Kentucky Direct Support Professional Credential Application Packet

For

Direct Support Professional Specialty in Health Support (DSP-SHS)

INSTRUCTIONS

Please review the following Qualification requirements. Select the Option which best meets your ability to achieve the DSP-SHS credential.

OPTION	QUALIFICATIONS	PORTFOLIO REQUIREMENTS
A	• Current certification in Kentucky as a Certified Nurse Assistant (CNA) • Demonstrate 1 year of experience as a CNA providing support to individuals with I/DD	• Copy of current license/certification from the Kentucky Board of Nursing as a Certified Nurse Assistant (CNA) • Resume demonstrating 1 year of experience as a CNA providing support to individuals with I/DD
B	• Demonstrate 1 year of full-time experience providing direct support services to individuals with I/DD with special health care needs • Submit completed copy of the Health Supports Competencies and Skills Form	• Resume demonstrating 1 year of full-time experience providing direct support services to individuals with I/DD with special health care needs • Completion of the Health Supports Competencies and Skills Form
C	• Submit a copy of current credential as a NADSP Specialist in Health Support	• Provide a copy of current credential as a NADSP Specialist in Health Support by the National Alliance of Direct Support Professionals

Please complete the following documents and electronically submit to the Kentucky Division of Developmental and Intellectual Disabilities.

1. Application for Credential (pgs. 4 and 5 of this document).
2. Employer Letter of Verification (copy is provided for your supervisor's use).
3. Signed Commitment to adhere to the Kentucky DSP Code of Ethics.
4. If you are completing the application under Option A, your application should include a copy of your current license/certification as a Certified Nurse Assistant (CNA). [You are not required to complete the Health Supports Competencies and Skills Form.]
5. If you are completing the application under Option B, please complete the Health Supports Competencies and Skills Form located on pages 1 through 27 of this packet. If you choose to submit additional information such as participant images or other participant personally identifiable information with the Competencies and Skills form, please include a copy of signed Release of Information statements.
6. If you are completing the application under Option C, please include a copy of your current credential in Health Support issued by the National Alliance of Direct Support Professionals.
7. Submit your completed Application to: KYDSPCP@ky.gov

If you have questions regarding the completion of this application, you may contact one of the following individuals:

Cheryl Bogarty at Cheryl.Bogarty@ky.gov

Barb Locker at Barb.Locker@ky.gov

Kathy Wilson at Kathy.Wilson@ky.gov

KENTUCKY DIRECT SUPPORT PROFESSIONAL CREDENTIAL PROGRAM APPLICATION

Date of Application: _____

Desired Credential: _____

First Name, Middle Initial: _____

Last Name: _____

Street Address: _____

City: _____

State: _____

Zip Code: _____

Phone Number: _____

Email Address: _____

How long have you been employed as a DSP? _____ Years, _____ Months

College of Direct Support User ID: _____

EMPLOYER LETTER OF VERIFICATION

To Whom It May Concern:

This letter is to verify employment of _____,
who is employed by _____
as a Direct Support Professional. I hereby verify that the above named employee:

- Meets the qualifications of Direct Support Professional outlined in 907 KAR 12:010;
- Has completed all training and personnel requirements as stipulated in 907 KAR 12:010; and
- Is considered to be an employee in good standing as demonstrated by performance evaluations.
- The above named employee has a minimum of one year experience in the field of Intellectual/Developmental Disabilities (I/DD).

Please contact me at _____ if you have any questions.

Sincerely,

_____
(Supervisor Electronic Signature)

_____
(Position/Title)

KENTUCKY DIRECT SUPPORT PROFESSIONALS

CODE OF ETHICS

Individuals serving in the field of developmental and intellectual disabilities as Direct Support Professionals (DSPs) are essential members of the participant's support team. Each day, DSPs are required to make independent decisions which involve practical and ethical judgments as they support participants in their communities. This requires individuals in the supporting role to analyze and apply values and beliefs, use creativity and out-of-the-box thinking to assist them in the fulfillment of their duties.

The primary role of a DSP is to assist one or more participants requiring supports to lead self-directed lives and actively participate in their communities and nation. The DSP must be able to recognize the societal prejudices and unintended consequences of service delivery systems that form barriers which prevent many individuals with developmental or intellectual disabilities from enjoying a high quality of life.

The DSP should embrace the concept of person-centered thinking which follows the path suggested by the unique preferences, gifts, and needs of the participant(s) they support. This implies the DSP works in partnership with the participant(s), and those who love them, toward a life of opportunity, well-being, freedom, and contribution. A DSP becomes involved in almost every aspect of an individual's life, including access to the community, personal finances, physical well-being, relationships at all levels, employment, and every-day choices. Thus, a participant's life can change dramatically with the coming and going of direct support professionals.

As a DSP fulfills the primary duties of his or her position, they are faced with ethical decisions daily. They also feel the conflict that often exists between the principles of their profession and the daily practices that result from numerous organizations, governmental, social, and societal policies and prejudices. The conflicts often result in the shifting focus from person-centered principles to a service-driven focus. Thus, it becomes imperative for a DSP to have a firm ethical foundation that assists him or her in the navigation of the influences that bombard them.

The Kentucky DSP Code of Ethics should serve and be used as a guide to assist the DSP in decision-making that is person-centered focused and contributes to the ongoing pursuit of securing freedom, justice, and equality for all.

As a Direct Support Professional, I hereby affirm the following:

1. Person-Centered Supports
   Each person has the right to direct his or her own life and support(s), and in my role as a DSP, I will maintain a high level of flexibility, creativity, and commitment that is focused on the participant(s) I support. Therefore, I commit to providing person-centered supports which focus on the unique social network, circumstances, personality, preferences, and needs/gifts of the participant(s) and will advocate on behalf of the participant(s) I support when individual preferences, needs, or gifts are neglected or when system needs override those of the participant(s).

2. Promoting Physical and Emotional Well-Being
   I will promote the physical and emotional well-being of the participant(s) I support by developing relationships that are respectful, based on mutual trust, and maintained within professional boundaries. Through these relationships I will assist the participant(s) in understanding available options and potential consequences as they relate to their physical health and emotional well-being; challenge others (including support team members) to recognize and support the rights of the participant(s) to make informed decisions involving personal risk; and be vigilant in identifying, discussing with others, and reporting any situation in which the participants I support are at risk of abuse, neglect, exploitation, or harm.

3. Integrity and Responsibility
   I will be responsible and accountable for my decisions and actions which include being conscious of my personal values and how they influence my professional decisions. I will seek advice and guidance from others as needed when making decisions, and affirm to practice and model valued behaviors and responsible work habits by maintaining a high level of professional competency through learning and on-going communication with others.

4. Confidentiality
   I will seek information directly from the participant(s) I support regarding their wishes in how, when, and with whom privileged information should be shared while acknowledging confidentiality agreements with participants are subject to state and agency regulations/policies. I also recognize confidentiality agreements should be broken if there is imminent harm to others or to the participant I support. Where the correct course of action is not clear, I will seek out a qualified individual who can help me to clarify the situation and determine the best course of action.

5. Justice
   To assure the person's preferences and interests are honored, I will seek to understand the guardianship or other legal representation of the participant(s) I support and help the participant(s) to understand their rights and responsibilities in meaningful participation in decision-making. I will strive to ensure access to needed information, services, resources, and equality of opportunity for each individual I support.

6. Respect

   I respect the inherent dignity and worth of the person and treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. I model respect for the human dignity of the individuals I support in my interactions and provision of opportunities and supports in a manner that reflects the individual participant as an integral member of his or her community worth of respect from others.

7. Relationships
   I will assist the participant(s) I support in the development and maintenance of meaningful relationships and will proactively facilitate relationships between the participant(s), their family, and friends. I agree to separate my personal beliefs and expectations regarding relationships from

those desired by the participant(s) I support based on their personal preference and will assure the participant(s) have the opportunity to make informed choices in safely expressing their sexuality.

8. Self-determination
   I respect and promote the right of participants to self-determination and will assist the participant(s) in their efforts to identify and clarify their goals that will direct the course of their lives by honoring the individual participant's right to assume risk in an informed manner, recognizing each participant has the potential for lifelong learning and growth, and by working in partnership with others to support the participant(s) living self-directed lives.

9. Advocacy
   I will advocate for the participant(s) I support for justice, inclusion, and full community participation through avenues such as supporting participants to speak for themselves in all matters where my assistance is needed; promotion of human, legal, and civil rights of all individuals and assisting others to understand these rights; advocating for laws, policies, and supports that promote justice and inclusion for people with disabilities and other groups who have been disempowered; locating additional advocacy services when those that I provide are not sufficient; recognizing that those who victimize people with disabilities either criminally or civilly must be held accountable for their actions; and consulting with people I trust when I am unsure of the appropriate course of action in my advocacy efforts.

DSP Electronic Signature: _____

Date: _____

Health Support Competencies and Skills Form

Employee Name: _____ **Agency:** _____
Email Address: _____ **Phone Number:** _____

Competency Areas
(All must be completed)

Advocacy: *The Specialist is knowledgeable about the diverse challenges facing the participant (e.g., human rights, legal, administrative, and financial) and is able to identify and use effective advocacy strategies to overcome such challenges in the role as an advocate. The Specialist shall:*		
Three (3) of the skills must be demonstrated	**Example**	**Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?**
1. Knowledge and ability to serve as an educator and role model to members of the community.	John and I were at the local public library researching information about Civil War battles in our local region. John has a habit of straightening material that is left scattered about to make things appear orderly. A community member was very rude and made multiple remarks related to John and his presence in the library. I calmly approached John and redirected him to the computer section of the library away from the community member. Once he was settled, I returned and calmly approached the community member and informed her John is a member of the community, and as such, he has every right to access the resources available to all citizens. I also spoke to her about John's view that materials should be kept orderly so people can find things they need/want. The community member did not apologize to either John or me, but instead went to the librarian to complain about John. John and I continued our research without further incident and when he asked why the community member didn't like him I told him it was because she didn't know him and she wasn't used to guys straightening up other people's messes. I asked to speak to the librarian privately regarding the incident with the community member. Both the librarian and I agreed that John is a valued patron at the library, that his assistance in keeping materials orderly is greatly appreciated by the staff/volunteers, and the community member's attitude and behavior violated John's individual rights, especially his right to being treated with dignity and respect. As a result of this incident, the librarian asked if it would be appropriate for her to talk with John about how he might become more involved at the library so community members can become better informed and more accepting of individual's with I/DD, especially individuals who have visible health related disabilities. I will talk with John to see if he is interested so we can talk with his Person Centered Team about this possibility.	

Three (3) of the skills must be demonstrated	Example	Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?
2. Knowledge and ability to invest in planning effort utilizing long-term strategies that are likely to enhance inclusion for the participant, promote community integration, and identify opportunities for the participant to develop and maintain relationships.	John has a long-time interest in Civil War history. Working with John using library resources, we had identified battlefields within our region as well as local/regional groups who conduct re-enactments on a scheduled basis. John had made plans with the "Confederate Raiders" to be an active member of an upcoming re-enactment. However, he needed to do some strength building exercises to improve his endurance/stamina and mobility. I worked with his OT/PTs to develop an appropriate exercise routine that would continue after his discharge from individual therapy. We met and discussed with John what exercises would be best for him so he could actively participate in the "battles." I was present with John during his last 2 OT/PT therapy sessions to make sure I know how to assist John to continue strength building but also how to warm-up correctly on "battle day." John has taught other members of the "Raiders" how to fall down without hurting themselves and more importantly he leads the group on warm-up exercises before they leave the parking lot to take their places in the battlefield. John has continued to improve his strength, stamina and physical mobility. By working with his health care providers, I have been able to help him work toward reducing his dependence on 24/7 oxygen so he is able to actively participate in battle re-enactments without carrying portable oxygen and his natural supports are learning the signs/symptoms when John needs to rest and become rejuvenated with oxygen throughout the day. John has started expanding his world and participating in community events that are of importance to him and provide him opportunities to have friends beyond paid supports to talk to, have dinner/coffee with, and get together around something of interest to John. This has motivated John to lose weight, improve his mobility so he doesn't always have to use a wheelchair or walker, and reduce his need for supplemental oxygen for extended periods of time. Although John will likely always need access to oxygen, he is working toward not requiring it 24/7.	

Three (3) of the skills must be demonstrated	Example	Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?
3. Ability to minimize and prepare for common barriers to the development of natural supports.	John sometimes struggles with communicating verbally, so he carries his iPad with him to help others understand what he needs/wants. The Community Access Specialist supported John in learning new and different social skills that he would need when participating in the group activities/events. As a Health Support Specialist, I worked with John to use his iPad to help people understand what he was trying to say, especially when he needed assistance with mobility and accessing his portable oxygen tank and cannula. We practiced the new skills with some of my friends who were willing to help and who did not have experience in working with individuals with I/DD who require health supports. My friends did not always understand John and so he was able to improve how he communicates with new acquaintances. By teaching him and practicing with people who do not work in the field of I/DD, both John and I learned how to be better communicators. Now he is an active and contributing member of the "Confederate Raiders" and they have learned how to use his iPad to personally communicate with John. The Community Access Specialist and I collaborate to work on John's physical endurance levels, especially without oxygen for extended periods of time. The natural supports have become comfortable with taking John to group meetings and assisting him as he has progressed from the use of a wheelchair to the use of a walker. I facilitated getting training for them on the use of portable oxygen, how to transport John in the vehicle and how to appropriately assist him in getting from the car to the meeting room. They identified access barriers and worked to successfully alleviate those for John. John now attends group meetings with the support of his friends while paid supports are being faded; however, his friends have my contact information in case something happens and they are unsure of what to do or how to react.	

Three (3) of the skills must be demonstrated	Example	Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?
4. Ability to promote the participant's partnership in the design of support services and in the development of the person centered plan of care; consulting and involving the participant in the support process.	Katherine had never been an active part of her plan of care meetings. She was used to everyone making decisions for her; but she would often demonstrate her likes/dislikes after the plan of care was being implemented. Katherine requires specialized health support, particularly in the area of G-tube feedings and colostomy care. I began working with Katherine on what she liked from her POC and worked to gain her respect and trust. Once she decided that I wanted to assist her in doing things she liked in spite of requiring support in the area of feeding and ostomy care, we started talking about some of the things she didn't like and why. One of the things in her POC was going bowling. She didn't like going to the bowling alley because it was noisy, the floor was slick, and she didn't like to bowl. She always went because others had decided she should, but usually didn't bowl very well because she was scared she would fall and the noise was overwhelming. She talked about enjoying other things including fishing and volleyball, both tied to memories of childhood and adolescence. Katherine and I talked about how she should tell her Person-Centered Team what she liked/didn't like so we could spend time looking for ways to enjoy those activities even though she requires medical support in a couple of areas while working with the Community Access Specialist to make new friends. We practiced how to speak up in the POC meeting and how I would be with her if she wanted me there to assist her in addressing ways to take care of her medical needs. At the next POC meeting, with some prompting and cueing from me, Katherine started talking about her likes/dislikes and a different POC was written. Katherine was excited that she got to choose what she wanted to do and is starting to show interest in making other choices.	

Three (3) of the skills must be demonstrated	Example	Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?
5. Ability to accompany and assist as necessary the participant to speak on their own behalf, encourage the participant to take a lead role in all communication with community members (e.g., doctors, nurses, physician assistants, and therapists) and only provide support as necessary for accuracy and completeness, and provide information to the participant on peer support and self-advocacy groups.	John and his Community Access Specialist located a regional Civil War interest group who participates in regional/local re-enactments. I collaborated with the CA Specialist about the plans and John's interests in becoming involved in the re-enactments. John had been inactive and had lost ground in terms of his ability to ambulate without the use of a wheelchair or walker. John had also become dependent on supplemental oxygen since he had gained a significant amount of weight due to his lack of mobility. Because of his interests in becoming involved with Civil War re-enactments, I talked with John about scheduling a visit with his primary care physician to determine what he needed to do to help prepare physically for pursuing his dream. I scheduled the appointment and went with John to make sure I knew what the doctor's orders were, what was reasonable and possible, the timeframe to expect progress, and any special instructions that might be required. I encouraged John to talk with his doctor to express his plans. With prompting, he told the doctor what he wanted to do using his iPad. I supplemented information as necessary for purposes of clarification, but always made sure that is what John was trying to say. I kept re-directing the physician's questions to John to answer first. The doctor wrote specific orders for therapy and dietary restrictions that would enable John to make progress with weight loss and strength building. Because John is growing more comfortable meeting and talking with people from the community and is working to be less reliant upon the wheelchair and building his strength and stamina, he and I have been researching various ways that he can become a peer support to help his peers become more active and eat healthier. He is very interested in the Health Matters program where he can lead others in healthy eating and exercising. He wants to share how learning appropriate exercises, healthy eating, and strength building has helped him get involved in a group that shares his interest in Civil War and how he is learning to take better care of himself so he doesn't always need an oxygen tank with him 24/7 or a wheelchair to get around. The CA Specialist is also helping him explore self-advocacy groups and becoming involved with them. John, the CA Specialist, and I meet together to make sure we are all working toward the same goals but not duplicating efforts.	

Three (3) of the skills must be demonstrated	Example	Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?
6. Knowledge, understanding, and ability to provide information about human, legal, and civil rights and other resources; facilitate the participant's access to such information; and assist the participant to use information for self-advocacy and decision-making about living, work, and social relationships.	**Please refer to Skill Statement 1 for background information related to the incident.** John and I discussed on the way home from the library that some people are not always kind. I used this opportunity to talk with John about how to conduct himself in case I or another support person was not nearby to assist him if someone treated him in a disrespectful manner or he felt threatened or unsafe. For example, if he is at the library and someone treats him disrespectfully how to excuse himself and find the librarian or another library staff member/volunteer. We talked about his rights and how he could advocate for himself if his rights were being violated. This opened the conversation to talking about how to be friendly and what it means to be a friend. I also learned what being a friend means to John since each of us have a different perspective around the differences between acquaintances, casual friends, and intimate friendships. John continues to increase the type and number of decisions he makes about being involved in the community as well as the types of individuals he would like to have as friends. He has also hinted that he would like a girlfriend and wants to research an online dating service he saw advertised on television. I asked John to be sure to talk about the dating service idea at his upcoming Person Centered Team meeting so we can support him in making wise decisions.	

Crisis Prevention and Intervention: *The Specialist is knowledgeable about crisis prevention, intervention, and resolution techniques and demonstrates ability to match such techniques to particular circumstances and individuals. The Specialist shall demonstrate:*		
Four (4) of the skills must be demonstrated.	**Example**	**Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?**
1. Ability to support the participant in identifying and learning alternative coping skills and how to avoid or reduce triggers to crisis.	After gaining the trust and respect of Katherine, we began discussing what things upset her to the degree she becomes frustrated and begins escalating to a stage of crisis. We identified things such as places with a moderate to high level of noise (example: the bowling alley) or situations where she perceives individuals are arguing because there are loud voices. I explored various strategies that might be used to support Katherine during these escalating situations to prevent or decrease the crisis situation for her specifically. Because we are exploring new experiences for Katherine, she and I agreed on a signal system to let me know she was beginning to feel overwhelmed or frustrated so we could discretely find a quiet place for her to regain her composure or exit the situation/event altogether and return home. The signal we came up with was that she would come along beside me and place her hand on my forearm and squeeze. A light squeeze would mean "I'm starting to feel overwhelmed/frustrated". The squeeze would get harder if she was reaching a point where she wanted to verbally or physically express her frustration and anxiety. For example, Katherine wanted to attend church. So I got information about various churches, styles of worship, and worship times. We attended one church where the music was a band playing contemporary gospel. Katherine was seated next to me and using our pre-arranged signal, let me know that the music was too intense for her and that she needed to retreat. We discretely left the sanctuary and found a quiet room where she could still hear the music and the sermon, but not as loudly. Katherine and I talked about the situation on the way home; I reassured her that she did exactly what she was supposed to do by letting me know it was time to leave; and she decided that maybe she should try another place where there was a more traditional service based upon her memories from childhood. Prior to learning this signal system, Katherine would have typically escalated to a degree where she would have displayed verbal and physical aggression as a way to relieve her frustration/anxiety.	

Four (4) of the skills must be demonstrated.	Example	Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?
2. Knowledge, understanding and ability to assist and support community members and others in understanding crisis, behavior management, coping skills, and treatment planning related to the participant.	Katherine and I explored 3 different church settings until we found a church that had a traditional worship style and the congregation members were both friendly and accepting of Katherine. After attending 4 consecutive Sunday morning worship services, Katherine asked about attending Sunday School with women her age. Katherine and I met with the pastor and talked about the different opportunities. With prompting and cueing, Katherine asked the pastor her questions and he asked if she would like to meet the Sunday School teacher. Katherine and I arranged a meeting with the Sunday School teacher at the church. Katherine and I talked with the teacher about some of the things like loud noises and people speaking loudly as if arguing as being some of the things that upset her. We shared with the teacher our signal system so she would not be surprised or upset if we needed to leave for a time if Katherine became overwhelmed. We also talked about Katherine's health issues and how sometimes her colostomy has a strange odor in spite of her attempts at hygiene. We talked about how embarrassing this can be and how Katherine needs support in going to the ladies room. During this meeting we talked about the things that are important to Katherine and only shared information that she was comfortable in sharing at that point in time. After attending Sunday School for a month, the ladies had become very accepting of Katherine. They asked if they could learn the signal system and help Katherine themselves so I could attend Sunday School for my age group if I wanted to. Katherine and I taught them the signal system and Katherine used it to try them out while I was quietly sitting in another room listening and being "on call" to help. The ladies did well and asked questions afterwards about what they could do differently or better. Katherine is starting to trust her classmates more and more and wants other members to know the signal system. I am working with the teacher and the rest of the class members on learning the signal system, what are ways to help Katherine such as quietly talking to her; explaining what is happening; how to physically approach her when she is getting agitated that is non-threatening to Katherine; and if they are at lunch or dinner, how Katherine can be a part of the group. I am also working with 2 of the ladies on learning how to appropriately assist Katherine when she needs to go to the restroom; however this remains a sensitive topic for Katherine for now. The friendships that Katherine is developing have not reached a level where such personal care is a natural part of friendship.	

Four (4) of the skills must be demonstrated.	Example	Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?
3. Knowledge, understanding, and ability to recognize signs of a health or behavior crisis and implement appropriate supports or obtain help in a timely manner.	John does not always tell us that he is not feeling well or that he is suffering from headaches that have been attributed to side effects from medication and related to weather conditions. Through observation and data collection, I have become able to recognize some of John's behaviors that cue me he is suffering from one of these headaches and that he needs a change in the routine or schedule for the day. One of the behavioral cues that John is either starting or is in the midst of a headache is his withdrawn appearance and his constant search for a chair or couch with arms in a darkened area of the room where he can prop his head in his hand. He may be watching other people while sitting there, but he is not engaged in conversations or any activities and he demonstrates a loss of interest in communicating with others using his iPad. If he is at home goes to his room where he keeps the lights off, the curtains closed, and his music is turned down low. Another signal is his change in music – during these times I have noted that he listens to more calming music similar to that played during meditation, more of a new age sound. When I note these changes, I seek assistance from the agency's medical program director according to agency policies/procedures in getting John the appropriate pain medication prescribed by his physician. I work with other staff to change the daily schedule to accommodate John's health care needs. I also continue to collect data, primarily through observation of John's behavior, to determine if there is a pattern associated with his headaches and if so, explore with the Person Centered Team ways that we can better support John through these times so that he doesn't have to miss events/activities that are important to him.	

Four (4) of the skills must be demonstrated.	Example	Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?
4. Knowledge, understanding, and ability to teach and support the participant in learning and practicing healthy coping skills such as boundary setting, self-identifying, self-monitoring critical information, self-advocacy, stress management, emotional regulation, and frustration tolerance during participation in community events/activities.	Katherine is increasing her participation in church and her involvement with her Sunday School class members is increasing to the stage where at least 2 of the members are asking to take her to breakfast or lunch one Sunday a month without paid supports. These have been relatively short outings due to Katherine's personal care needs. Typically, staff help Katherine with her personal care needs before the small group leaves the church. One of the keys to going out to public restaurants is the noise level. I researched different approaches that I might be able to use to teach Katherine additional coping skills in the area of stress management related to her colostomy and fear of something embarrassing happening in public as well as her frustration tolerance. I located a website that provided information used in classrooms to teach students these skills and I contacted the local school district's special education director to see if there would be a teacher who would work with Katherine and me on learning some of these skills. The teacher she recommended and I share a mutual acquaintance and she agreed to help us learn stress management and frustration tolerance strategies so Katherine can expand her community participation. We are meeting with the teacher on a weekly basis to learn a new skill, practice it, and then try another one. Some days Katherine does really well and there are others where she reverts to previous behavior patterns. I have observed that on the days she reverts to previous behavior patterns she has been at Day Training all day with SJ, who is also a housemate. Since Katherine has only recently started (last 6-9 months) practicing self-advocacy skills; she does not always know how to deal with SJ. I mentioned this to the teacher and so we are exploring ways for Katherine to self-monitor her frustration level when she is around SJ and how to distance herself emotionally and physically from SJ in a somewhat limiting environment. I have also noted that on those days Katherine's demeanor changes once she and I get away from the residence and we begin practicing new skills on our way to different activities that Katherine has chosen to explore or become involved with. I will discuss my observations and noted patterns of behavior with Katherine and her Person Centered Team to explore changes in the Plan of Care and placing distance between Katherine and SJ so they are not together all of the time. That may mean that either Katherine or SJ will move to a different home or day program so that they are not together so often.	

Four (4) of the skills must be demonstrated.	Example	Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?
5. Knowledge and understanding of medications prescribed for the participant; the ability to identify and monitor interactions/side effects caused by medication; and the ability to provide the participant's Person-Centered Team and other DSPs examples of how physical and medical conditions (acute and chronic) and medication side effects can trigger or contribute to challenging behavior.	Nancy is a young lady with ID also deals with from depression and other medical conditions. This means that Nancy has a daily medication regiment that must be carefully monitored. It took months to find the right dosage levels, the right combinations, and the appropriate times of day for Nancy to take her medication. Throughout the trial and error period, I observed Nancy and her behavioral patterns, noted the changes as a result of medication, recorded what she ate as well drank. Nancy also smokes so this was also a factor in observing her reaction to medications. I accompanied Nancy to her medical appointments to discuss observed physical and behavioral reactions with the appropriate clinician, reviewed the medication list and dosage with him/her, and made sure that I understood any changes made in her medications. Nancy's pharmacy always puts informational inserts about all medications with each prescription, and I made sure that I reviewed this information for the typical side effects from each medication, if there were special instructions regarding how the medication should be taken (i.e., with/without food, with/without milk, etc.). I learned through observation and keeping detailed notes that Nancy's body processed certain medications faster than others; that some medications needed to be taken with food to prevent stomach upset; that certain medications worked better if they were taken at different times in the day and not all at once in the morning; and that some medications caused Nancy to be very lethargic and incapable of making informed choices or decisions. I also observed the behavioral changes when certain medications were taken early in the day versus later in the day. It was noted that when Nancy missed a dose of her anti-depressant, the effects were not seen in her behavior or demeanor until 2 days later when she fluctuated between crying for no known reason to throwing things at staff or other individuals when they touched her. This usually lasted for a period of 3-4 hours (sometimes less). I discussed my observations with her medical providers, and as adjustments were made in medications we found an acceptable routine that did not leave her virtually incapacitated. Throughout the process, I provided Nancy's Person-Centered Team with information about her individual reactions to medication; how different medications impacted her behavior and what to expect if a dose of certain medications were missed. I provided updated information to all DSPs who support Nancy to ensure they have the most accurate information. The changes in Nancy have been dramatic since we have finally found a balance. She makes more independent choices and she keeps saying how much better she feels.	

Four (4) of the skills must be demonstrated.	Example	Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?
6. Knowledge and understanding that an abrupt or serious change in emotions and behavior are potential signs of a behavioral or physical health problem and informs appropriate professionals in accordance with the participant's Person Centered Plan of Care.	Terrance is a very congenial older gentleman who is quiet, generally content, and easy going.. I had worked with Terrance for awhile; and because he was aging and starting to experience health related issues; I started to provide more health related supports. Terrance could not always tell me what was bothering him. He didn't generalize that when someone has a headache they take an aspirin or Tylenol for the pain, so he would just endure it. But as he aged, his pain tolerance became increasingly lower because too many things ached, hurt, or bothered him. I learned his behavioral cues that something was bothering him and began asking questions that allowed him to point to where he hurt to help determine what might be going on. I would always share this information with other staff so they could provide appropriate relief according to his Plan of Care. However, one morning when I went to get Terrance his whole demeanor had changed. He was not his usual congenial self. He was combative, visibly angry and refused to take his medication, and he was clearly in a crisis situation. I quickly reviewed what had happened the day and evening before to see if there was something that could explain this abrupt change in Terrance. Nothing seemed to stand out as being a trigger. Being very familiar with his medication, I checked the MARs to make sure he had received the right medication at the right time and at the right dosage and that nothing different had been introduced. Knowing that this was a very abrupt and serious change in Terrance, I began talking to him and trying to de-escalate the situation, but as I talked to him I observed his reactions and facial features. It was apparent he was in physical distress so I immediately called 911. Later we learned Terrance was having a stroke and couldn't tell us. I called our medical program director to report what was happening. She contacted Terrance's case manager since I was busy working with Terrance. Terrance was taken to our local Emergency Room and then transferred to a more appropriate facility. Terrance was having a stroke but had been unable to tell us what he was feeling. While Terrance was able to recover to some degree from this stroke, it became very apparent that additional training was needed by all staff supporting Terrance as well as his housemates. We were very fortunate this was not catastrophic and that we were able to get Terrance the necessary medical treatment quickly. Terrance returned home after a period of treatment and rehabilitation and some changes to his lifestyle have been required. Slowly he is returning to the old Terrance and getting back into a somewhat slower routine. He continues to attend his men's Bible Study group and his friends from church continue to pick him up and go to church, dinner, desert, etc. However, staff and friends have received training on stroke symptoms and Terrance's cues that something might be wrong.	

Facilitation of Services: *The Specialist is knowledgeable about a range of participatory planning techniques and is skilled in facilitating the development, review, documentation and maintenance of the participant's access and involvement in integrated community settings as defined in the participant's person centered Plan of Care. The Specialist shall demonstrate:*		
Two (2) of the skills must be demonstrated.	**Example**	**Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?**
1. Knowledge, understanding, and ability to implement the person centered Plan of Care, utilizing communication preferences and positive behavioral and instructional strategies and techniques appropriate for the participant in the development of friendships, relationships, and community building.	Stephanie was an avid reader of young adult novels. While she was an avid reader she primarily communicated non-verbally, often becoming frustrated when people did not understand what she was trying to tell them, and required one-on-one support staff due to seizure activity and significant difficulty walking place to place. As the Person Centered Team developed her Plan of Care, we explored ways to increase Stephanie's presence and participation in the community that somehow related to reading. I had been supporting Stephanie for almost 2 years, so I had an understanding of how she communicated, what her gestures meant, and what her limited vocalizations meant. I talked with Stephanie about joining a book club at the local library where a small group would read a book and discuss it on a weekly basis. I did this by explaining what a book club does, how she could participate, and how going to the library to hear what other people thought about a book could help her learn new things. Her body language indicated that she wanted to try this: smile (more like a big grin), nodding her head yes, and arm gestures that indicated she was getting excited about reading new things and meeting new people. As I talked with Stephanie about exploring the book club idea, I also talked to her about how she and I needed to become better communicators so other people could understand what we were trying to say. That meant we needed to learn how to use our body language better and work on pronouncing words better. When I would approach Stephanie with a "we" attitude, she was more willing to participate and learn because she believed she was helping me, and that I was not trying to fix her. Stephanie and I practiced communication skills with other direct support professionals as well as with members of my family who didn't know her very well. This helped to increase her tolerance level so she could be successful as a book club member. Stephanie was able to join the book club and with a little practice with Stephanie, the book club welcomed her.	

Two (2) of the skills must be demonstrated.	Example	Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?
2. Ability to discuss outcomes of interactions and events with the participant and members of the person centered Team to determine what, if any, changes may need to be made in the participant's person centered Plan of Care.	I continuously reviewed the POC and the forms that Stephanie's Case Manager suggested we use on developing friendships and relationships in the community to make sure I was on the right track with what the Team (including Stephanie) decided. Using my personal network of friends who are avid readers and the local librarian, I researched and located a book club that met weekly. Stephanie and I began attending the book club meetings when they started reading and discussing a new book. I quickly learned from observing and from talking with the club members that they enjoyed using iPads and audio books to help with their discussions. Stephanie and I talked about how it might be helpful to use an iPad or something similar to not only download and read her book but to also communicate with other people. I was able to borrow an iPad for a day and downloaded a book for Stephanie to explore. I was also able to show her how we could find different apps to help communicate with other people. Stephanie's eyes lit up and when she found a way to communicate using the iPad, I couldn't get her to quit "talking." I contacted her Case Manager and asked how we could get Stephanie an iPad as quickly as possible and explained the changes that this one day of using an iPad had made. It was like Stephanie had been waiting for me to catch on that she had a lot to say but couldn't make me understand. The CM worked with me and we obtained an iPad for Stephanie as quickly as possible. After we found Stephanie had a lot to communicate to us, the CM and I agreed the Team needed to meet and revisit her POC to make changes. Stephanie continues to learn new ways of communicating with her iPad and the Team has improved communication among Team members so we can better support her with new experiences and developing new relationships.	

Two (2) of the skills must be demonstrated.	Example	Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?
3. Ability to modify implementation of support interventions to ensure they are person-centered for the participant with special health care needs.	Teresa is a lady that experienced several traumatic events in childhood and as a young adult. As I reviewed her life history and the daily notes from other staff members in my agency, I realized that trust is not something that is easily earned. In fact, the daily notes seem to reflect that Teresa will intentionally do things that push people away. Because Teresa requires a wheelchair for mobility, decubitus formation is a special concern. She also is monitored for signs of constipation not only because of lack of exercise, but also because of medication side effects from chronic pain management. Keeping these things in mind, I began to develop a rapport with Teresa by finding some common interests. I tried several different topics and stumbled across the fact that she loves dogs. So I found a way to talk about my new puppy, Darcy, and would show her pictures of Darcy chewing on my new shoes, a stuffed animal, or whatever toy that Darcy chose for the day. That broke the ice with Teresa. After checking Teresa's medical records for pet allergies, I made arrangements for Darcy to come visit Teresa. From that day forward, she began to trust me helping her no matter how much it hurt. Darcy has scheduled visits with Teresa and since Darcy is small Teresa can hold her without difficulty. Making this connection helped me to gain Teresa's trust so I can treat her skin breakdown without Teresa getting combative, find new ways for her to move around so her weight is shifted while sitting in the wheelchair, and actually getting her to become more active in moving her upper extremities and improve circulation. If Teresa is not feeling well, she asks if Darcy can come a different day because she enjoys playing with Darcy. I have learned by looking back through the daily notes and by analyzing the behavioral patterns, that this is a good indication Teresa is getting constipated and I need to take appropriate action to alleviate her discomfort following the treatment plan outlined by her primary care physician. I also ask Teresa about what she is feeling and if there is something in particular that is hurting. She is learning to tell me what is hurting or bothering her and this has led to preventing decubitus from forming. Since I introduced Darcy into Teresa's routine we have observed and documented the following: Teresa is exercising her upper body while playing with Darcy and has improved her range of motion, her angry outbursts are decreasing, she is improving her communication with several staff members who are pet owners as they exchange stories, and she is slowly changing her diet to help with constipation. We have also noticed a marked difference in Teresa's attitude on days that Darcy visits. When Darcy spends the day with Teresa, she is calmer; has a purpose because she makes sure Darcy has food, water, treats, and a toy; has a beautiful smile that lights up the room; talks more which is improving her communication skills; and increases her exercise which is making a difference with chronic pain issues as well as with decubitus.	

Two (2) of the skills must be demonstrated.	Example	Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?
4. Ability to work with others to create effective, long-term supports in the use of natural supports and fades the necessity for health supports, as appropriate, during the participant's participation in community events.	Terrance had become a part of a Men's Group at a local church. The men had worked with Terrance's DSP's to learn the necessary supports and had faded the need for paid supports to accompany Terrance to their weekly meetings. Different members picked Terrance up at his house to go out to lunch/dinner or go do other activities in which the men were involved in. Terrance's needs changed after his stroke. Several of the men had been very instrumental in Terrence's recovery by visiting him throughout his time in the hospital and rehabilitation center. They even made sure that Terrance had Christmas while he was hospitalized. Upon returning to his home after recovery and rehabilitation Terrance's person centered Team met to determine how we could support him in returning to his Men's Group and what that would require given his new medical support needs. Terrance was anxious to get back into the group and he made sure the Team knew this is very important to him. In fact, we invited members of the men's group to attend the Team meeting to help us determine how this could be facilitated. They let us know he is a valued member of their group and 2 of the members attended the meeting so they could be part of the process. We developed the plan of care and it was determined that initially I would be on-site at the group meetings to assist him with his new medical needs until Terrance regains his strength to the greatest degree possible. We also agreed that our agency's RN Trainer would also train the group members on appropriate supports for Terrance that can be delegated to non-licensed supports and also on learning the signs/symptoms of a stroke since Terrance is an increased risk for a second stroke. It was also agreed that a male DSP will initially go with the guys to lunch/dinner where it will not be as noticeable that Terrance requires paid supports. The members of the men's group are continuing to learn along with the rest of Terrance's Person Centered Team how to support Terrance. We have developed a communication plan that keeps everyone informed and his friends have requested Team meetings on at least 2 occasions to discuss what they have learned, the questions they have, and ideas for supporting Terrance without paid supports always being present. The men want Terrance to be "one of the guys" and their circle of friendship is a tight-knit circle. They support one another in a variety of ways and they want Terrance to be a part of that because he is a key member in their support circle. We are working on a plan to fade paid supports to the greatest degree possible as we also help Terrance to recover and adjust to his new "normal." We are not done with the story…the best is yet to come.	

Supporting Health/Safety/Wellness: *The Specialist promotes the health, safety, and wellness of the participant through health maintenance and prevention strategies, accurate medication administration, knowledge of general and participant specific health and safety rules/plans, and first aid and emergency procedures. The Specialist shall demonstrate:*		
Two (2) of the skills must be demonstrated.	**Example**	**Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?**
1. Ability to assist the participant in the implementation of health and medical treatments (e.g., glucose blood testing, range of motion exercises, respiratory treatments) in a manner respectful and sensitive to individual needs and preferences and as trained by qualified professionals (e.g., nurse, occupational/physical therapist, respiratory therapist).	Although Terrance completed rehabilitation at a specialized facility, he continues to need to need to complete a routine of physical therapy exercises to improve his range of motion as well as rebuild his strength in the left side of his body. I received hands-on training from his Physical Therapist so Terrance can do exercises at home and at other times throughout the day. Terrance doesn't like to draw attention to himself and he doesn't like for others to know that he needs to do exercises to continue recovering from the stroke. Terrance tires easily so we have to chunk the exercises. I arrive at Terrance's house early 3 mornings each week to assist him in doing his morning exercises before the day begins. We have arranged for him to perform his exercises in his bedroom while his housemates are getting showered and dressed for the day so he doesn't have an audience. During the day, I have found that if we use a curriculum like Health Matters that Terrance can do his exercises while leading a small group in exercising. He enjoys leading the group and is not embarrassed about "exercising". Other times during the day I find ways to incorporate the physical therapy exercises in whatever activities we are involved with. For example: he needs to strengthen his neck muscles, so while we are riding in the car he does the neck stretches and muscle building exercises. If we are not out in the community on errands or going to lunch or meetings, Terrance and I find a room where we can go do the full routine of exercises as his strength and stamina allows. I also look for ways that I can include his range of motion exercises in general daily living activities so that not even Terrance knows that he is going PT exercises or I find ways to make it a challenge to Terrance and others so that Terrance is not singled out but there is a group of guys competing on who can do a particular activity better than the rest. Since Terrance is concerned about his public image, he is motivated to work toward walking with a cane and not a walker. He perceives walking with a cane as dignified, so in collaboration with his physical therapist, we continue to do exercise routines that will help him to achieve this goal. Terrance continues to make progress and grows stronger each week. He receives PT services 2x a week and now the PT is focusing on helping Terrance learn to walk appropriately with a cane for short periods of time until he gains the strength and balance necessary to fade away from the use of the walker. Terrance is excited about learning to walk with a cane and being a dignified gentleman. His friends from church are very encouraging and have planned a special dinner to celebrate his progress and sustain his positive attitude.	

Two (2) of the skills must be demonstrated.	Example	Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?
2. Ability to assist the participant to develop strategies that promotes health maintenance (e.g., special diets, exercise).	**Refer to Crisis Prevention & Intervention, Skill 5 for background information.** Nancy has a medication regimen, that after careful observation, documentation, and analysis of daily notes, indicated a need for her team to meet and develop a revised plan of care related to diet and exercise. Nancy and I discussed the different kinds of food that seem to upset her stomach as well as those that made her feel very sleepy an hour after eating prior to the meeting. At her Team meeting, we discussed many different ideas about improving how Nancy feels and how different foods contribute to different moods, feelings, and general well-being. The Team determined that it would be good for Nancy and I to meet with a trained nutritionist to develop a meal plan that complement the medication regimen but that also was pleasing to Nancy. We scheduled a meeting with a nutritionist. Nancy and I worked with the nutritionist to develop a meal plan that took into account many factors: medication, her smoking and urges for a cigarette at certain times related to food/drink/meals. Nancy is learning self-advocacy and so would speak up when something was being discussed that she did not like at all. At the end of the meeting, Nancy had a meal plan that had a combination of new things to try, foods that she truly enjoys but now in moderation, and foods that she is familiar with but will be cooked or prepared in a different manner. Nancy agreed to give the new meal plan a month before we meet with the nutritionist again to tweak the meals and possibly include new things and some familiar entrees. Once we got home, Nancy and I sat down and looked at the meal plans and she chose what she wanted to start with since we needed to go to the grocery store and pick up needed items. We also discussed how we could start doing exercises that might help her feel better. I mentioned the idea of giving up smoking but that is not something that she is ready to work on. Making healthier food choices and exercising is stretching the amount of change she is willing to make at the moment. Smoking cessation is something we will attempt at a later time when she has enjoyed success in changing her diet and exercising. Throughout this entire process I have made sure that Nancy has participated in the decision making. Her residential staff are learning how to help Nancy prepare her meals and supporting healthier choices when she is making dinner. This has been a growing experience for both the staff and Nancy. However, the most positive benefit is that Nancy is sticking to the new diet much better, the number of behavioral incidences are decreasing, and she is starting to tell her housemates that they need to eat better so they will feel better.	

Two (2) of the skills must be demonstrated.	Example	Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?
3. Ability to express concerns regarding the participant's health trends and provides updates regarding health and wellness treatment plans and outcomes to the participant's Person Centered Team.	I began supporting Nathan when he first arrived at our agency. Nathan had been in multiple placements before coming to us. I reviewed his life history to try and get a general idea of what had occurred in his life to this point. Unfortunately, I found gaps in the information that didn't explain or describe some of his medical needs. However, I did learn enough to infer that he had experienced more than one potentially traumatic event. Psychological trauma is experienced by each individual differently; his records seemed to indicate that he not only suffered physical trauma but that it was highly probable that he also experienced psychological trauma. For example physical abuse had been confirmed and he had suffered multiple broken bones over a period of time. Sexual abuse was alleged but there was no information related to the outcome of the allegations. So I made a request for information to fill in the gaps. In building rapport with Nathan, I approached the situation as if he had suffered both physical and sexual trauma. I wanted to make sure that Nathan felt safe in his new surroundings, that he felt valued, and that he quickly learned he would be treated with dignity and respect by those paid to support him. Nathan did not trust easily and it took time to build rapport and develop a trusting relationship. He erected barriers that made it difficult; but over a period of 3-6 months he slowly began to be accepting of his housemates and me. As for residential support staff that is a more difficult area because we experience a high rate of staff turnover. Nathan has difficulty with staff turnover and a review of daily notes indicates that when new staff who are tall and broad shouldered arrive, he begins having nightmares, an increase in agitation, and is likely to escalate into a crisis situation very rapidly. In addition to noting these behaviorally related incidents, I also observed a marked difference in his appetite, his reactions to receiving support with his personal hygiene, and an increase in seizure activity. For example, if a new staff person is tall and broad shouldered, within 3 days Nathan will have 1 or more seizures. After observing what was working and not working with supporting Nathan and after receiving additional life history information, I requested a Person Centered Team meeting to discuss my observations and concerns. Nathan has been with us for 9 months and we continually learn new things about him. However, based upon data and trending of his behavior and seizure activity, the team has determined that an assessment for PTSD is warranted. I am working with his CM to facilitate getting the assessment and hope that we are able to facilitate getting Nathan the necessary treatment plan to ease his anxiety and stress. I don't know what the outcome will be. We still have several options to explore and Nathan is still learning to trust his Team and all those who support him on a daily basis.	

Assessment: *The Specialist is knowledgeable about formal and informal assessment practices in order to respond to the needs, desires, and interests of the participant. The Specialist shall demonstrate:*		
Two (2) of the skills must be demonstrated.	**Example**	**Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?**
1. Knowledge and understanding of various assessment types and processes used to discover preferences, capabilities, and needs of the participant and the use of assessment information in the development and review of the individual's person centered Plan of Care.	Nathan, who is 25, has only been with our agency for 9 months. There is much we continue to learn about Nathan. He has a diagnosis of Autism; however, as I discussed earlier, he demonstrates signs of PTSD which might be attributed to experiences of physical and/or sexual abuse prior to being placed within our agency. Nathan does not communicate with us verbally; however, his life history contains information that at one time he communicated verbally with family members, peers, and a paraeducator who supported him during his middle and high school years. Nathan's Case Manager provided us with several worksheets to help us think through, gather, and record information surrounding Nathan's preferences and capabilities. We also have the results from Nathan's SIS and HRST assessments from which to glean information as we continue to explore best practice person centered approaches to supporting Nathan. I have located additional person centered tools to assist with discovering Nathan's preferences, capabilities, and needs that are not related to his physical well-being but are more intrinsic and results in Nathan finding meaning in life. I have taken bits and pieces from all the worksheets and planning tools to come up with a profile focused on Nathan. I chose different pieces from the variety of resources as a way for me to understand Nathan and collect data that will be meaningful in reviewing and revising Nathan's Plan of Care. Using the different styles I found from O'Brien & O'Brien; B. Mount; M. Smull; A. Amado; and others I developed a tool that allowed me to collect specific information related to Nathan. I have learned that if I only use one way of data collection, I miss a lot of valuable information because I get tunnel vision. Whereas by being familiar with multiple ways to gather information, I can better consider what Nathan tells me with his behavior, and otherwise think outside the box because I don't feel confined to one single way of doing person centered thinking. This has allowed me to present information at Nathan's previous team meetings to amend his Plan of Care, review what's working/not working, and determine if additional psychological or medical assessments need to be considered. In addition to seeking an assessment to determine if Nathan is suffering from PTSD, we are also reviewing the data related to his seizure activity and whether a medical appointment is warranted. I continually look for tools and approaches to help me think outside the box when supporting individuals who may not be comfortable or able to verbally express their preferences. This in turn helps me be a better advocate for the individual if he/she has not learned the skill of self-advocacy.	

Two (2) of the skills must be demonstrated.	Example	Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?
2. Ability to accurately relay information regarding the individual in areas such as characteristics, behavior, areas of vulnerability, medical history and onset of new health-related issues (symptoms), and levels of supervision required for activities of daily living.	*Charles is a middle-aged gentleman I supported for a period of 18 months. When I first met Charles I thought he was very shy, especially in going to new places. I also noticed that he was starting to need additional help with ADLs that he had been very independent in accomplishing. I also noticed that he would either get closer to the TV or not watch TV at all, which was uncharacteristic. I talked with all the DSPs who support Charles and we discussed the differences we were beginning to notice in Charles. Because of his age, I talked with our medical program director and Charles' case manager about my concerns. We reviewed his medical history and determined that Charles should get an eye exam. We scheduled an appointment and I accompanied Charles to the appointment. It was determined that Charles was suffering from cataracts and needed to have outpatient surgery to correct his vision. Once he had the cataracts removed and had recovered, I began to see a different Charles. He really wasn't shy. Instead he had been afraid because he couldn't see things clearly. Now Charles is involved in different community related activities, enjoys going to a variety of restaurants, and loves to tell stories about his childhood when talking with local farmers. Since he is able to see clearly, Charles is experiencing a new life. His level of supervision for ADLs is continuing to decline, his behavior and attitude is much different, he is more excited about each day and seeing things that he has missed. The DSPs and I continue to monitor Charles' areas of vulnerability, especially now that he is more involved in the community. The CA Specialist continues to work with Charles on developing new skills while being in the community and is also working to find local farms that have potential for Charles to become engaged with the farming community. I still monitor Charles' health concerns; however, with the increase in activity and the reduced fear of being out in the community, his health is also improving. I am continuing to work with his physician on reducing medications such as those for anxiety and high blood pressure. As we begin the fading of these medications, I ensure that all appropriate support staff are updated, and I also communicate any changes with his CM as well as with our medical program director. We are experiencing a new Charles and love what we are learning about him.*	

Two (2) of the skills must be demonstrated.	Example	Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?
3. Ability to utilize knowledge of characteristics of specific disabilities, diseases, or health conditions and how they affect the life of the individual during formal and informal assessment practices.	*Naomi is a 30-year old lady who has multiple disabilities that has impacted her physical health significantly. Her primary diagnosis is Down's Syndrome which puts her at an increased risk of dementia at an earlier age. This was not something that anyone ever considered when doing assessments, either formal or informal, to determine Naomi's plan of care. After conducting research related to the increased risk of dementia for individuals with Downs Syndrome and the signs/symptoms of early onset of dementia, I began to be more observant of Naomi, especially when we had medical appointments. As I observed Naomi in her natural environment, I began to note small, yet incremental changes in her cognitive abilities as well as changes in her behavior. During one of Naomi's routine medical appointment, I discussed these changes with her primary care physician privately. Because Naomi is somewhat of a people-pleaser, it is sometimes difficult to distinguish between a true response and what she thinks you want to hear. I had worked with Naomi long enough to determine when she was telling me something she thought I wanted to hear because her body language and behavior did not necessarily match the response. Knowing these things about Naomi, I consulted with our medical program director to discuss the best approach to collaborating with Naomi's primary care physician to determine if she is suffering from early onset of dementia. We didn't want to alert Naomi that we were concerned something was wrong as that would only perpetuate her behavior of telling us what she thought we wanted to hear. At a scheduled medical appointment, her physician began asking Naomi questions that she would typically be able to respond without assistance. When she couldn't answer, she would look at me to either answer for her or provide her prompts for the right answer. I provided few responses and few prompts so the doctor could accurately assess and diagnose. After a series of formal assessments and diagnostic tests, it has been determined that Naomi is in the early stages of dementia. We continue to research ways to support Naomi and keep her as mentally and physically active as possible. Her multiple disabilities present challenges in keeping her physically active; however, we find multiple ways to keep her engaged in mental tasks that don't overwhelm or frustrate her. She continues to be involved in a women's group that meets regularly to work on crafts and quilts. They have noticed changes in Naomi's interactions with them and have inquired about how they can help her in ways that friends help one another. They continue to be patient and try to find humor in situations in ways that are not demeaning or disrespectful.*	

Two (2) of the skills must be demonstrated.	Example	Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?
4. Ability to recognize and respond to signs of changes in the individual's health or behavioral status and share critical information gained from daily observations and informal assessment with appropriate professionals in an effective and timely manner.	*I supported Karen for about 18 months. It took a little bit of time to build a trusting relationship with Karen. She wanted to make sure I wasn't just going to be there today and gone tomorrow. You could say she put me through the paces Karen-style. Karen had a great love for chocolate, Pepsi, and Rice-Krispy treats. She also loved macaroni-and-cheese and loaded baked potatoes. You could always count on those items being ordered anytime we went to a restaurant where they were offered. When I began supporting Karen, I had noted that Karen was border-line obese. While she had not been diagnosed with Type II diabetes, there was the potential given her love for sweets, things with lots of carbs, and minimal exercise. Over the course of 12 months, I began noticing changes in both Karen's behavior and her eating patterns. Her craving for sweets was increasing, her tolerance of not getting what she wanted/when she wanted was becoming increasingly shorter in duration, her need for something to drink all the time was increasing, and she was easily agitated. I reviewed daily notes from other staff members and began keeping closer track of her food/drink intake. As changes in Karen's behavior escalated, I requested an appointment be made with her primary care physician to determine if Karen had developed Type II diabetes. At the appointment, Karen told the doctor what she loved to eat and drink and I shared with him my observations and concerns to supplement what she had told him. After a series of tests, it was determined that Karen had developed Type II diabetes and was placed on oral medication as the first step to help control her sugar levels. All staff who support Karen have received training on her particular needs and signs/symptoms they need to be observant for that indicates Karen's glucose levels need to be checked. We have also developed plans of action and methods of communicating critical information as we work with Karen's physician on the best treatment regimen for Karen. We also are working to interest Karen in our Health Matters program so that she can learn to make healthier choices about food and exercise.*	

Documentation: *The Specialist is knowledgeable of regulatory and agency documentation requirements and is able to manage these requirements in a thorough and efficient manner. The Specialist shall demonstrate:*		
Two (2) of the skills must be demonstrated.	**Example**	**Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?**
1. Ability to document and communicate information regarding the participant's involvement in community events/activities and the impact upon the participant's health status in a professional and culturally sensitive manner.	*Terrance experienced a short-term debilitating stroke that required time for recovery and rehabilitation. Throughout his recovery period I documented and communicated information regarding his health status to his Person Centered Team as well as his attending physician and therapists. I documented short trips into the community, how these impacted his physical health, and just as importantly how they impacted his mental and emotional health. Terrance has a strong faith and I made sure to include information about his friends from church and their impact upon his physical, emotional, and mental health. Terrance is very proud of his recovery from such a scary experience and he always tells his friends in the men's group how much he appreciates all they do to help him get better and stronger.*	

Two (2) of the skills must be demonstrated.	Example	Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?
2. Ability to observe, record, and monitor a participant's behavioral patterns related to medication management and observe behavioral patterns which may indicate a sign of change in the participant's behavioral or physical health status.	I maintain daily notes with all the people I support. I include conversations with the person, any observations I have made, and I always discuss the steps we are working on so it is clear how we got from point A to point B especially when there are changes in medication. At the end of the month, I review these daily notes and then I look at the previous month or 2. I look to see where progress has been made, and include that progress in the monthly summary. For Nancy in particular, I always start the monthly summary with the positive things that have happened and I make sure to document how she has made progress in reducing behaviors. By reducing the negative things, Nancy is able to get out more often and explore her community. I also include any issues and concerns but I think it is only fair to document the positive in addition to any issues.	

Two (2) of the skills must be demonstrated.	Example	Tell us your story. Who did you support? What did you do? How did you do it? How is the individual's life different because of your support?
3. Ability to recognize and document critical information to share with others and maintain complete, objective, and accurate information regarding medically related signs and symptoms and related behaviors to share with others.	Since I began working with Nathan I have always strived to document and pass on any behavior issues he may have so that his team can keep up to date on his progress. Information regarding his behavior has always been a critical component to his supports, particularly since we suspect he is suffering PTSD. What I have also learned is that the positive aspects of his behavior are also critical information that needs to be captured and shared. I documented and communicated to his team information about his desire to have more control over his snacks and wanting to sleep-in a couple days a week. Since then, other members of Nathan's team have tried new approaches and we are seeing fewer negative issues. We have noted that Nathan seems very anxious and fearful of men who are tall and broad shouldered, and have taken that into account when hiring staff for his home. His person centered plan of care has since been updated to include new approaches that are important to Nathan.	