



## Individual Progress Review Directions

### Overview:

DDS no longer requires **all** teams to hold *quarterly or six month meetings* to review individual plans. Individual plans will be updated annually at a team meeting or more often if an individual's needs change during the year resulting in a change in services. This change will reduce required meeting time and enable case managers and other team members to dedicate more of their time to consumers and their other duties. The change does not apply to Community Companion Homes and to ICF/MR settings. Those residential and day providers will continue to complete quarterly reviews of individual plans.

As an alternative to team meetings, providers of residential and/or day supports are required to submit a written six month progress review to the case manager **and** other team members prior to the annual plan and six months thereafter. At a minimum, other team members who should receive the six month reviews are the individual's family and the residential or day providers. (i.e. the day provider should submit their review to the case manager, family, and residential provider and the residential provider should submit their review to the case manager, family, and day provider).

Teams should meet at least annually to update the Individual Plan. Team members should inform case managers at any time an individual's life circumstances or needs change resulting in a need to convene the team to change the plan of services. Teams should meet when:

- The individual, family or guardian requests a meeting, for example to plan a different outcome, new service, or different provider
- The person's needs change resulting in an increase or decrease in services
- One or more new service is added or discontinued
- There is a change in a service provider.

Individual team members and clinicians should continue to monitor individual's health status and progress on teaching strategies and behavioral plans according to best practice and the person's specific needs. For example, regular quarterly nursing care plan reviews should continue as well as monthly or quarterly reviews of behavioral plans and data. All providers need to use the Individual Progress Review Forms additional supporting data, such as behavioral graphs, can be attached, as applicable.

### Directions: "How to Fill Out the Individual Progress Review"

1. Prior to filling out the Individual Progress Review, the provider should review the current individual plan. The provider is responsible to complete the Individual Progress Review on all actions and steps that are identified as the provider's responsibility in IP.5, the Action Plan and IP.6, the Summary of Supports and Services sections of the individual plan.
2. The provider must fill out the top section of the form to identify any updates or changes in the individual's life circumstances. Any significant changes to the person's status in any of the Personal Profile areas must be indicated by checking the appropriate box and describing the update or change. Identification of changes in the person's needs or life circumstances should prompt communication with the DDS Case Manager at any time during the year to determine if a team meeting is necessary. In the absence of the semi annual meeting, it will be crucial for the provider to maintain good communication with the DDS Case Manager regarding any changes experienced by the individual.

3. If the individual received any new assessments during the review period, the appropriate box must be checked with specific information about the type of assessment completed and significant results. The assessment should be attached. If the provider recommends the need for a new assessment, this should be indicated in the checkbox and details specified.
4. The remaining sections of the form will outline the specific service(s) delivered by the provider as summarized in the Summary of Supports and Services (IP.6)
5. The provider must refer to the Action Plan (IP.5) and report on progress toward each area and indicate next steps where applicable. There may be several issues or needs on which to report depending on the number and type of services being delivered by the provider and the number of goals areas in the plan. A new section must be filled out for each issue or need identified as the provider's responsibility in the Action Plan.
6. Attachments may supplement the information provided on the Individual Progress Review. If there are any written assessments, summaries, reviews or reports being shared with the team, the appropriate box must be checked indicating attachments.

**Here are examples of how to complete reviews of areas of need:**

**Waiver Service(s) (from IP.6): Individualized Home Supports (Supported Living)**  
**Action Plan (from IP.5)**  
**#1. Issues or Needs:** Jane requires support with healthcare coordination  
**#1. Desired Outcome:** Increase independence in managing health supports  
**Progress made towards Actions and Steps** (Include information about progress, whether steps should continue or be modified)  
**A:** Jane continues to need assistance from staff with scheduling medical appointments. All scheduled appointments were attended and there are no significant medical issues.  
**B:** Staff continues to assist Jane with transportation to medical appointments. Jane is working with staff on increasing independence in this area by taking the Transit Bus.  
**C:**  
**D:**  
 See Attached  
**Additional Concerns/Comments:** Staff will accompany Jane on the Transit Bus for the first few trips to ensure she feels comfortable and able to successfully attend appointments. Staff will follow up with Jane on any health concerns identified or recommendations for future appointments.  
**Recommendations:** None at this time

**Waiver Service(s) (from IP.6): Supported Employment Services**  
**Action Plan (from IP.5)**  
**#2. Issues or Needs:** Jane would like to earn more money for leisure activities  
**#2. Desired Outcome:** Develop work skills, decrease tardiness, and increase wages  
**Progress made towards Actions and Steps** (Include information about progress, whether steps should continue or be modified)  
**A:** Jane's job coach was able to support her to find ways to complete her job tasks more efficiently through the use of a job checklist using pictures. Jane's work skills, productivity on the job and wages have increased during the last two months. Her earnings have increased by \$10 a week on average. Jane is more satisfied with her work and reports being able to go out to dinner more often with increased wages.  
**B:** The frequency with which Jane arrives at work tardy has decreased from once a week to less than once a month. She reports she is much happier on the job and looks forward to going to work.  
**C:**  
**D:**  
 See Attached  
**Additional Concerns/Comments:**  
**Recommendations:** Continue with current support arrangement. If progress continues, consider future reduction in job coach supports.