

Individualized Service Plan (ISP)/Care Planning Instructions

I. Purpose

The ISP/Care Planning Instructions is a guidance tool that outlines the person centered planning elements of the Individualized Service Plan (ISP) which is required to be completed by all Developmental Disabilities Individual Support and Care Coordination Organization's (DISCOs) and/or contracted entities responsible for facilitating and or writing individual care plans for individuals eligible for OPWDD services who are enrolled in Managed Long Term Care.

OPWDD will not build an electronic ISP document; this is the responsibility of the DISCO. However, as outlined in Section XX of the ISP guidance OPWDD has established the standard, minimum data elements that will be known as the Care Coordination Data Dictionary.

The DISCO will be responsible for developing, with the individual, the care plan also known as the ISP. It will contain all managed care plan information; however, it is not encounter data nor will it serve as service documentation data. The ISP may be part of an individual's larger electronic health record (EHR).

The DISCO will be responsible for directly providing all documentation beyond the ISP to OPWDD and other entities with right to audit managed care entities and the services being delivered.

OPWDD has defined the data exchange requirements and can be found on the OPWDD Internet website at the following link [insert link](#) and in section XX of the ISP guidance

The DISCO will be responsible for sharing the ISP with all providers serving the individual, potentially including an OPWDD Developmental Disabilities State Operations Office (DDSOO).

II. Individualized Service Plan (ISP)

An Individualized Service Plan (ISP) is a comprehensive electronic document resulting from a person centered planning process directed by the individual served, with assistance as needed by a representative identified by the individual and in collaboration with the care coordination team. This is an understandable and usable personal plan for implementing decisions made during personal planning and includes all service and habilitation plan components. This plan summarizes what a person wants and needs and his/her unique network of supports and services. The ISP does not serve as a clinical assessment; but rather is a summary of assessments. It is not a repository of all information about the person, additional information is found in other sources such as the Coordinated Assessment System (CAS), historical summaries, clinical assessments, etc.

1. ISP Format and ISP Instructions

The DISCO and all downstream providers must use an electronic ISP format that includes all of the required elements and sections of the OPWDD ISP as outlined in the Care Coordination Data

Dictionary. Additional information and additional sections may be added throughout the ISP as the DISCO and individual deems necessary. Only the elements in the Care Coordination Data Dictionary will need to be transferred to OPWDD. The DISCO is responsible for monitoring OPWDD's website for element updates and modifications to ensure that all required elements are being captured and reported back to OPWDD.

2. Initial ISP

Within 10 business days of notice of the member's enrollment into the DISCO, the care coordinator shall conduct a face-to-face meeting with the individual. Within 20 business days of enrollment into a DISCO the member's plan of care/ISP must be developed with the member using a Person Centered planning process and at a minimum must include:

- Description of the person
- Desired health, functional, and quality of life outcomes
- Observable/measurable action steps to achieve outcomes that will be taken by the person, paid and unpaid service providers, and other persons who will support the individual
- Pertinent demographic information regarding the member
- Safeguard description and supports needed to keep the individual safe from harm
- Employment status
- Services the individual will receive both HCBS waiver services and non-waiver services
- Expectation of how goals and outcomes will be achieved
- Detailed back up plan for situations in which regularly scheduled HCBS waiver providers are unavailable or do not arrive
- Relevant information pertaining to behavioral support that is needed
- Relevant information regarding physical health conditions and treatment
- Frequency of planned care coordinator contacts needed
- Steps that must be taken by the individual in the event of an emergency that differ from the standard emergency protocol

3. Submission of the Initial ISP

From the date of enrollment the DISCO has 20 business days to develop the initial ISP and an additional 5 business days to provide the approved ISP to OPWDD, as well as with the individual and all service providers.

4. Changing / Updating the ISP

- a. ISP Review – The plan of care is reviewed at least twice annually for the purpose of reviewing the results and /or effect of the delivered supports and services on the person's satisfaction; functional/clinical status; and quality of life outcomes and determining whether any changes are needed to the plan and the person's supports and services to effectuate desired outcomes and results. The individual shall lead the planning process and participants of the planning meeting should be chosen by the individual. The planning meeting should take place at times and

locations that are of convenience to the individual. All ISP reviews and updates should utilize a person centered planning process that provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions. Through this process cultural considerations of the individual need to be taken into account and should be reflected in the planning process. Within 5 business days of being approved by the Lead Care Coordinator the reviewed/updated ISP must be sent to the OPWDD warehouse

- b. All person centered planning meetings, ISP updates and /or review meetings must occur at times and locations of convenience to the individual.
- c. Updates - Review and update of the plan must also occur when the person or the person's guardian requests that information be changed or added and / or when the need for supports and services change. The plan should change as the person changes. A planning meeting should be arranged to include people chosen by the individual and occur in a timely response to the request to hold a meeting. The meeting should be held in a location that is of convenience to the individual.
- d. An ISP is considered approved once the lead care coordinator has reviewed and signed.
- e. The care coordinator shall sign and date the plan of care, along with any updates. The members care coordinator shall ensure that the member reviews, signs and dates the plan of care as well as any significant updates.
- f. All information and documents must be provided in plain language and in a manner that is accessible to the individual. All providers must adhere to MHL 633 as well as Title VI of the Civil Rights Law of 1964, which both outline that services *must* be provided in a culturally competent manner, and that any consent forms or other vital documents *must* be written in a way that is understood (plain language) and translated to the preferred language of the individual and/or family member, guardian, etc. Further information can be found on the OPWDD website at the following link: <http://www.opwdd.ny.gov/resources/language-access>
- g. The individual must be informed by the DISCO of the method in which he/she can request updates to his/her ISP as needed or wanted.
- h. Changes to the ISP will only be sent to the OPWDD data warehouse when they have been reviewed and signed off by the lead care coordinator.

III. The Sections of the ISP

Section 1: Demographic and Profile Table

This section provides basic information on the individual and then describes the person using a person centered process.

a. Identifying Information:

The identifying information within section 1 is to capture information such as full name of the individual, Medicaid number or CIN number, TABS ID number, address, DISCO enrollment information, Lead Care Coordinator information, Initial ISP date, ISP review date.

b. Profile Section

The profile section of the ISP includes the home profile, work profile, relationships profile, and health profile. Each of these sections have been designed to be a combination of question and answer fields as well as free text to provide a person centered narrative that includes personal history and appropriate contextual information, as well as skills, abilities, aspirations, needs, interests, challenges, etc., learned during the person-centered planning process, a record review, and any assessments completed.

The Profile section should describe the person seeking supports and services. The Profile should begin with the person and be a reflection of their interests and needs. It includes selected person centered information about the person discovered during the planning process. The profile may address abilities, skills, preferences, accomplishments, relationships, health, cultural traditions, community service and valued roles, spirituality, career and employment, recreational interests and enjoyment, challenges, needs, pertinent clinical information, or other information that impacts how supports and services will be provided. The profile tells the reader about the person and his/her current needs and wants. It assists those helping the person provide supports and services with an understanding and sensitivity to what is important to the person. This information is necessary to successfully put the plan into action. The profile is not a static history of the person. It is updated regularly in order to accurately reflect the person's changing needs and goals. It is not necessary to indicate age, height, weight, etc. unless this information relates to the person's needs and services.

Use the following questions as a guide when writing the profile:

- What does the person identify as important in their life?
- What are the individual's strengths and preferences?
- What is not working in the individual's life and is a change requested?
- What is unique about this individual?
- What does this individual want their life to be like?
- What are their goals?
- What will this plan accomplish?
- In what type of setting does the person live and in what type of setting would they prefer to live?
- Would this individual like to participate in paid, competitive employment?
- What type of work is this person interested in?
- Would this person be interested in an employment training program, such as an internship?
- Would this person like to be a volunteer?
- What type of volunteer work interests this person?
- What specialized supports would this person need in order to have a successful work or volunteer experience, such as transportation or travel training?

Section 2: Outcomes and Support Strategies Table

The Outcomes and Support Strategies section of the ISP will include the following information: goal description, valued outcome, actions steps, responsible party, service type, time frame for action steps, evidence of achievement, special considerations, and Personal Outcome Measures.

- a. **Goal Description** - this is a free text section that must provide the specific details around the goal/valued outcome.
- b. **Valued Outcome** – Valued outcomes are the person's chosen life goals and are the driving force behind the services and supports the person receives. The valued outcomes should simply state what the person wants to achieve. List the person's valued outcomes that derive from the

profile and planning process. There must be at least one valued outcome for each HCBS Waiver service the person will be receiving. The Waiver Service is “authorized” only where the service relates to at least one of the person’s valued outcomes.

- c. **Action Steps/Objectives** - the specific supports and services related to each goal/valued outcome. Objectives are the measurable (i.e. observable) action steps that are aimed at achieving the valued outcome. Action steps should be written so that they can be measured and evaluated. Action steps will lead to the specific approaches, activities and services that are provided.
- d. **Responsible Party** - identify the individual(s) who will be responsible for implementing and documenting progress toward the goal; needs to relate to authorized-funded services & natural supports, and community resources
- e. **Service Type** – This includes natural supports, Residential Habilitation, Day Habilitation, Community Habilitation, Supported Employment, Pre-Vocational Services, Respite, Adaptive Devices, Environmental Modifications, Plan of Care Support Services, FET, Consolidated Supports and Services, Community Transition Services, Intensive Behavioral Services, etc.
- f. **Time Frame for Each Action Step** – indicate the date the goal it is anticipated the goal will be achieved.
- g. **Evidence of Achievement** - Identify how the responsible party will verify that they are working towards the goal/valued outcome and the action steps
- h. **Special Considerations** – If applicable this is a free text area to provide information regarding health and safety concerns that may need to be considered in assisting the individual to achieve his/her valued outcome.
- i. **Personal Outcome Measures (POMS)**- Identify the POM that best fits with the goal and valued outcome as determined by the individual, care coordinator and/or the care coordination team.

Section 3: Health and Safety / Individual Plan of Protective Oversight Table

This section is formerly the safeguards section that must be in place to keep the person safe from harm. The Individual Plan of Protective Oversight (IPOP) will no longer be an attachment of the plan of care, rather this information will be captured and reported in this section creating one comprehensive document.

Health and Safety Supports are actions to be taken when the health or welfare of the person is at risk. All staff, as appropriate, must have knowledge of the person’s health and safety supports and the information on these supports must be readily available to service provider staff.

Fire safety must be discussed in this section for all individuals. The care coordinator must ensure that there is a current and reasonable assessment of the person’s specific needs relative to his/her capacity to evacuate the home in a timely manner in the event of a fire emergency. If the person lives in a non-certified site, the care coordinator must ensure that actions and recommendations relative to addressing a person’s assessed fire safety needs are specified in the Plan.

As required in 14 NYCRR Part 633, the medication records are distinct and separate from the Plan. The Plan references the medication records as containing important health related information when applicable. If the service provider is teaching the person to self-administer medication, that activity and methodology should appear in the Plan.

Providers of residential habilitation must have written procedures for providing back-up supports to individuals when the absence of the provider's regularly scheduled staff would pose a serious threat to the person's health or safety. For IRAs, this information must be included in the ISP.

When completing this section the care coordinator and individual should discuss the inclusion and evaluation for the person's dignity of risk. The individual, staff, and other persons involved in the individual's life should evaluate when there are opportunities that the individual wants to engage in that could be determined as "risky." Think of the perceived risk, as not being based on the person's ability, but on the ability to provide support.

To evaluate "risk" and the individual's responsibility and ability to calculate the risk, the following factors should be considered:

- Weighing the benefits to the individual and the rights of the individual against the "risk"
- Ways to empower the person to improve their ability to make informed decisions through education and self-advocacy skills
- Evaluate possible resources and environmental adaptations that can allow the person to take the "risk," but mitigate potential hazards.

The Health and Safety Section should identify if any need areas are associated with the individual's Valued Outcomes and goals, the supports and services associated with the need area, and the expected result of providing the supports and services. This section should capture the supports and additional plans needed, if any. In addition, there should be described the expectation of data collected and how supports or services are to be documented to ensure that the expected result is occurring.

Many of the elements in this section will have two parts to provide a clear description of the person's area of need. The parts will consist of:

- A question to identify if there are any concerns in the particular area of need
- Space to provide free text outlining the expected result details and will outline the expected outcome of putting the identified safeguard in place.

Section 4: Authorized and Funded Services Table

This section must capture all authorized services that the individual is receiving. This includes:

- A. DISCO paid Medicaid Services - OPWDD auspice
 - B. DISCO paid Medicaid Services - Long Term Supports not under OPWDD auspice
 - C. DISCO paid Medicaid services - Other
 - D. Key Fee For Service (FFS) Medicaid Services – not paid by DISCO
 - E. Non Medicaid Services under OPWDD auspice - not paid by DISCO (ISS, FSS, Workshop, and other 100% State Funded Services).
- A. **DISCO Paid Medicaid Services - OPWDD auspice** are those Home and Community Based Wavier Services (HCBS) that the DISCO is responsible for providing within the DISCOs network of authorized providers.

- B. **DISCO Paid Medicaid Services - Long Term Supports not under OPWDD auspice** services would include Adult Healthcare, Social Day Care, Personal Care & CDPAP, Home Health Agency, Personal Emergency Response System, and Private Duty Nursing Services. This section would also include non-OPWDD behavioral supports and services under auspice of OMH and OASAS.
- C. **DISCO Paid Medicaid Services – Other.** This section would include dentistry, Vision Care, Durable Medicaid Equipment (DME), etc.
- D. **Key Fee For Service (FFS) Medicaid Services – not paid by DISCO**
- E. **Non-Medicaid Services Under OPWDD Auspice – Not Paid by DISCO.** This section would include ISS, FSS, Workshop and other OPWDD non- Medicaid Supports or 100% State funded services.

Section 5: Natural Supports, Other Services, and Community Resources Table

Natural Supports and Community Resources exist in the community for everyone. They are routine and familiar supports that help the person be a valued member of his or her community and live successfully on a day-to-day basis at home, at work, at school, or in other community locations. Assistance related to achieving a valued outcome should be noted.

This section should contain capture people, places, or organizational affiliations that are a resource to the person by providing supports or services, such as family, friends, neighbors, associations, community centers, spiritual groups, school groups, volunteer services, self-help groups, clubs, etc. Include the name of the person, place or organization as well as a contact number and address of each. Also provide a brief statement about what is being done to help the person. List the activities that the person likes to participate in. When thinking about natural supports consider these questions: What does the person like to do? What are the person's favorite places? Who are the most important people in the person's life? All services and supports being provided should relate back to the Individual's valued outcomes and goals. Although some valued outcomes and goals will be similar for individuals; services, approaches, supports and activities will differ depending on the individual's strengths and needs.

Other services/supports are those supports that the individual may receive such as Primary Care Physician, Dentist, Psychologist, Podiatrist, Psychiatrist, Dermatologist, ACCESS-VR, and Other. Each of these services received by the individual must also include the name, contact number and address of the providing specialist.

Section 6: Preventative Medical Planning Table

This section has been designed as a series of questions pertaining to the Individual's medical planning. Through the Person Centered Planning process, assessments, and file review the Care Coordination team should gather the required information. This section should be kept up to date to ensure that current descriptions and dates are reflected in the ISP. Refer to the Care Coordination Data Dictionary for further directions on how to complete and answer the question in this section

Section 7: Behavioral Support Needs Table

This section captures the behavioral support needs of the individual. The information gathered in this section does not replace a Behavior Support Plan or other behavior management plans. If an individual has a formal plan in place it must be attached to the ISP.

Through the Person Centered Planning Process, assessments, and file review the Care Coordination team should gather the required information to answer the questions outlined in this section. If question(s) in this section are not relevant or do not pertain to the Individual the Care Coordinator should indicate “no concerns at this time” or “no known history” when completing the ISP. Additional guidance and planning tools on rights modifications and restrictions can be found on the OPWDD website at the following link: [insert link](#)

Refer to the Care Coordination Data Dictionary for further directions on how to complete this section.

Section 8: Employment Information

This section of the ISP provides additional information on an individual and his/her employment status. This section tracks the employment setting, the hours worked, and average wage.

Section 9: Personal Outcome Measures – Certified Interview Table

This section of the ISP is to be completed by a Council on Quality and Leadership (CQL) certified interviewer to ensure that interviews collect information in a consistent way using the CQL process to produce valid and reliable data to measure the effectiveness of the person centered supports being delivered.

To determine if people are being supported well in the areas that are most important to them CQL has developed a process for interviewing individuals and the people who know them best such as their family members or direct support staff and collecting information on how the POMs are being achieved through their supports and services. POMs measure quality by looking at the effectiveness and outcomes of services. This is measured by examining how people move toward their goals and advance in skills, independence and inclusion through valid and reliable outcome measures that focus on what is meaningful to the person. The individual will direct this conversation and report how the supports being provided promote his/her unique desired outcomes.

Section 10: Willowbrook

This section is to be completed for only those individuals who are Willowbrook Class Members. The Care Coordination Entity will be required to follow all procedures in accordance with the Permanent Injunction.