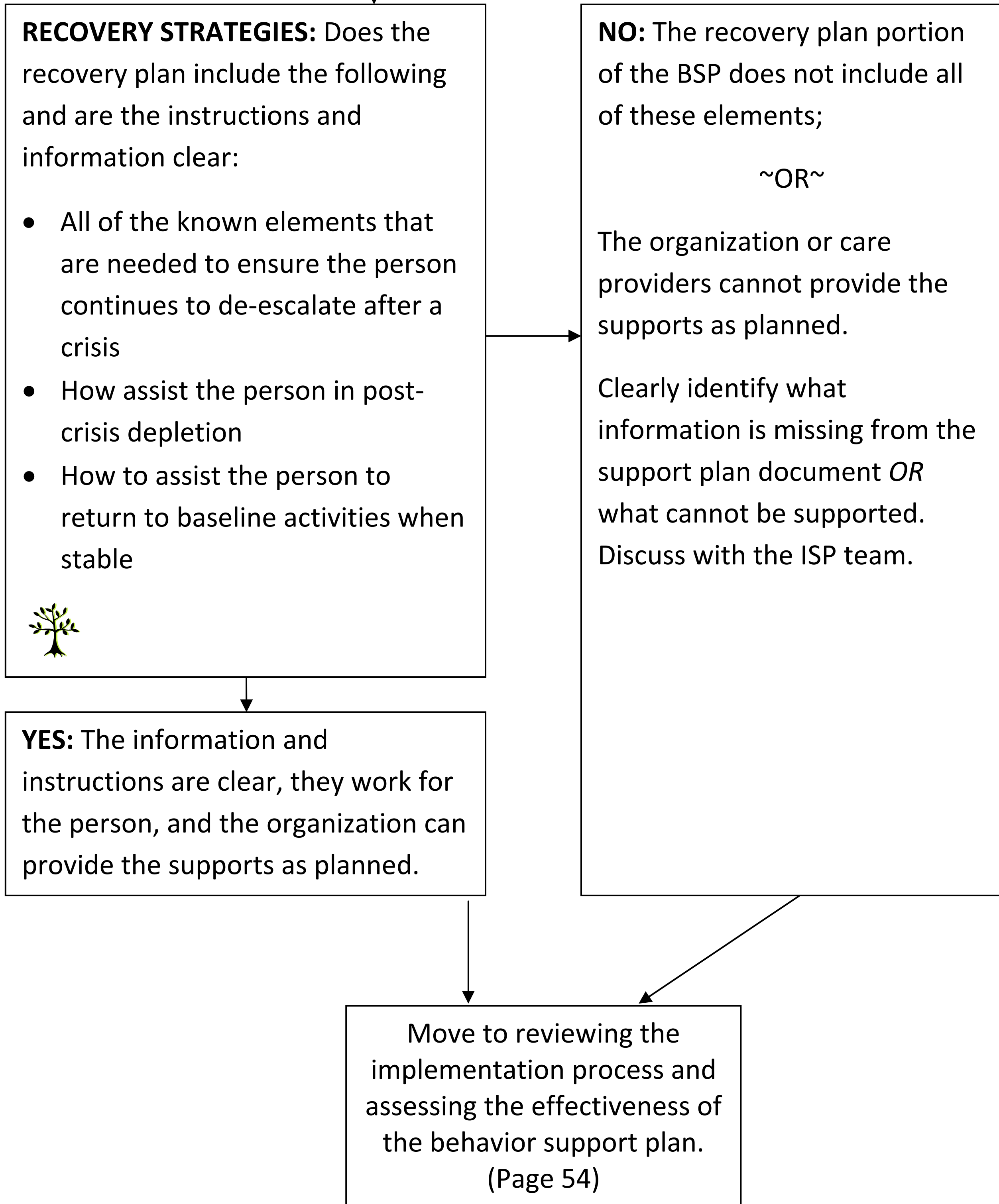

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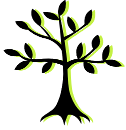

Decision Process Guide: The Behavior Support Plan, Plan “D”

Complete the following “Plan ‘D’ checklist”.

Item	Yes	No
1. Recovery plan meets OAR requirements.		
2. Person’s friends, family and care providers were consulted for strategy/support ideas.		
3. A clear description of how the person looks and acts when they are de-escalating is included.		
4. Supports are based on the FA and PCP and include:		
a. Strategies to avoid re-escalation		
b. How to communicate with the person when they are calming down, including personal space considerations		
c. What to consider in the environment in order to help the person continue to calm down		
d. Needs for physical sustenance, privacy, or comfort the person typically has and how to provide these		
e. How to know the person has stabilized (how they look and act)		
f. When and how to support the person to return to baseline activities		

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Implementing the Behavior Support Plan

1. The ISP team members review and approve the BSP.
2. Staff are trained in the plan and in OIS if required.
3. The Behavior Specialist/OIS Instructor provides follow up every 30 days.
4. The program manager regularly monitors for adherence to the plan.
5. The OIS Instructor or another agency/provider organization person certified in OIS Oversight provides incident report reviews of protective physical interventions and conducts monthly OIS practice with care providers.
6. The Behavior Specialist collects, reviews and summarizes behavior data at least monthly.
7. Behavior Specialist or program manager forwards behavior data summaries to ISP team members for review monthly.
8. Plan modifications/changes are submitted to the ISP team for review and approval before being implemented.

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Decision Process Guide: Implementing the Behavior Support Plan and Assessing its Effectiveness

Check if completed or assessed	1. Interview the person and care providers, and review behavior data to determine the following:
	a. Are the supports effective?
	b. Is there data tracking?
	• If so, who is monitoring and summarizing?
	• Is this presented to the support providers as a learning tool?
	• Are the instructions for completing data clear?
	• Do support providers understand how to complete this documentation?

Check if completed or assessed	2. Determine the following:
	a. How often is the success of the plan being reviewed? (If the behaviors are continuing, more frequent review is highly recommended.)
	b. What is the method of review?
	• Does it include interviewing support providers across shifts and environments?
	• Does it include additional observation?
	• Review of incident reports?
	• Review of progress notes or other communication logs?
	• Review of MAR?
	c. Are written summaries of behavior completed on at least a monthly basis?
	• Do summaries include graphs that show patterns of frequency, duration, intensity, or severity, or comparisons between review periods?

Check if completed or assessed	3. Determine the following:
	a. Is the progress of the person toward learning the prescribed functional alternative behaviors being tracked?
	• How?

Check if completed or assessed	4. Ask the team:
	a. Are we reviewing the progress of this plan regularly?
	• If not, how can we do this more consistently for the benefit of the person?

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Community Supports and Crisis Intervention

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