

BRING A CHILD INTO FOCUS



Individual Interagency Intervention
Plan (IIIP) Overview
Fall 2002



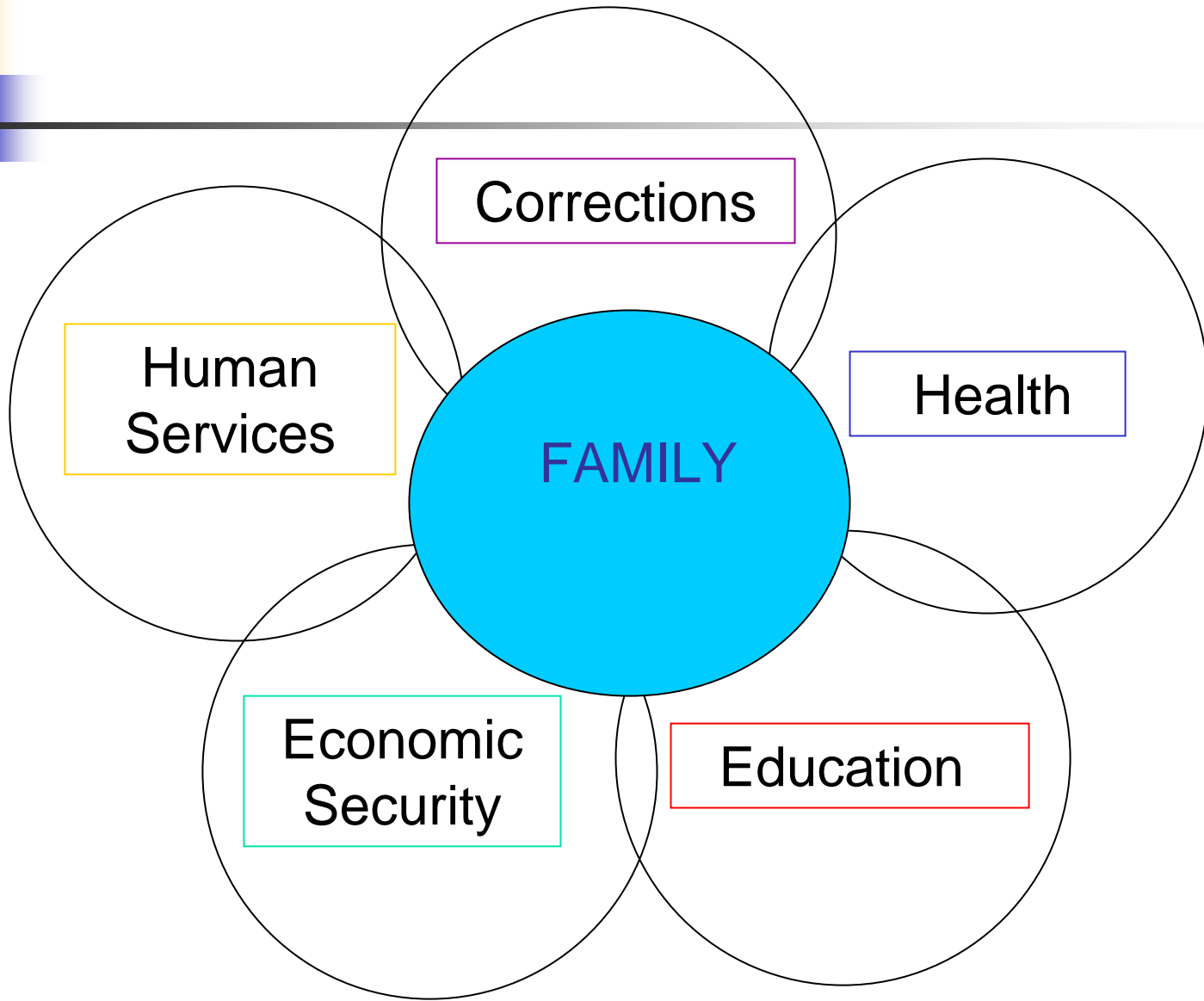
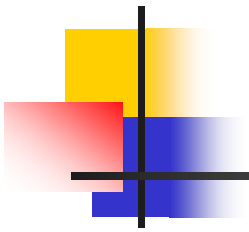
Introduction

In 1998, the Interagency Services for Children with Disabilities Act was passed in Minnesota. This state legislation supports the development and implementation of a coordinated, multidisciplinary, interagency intervention service system for children and youth with disabilities ages 3 to 21. Even though this legislation starts at age 3, the intent is to have a birth to 21 system, transitioning children from Part C (Early Intervention) at age 3. This legislation was proposed in response to the multiple, parallel, yet often unconnected service delivery system currently operating in Minnesota. The goal of the legislation is to streamline service delivery by reducing duplication of services from multiple service providers and by increasing collaboration and cooperation among all partners providing services to children and youth with disabilities and their families.



Minnesota System of Interagency Coordination for Children and Youth With Disabilities Ages 3-21 (MnSIC)

- Minnesota statutes 125A.023 - State Responsibility
 - Coordinated interagency services
- Minnesota statutes 125A.027 - Local Responsibility
 - Interagency early intervention committee (IEIC) responsibilities
- Target population
 - Ages 3 through 21
- Interagency collaboration
 - 14 Programs and Initiatives under 5 state



Corrections

Health

FAMILY

Education

Economic
Security

Human
Services



State Agency: Education

- Programs and Initiatives to be Coordinated
 - Individuals with Disabilities Education Act (IDEA)
 - The Head Start Act
 - Family Service Collaboratives
 - Community Transition Interagency Committees (CTICs)



State Agency: Health

- **Programs and Initiatives to be Coordinated**
 - Maternal and Child Health Program Until Title V of the Social Security Act
 - Maternal and Child Health, Children with Special Health Needs
 - Community Health Services Grants
 - Women Infants and Children (WIC) , Fetal Alcohol Syndrome (FAS), Maternal and Child Health Special Needs Projects



State Agency: Human Services

- Programs and Initiatives to be Coordinated
 - Medical Assistance
 - Developmental Disabilities and Bill of Rights Act
 - Children's Mental Health Collaboratives
 - Family Community Support Plan
 - Minnesota Care
 - Community Social Services Act



State Agency: Economic Security

- Programs and Initiatives to be Coordinate
 - Rehabilitation Services (RS)
 - State Services for the Blind (SSB)



State Agency: Corrections

- Programs and Initiatives to be Coordinated
 - Juvenile Court Act Services



What is the IIIP?

Individual Interagency Intervention Plan

- Both a document and a process
 - Mandated at state and local level
 - Option chosen by parents
 - Once requested, school and state agencies must comply with policy and use state approved document known as the IIIP
 - available in printed form and web based



Individual Interagency Intervention Plan

Bring a child into focus by seeing the child in all environments: home, school, and community. Then create a written plan with the family and service providers in a broad array of contexts (IEP, CADI, CAC, ISP, TBI, IFSP, IFCSP, IFSF, ICSP, & Home Care Plans)

Team members with different backgrounds, agency parameters, personalities, and expertise work together to improve children's outcomes.



The IIP replaces these plans:

- Individualized Service Plan (ISP)
- Community Alternative Care Plan (CAC)
- Community Alternatives for Disabled Individuals Plan (CADI)
- Traumatic Brain Injury Plan (TBI)
- Individualized Education Plan (IEP)
- Individual Family Community Support Plan (IFCSP)
- Individual Family Service Plan (IFSP)
- Individual Community Support Plan (ICSP)
- Multi Agency Plan of Care



These plans are coordinated through the IIP

- Individualized Plan for Employment (IPE)
- Corrections Plans
- Individualized Habilitation or Program Plans (IHP, IPP)
- Individualized Treatment Plan (ITP)
- Out of Home Placement Plans
- Nursing Care Plans
- Home Care Plans
- Other provider or program specific plans



When Do We Start?

- IIRP being initiated in stages -
 - January 2001 Ages 3-5 (or to K)
 - July 2001 Ages 6-9
 - July 2002 Ages 10-14
 - July 2003 Ages 15 through 21



Who is Eligible?

- Children ages 3 through 21
- Children who meet Special Education eligibility criteria resulting in an IEP
 - This does NOT include 504 plan (adaptations), Title 1 or ESL

AND

- Receive services from at least one other publicly funded agency
 - For example a county developmental disabilities coordinator, a Rule 79 case manager, Waiver programs, or a home care provider



Family-Centered Service Coordination

- It links philosophy and principles of family-centered care and aspects of traditional case management
- Families in consultation with professionals, determine the services they want and make the final decision about their service plans
- Creates opportunities for the family to meet its own needs and to chart the course of the family's future



Each Child and Family is Unique

HOPES

DREAMS

CONCERNS FOR CHILD

FAMILY STRENGTHS

NEEDS

PRIORITIES

BELIEFS & VALUES



Family Centered Thinking

A family has a life time role with their child, a professional's role is time limited

Families differ in the strategies they adopt to realize their dreams for their children and themselves and in the kinds of support they need from formal service systems

Family centered professionals acknowledge and respect this diversity

The IIIP Team will be unique to each family



Looking from a New Perspective

Traditional Approaches	New Approaches
Focus on the child	Focus on the child in the context of the family
Focus on deficits, pathology, illness, weakness	A view of all children and families as having strengths and resources
Focus on the power and control of the Case Manager	A recognition that families are the ultimate decision makers
Focus on working within complex, uncoordinated service systems	Focus on changing these systems to make them more responsive to children and families

Service Coordination Paradigm Shift

System- Centered Service Coordination (Current Plan)	Family-Centered Service Coordination (Preferred Plan)
Determine client eligibility within an agency	Help families to find available services and to access self-identified services
Identify client needs from existing agency services	Help families identify their needs from an array of formal & informal supports
Mobilize services for the client	Help families to coordinate needed services
Keep records for the agency and collect data for agency reporting	Keep relevant records, families do the same
Be accountable to agency rules and regulations	Help monitor services for effectiveness for families
Be cost-effective for the agency	Work in partnership with families



CHALLENGE YOURSELF

You need to constantly challenge your own concept, even if you are proud of what you have created.

Continually re-focus interventions based on the family-centered model

As you design interventions, ask yourself...

- “What is my intention for this child?”
- “How will this action nurture and support the child?”



REMIND YOURSELF

Learning, growth, and possibilities happen in whatever environment the child is in

Parents focus less on task content and technical components and more on process and the intent behind it

Positive mutual regard...for the child, the family, & your colleagues



COLLABORATION

Partnership is built with trust, respect, and motivation

“Appreciation is a wonderful thing. It makes what is excellent in others belong to us as well” –Voltaire

“Partnership may feel least comfortable when it is most necessary” – John C Maxwell



TEAMING

- When we view ourselves as interdependent with others, we see beyond ourselves and recognize -
 - Strengths more than risks or deficits
 - Relationships more than programs
 - Unleashing, not directing or controlling
 - Engagement with families more than services for children/youth



Ready, Set, Go

- Include all invested persons
- Begin with strengths, interests, & priorities
- Specifically determine what needs exist
- Develop a common plan



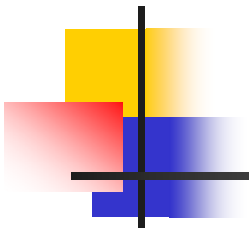
First Steps

- Give parents comprehensive information in a manner that enables them to consider whether the IIP is a “good fit” for them.
 - If they have an IFSP/IEP and receive services from one or more publicly funded agencies, offer the IIP prior to the annual plan date or when new services are initiated.
 - Give family the four (4) family support pages of the IIP document to help them get started.
 - Obtain interagency release of information
 - Family selects team members



Meeting Model

- Schedule Meeting
 - Give adequate notice to all participants
- Prior to meeting:
 - Share critical assessment /evaluation information with the family and other team as needed
 - Encourage family to prepare family pages-CORE: Family/Student Considerations, OPTIONAL: Family Considerations & Concerns, Meeting Plan, Action Plan (help if necessary)

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- Prior to meeting, cont.
 - Identify plan facilitator
 - Develop written agenda with family
 - Identify accommodations/translator needs



- At the meeting:

- Plan facilitator begins process

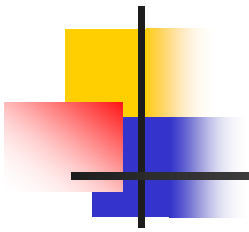
- Starts introductions, each person will describe their connection with the child/family (1 minute or less)
- State purpose of meeting
- Review agenda and meeting length
- Identify note taker and time keeper
- Ask family to share concerns & needs



- Facilitator leads discussion

- Begin with family/child issues

- Review CORE: Family/Student Considerations
- Other OPTIONAL family pages can be useful in focusing on priority areas
- “What do you want us to know about your child?”
- Share related strengths, concerns, and needs

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- All members of the team
 - Participate in the discussion of concerns/needs in home, school, and community
 - Use CORE: Description of Child/Student page and address all pertinent areas
 - Use order of listed domains to guide discussion
 - Any domain area checked should have Strengths/Current Status and Concerns/Needs completed for home, school, and community



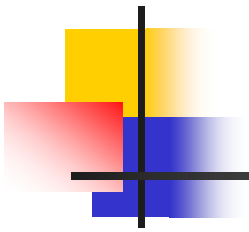
CORE: Description of Child/Student

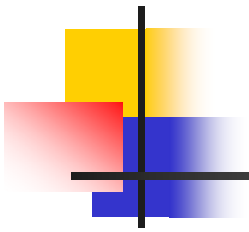
- Current Health & Medical Status
- Physical/Motor Development
- Basic Senses Including Hearing & Vision
- Academic Performance/Cognitive Development/Intellectual Functioning
- Social/Emotional/Behavioral Development
- Environmental (basic needs)
- Other



CORE: Description of Child/Student

- Adaptive Development
- Community Access/Use/Participation
- Legal Representation
- Employment
- Home Living
- Recreation & Leisure
- Postsecondary
- Self Help Skills

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- All members of the team
 - Identify general goal statements
 - Describe how they will be addressed/coordinated
 - By whom
 - With what services
 - Global goals will be written across all environments, home, school, community where applicable
 - Providers are only responsible for outcomes that fall under their program mandates. Nothing in the law increases or decreases the obligation of state, county, or local school partners to pay for education, health, or social services

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- All members of the team
 - Review notes
 - Summarize what was agreed upon
 - Parent will decide whether plan document will be completed via paper or secure web site
 - If web, all plan contributors and parents **MUST** have access
 - Determine how to communicate progress and updates



- At or After the meeting

- Plan facilitator will complete CORE: Demographic Information, Team Member Summary, & Description of Child/Student domain areas as identified
- Each team member that contributes services will enter their own data on above, plus CORE: Services.
 - Strengths/Current Status
 - Concerns/Needs
 - Goal/Outcome & Objective/Indicators
 - Services
 - Additional Required Elements



- At or After the meeting

- Service providers obtain appropriate signatures and approval on service page
- Plan Facilitator or other designated person(s) collects document pages
- Parents receive IIP document in timely manner for review and signature
 - Parents are aware of dispute process
- IIP is distributed



What About....?

- Do we need to complete every page?
- Entire IIP may not need to be completed.
 - CORE section = YES
 - ADDITIONAL REQUIRED ELEMENTS = depends on
 - Child/student age
 - Need for services by agency/program
 - Which plan the IIP replaces



What's Missing?

- Additional necessary information may NOT be required to be documented on the IIP, rather, it can be documented in a file based on agency/program mandates ie.
 - Parent Notification and Authorization
 - Confidentiality and privacy rights
 - Appeals/Mediation
 - Due Process
 - Worksheets and supporting documents
 - Assessments and evaluation reports
 - Billing forms



Bring a Child Into Focus

- The IIP process and document is
 - Individualized –each child is a promise and a possibility, with characteristics uniquely theirs
 - Families want partners to “know and fall in love with their child”
 - Strength based – families are strong, resilient, and capable
 - Allows partners to “see” a child in greater dimensions of skill and potential
 - Focusing on strengths opens the future and increases potential for change and positive progress



See a child “in his world”

How will you bring a child into focus?

How will you...

engage with

discover

respond

create

celebrate ???



TRAINING OPPORTUNITIES

Multi-agency training events will be scheduled monthly to support the collaborative vision of the IIP

Professional staff are available to assist with the IIP documentation and teaming efforts

Parents will be informed of the opportunity to choose the IIP Process from all agency staff and parent outreach events; they have a right to be fully informed about the IIP process as they make their decisions for their family

Remember...we are designing this system together

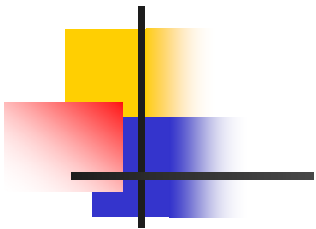


Let's Get Started !

We can build on what we have already created in Clay County and make the vision of the Individual Interagency Intervention Plan (IIP) a reality by:

1. Receptivity: cultivating openness to change
2. Awareness: highlighting the possibility of change
3. Mobilization: Organizing for change
4. Action: Making change happen
5. Continuity: Ensuring that change becomes a way of life

Unleash the capabilities of a person in all of the setting in which the person's life intersects with others



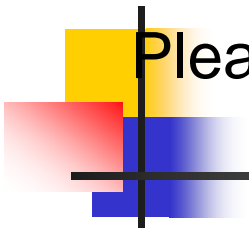
MnSiC

Minnesota System of Interagency Coordination



*Working together to improve
services for children and youth
with disabilities and
their families*

www.mnsic.org



Please direct comments, concerns, ideas, and needs to me
at:

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