Supports Intensity Scale (SIS) & Support Budget Planning

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Objectives

Today's Session

Sharing information about the SIS and Supports Budget Planning

What We Believe

One question to ask…

Why are we doing this?

Truly Person-Centred System
Better outcomes
Self determination
Community and Relationships
System Transparency, Fairness & Equity
Opportunities & Pathways to employment

building on abilities

What is it?

- ***building on abilities (BOA)*** is a project within Community Living disABILITY Services (CLDS) that aims to transform supports for people with intellectual disabilities based on needs.
- CLDS along with partners in the community including self-advocates, families and agencies strive to develop a service delivery system and make decisions about supports and services that are fair, equitable and consistent
- Change is necessary to make certain people receive the support they need in order to:
  - Lead satisfying lives, connected to their communities.
  - Make decisions, directing their own lives.
  - Stay connected with family and friends and other important relationships.
- Aim is to build on the mission CLDS to support people with intellectual disabilities to live in the community and to enhance their quality of life.
- To help us better achieve this goal, CLDS is using the Supports Intensity Scale (SIS) to assess individual support needs. The SIS is a standardized assessment tool designed to measure the level of support a person needs to participate in everyday life.

building on abilities

What is it?

- CLDS intends to continue building a person-centred system that is sustainable for future generations of Manitobans with intellectual disabilities.
- BOA aims to make certain people with intellectual disabilities:
  - Get the right amount of services based on their assessed needs.
  - Are aware of their own personal “supports budget” that they have available to access services.
  - Have flexibility to choose which services they want.
  - Plan for the range of supports that they may receive, and then receive those supports.

Assessing Needs

Supports Intensity Scale is an assessment developed by AAIDD

SIS
Supports Intensity Scale

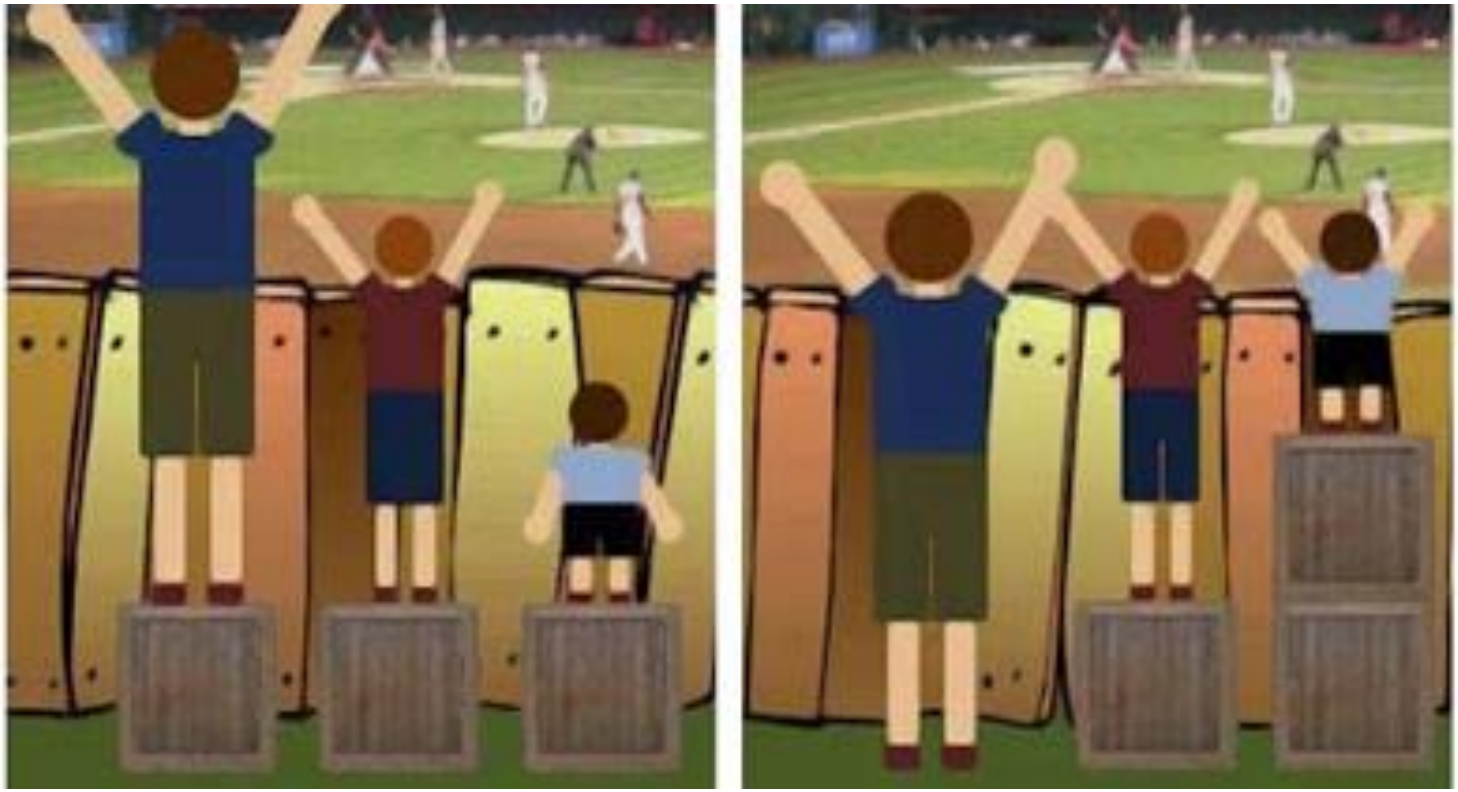
aaidd
American Association on Intellectual and Developmental Disabilities

AAIDD is a leader in the field of intellectual and developmental disabilities.

The organization is tireless in the promotion of progressive policies, sound research, effective practices and universal human rights for people with intellectual and developmental disabilities.

Assessing Needs

Supports needed to be successful



Assessing Needs

History and Development of the SIS approach by AAIDD

- The SIS is a valid and reliable assessment tool, specifically designed to measure the type, frequency and intensity of support an individual needs to participate in community life.
- The SIS was developed over a five-year period by a team of experts from the AAIDD. This team included self-advocates, family members and professionals in the field of developmental disabilities.
- The SIS measures support needs that an individuals needs to be successful in the areas of home living, community living, lifelong learning, employment, health, and safety and social activities. It also looks at how an individual protects and advocates for themselves, and extra support needed to deal with exceptional medical and behavioral needs.

Assessing Needs

What We do with SIS – Many Uses for Participants Benefits

- It can be used in combination with other assessment tools as determined necessary.
- It can help to identify areas on which to concentrate:
  - Developing a transition plan in school.
  - Help agencies when developing program proposals.
  - Communicate support needs within CLDS and within agencies (changing staff).
  - Identify goals and support needs prior to a planning meeting.
  - Inform Resource Coordinators about support needs.
  - Help individuals make plans to live independently.
  - Provide information for SDM hearing.
  - Inform a Personal Supports Budget based on the support needs of the individual.

Assessing Needs

What SIS is not

- SIS is not a:
  - Test – a participant is not asked if they can or can't do things, no demonstration of skill or competencies during the assessment.
  - Diagnostic evaluation or psychological evaluation.
  - Planning meeting, but a collection of information to inform planning.
- SIS does not:
  - Provide a diagnosis or determination of CLDS program eligibility.
  - Tell us what to do – it helps inform decision making.
- There is no right or wrong answer – answers are based on discussion and agreed upon by consensus.

Preparing for SIS

- SIS is completed after eligibility is determined or as support needs have changed. Have a conversation with program participants and their families about getting ready for the SIS interview.
- The assessment is around 90 questions and can take a few hours.
- It can possibly be an emotional experience, help by coming with a supportive and positive attitude!
- SIS Facilitators can be flexible and can make accommodations to support an individual's support needs during the assessment. This may mean location, seeing the questions ahead of time, or taking frequent breaks.
- The program participant does not need to be present for the assessment but needs to be met by the Facilitator.

Preparing for SIS

- Please inform the SIS Facilitator of any sensitive subject areas and consult with them about how they should be managed.
- Have the program participant and families think about what is important to and for the individual so that it can be considered during the assessment.
- A SIS can be completed after or prior to a person centred plan, these plans can be facilitated privately, by an agency or whomever the individual prefers. Use the PCP and SIS together.
- The program participant should consider who they would like present at the assessment (we require at least 2 respondents and suggest no more than 5).
- A SIS assessment can be updated as support needs change.

Identifying Support Needs

Training is required for CLDS to administer the tool

- In order to ensure the integrity of the tool, inter-rater reliability and overall consistency, AAIDD requires that individuals administering the tool are fully trained by certified SIS trainers.
- To date, 10 CLDS staff have received SIS training and have been certified to conduct SIS assessments.
- SIS Facilitators are observed conducting assessments by a provincial SIS trainer on an ongoing basis to ensure consistency and accuracy of the tool as well to ensure the principles of the assessment are followed.
- If there is a need to update information as support needs, contact the SIS Program Manager through your CSW or Area Supervisor.

What if the SIS doesn't seem right?

- It is quite possible that the SIS information is old and that support needs have changed.
- Sometimes people are hesitant about sharing information during the assessment when the participant is there – this is why it is important to identify sensitive topic areas, to ensure all relevant information is collected.
- In some cases, very rarely, the SIS is not able to capture the true intensity of an individual's support needs. Sometimes this might be due to other family issues, some rare support needs, or mandated services. In these cases, a CSW can work with their supervisor to request an exceptions review or additional funding.

Assessing Needs

Person-Centred Planning and SIS

- The SIS was created to support **Person-Centred Planning.** Person-Centred Planning is a planning method that is designed to focus on the life vision and preferences of the individual. Emphasis is placed upon the individual directing their own service planning.

Assessing Needs

Person-Centred Planning and SIS

- The individual's planning team can use the SIS to inform decisions about the types and intensities of supports needed in various settings.
- SIS can be used to prioritize preferences and identify supports needed.
- This information can be transferred to the person-centred planning process as objectives.
- The individual and team can monitor the extent to which the desired life experiences and goals are being realized.

Assessing Needs

Person-Centred Planning and SIS

- SIS shifts thinking from “fixing” the individual to identifying and developing supports that enable the person to participate in his/her community.
- SIS ensures that important facets of a persons’ life are not being overlooked.
- SIS can help identify changes in support needs over time or identify barriers to success.
- Help to identify possible challenges before they happen.

Assessing Needs

Person-Centred Planning

From SIS to a Person Centred Plan

Important "For" (This can include items that are required for the Person to remain safe and healthy that were discussed during SIS assessment. Think of any information or support needs that are essential for positive life experiences to occur on a consistent basis; e.g. physical supports to eat meals, having someone help the Person navigate their Community or having a behaviour management plan.)

1. **To have assistance in preparing meals and some support (e.g. have larger food portions "cut-up") with eating safely.**
2. **Having someone to provide support with making purchases in the community (e.g. to exchange payment at the movies and banking).**
3. **To know what is happening during the day as it feels better to know what to expect (e.g. to have a visual schedule and routine).**

- These items were identified as important "For" the individual because they were recognized by the support team members and had emerged from the SIS as significant support needs.
- These items can also be used for any other "Supports Needs" section of another planning process.
- These items can be listed as "Goals" for skill development if desired, to achieve a greater level of independence.

Assessing Needs
Person-Centred Planning

Important "To" (This can include items or other individuals/groups that the Person values to have positive life experiences. Think of the elements or relationships in life that help the Person feel satisfied, content, fulfilled and happy ; e.g. desires to go to the bank independently, personality traits they value in people that surround/support them or having a consistent routine.)

1. **To make sure activities happen in the same order everyday (e.g. Routine).**
2. **To feel really comfortable and trusting in all people that provide support (e.g. take the time to get to know me before helping in the home).**
3. **To have the opportunity to go to Garage's Sales in the summertime with family.**

- These items were identified what is important "To" the individual as they were recognized by the person and referenced in the SIS interview.
- At times, important "To" can reference an individuals preference in support needs (e.g. routine), but can also highlight desired interests, hobbies or relationships.

Assessment Needs
Person-Centred Planning

What could be improved (Identify areas of the Person's life where positive experiences are not occurring on a consistent basis; e.g. Person feels that they are not a part of their community, not satisfied with work placement or current support services).

1. **Don't have many opportunities to get out and be active. The SIS confirmed that direct support is needed to engage in community activities and leisure.**
2. **Be more independent with meal preparation and making more enjoyable meals (variety).**
3. **Would like to have a girlfriend and more friends.**

- These items were identified as "What could be improved" because they were identified by the program participant during the person-centred planning session and referenced within the SIS interview.
- This may be an area to identify "support gaps" or opportunities to promote more independence, skill building, and self directed life.

Assessing Needs
Person-Centred Planning

- Here are some examples of an individual goal within Person-Centred Planning and how it can be supported by others in the person's life.

Daily Support Goals (Person can advise of any goals they have in the area of their day-to-day life with regards to their support; e.g. Person would like to receive additional support to feel healthy, or to increase their participation in community and leisure activities. You may be able to refer to "What can be improved" question). Make sure to include who is responsible for assisting the individual with the goal and expected timeframe for achieving the goal.

GOAL	STEPS	WHO	WHEN
Go out more outings in the community that involve exercise.	Evaluate the daily schedule to think of good times to go out.	Individual with help from Support Staff	1 week
	"Brainstorm" a list of things that are interesting to do and places to go (might need a gym membership).	Individual with help from Support Staff.	1 week
	Begin a routine where I know that I will be doing exercise in the community 3 times per week.	Individual and Support Staff	2 weeks

Assessing Needs
Person-Centred Planning

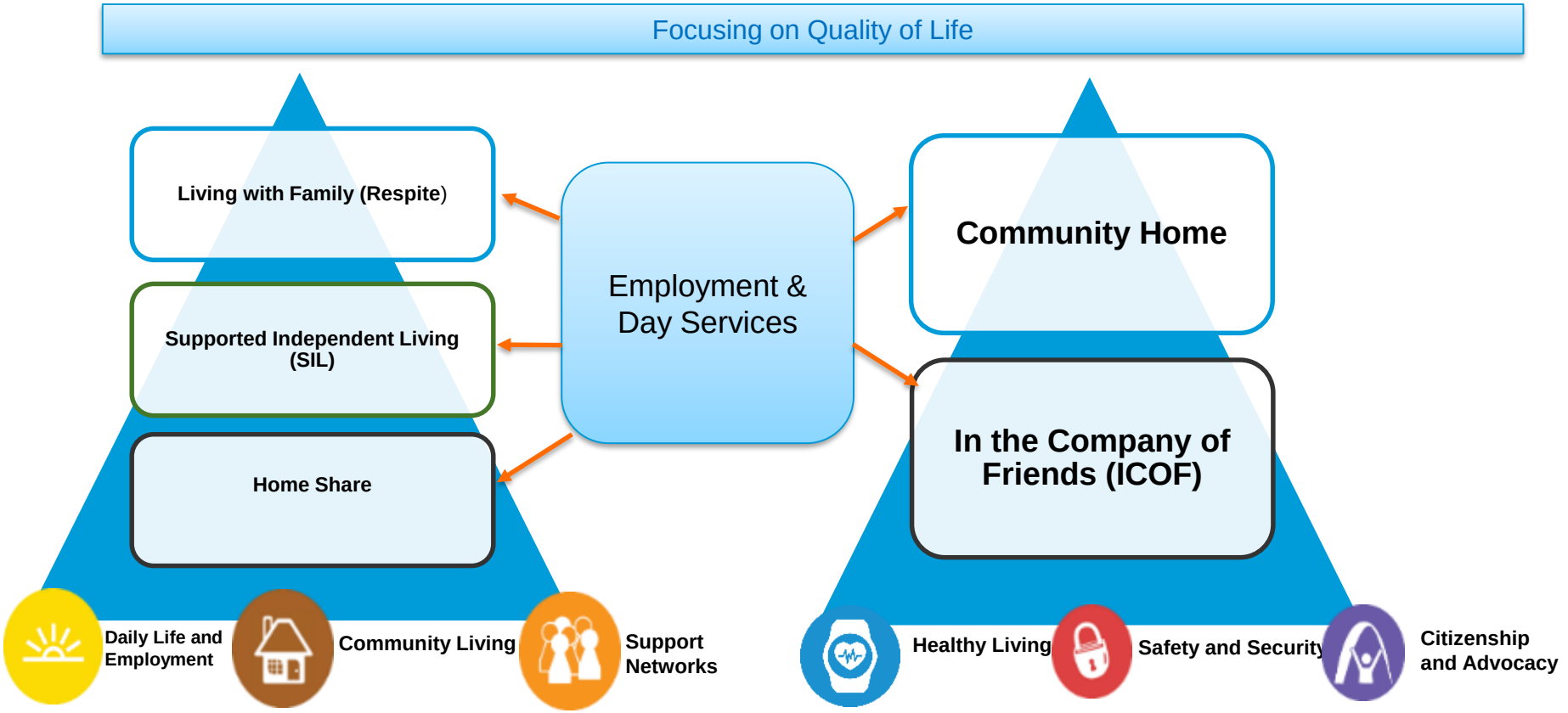
- Here are some examples of an individual goal within Person-Centred Planning and how it can be supported by someone in the person's life.

Learning and Skill Building Goals (Person identifies areas where they would like to develop additional skills to have more positive experiences in their life/Community; e.g. develop independent living skills, enroll in a employment training course, or learning how to budget.) Make sure to include who is responsible for assisting the individual with the goal and expected timeframe for achieving the goal.

GOAL	STEPS	WHO	WHEN
To become more independent in preparing meals.	Talk about meals I enjoy and would like to make on my own.	Individual will talk to Respite Support and Family.	This week
	Get recipes and watch videos online of meals being made.	Individual will get support to finding videos.	Next week
	Practice making favorite meal at least once per week.	Individual and Support Network will supervise.	Next month

Determining Supports

Quality of Life Outcomes



General Approach

The **Supports Intensity Scale (SIS)** is used to assist with establishing individualized budgets. This also provides a way for policy makers to make fiscal choices that are **fair & predictable**, but also makes the **best use** of available money that's consistent with driving system **principles**.

Allocating resources to people based on their assessed level of need. Each person receives **what they need**.

Establishing a **best fit** solution for most but taking care to accommodate individuals with extraordinary needs.

Determining Supports

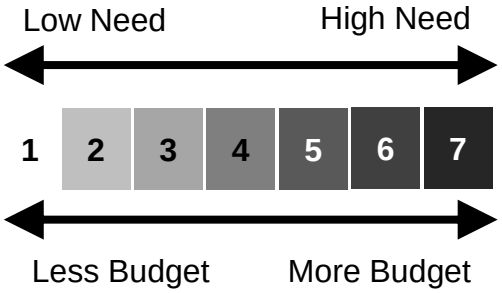
Benefits of a Supports Budget Planning for Service

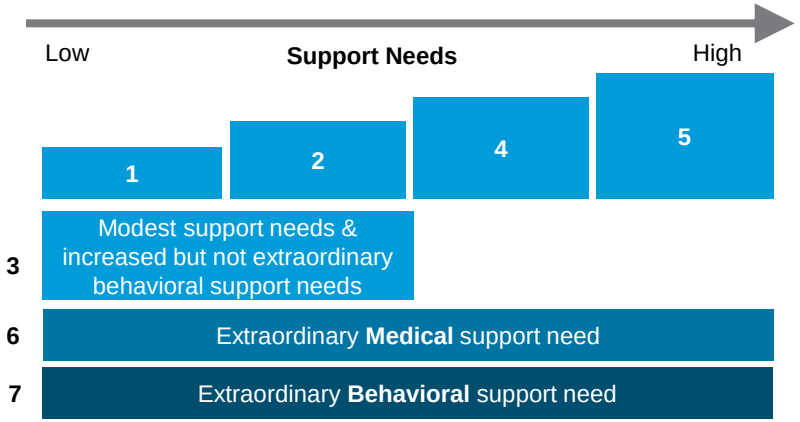
- Transparency.
- Equity.
- Consistency.
- Supports Budget Level in one region is the same as in another.
- Improved outcomes – individuals will be receiving the right level of support at the right times in their life.
- Ongoing review (every three years or as needs change).
- Verification process for exceptional needs.
- Exceptions review process.

Determining Supports

The SIS and Supports Budget Planning for Services

- All individuals receiving CLDS services have/will participate in a SIS interview. One purpose of participating in a SIS assessment is to allow an individual to be given a support budget level.





- Support Budget Levels are used later to determine the support budget amount that an individual will receive. The SIS is a measure of general support needs and includes medical and behavioral sections.
- To obtain additional information regarding support needs, CLDS has adopted the use of Supplemental Questions (SQs) in addition to the SIS assessment.
- When the SIS is administered, certain responses require that Supplemental Questions be asked. Responses help to clarify supports which are needed to ensure the safety and wellbeing of an individual with extraordinary medical or behavioral support needs.
- A Verification process has been developed to confirm whether an individual has exceptional medical and behavioral support levels.

Determining Supports

Supports Budget Levels

- The SIS allows for scale scores to be calculated related to various sections. The table shows the criteria used to offer Support Budget Levels to individuals to one of seven categories with the following information.

Support Budget Level Criteria				
Support Budget Levels		**Sum ABE**	**3A (Medical)**	**3B (Behavioral)**
1	**Least Support Needs**	**0 to 22**	**0 to 6**	**0 to 6**
2	**Mild or Moderate Support Needs**	**23 or 30**	**0 to 6**	**0 to 6**
3	**Mild to Moderate Support Needs & Moderate Behavioral Challenges**	**0 to 30**	**0 to 6**	**7 to 10**
4	**Moderate Support Needs & Mild to Moderate Behavioral Challenges**	**31 to 36**	**0 to 6**	**0 to 10**
5	**High Support Needs & Mild to Above Average Behavioral Challenges**	**37 to 52**	**0 to 6**	**0 to 10**
6	**Extraordinary Medical Challenges**	**Any**	**7 to 32** or **Verified** Extraordinary medical risk	**0 to 10**
7	**Extraordinary Behavioral Challenges**	**Any**	**Any**	**11 to 26** or **Verified** Danger to others **or** Extreme self-injury risk

Determining Supports

How are Support Budget Levels calculated?

- Using the SIS, the sum of the standard, not “raw,” scale scores in Parts A, B, and E in Section 1. These include scales on Home Living Activities, Community Living Activities and Health and Safety Activities.
- Scale scores associated with Exceptional Medical and Behavioral Needs Section Part A on Medical Needs (scored 0-32) and Part B on Behavioral Needs (scored 0-26).
- Responses to Supplemental Questions and verification determinations described above are used to assign individuals to Level 6 or 7.

Determining Supports
Supplemental Questions & Verification

CLDS Verification Criteria		
Topic	SIS Items	SQ Items
Medical Risk	2 on any items in 3A	Yes to 1, 1A, and 1C
Community Risk—Non-Convicted	2 on questions 1,2, or 7 in 3B	Yes to 2, 2A, 2B, and 2C
Community Risk—Convicted	2 on questions 1,2, or 7 in 3B	Yes to 3, 3A, 3B, and 3C
Self-Injury Risk	2 on questions 4,5, or 6 in 3B	Yes to 4, 4A, 4B, and 4C

What it means?

During the SIS interview, the SIS Facilitator asks a short series of additional Supplemental Questions. These questions, focus on information particular to medical and/or behavioral support needs. These SQs cover four topics:

- ❑ Severe medical risk;
- ❑ Severe community safety risk (Convicted);
- ❑ Severe community safety risk (Non Convicted);
- ❑ Severe risk of injury to self.

Verification is a case record review conducted to identify individuals with exceptional medical or behavioral support needs who did not automatically meet criteria through their responses to the SIS Exceptional Medical and Behavioral Support Needs section alone.

Determining Supports

Supplemental Questions - Severe Medical Risk & Severe Community Risk

SEVERE MEDICAL RISK

1. The Individual requires exceptionally high levels of staff support to address severe medical risks related to inhalation or oxygen therapy; postural drainage; chest PT, suctioning; oral stimulation and/or jaw positioning; tube feeding; parenteral feeding; skin care turning or positioning; skin care dressing of open wounds; protection from infectious diseases due to immune system impairment; seizure management; dialysis; ostomy care; medically-related lifting and/or transferring; therapy services, and/or other critical medical supports? To answer "yes" requires at least one 2 rating in Section 1A.

( ) Yes ( ) No

a. **The Individual requires frequent hands-on staff involvement to address critical health and medical needs?** yes/no

(The Individual requires frequent and lengthy hands-on staff involvement to address critical health and medical needs. This means that medically-related treatments; transfers, lifts, and positioning; and/or direct monitoring routinely requires extensive 1:1 and/or2:1 staff support to perform and complete. Examples include lengthy periods of wound care, complicated manual/mechanical transfers, the need for frequent 2-person repositioning at night, and administering other critical medical treatments).

b. **The Individual's severe medical risk currently requires direct 24-hour professional (licensed nurse) supervision?** yes/no

(The severity of the Individual's medical risk currently requires direct professional care on a 24-hour basis. Direct professional care is defined her as RN supervised care which is delivered by an RN, LPN, or delegated/trained staff).

c. **The Individual has medical care plans, in place, that are documented within the ISP process?** yes/no

(The individual has medical care plans, in place related to these support needs, such as Risk Tracking Record and Health Protocols, Health Care Plan, Nursing Care Plan, etc. It is not expected that these documents be brought to the ReBAR Assessment, but that they be made available, if requested, for later review).

d. How many days per week is the extensive support required? [ ]

Approximately how many hours per day? [ ]

e. Describe the imminent **(i.e. within the next 30 to 60 days)** consequences if no support is provided to address the individual's severe medical risk.

SEVERE COMMUNITY SAFETY RISK

2. The Individual is currently a severe community safety risk to others related to actual or attempted assault and/or injury to others; property destruction due to fire setting and/or arson; and/or sexual aggression and has been **convicted** of a crime related to these risks? To answer "yes" requires at least one 2 rating in any of these Section 1B items: "Prevention of assaults or injuries to others", "Prevention of property destruction (e.g., fire setting, breaking furniture)", "Prevention of sexual aggression".

( ) Yes ( ) No

a. **The Individual has been found guilty of a crime, related to these risks, through the criminal justice system?** yes/no

(The Individual has been found guilty through the criminal justice system, including but not limited to the Psychiatric Security Review Board, of a criminal action involving actual or attempted assault and/or injury to others; property destruction due to fire setting and/or arson; and/or sexual aggression).

b. **The Individual's severe community safety risk to others requires a specially controlled home environment, direct supervision at home, an/or direct supervision in the community?** yes/no

(The severity of the Individual's community safety risk to others currently requires a specially controlled environment that limits the individual's ability to leave the home setting without direct supervision; and/or requires direct supervision during all waking hours within the home setting. Direct supervision is defined her as exclusive 1:1 staffing dedicated to this Individual and/or the constant availability of staff whose primary responsibility is to provide an immediate physical intervention, as needed).

c. **The Individual has documented restriction in place, related to these risks, through a legal requirement or order?** yes/no

(The Individual has documented restrictions in place, related to these risks, through parole, probation, visitation or proximity restrictions, court order, or other legal requirements. There restrictions are addressed within the Individual's ISP process, in documentation such as the Risk Tracking Record, Functional Assessment and Behavioral Support Plan, Safety Plan, Psychosocial/sexual Evaluation, Post-prison Supervision Conditions, and/or Probations Conditions, etc. It is not expected that these documents be brought to the ReBARR Assessment, but that they be made available, if requested, for later review).

d. How many days per week is the extensive support required? [ ]

Approximately how many hours per day? [ ]

e. Describe the imminent **(i.e. within the next 30 to 60 days)** consequences if no support is provided to address the individual's severe community safety risk.

Assessing Needs
What do the scores mean?

- The summary report for the Adult Supports Intensity Scale includes general information about the individual followed by a summary of the SIS results. The information provided below may be helpful in understanding the SIS report.

A. Scores	**Raw Scores** are the total number of points received in each section of the SIS. Raw scores alone are not particularly helpful for understanding support needs until they are changed into "standard scores", which are more easily compared and used.
	Standard Scores provide a consistent system for comparing raw scores from one section to another. On the SIS, they can range from 1-20. As compared to the developmental disabilities population, ➢ A standard score of 10 is average and indicates that the individual needs an average amount of support in that area ➢ Standard scores above 10 are generally higher than average ➢ Standard scores lower than 10 are considered lower than average
	The Percentile Score shows the percentage of people whose scores are at or below a given raw score. For example, a score at the 37th percentile shows that the individual's score is the same as or higher than the scores of 37% of the people in that section and 63% of the people had a higher score.
	The Confidence Interval relates to the assessment's accuracy and not to the individual's support needs.
	Activities Standard Score Total: This is the sum of the Standard Scores.
	The Support Needs Index (SNI) shows an overall summary score. An SNI of 100 is average and indicates average support needs. Scores above and below 100 show higher and lower than average support needs.
A. Graph	The bar graph provides a visual picture of the person's standard scores, percentiles and support needs. The higher the bar, the greater the support needs.
A. Section 2	*Section 2* rank orders protection needs from highest to lower priorities for the individual.
A. Medical and Behavioural	*Medical and Behavioural* scores show the total points received; scores above 5 are notable.

Determining Supports

How are Support Budget Levels calculated?

Support Needs Profile - Graph

The graph provides a visual presentation of the six life activity areas from section 2.

The graph reflects the pattern and intensity of the individual s level of support. The intent of the graph is to provide an easy means to prioritize the life activity areas in consideration of setting goals and developing the Individual Support Plan.

Activities Subscale	Total Raw Score	Standard Score	Percentile	Confidence Interval (95%)
2A. Home Living	55	11	63	10-12
2B. Community Living	63	11	63	10-12
2C. Lifelong Learning	81	13	84	12-14
2D. Employment	66	11	63	10-12
2E. Health and Safety	67	12	75	11-13
2F. Social	59	11	63	10-12
Total:	**391**	**69**		

In this example, this individual would be assigned into **Supports Budget Level 4** with a total standard score in **SUM ABE of 34**. Need to also consider response to the Supplemental Questions related to Exceptional Medical and/or Behavioural sections.

	Support Levels	Sum: Sections A, B, & E	Section 3A Med Support	Section 3B Behavior Support
1	Least Support Needs	0 to 22	0 to 6	0 to 6
2	Mild or Moderate Support Needs	23 or 30	0 to 6	0 to 6
3	Mild to Moderate Support Needs & Moderate Behavioral Challenges	0 to 30	0 to 6	7 to 10
4	Moderate Support Needs & Mild to Moderate Behavioral Challenges	31 to 36	0 to 6	0 to 10
5	High Support Needs & Mild to Above Average Behavioral Challenges	37 to 52	0 to 6	0 to 10
6	Extraordinary Medical Challenges	Any	7 to 32 or Verified Extraordinary medical risk	0 to 10
7	Extraordinary Behavioral Challenges	Any	Any	11 to 26 or Verified Danger to others or Extreme self-injury risk

Determining Supports

SUM A, B & E

- HSRI sought to build statistical regression models to associate SIS scores (independent variables) with historical expenditures (dependent variables). It consistently found that an equation of the sum of scales A-B-E achieved this objective best. Adding in the other scales, including the Supports Needs Index, did not strengthen the equation and may actually weaken it.
- Consider that all the scales in this part of the SIS measure the same thing, i.e., support need. Adding more items to any of the scales would not necessarily add to one's understanding of a person's support need.
- HSRI discovered that when trying to understand the relationship of support need with historical costs, that the sum of scales A-B-E worked better together than any other combination of scales, including the Support Needs Index, or individual item combinations. As a result, HSRI uses the sum of A-B-E to assign individuals to support levels.
- Some items refer to common activities repeated everyday (eating, using the bathroom) and respondents have good experience with these. Others, as in the employment section, may refer to activities requiring more speculation to answer, and especially so if the individual is not working. As a result, this may explain why the employment scale did not fare as well as other scales when tested within a regression equation.

Determining Supports

Exceptions Review Process – How it Works

- The Exceptions Review Process is a way to address the needs of people who are genuinely outliers in whatever level they are assigned. This may apply to people who have needs above and beyond those addressed in the support level or they just have unique needs which are not captured and addressed within the level's service package.
- CLDS eligible individuals receive one of seven Support Budget Levels based on the SIS interview. These levels, as well as an Individual's living situation, determine the Personal Support Budget that an individual will receive.
- CLDS recognizes that in any level-based funding system a small percentage of individuals will have extraordinary support needs that are beyond their assigned budget and service package. As a result, CLDS has developed policy and procedures to guide the process for identifying and reviewing these cases.