1 Interdisciplinary Team Process

1.1 The primary objective of the Interdisciplinary (ID) Team will be to establish individual plans and modify services for optimum effectiveness. The ID Team will identify the goals of each person served by OPTIONS, taking into consideration personal choices, strengths and needs. The person served will be central to the development of the Individual Service Plan (ISP) and the on-going evaluation process. The ID Team will also involve significant family members (with permission of the person served) and referring/funding agency representatives in the ISP process. Information gathered from these sources as well as other professionals such as physicians and counselors as applicable, will be integrated with information provided by OPTIONS' Community Support Specialists (direct care staff members) and input from the person served to create ISP goals and objectives. The ID Team will oversee the implementation of the ISP, monitor progress, and direct necessary changes.

1.2 Case managers from referring and/or funding agencies will be actively involved in the development of the person's ISP. OPTIONS will not modify or update an ISP without input by the referring/funding source case managers. It is preferred that case managers attend each meeting but when not possible, may consult by phone or email prior to the meeting or prior to changes being implemented.

1.3 When a person is referred to OPTIONS, the Referral Committee will evaluate information contained in the referral packet. When the committee determines that admission may be appropriate, a pre-admission screening evaluation interview with the referred person will be scheduled. The issues of goals and plans for the future will be discussed, and OPTIONS will seek to identify the short and long-term goals and desires of the referred person.

1.4 Following this interview, a pre-admission review will be held to discuss information gained from the referral packet and the pre-admission screening evaluation. The Referral Committee will determine whether admission to the specific service for which the person is being referred to is appropriate and will be capable of meeting the needs of the referred person.

1.5 The initial assessment process begins with the pre-admission screening evaluation and the pre-admission review. Goals and plans for the future are discussed during this process. In a Community Care Licensed service, a needs and services assessment will be completed the first week of admission. In all programs, within 30 days of admission, the ID Team, including the person served, will meet to review and update all information relevant to the treatment plan. This review will include an assessment of personal goals, developmental status, disabilities/abilities, and

developmental strengths and weaknesses. The Program Manager acts as the ID Team leader. The ID Team leader will ensure that each member of the ID Team is present and/or has provided input regarding the needs of the person served and provides recommendations. During this meeting, the ID Team will develop an individual service plan (ISP) for meeting the needs of the person. The person served, as a member of the ID Team, will be consulted throughout this process to ensure the relevance of any and all goals established by the ID Team. A person served may choose to complete a person-centered plan prior to the meeting to help prepare for the meeting. Significant family members/ advocates and referral/funding agency representatives will provide additional information relevant to the development of the ISP. Unless legally conserved, the person served may choose the ID Team members who participate in the planning meeting. The ID Team will identify specific barriers to independent living in observable and/or behavioral terms. The ISP will address these specific barriers and include expected outcomes in measurable terms. The ISP, as a document, will also include: date of implementation, identification of the case manager responsible for overall implementation of the plan, persons responsible for other specific aspects of the plan, work assignments and/or activities that are consistent with goals and relevant to current geographic opportunities, and specific techniques and methods to be employed in realizing goals. The final written ISP will be reviewed with the person served and provided to the referral/funding agency representatives. A person served will be provided a copy of their ISP if desired.

1.6 The ID Team will monitor progress toward ISP goals and objectives and will re-evaluate the status of the person at least annually or more frequently as needed. During these reviews, the ID Team will also consider the following issues: need for continued program services or alternative placement; need for conservatorship if applicable, protection of civil and legal rights, recreational interests, and the safety of the person and others in his/her environment. The Program Manager, as a representative of the ID Team, will coordinate on-going communication between individuals and organizations providing services to the person served.

2 Interdisciplinary Team Membership

2.1 The Interdisciplinary Team will include some or all of the following members and personnel, based on the individual needs of each person:

Chief Executive Officer
Qualified Intellectual Disability Professional (QIDP)/Program Manager
Program Director
Program Manager
Registered Nurse or RN Consultant
Program Supervisor or Program Coordinator
Community Support Specialists

Other Health Care Professionals as needed
Regional Center Service Coordinators or other Funding Representatives
Family and friends as requested by the person served

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