Workforce and Talent Management

Training Curriculum Series

Individualized Service Plan

Instructor's Manual

EDUCATION & TRAINING
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Agency Requirements for MSC Course Delivery

The MSC curricula found on OPWDD's website www.opwdd.ny.gov may be delivered by provider agencies that meet certain specified conditions.

For information, please go to:
http://www.opwdd.ny.gov/opwdd_careers_training/training_opportunities/documents/msc_agency_requirements_train

If you have any questions, please contact OPWDD Talent Development and Training at (518) 473-1190.

Instructor Requirements for MSC Delivery

Instructors must be an employee of, or affiliated with, an approved Agency/Provider Association operated or certified by OPWDD or other organization associated with the OPWDD service system.

In order to present training in Individualized Service Plan, instructors must have a minimum of two years experience with people with developmental disabilities and providers of developmental disabilities services.

Instructors must have a minimum of two years of Medicaid Service Coordination work experience, or in another title with comparable working knowledge of Medicaid Service Coordination.

Instructors must be permitted by their agency sufficient time to participate in the requirements of this role.

Instructors must regularly monitor OPWDD's online curriculum for updates.

The Instructor or the Instructor's agency is responsible for retaining the signed, original sign-in documents for a period of six years from the date of training.

If you have any questions, please contact OPWDD Talent Development and Training at 518-473-1190.

Individualized Service Plan
Instructor's Manual
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Instructions to Trainers

This curriculum is intended to support an informal session that allows for discussions and applied skill building. This course is most effective in-person. The activities and give-and-take nature of the format complements the person-centered nature of the course contents.

With this in mind, here are some suggestions:

- Always use personal examples to emphasize a point. This holds interest and personalizes the presentation. This is especially important for the first hour when there are no activities except for an icebreaker.

- You may add your own activities to enhance the impact of the information. Be careful of time frames. The training time schedule is extremely tight.

- Specifically apply the information to children and adults with severe and profound disabilities when you can. Participants often find it difficult to apply the person-centered approach to planning to these two groups.

- Encourage questions and discussions as you go along. This is how we all learn. Participants will remember about 40% of what you say but 100% of what they say. Be aware, however, of specific issues or unique problems that could eat up time and be too far afield. Use a "parking lot" for these topics. Always be aware of the topic at hand and bring the group back to the agenda as needed.

- This is a long day. Be aware of sidebar conversations, room temperature, and the need for unplanned brief breaks.

- Built into the curriculum is an introduction and closing summary for each section. This helps to understand the complementary nature of the topics, transition from one topic to the other, and tie the day together.

- The material has more information than you have time to use or present. Since each group seems to have a unique theme to questions and discussions, this comprehensive approach was used to give you as much information as possible. With experience you will prioritize and summarize in the interests of time.

- Information in this curriculum is not meant to be read. Please extract the essence of the information and use your own words.

- Over time the number of residential and day habilitation staff attending the ISP course is growing. Also, more quality assurance staff are attending. Remember to focus the material to everyone, not just service coordinators.

Note:

Activity #3, Simulated ISP Planning, includes having a "focus person" who is either a self-advocate or a training participant. Having a self-advocate is recommended for this activity. In the past the Self-Advocacy Association of NYS (SANYS) has been very pleased to provide people who are interested in participating. Local information for SANYS can be found at: www.sanys.org

Overview and Course Introduction

Refer to Participant Manual Page #3 / Show Slide #2

Welcome:

- Introduce yourself and significant others.
- Give an overview of the course, purpose and objectives, materials used and general presentation style.
- Discuss that this is a required MSC course.
    - **You might say:**
      As service coordinators you are responsible for writing the Individualized Service Plan (ISP) for all individuals on your caseload.

Briefly Review Course Outline:

- Module One: Defining the Individualized Service Plan (ISP)
- Module Two: Developing the ISP
- Module Three: Simulated ISP Planning
- Module Three: Writing the ISP

Purpose of the Course:

- To outline the importance of designing a personal plan for a person with developmental disabilities. The ISP is a blue print that summarizes what the person wants, needs, and aspires to and the help needed to fulfill these wants, needs, aspirations.

Objectives of the Course:

- To define the ISP and explain its importance
- To identify the components of the ISP
- To explain how to apply Person Centered Principles in writing an ISP
- To compile the necessary attachments to the ISP
- To discuss how to implement the ISP

Format:

- Presentation of material
- PowerPoint Slides (optional)
- Group activities
- Discussions
- Questions and answers throughout the day

Participant's workbook:

- An agenda for the session
- Written Information
- Activity worksheets
- The ISP form and instructions

Materials:

Power Point Slides (optional)
Easels with flip charts for each group
Colored markers for each group (blue, black, red, and green)
Masking tape

Briefly Review:

OPWDD's Mission, Vision, Values and Guiding Principles

Refer to Participant Manual Page #3 / Show Slide # 3

You might say:

"Before we get into the specifics of the ISP, let's first talk about OPWDD Vision, Mission and Guiding Principles". It outlines OPWDD's responsibilities for the provision of services for people with developmental disabilities in order that they receive supports and services to successfully lead richer lives.

Logistics

- Sign-in sheet
- Rest rooms are located:
- Restaurants are located:

Introductions

Ask participants to introduce themselves and include the name of their agency and their role or function.

Optional Activity

By a show of hands:

- How many people have been service coordinators for over 5 years? 3-4 years? 1-2 years? Under a year?
- How many have received previous training on the ISP?
- How many have never written an ISP?

Ice Breaker

The purpose of this activity is to emphasize that the ISP is a personal plan and to also help participants get to know other people that they are sitting with at the table.

1. **Trainer gives personal information as follows:**

   - If something should happen to me, and I need help at home and away from home, and I had an ISP, the first sentence of my profile would say ……

   - I would also include things that are important to me like ……

   - **Emphasize:** Why would I include these things in my profile? Because I want the people who are helping me to know who I am, what's important to me, what I want, and what I need. This information will have an impact on how I receive service and supports.

2. **Ask participants to give personal information about themselves as follows:**

   - Think to yourself: What would you want in your profile that would make a difference in how you receive services and supports?

   - Now, turn to someone next to you and share one thing you would want in your profile.

   - After 2-3 minutes ask for volunteers to tell the larger group what they would want in their profile. Comment on how personal the information is and how important this is for an understanding of the ISP.

Module One:
Defining the Individualized Service Plan (ISP)

Refer to Participant Manual Page # 4 / Show Slide # 4

Purpose of this module:
To start talking about the major philosophies involved in the development and implementation of the ISP.

Objective of this module:
To define what the ISP is and explain its importance for an individual.

Specifically we'll cover:

- What is an ISP?
- Who has an ISP?
- How the ISP is used?
- What do collaborative planning and the resulting ISP accomplish?

Note to Trainer:

This section is intended to briefly define the ISP and the philosophies for the day. Do not linger on any one topic in this section as they are only meant to set the stage for more detailed information to follow throughout the day. Briefly list out the topics that will be seen in this section:

Method:
Presentation

Materials:
Participant Manual
Power Point Slides (optional)

Time:
Approximately 30 minutes

Module One:
Topic One: What is an ISP?

Refer to Participant Manual Page #5/ Slide #5

Say:

- **An ISP is a written personal plan**

The activity we completed at the beginning shows that the ISP is intended as a personal plan.

An ISP is an understandable and usable written personal plan for implementing decisions made during personal planning. It summarizes what a person wants and needs and his/her unique network of supports and services. This network is the person's Individualized Service Environment (ISE).

The ISP is not a summary of past events and evaluations. Though it may contain clinical information, the ISP does not serve as a clinical assessment, a summary of assessments, a psychosocial evaluation, a progress summary, or a comprehensive functional assessment. It is not a repository of all information about the person and not a stand-alone document. Additional information is found in other sources such as clinical assessments, habilitation plans, historical summaries, etc. It is not a system-centered report.

- **An ISP is a plan that is developed through the collaborative planning process**

Collaborative planning produces the richness of personal information used to help the person plan and choose his/her personal valued outcomes. This is a joint effort that seeks to listen, discover, and understand the person with disabilities. This information truly personalizes the ISP and insures that it's the person's plan, not the system's plan, for his/her future.

Give an example of a time when you wrote an ISP without planning with the person first. Point out how difficult it was to write and how it may not have been the person's personal plan but a report of what others wanted for the person.

- **An ISP is an agreement**

The ISP is an agreement between the person with disabilities and the service coordinator about what the person needs and wants, who will assist in the pursuit of his/her valued outcomes, and the supports and services needed to live a successful life in the community. The signatures at the end of the plan attest to this agreement and validate these informed choices.

- **An ISP is a document that substantiates Medicaid billing for HCBS Waiver Services**

A plan is required by Medicaid to describe the billing of HCBS Waiver Services. This plan is the ISP. For this reason, accuracy and timeliness of the ISP is critical. This will be presented and emphasized later when we review how to assemble the ISP.

Summary/Transition:

Provide a transition to the next topic: Who has an ISP.

You might say:

Now that we know what an ISP is, let's talk about who would have an ISP.

Module One
Topic Two: Who has an ISP?

Refer to Participant Manual Page #6/Slide #6

Say:

An ISP is developed, written, and maintained for everyone enrolled in Medicaid Service Coordination (MSC) or the Home and Community Based (HCBS) Waiver regardless of where they live or what services and supports they receive.

The ISP is also maintained for people who are enrolled in the waiver and receive Plan of Care Support Services.

Summary/Transition:

Provide a transition to the next topic: How is the ISP Used?

You might say:

We've talked about the purpose of the ISP. In the next section we will discuss how the ISP is used.

Module One
Topic Three: How is the ISP Used?

Refer to Participant Manual Page #7/Show Slide #7

Introduce topic:

This gives an overview of how the ISP is used:

- **As a document that "locks on" to outcomes**

The ISP gives a clear understanding of the person's valued outcomes for receiving supports and services. "Locking on" to outcomes gives direction and purpose to all supports and services and opens up an awareness to what has to be done and how it will get accomplished.

Give a personal example from your own life of when you were determined to reach a goal and how your commitment automatically opened up your awareness to the resources and information you needed to pursue that goal. For example, renovating an old house or finding the money to send your child to college.

- **As a communication tool that gives direction and guidance to providers of supports and services.**

It tells the reader about who the person is, what he/she needs and wants, and who is helping the person. This knowledge impacts the quality of the person's current and future life and includes safeguards to keep the person well and safe.

- **As a master plan or blueprint for the person's life resulting from collaborative planning.**

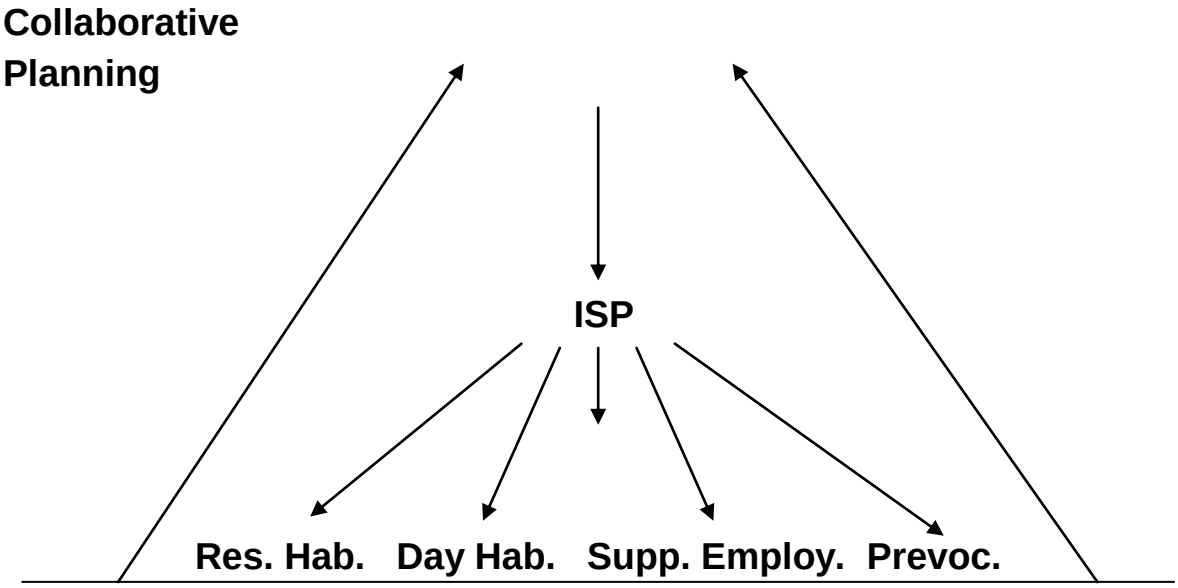
The ISP is the over-all or umbrella plan.

Other plans, for example residential or day habilitation plans, are more specific plans to help the person pursue his/her outcomes.

There must be a relationship between the person's valued outcomes in the ISP and these other types of service plans. This relationship can only occur through planning collaboratively with the person, his or her advocate, and providers of supports and services.

Show Slide # 8

Refer to the following flow chart in the workbook on page 7.



Review the chart and say:

Collaborative planning comes first, followed by the completion of all other plans. The service coordinator writes the ISP and service providers develop their own plans after collaborative planning has begun.

It never works as well when the service coordinator and other providers come to the meeting table with plans already written. How do they know what the person needs and wants?

Give an example of how you wouldn't like a plan written for you without planning with you first (for example a financial plan, a retirement plan, a plan to help your child in school, a home building plan, etc.)

Refer to Participant Manual Page # 8 / Show Slide # 9

Say:

- **As a written document that coordinates supports and services**

The ISP identifies and records the coordination of the person's Individualized Service Environment (ISE). It shows how supports and services are harmonized and funded. This prevents duplication of services and avoids unnecessary services.

- **As a tool that sets accountability**

The ISP clearly sets accountability for who will assist the person, why, how often, start date, and for how long. Motivation and responsibility often come from being accountable.

Give an example from your personal life of when being accountable made a difference. For example, a project at work or care of an ill family member.

- **As a document required by Medicaid**

Medicaid requires the ISP for people enrolled in the HCBS Waiver and Medicaid Service Coordination (MSC). These Medicaid services must be provided according to a written plan.

- **As a Plan that describes HCBS Waiver Services**

As mentioned earlier, the ISP describes HCBS Waiver Services. If a waiver service is not authorized in the ISP the provider of the waiver service cannot bill Medicaid. Further information on this will be provided this afternoon.

Summary/Transition:

Provide a transition to the next topic area: What do collaborative Planning and the ISP Accomplish?

You might say:

We've discussed how the ISP is used and the purpose of collaborative planning. In the next section we'll talk more about collaborative planning – what collaborative planning is and what the ISP accomplishes.

Module One
Topic Four: What do Collaborative Planning and the Resulting ISP Accomplish?

Refer to Participant Manual Page # 9 / Show Slide # 10

Say:

- **Satisfaction with the supports and services received**

Satisfaction with the assistance he/she is receiving. The person should decide if the ISP is working. Sometimes he or she will need help making this decision. In such situations, the advocate, service coordinator and others must judge from the person's point of view.

- **A successful and desirable life in the community based on the person's valued outcomes.**

The ISP is working if the person is pursuing his or her valued outcomes and living a successful and desirable life in the community based on his or her valued outcomes.

- **Health and safety**

Health and safety at home, work, school, and in the community.

- **Community membership and valued social roles**

Develop and maintain valued social roles and true membership in his or her community.

Summary/Transition:

Provide a transition to the next Module: Developing the ISP.

You might say:

In the previous module we talked about the ISP in general. We saw what the ISP is and its importance in relation to the individual. Without the ISP, there would be no general guidelines for the person to achieve his/her wants, needs, dreams, etc. We also discussed collaborative planning which is at the core of the ISP from the planning, to the writing, to the implementation of it. The ISP cannot be without the collaboration of all the different supports and service providers involved with the individual.

In the next module we will discuss the development of the ISP. We'll talk about planning for the ISP and we will talk about the different steps of the ISP planning process. These steps go from gathering information, finding themes based on information gathered, developing valued outcomes, identifying safeguards, and developing next step strategies based on the outcomes developed.

The philosophy of collaborative planning will be repeated in many different ways throughout the day. As you see, the ISP is much more than a record-keeping system. It's a tool to make things happen for a person! Remember, collaborative planning is first – the ISP and other types of plans flow from planning!!!

"A person centered plan is a means and not an end. The life that the person wants is the outcome not the plan that describes it." (Michael W. Smull, University of Maryland)

Module Two:
Developing the ISP

Refer to Participant Manual Page # 10 / Show Slide # 11

Purpose of this module:
To introduce participants to the concept of ISP planning from a person centered perspective.

Objectives of this module:
- To give an overview of the significant characteristics of the person-centered approach to planning.
- To introduce the five sequential steps to ISP planning.
- To define "Assessment" under gathering information and provide examples of assessment tools.
- To gain knowledge about assessing health and safety.
- To practice using discovery tools.

Specifically we'll cover:
- Planning from a Person Centered Perspective
- Introduction to the Five Sequential Steps to ISP Planning
- Step 1: Gathering Information as the Basis for Planning
    - Definition of Assessment
    - Assessment Tools
    - Discovering Information
        - Activity #1: Areas of Discovery
        - Activity #2: Paint a Portrait of Yourself

Method:
Presentation, discussion, and skill building activities

Materials:
Participant Manual
Power Point Slides (optional)
Easels with flip charts for each group
Colored markers for each group (blue, black, red, and green)
Masking tape

Time: Approximately 2 hours, 20 minutes
NOTE: Usually a quick break for participants is recommended between Module 2 and Module 3.

Module Two
Topic One: Planning from a Person Centered Perspective

Refer to Participant Manual Page # 11 / Show Slide # 12

Say:

Planning from a person-centered perspective seeks to listen, discover, and understand the person with disabilities. "It is a process of learning how a person wants to live and then describing what needs to be done to help the person move toward that life" (Michael W. Smull, University of Maryland)

Planning for the ISP is characterized by the following:

- **Planning builds on the person's abilities and skills**

The planning process capitalizes and builds on an individual's abilities and skills to form a quality lifestyle for the person. Though other factors that impact the person's life are considered, knowing abilities and skills can set a direction, give guidance, provide positive motivation, and increase the likelihood of success.

Give an example of a person who pursued or achieved an outcome in life based on abilities and skills. Suggestion: A man who knows movies may be very successful working in a video rental store. Or you may want to provide a scenario and ask what the person's abilities and skills are that will help the person plan.

Ask for an example from the group.

- **Planning creates a clear vision of a positive and desirable future**

Though planning may start with some general ideas of what the person wants and needs it should evolve into a clear vision of a positive and desirable future. The clearer the vision, and the more specific it is, the greater the likelihood that it will be achieved because we know where we're going and what needs to change to get there.

Give an example of a clear and specific outcome. Suggestions: An apartment with my friend John in a rural area on the first floor with two bedrooms and a cat;
down time to listen to classical music in my room when I get home in the afternoon and on weekends; a best friend to play with at school during recess.

Vague outcomes don't work because you don't know where you're going, it's easier to give up or compromise the outcome, and you have no idea if you got there.

Give an example of a vague outcome. Suggestions: To be more included in my community or to be a better person.

- **Planning is collaborative**

Ask:

Who should be part of the planning process?

You may want to write down the answers on the flip chart.

Collaborative planning is central to the success of planning. Participants may include family, friends, clinicians, support brokers, advocates, caregivers, service coordinator, and service providers. When able, the person with disabilities decides who will be part of planning. These members of the planning circle should know the person well and be important in the person's life. Caregivers are essential to this process. This is especially meaningful for people who are unable to verbally articulate information and choices. The following are characteristics of collaborative planning:

- The person is always central in the planning process.
- The wider the representation of people involved in planning, the richer and more meaningful the planning will often be.
- Collaborative planning fosters a personal commitment from group members and strengthens the person's planning circle.
- Participation by people providing supports and services not only provides valuable information and assistance but helps to better understand, and be a part of, the person's vision and valued outcomes.
- Collaborative planning facilitates the complimentary nature of services and supports as the person's network or ISE is designed.

- **Planning is ongoing**

Planning is ongoing, recurring, and not stagnant. It is an evolving series of discussions or interactions that occur initially, as the person or situation changes and as discoveries are made.

Planning is not a single event or meeting nor does it naturally occur in 6 month intervals.

Give a personal example of when your plan needed on-going changes and modifications. For example, building a house; choosing a college; making career choices; or planning for retirement.

Ask for other examples.

Show Slide # 13

Say:

Planning fosters inclusion, valued social roles, informed choice, self-determination, and reflects culture and ethnic heritage.

Community inclusion is an essential result of planning so that people may lead lives of contribution and be seen as valued members of the community. Planning should increase the person's opportunities in five areas:

Community presence
Community participation
Personal choice
Valued social roles, and
Learning competencies that promote contribution to the community

Informed choice and self-determination is central to the planning process. The person is in the center, not the rim, of all activities and decisions. If skillfully accomplished, it leaves the person "empowered" and in control of the direction of his or her life.

The planning process reflects the person's culture and ethnic heritage. This could be evident in the information gathered about the person, in the valued outcomes chosen by the person, or in the types and locations of supports and services selected.

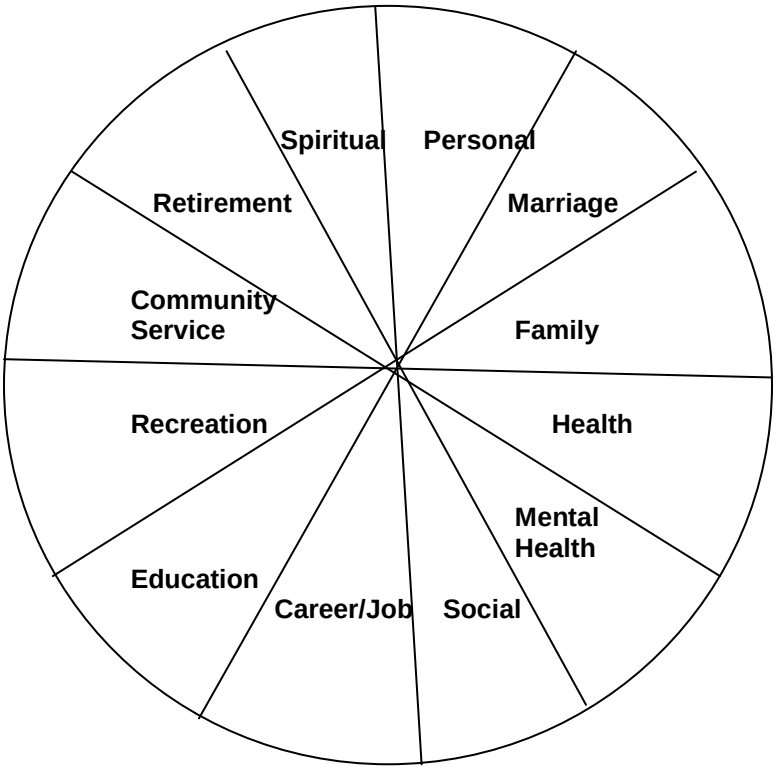
- **Planning takes patience and commitment**

The person-centered approach takes patience from everyone involved, the development of a relationship with the person and an ongoing commitment to the person. Planning cannot be rushed.

- **Planning creates a balanced and big picture view**

Refer to the following graphic in the workbook on page 12. Show Slide # 14

The Big Picture



Planning creates a balanced and big picture view of a person that takes in many aspects of life, not just what needs to be "fixed". These life areas may include spiritual, personal, marriage, family, career, education, mental health, education, community service, physical health, hobbies, social, culture, recreation, work, and retirement. This comprehensive view helps to clarify if some areas are left out, are under-emphasized or even over-emphasized. <u>This does not mean, however, that all these areas must be reflected in the ISP.</u>

Summary/Transition:

Provide a transition to the next topic area: Introduction to the Five Sequential Steps (A Guide to Planning).

You might say:

We just described the importance of planning for the purpose of the ISP. Now we will review the 5 sequential steps to developing the ISP. Trainer should name the steps/briefly describe the first one, then move on to the 2nd one, and so on, giving the participants time to absorb the information.

Step 1: **Gather information as the basis for planning.**

Step 2: **Identify themes in the person's life.**

Step 3: **Choose personal valued outcomes**.

Step 4: **Identify safeguards.**

Step 5: **Develop next-step strategies and a personal network of assistance (Individualized Service Environment).**

Module Two
Topic Two:
Introduction to the Five Sequential Steps (A Guide to Planning)

Refer to Participant Manual Page # 13 / Show Slide # 15

Say:

Now that we have reviewed some important characteristics of planning from a person centered perspective, we are now going to look at how this planning can occur within Five Sequential Steps.

Explain that the **five sequential steps** provide a general guide to planning from the person-centered perspective. Since planning is ongoing, the steps are often continuous and may overlap even though they are presented here as distinct parts of a process. These steps are best used for planning meetings, during reviews of the ISP, or as discoveries are made and changes occur.

Introduce the five steps to ISP planning with a very brief description of each:

Step 1: **Gather information as the basis for planning.**
This is a listening and learning step that increases our understanding of the person.

Step 2: **Identify themes in the person's life.**
Themes are summary statements that are used as cues or indicators to what the person needs and wants for successful living and the keys that impact the person's day-to-day life.

Step 3: **Choose personal valued outcomes**.
Valued outcomes are destinations or end results.

Step 4: **Identify safeguards.**
Safeguards are the actions needed to keep a person safe from harm.

Step 5: **Develop next-step strategies and a personal network of assistance (Individualized Service Environment).**
Action steps, strategies, resources, and funding sources are identified.

Elaborate:

The sequence of the steps is critical to their effectiveness. For example, if step 5 is considered first, the available resources will control the planning and dictate the person's outcomes and future.

Summary/Transition:

Provide a transition to the next topic: Assessment Tools

You might say:

Later today we will be doing an activity that will reinforce the five steps that we just learned through simulating an ISP meeting. Before we move into the simulation, the next topic will focus on the first step to ISP planning and helpful tools for gathering information.

Module Two
Topic Three: Assessment Tools

Explain what participants should expect for this section: Gathering information is an important basis for planning and service plan development. In this section we will become familiar with some tools that are helpful in planning.

Introduction:

How Learning and Discovery Occurs:

Refer to Participant Manual Page # 14 / Show slide #16

The following is a brief interchange with the participants that opens the door to thinking about the various ways information can be discovered on an on-going basis, in preparation for a planning meeting, or at a planning meeting.

Explain:

This is a listening and learning step that increases our understanding of the person. Not just in traditional ways (background, diagnosis, needs, and strengths) but in a personal way. It's a treasure hunt that looks deeper into the person's life to discover such things as capacities and dreams.

Discuss:

In developing an ISP, the service coordinator's role includes that of assessment and continual re-assessment. In other words, the service coordinator takes actions in order to determine a person's functional status, service needs, personal goals and preferences. Service plan development is based upon this assessment.

Make the point:

Assessment is one of the first steps in the service plan development process. The assessment process for the ISP incorporates observational and descriptive methods, not only clinical assessments.

Say:

The purpose of assessment is to broaden the service coordinator's understanding of the person. Assessments can be formal and structured or informal and unstructured.

Ask:

What are ways to get to know the person better and discover personal information either on an on-going basis, in preparation for a meeting, or at a planning meeting?

Possible answers/responses: Trainer will elaborate on each of the bullets in the list.

- Talk to the person and talk to people who know the person well (natural supports, friends, family, service providers, teachers, etc).
    - Elaborate: Direct discussion with the person (what the person says) and others that know the person well; know what to ask and how to ask it.
- See the person in different environments and look around his/her environment, especially at home. Visit his/her "hang-outs".
    - Elaborate: Direct observation includes assessing the person in their different environments. Face-to-face service meetings and home visits are tools used for observing and assessing health and safety issues. Spend time with the person and notice their likes, dislikes, frustrations, joys, etc.
- Read written information: Look at formal assessments and evaluations such as psychological, physical, social, medical/nursing OT, PT, Speech, functional, vocational, risk assessments, etc. OPWDD Developmental Disabilities Profiles (DDP 2: Information on diagnosis, adaptive, maladaptive and medical issues, skills and challenges; DDP 4: Unmet needs).
    - Elaborate: Initially, eligibility for services is determined though an assessment process based on clinical and diagnostic tools. These tools are helpful at other times in the assessment process, although the service coordinator should use caution to make sure the information is not out-dated.
- ISP meetings are ways to gain input from those who know the person best.
    - Elaborate: This is an occasion for collaborative planning (everyone is in the same room).
- Personal Futures Planning
    - Elaborate: Further tools, called "Maps" that help to learn about a person by getting to know the person and what their life is like now, developing ideas about what he or she would like in the future, taking actions to move towards the future which involve exploring possibilities within the community and looking at what needs to change within the person's services.
- Use interest inventories:
    - Elaborate: An example of an interest inventory is the "Areas of Discovery" which we will review and use later. This is a tool that helps us to learn what works and what doesn't work for a person.

Summarize:

In order to assess, or discover, the service coordinator gathers information to get a clear picture of the person. The service coordinator should use various tools that they have available in order to conduct a comprehensive assessment. The information gathered is used to develop the personal plan. The examples just discussed are ways to gather information about a person. The list can change based upon new tools the service coordinator becomes aware of.

Module Two
Topic Four: Assessing Health and Safety

Refer to Participant Manual Page # 15 / Show Slide # 17

Discuss:

Assessing Health and Safety

The ISP is driven by valued outcomes that are identified by the person and also identifies support for health and safety needs. Safeguards are necessary in order to keep the person healthy and safe. They describe actions to be taken when the health or welfare of the person is at risk. Fire safety and evacuation ability is required in the ISP.

Give some examples of safeguards. Express that aside from evacuation ability in the event of a fire, safeguards vary depending on the person's needs.

- Ability to evacuate their home in a timely manner in the event of a fire emergency
- Chronic medical conditions
- Allergies
- Level of supervision a person requires at home either generally or during specified activities such as bathing and eating and while in the community
- A person's special dietary needs, consistency of foods and assistance while eating
- The assistance a person requires for medication administration or ability to self-administer medications
- Ability to give consent
- Safety awareness or ability to travel independently
- Ability to manage finances

Emphasize:

Safeguards need to be reviewed and revised whenever a risk factor is identified or a person's needs warrant a revision. An example would be a person who develops an acute or chronic health condition and new now needs additional assistance performing activities he or she could safely perform previously.

Summarize/Discuss:

We've discussed how safeguards are identified though the assessment and discovery process for a person as part of planning. We will be discussing safeguards further in Module Three through a simulation activity. In Module Four we will discuss where safeguards are listed in the ISP and how they are referenced in other plans. For example, if the person lives in an IRA, safeguards are listed in the Plan for Protective Oversight (IPOP) and can be referenced in the ISP as, "See attached Plan for Protective Oversight". The plan is then attached to the ISP.

Habilitation Plans provide greater detail as to how safeguards are ensured within the context of the respective service environment. The service coordinator should also include in the ISP safeguards that pertain to other environments where the person spends time.

The service coordinator has the responsibility to monitor the implementation of the interventions documented in the safeguards section of the ISP and/or IPOP. The service coordinator advocates on behalf to the person to assure that the interventions are carried out properly and in a timely manner.

Assessing a person's needs includes determining adequate safeguards and oversight.

Instructor Note:

Alert participants to the OPWDD Website at www.opwdd.ny.gov
Discuss that OPWDD issues "Health and Safety Alerts" that are available on the website. These alerts have information and guidance about health and safety issues. The November 2011 issue discusses "Keeping Individuals Safe by Following Their Plan". Check the website regularly for new issues.

Transition to the next area which is the "Areas of Discovery". You might say:

Now we are going to practice some of the things we've been talking about. We'll start with learning how to use the "Areas of Discovery", which is a good assessment tool for learning about a person. Then we'll have another activity "Paint a Portrait of Yourself" which is an activity that will give us some introspection about our own needs and wants. Later, we'll move on to the simulated ISP activity and practice the five steps to planning. At the end of the day, we'll wrap-up with Module Four: Writing the ISP.

Module Two
Topic Five: Discovering Information

Activity # 1: Areas of Discovery

Refer to Participant Manual Page #'s 16, 17, and 18 / Show Slide #18

Explain the importance of the areas of discovery: This is a tool that helps to learn what works and what doesn't work for a person. This is important in person-centered planning. Use these types of questions to learn information about a person (information about their interests) and information about the person in their different environments.

This activity is designed to brainstorm possible areas for learning and discovery before reviewing the "Areas of Discovery" list on the next two pages.

Ask what information or areas for discovery would you gather to help a person plan his/her life?

Optional Method (but time consuming): Do a "go-around" and each in turn would contribute an area of discovery.

Write answers on the flip chart. Continue for about 5 minutes. Encourage person-centered information.

Refer participants to the "Areas of Discovery" sheets in their workbooks on pages 16 & 17 and give them a few minutes to read through the list.

Ask what items on the list would they explore and their next planning meeting?

Say:

- This list could be used during reviews of the ISP, face-to-face meetings with the person, or any other time that information is gathered.

- **Emphasize that this is not an all-inclusive list. Each topic area could be expanded and other topics added.** Encourage participants to do so as they work with the list in the future.

- The list is intended as a "trigger tool" to give the planning process a person centered perspective.
- This list can be used for everyone we help, including children and people with severe and profound disabilities.

Areas of Discovery

Relationships
Who is the person close to? React positively to? Who does the person trust? Does the person have friends? Who does the person go to or reach out for? Talk to?

Abilities and Skills
What are the person's talents? Capabilities? Skills? Gifts?

Preferences
What food does the person like? What are the persons Interests? Likes? Hobbies? Personal space needs?

Places
Where does the person spend time? In segregated sites? In the community? During the day? During evenings and weekends? Where does the person like to be?

Accomplishments
What has the person accomplished in life?

Contributions
How does the person contribute to the richness of his/her own life and the lives of those around him/her? At home? At work? In the community?

Background
What is the overview of the person's life experiences? What positive experiences has the person had? Have there been any traumas, loss or grief? What hasn't worked in the past? Are there any stories about his/her life the person wants to tell?

Health
Are there any conditions that threaten the person's health? Promote the person's health? Does the person have any physical limitations? Medical conditions?

What works for the person?
What makes the person happy and bring joy? What things create comfort? When does the person smile?

What doesn't work for the person?
What makes the person frustrated, angry, or cause boredom? What does the person dislike?

Lifestyle
What is the person's daily routine? Life patterns? What characterizes the person's lifestyle?

Challenges
What are blocks to new opportunities? Obstacles to pursue outcomes? Any temporary setbacks? How does the person handle change?

Culture
Does the person have any cultural traditions? Strong cultural ties? Beliefs? Values?

Motivation
What has personal pay value for the person? What positively or negatively motivates the person?

Hopes and Dreams
What does the person want to try? Achieve? Experience? What are Mom and Dad's hopes and dreams? What is the person's positive vision of the future?

Fears
Is there anything the person is fearful of? Anticipated transitions? Harm?

Decision Making and Control
What control does the person have over his/her own life? Does the person make decisions?

Personal Characteristics Are there any personal characteristics that earn the respect of others? That causes rejection? **Communication** How does the person communicate feelings, fear, choices, decisions, joy, and sadness, pain? Is any special assistance needed? **Community Inclusion** Is the person a valued community member? Does the person belong to clubs and organizations? Does the person do volunteer work? Does the person have valued roles at work and in the community at large? What are the person's reactions in large groups? Community outings? What help does the person need in the community? **Spirituality** Does the person have a religious affiliation? Does the person attend or would like to attend church? How does spirituality impact his/her life? **Clinical Information** That impacts planning.	**Choices** Does the person have opportunities to make choices? What personal choices does the person make on a daily basis? Are the person's choices listened to and supported? Does the person receive encouragement to make choices and decisions? **Learning** Does the person have opportunities for new experiences? Does the person learn new skills? What skills would the person like to learn? What educational goals does the person have? **Supports** What supports are currently available to help the person live a successful life? Are there any natural and community supports? Paid supports? What supports and services don't work for the person anymore? **Non-Negotiables** What can't the person live without? What does the person feel very strongly about?	**Satisfaction** Is the person satisfied with the supports and services received? With his/her lifestyle? Daily routine? **Enjoyment** What does the person like to do for fun, leisure and recreation? **Independence** Does the person have or want any freedoms? What would the person like to do independently? What level of supervision does the person need? Are there any mobility issues or needs? **Safeguards** What needs to be in place to keep the person safe from harm? Adaptive equipment? **Habits** What personal habits work for the person? What doesn't work anymore? Any rituals? **Values** What does the person value in life? What is important to the person? **Beliefs** What does the person believe in? About himself/herself? Others?

Activity # 2: Paint a Portrait of Yourself

Refer to Participant Manual Pages # 19 and #20

This activity is designed to personalize the process of discovering information. It opens up awareness to two things:

1) the sensitive nature of personal information and
2) what it must be like to be the focus person of planning.

The activity concludes with best practices for planning generated by the experience.

Encourage discussion and expression of reactions throughout the activity.

Explain that this is an awareness exercise to better understand the process of discovering information.

Ask participants to complete, on an individual basis, the "Paint a Portrait of Yourself" worksheet in their workbooks. They have 5 minutes to answer the questions. (A copy of the worksheet is on the next page)

After 5 minutes, **Ask** the participants to turn to a person next to them and share their answers to question #4 and #5. Allow another 5 minutes.

Ask if there are any comments or reactions to the activity (this is an open-ended question that always starts the discussion).

Write comments and reactions on the flip chart. Ask if others experienced the same reaction.

Ask for best practices for planning generated by this experience. (Common reactions and accompanying best practices are located after the worksheet)

Write best practices on the flip chart.

Paint a Portrait of Yourself

1. Who am I?

2. What am I good at?

3. What do I have difficulty doing?

4. What do I like most about myself?

5. What do I like least about myself?

6. What kind of challenges do I have?

7. What could I use help with?

8. What personal goals do I have for myself?

9. What needs to change to make things happen for me?

10. Who's accountable to make things happen in my life?

Common Reactions and Comments	Best Practices
Hard to answer direct questions. Felt "on the spot".	Start with a dialogue/conversation. Help the person prepare for the meeting. Write an agenda or think about questions ahead of time.
Hard to be honest	Develop a trusting relationship.
Very Personal; felt exposed; didn't want to share	Respect the personal nature of information and don't assume the person can handle these revelations.
It was fun and easy or didn't like the activity at all!	Recognize that each person has a unique reaction to planning.
Felt rushed	Understand that planning is a process and takes time. Be patient.
Impact of writing answers on paper	Writing information on paper creates a visual path to the future. The flip chart method works!
Felt uncomfortable	A comfortable and neutral meeting location is often helpful.
Sharing was hard • My boss was my partner • Easier to tell a stranger • Personal information	Reassure that the information is confidential and be sensitive to the possible misuse of information as power and control over the person.
Looking at goals reminds me I haven't started yet and creates anxiety	Follow-up and commit to the planning process.
Saw themes/patterns in my answers	Use themes and patterns as cues or indicators for planning
Easier to answer negative questions	Focus on the positive

Module Three:
Simulated ISP Planning

Refer to Participant Manual Page # 21 / Show Slide # 19

Purpose of this module:

To practice the Five Steps to ISP Planning.

Objectives of this module:

- To practice ISP planning skills

Specifically we'll cover:

- Review/Practice the Five Sequential Steps to ISP Planning
  - Activity #3: Simulated ISP Planning

Method:

Presentation, discussion, and skill building activities

Materials:

Participant Manual
Power Point Slides (optional)
Easels with flip charts for each group
Colored markers for each group (blue, black, red, and green)
Masking tape

Time: Approximately 1 hours, 40 minutes
40 minutes: Step 1 (Simulated ISP Planning)
60 minutes: Steps 2-5 (Simulated ISP Planning)

NOTE:

Recommended breaks during Module Two, Developing the ISP:

- A break is recommended after Step 1. If course is given in one full day, this is usually the lunch break.
- Start with Step 2 (Simulated ISP Planning) after the break.

Activity #3: Simulated ISP Planning

Introduction to Activity:

Say:

The following activity is the applied skill building portion of the day. We will be breaking up into groups to simulate a planning session for an individual.

Review the following with the participants:

Each group will conduct a planning session using the person-centered approach to planning and complete the first three steps to planning:

Step 1: Gather information as the basis for planning
Step 2: Identify themes in the person's life
Step 3: Choose personal valued outcomes

Note to Trainer:

Be sure every group has the needed markers and tape. Groups of 4-6 are preferable. More results in sidebar conversations and makes it difficult for people to focus.

Self-Advocate as the Focus Person: see note under instructions to trainer at beginning of manual

You may want to invite self-advocates to attend the training and participate in the following activity as the focus person. Ask one self-advocate to join each group. This would replace the format of "Choosing a focus person" described on the next page. The self-advocate would be invited to attend the training session for 11:00 and remain until 2:00 with an hour for lunch between 12:00 and 1:00.

The role of the self-advocate would be to participate in the first 3 steps to planning: 1. Gathering Information 2. Identify themes and 3. Identify Outcomes.
Use your facilitation skills to involve the self-advocate in discussions and to determine his/her reaction to each step.

Step 1: Gather information

Refer to Participant Manual Page #22 / Slide # 20

Instructions:

- **Identify a facilitator.** The role of the facilitator is to ensure that the process is person-centered, that people are listening and participating, and that the activity is moving forward.

- **Identify a recorder.** The function of the recorder is to write on the flip chart the information learned during the planning session. When one sheet is filled, remove it from the flip chart and hang it on a nearby wall. Tape will be made available. Colored markers may be used for emphasis: Green for strong likes or things that work for the person; Red for strong dislikes of things that don't work for the person. Blue and black are neutral colors.

- **Choose a focus person (this is not necessary if a self-advocate joins the group).** This is the person who will be the focus of the planning session. Someone in the group must volunteer to give information about a person with a disability that he or she knows well. It is more effective if more than one member of the group knows the person. You may want to choose someone who has challenges, difficulties, or is experiencing life transitions.

- It is the role of all group members to discover information by asking questions, exploring pathways, and learn as much as possible about the person. Refer to the list "Areas of Discovery" for assistance.

- Of course, do not reveal the person's identify. Use a different name.

- Each group has 30 minutes to complete Step 1: Gather information as the basis for planning.

- **Do not move on to Step 2 or 3 at this time.**

Note to Trainer:

Move from group to group and learn a little about each focus person. Sit with each group for a few minutes. Provide guidance if needed but do not give answers or lead the discussion. Learning from the process is part of the value of this exercise.

After 30 minutes:

The next part of the activity is to discover and discuss the characteristics of the process that the groups experienced. The purpose is become aware of these characteristics and to highlight best practices for planning in groups.

Ask:

By a show of hands, how many people thought they discovered person centered information? Please give me some examples.

If self-advocates are participating, you may want to start by asking each person his/her reaction to this activity so far.

Refer to Participant Manual Page #24 "Best Practices" discovered during the planning session.

Ask "What are the characteristics of your group process so far? In other words, how did it go?" (You may ask this question of each group or the entire class). This is a very open-ended question and you will get a variety of answers.

The following are common characteristics mentioned with suggested responses:

- **Difficult not to jump ahead and offer solutions or resources.**

  Though groups may want to note suggestions made, this is not the time to follow those pathways in detail or for any length of time.

- **Learned a great deal about the person in a short amount of time.**

  When planning is collaborative and everyone knows the person well a wealth of information is discovered. However, planning can't be rushed!

- **The more we learned the more pathways were explored.**

  The depth of information learned characterizes personal planning. How easily were you able to discover person-centered information? Were any insights missed because certain people or providers were not present?

- **It would have been different if the person with disabilities was present (if a self-advocate was not present).**

  How it would have been different? Maybe it would have been a slower process, a more personal process, or language used would have been different. Observations of the person would have expanded our thinking.

- **Collecting information in categories was helpful. So were the colored markers.**

  Though collecting information in categories was not required, some recorders may have done so and found it helpful to organize his/her thinking and that of the group.

- **Writing the information on the flip chart was a great visual.**

Encourage participants to use the flip chart method at their next review or planning meeting.

Note to trainer:

This is a good time to summarize what has been taught already and provide a transition to the next part of the course.

Say:

We've reviewed:

- The definition of an ISP
- Major sections of the ISP
- Characteristics of planning from a person centered perspective
- The five sequential steps to planning:
  - Step 1 (Gather Information as the Basis for Planning)
    - Areas of discovery that could be used in planning
    - Awareness exercise of what it must be like to be the focus person of planning
    - Began planning from a person centered perspective in groups

Next we will:

- Continue planning in groups and follow Step 2 (Identifying themes) and Step 3 (Choosing personal valued outcomes)
- Review and discuss Steps 4 and 5 of the planning process (Identifying safeguards and next step strategies)
- Learn how to assemble the ISP document once the planning has begun.

We will continue planning in groups and begin with Step# 2 in the planning process (identify themes in the person's life).

Step #2: Identify Themes in the Person's Life

Refer to Participant Manual Page # 25/ Slide # 21

Explain and Discuss the following:

As information is gathered, patterns or themes in the person's life begin to emerge. Themes are summary statements of information learned so far that seem to thread though a person's life and keep on happening. They can reveal patterns in daily life. Sometimes themes are keys that open a new world of understanding about the person.

Themes are used as cues or indicators to:

- The person's valued outcomes and the vision of a positive and desirable future.
- What's not working for the person that should be minimized
- An individualized quality life for the person.
- How service and supports should be provided.

Give an example of a theme in your personal life.

Some examples of themes are:

- Lack of friends that are not paid to be with him or her
- Likes to be with others and enjoys friendships
- Is a fighter and is determined
- Has strong cultural interests
- Is a survivor
- Lacks community membership
- Doesn't see himself/herself as a person with disabilities
- Must be organized and have a routine
- Has many capacities, attributes, and skills
- Has multiple health needs
- Has no permanency in home or work
- Values personal attention from others
- Must be physically active
- Is very easily bored and frustrated
- Makes few choices and is not in control of his/her own life
- Loves a certain type of music
- Is strongly connected to family

Introduce the 2nd part Activity #3: Simulated ISP Planning

Ask each group to identify at least two themes for the person they are discussing and write them on the flip chart.

After 5 minutes **ask** each group in turn to tell the larger group at least two themes.

As each group speaks, **comment** on how the themes are cues or indicators for one or more of the following:

- The person's valued outcomes and the vision of a positive and desirable future.
- What's not working for the person that should be minimized.
- The key elements that impact the person's day-to-day life.
- An individualized quality life for the person.
- How service and supports should be provided.

For example, if someone likes to be around others, singular activities would be frustrating for the person.

Ask if other members of each group want to add anything to the spokesperson's presentation.

Step 3: Choose Personal Valued Outcomes

Refer to Participant Manual Pages #26 and #27/ Slide #22

Explain and Discuss the following:

If themes give a direction, then outcomes are the destination or valued end result. The gathered information and an understanding of the person's themes in his/her life help the person decide needs, wants, and aspirations.

Outcomes are **anchors** for the services and supports that the person will receive. All providers of supports and services must know what they are. Some providers will provide services based on these outcomes (residential habilitation, day habilitation, day treatment, service coordination, etc.)

Outcomes can be dreams or simple day-to-day choices. They can be desires, needs, wants, or aspirations.

Ask for examples of outcomes.

Examples of outcomes are:

- Living in a safe home in Rochester with my friend Sam
- Being understood by the staff around me, especially when I want or need something
- Enjoying the garden and backyard each day
- Learning how to speak up for myself, especially in group situations like my planning meeting
- Being comfortable in my wheelchair and without pain
- Joining my local fire department as a dispatcher
- Learning self-protection when I'm in my neighborhood alone

Explain and Discuss that outcomes are:

- From the perspective of the person. They are not "externally" set without planning first.
- Clearly stated and as specific as possible at the time. Vague outcomes can leave the person's life up to chance.
- Chosen based on informed choice and empowerment.
- Built on capacities and interests. Assessments by themselves do not define outcomes.
- Responsive to change. Outcomes can change at any time.
- Not limited to skill development.
- Coordinated throughout the person's network of supports and services.
- As anchors, everyone can help the person pursue the same outcome, but in different ways by emphasizing different skills or experiences.
- Pursued by omitting or limiting unnecessary prerequisites. Don't erect barriers, break them down.
- Getting a clinical service is not an outcome. It supports an outcome. For example, "to get physical therapy" is not an outcome. "To have more flexibility in my arms and legs" is an outcome that is supported by receiving physical therapy.
- Parents often choose outcomes for their children. But remember, the child's interests and choices must be considered.
- Though outcomes can help the person to maintain a skill, ability, interest, or life situation, please use them sparingly. Outcomes were designed to move a person's life ahead and to have experiences and opportunities that do not simply repeat the past.

Say:

Some outcomes may not seem realistic at first or very difficult to attain.

Refer to Participant Manual Page # 28

Ask "What would you do in these situations?"

Possible answers:

- Help the person to pursue the outcome by taking a step by step approach and providing assistance along the way. For example, getting a driver's license, getting married, having children, or going on vacation to Australia. Trial and error and some failure are how we all learn. However, we must protect the person from harm.

  Ask for examples of when a person pursued or achieved a dream.

  Give one of your own examples.

- Look behind the request for a hidden or other meaning. A person who wants a driver's license may want more freedom or a person who wants children may want to nurture.

  Ask for examples of when they looked behind the dream.

  Give one of your own examples.

Note to trainer:

If a participant gives a negative outcome (drinking alcohol to excess; sitting around all day with nothing to do) respond by asking the group for comments. Summarize by saying that as professionals and Medicaid providers we do not help people to pursue an outcome that will threaten the person's health and safety or that of others. Nor do we help people build negative futures or waste their life.

Review the following briefly:

Refer to Participant Manual Page #29

Characteristics of Outcomes:

- Outcomes are for everyone, not just those with more abilities. The key is they come from personal planning.

- The experience of caregivers and others who are close to the person when choosing outcomes is very important, especially for people who have difficulty expressing or deciding what is important in their lives, who have minimal community life experiences, or who have severe or complex disabilities.

- When children are the focus of planning, their parents help to choose outcomes. Sometimes these decisions help the family as a unit as well as benefiting the child. Examples are choice of respite, residential habilitation, or school supports. However, the child's needs and choices must be considered in planning.

- Though outcomes can change at any time after the plan has been designed and implemented, it is often wise not to rush or be overly anxious to make these decisions. A thoughtful process that is truly person centered takes time and should never be superficial.

- There does not have to be an outcome for each ISE value. (Individuality, Inclusion, Independence, and Productivity) Instead, the planning process should produce outcomes that are specific to the person's interest, desires and hopes.

- Outcomes are always chosen with concern for the person's health and safety.

- Outcomes are not just need-driven. They derive from the person's interests, talents, preferences, and choices.

Remind:

Remind the participants that this is the 3rd part of the activity: Simulated ISP Planning. Now we will identify valued outcomes based upon information gathered from the Areas of Discovery and the themes we discovered.

Ask each group to identify at least two outcomes for the person they are discussing and write them on the flip chart.

After 5 minutes **ask** each group in turn to tell the larger group at least two outcomes.

As each group speaks, **comment** on how the outcomes**:**

- Are from the perspective of the person
- Come from the planning process
- Are specific and clear
- Are a vision of a positive a desirable future
- Are anchors for supports and services

Ask if other members of each group want to add anything to the spokesperson's presentation.

Say that this ends our group activity portion of the agenda. Thank you for your cooperation and participation. You all did a great job.

If self-advocates are participating, be sure to applaud their cooperation and participation. It's not easy to talk about yourself with people you may not know.

Review what steps were covered in the previous activity (Gather information, identify themes, identify personal valued outcomes). We will now go over the last 2 steps of the ISP planning process:

- Step 4: Identify safeguards

- Step 5: Develop next-step strategies and a personal network of assistance

Step 4: Identify Safeguards

Refer to Participant Manual Page # 30 / Slide # 23

Discuss that when a good planning process is implemented, the safeguards the person needs should be apparent. Trainer should refer back to one of the individuals referenced in the simulated ISP planning activity to illustrate and link the planning process with identifying safeguards.

Explain and Discuss the following:

- Safeguards are supports needed to keep the person safe from harm and actions to be taken when the health or welfare of the person is at risk.

- Safeguards are significant issues discovered during the planning process that are individualized and specific to the person.

- Safeguards are not meant to be so wide-ranging that routine supports, such as a yearly dental exam or receiving three meals each day, are always identified. Not every conceivable risk or danger is identified. A cookie-cutter approach to safeguards is discouraged.

Ask for examples of safeguards.

Examples of safeguards are:

- fire safety (required in every ISP or the attached Individualized Plan of Protective Oversight))
- certain types of medications (for example, a heart medication) or specific health care needed.
- supervision needed for community inclusion strategies
- food consistency or special diets
- allergies and any immediate steps to be taken
- sun sensitivity because of certain medications
- action steps for self-abusive behaviors or behavior that could cause injury to others
- vulnerabilities at home and in the community
- the need for readily available written information about the health and medical status of the person
- needed hospital coverage or special instructions that should accompany a person if admitted to a hospital
- preventative actions to avoid (a) disease or infections, or (b) exacerbating an existing medical problem

Refer to Participant Manual Page # 31

The person's fire safety needs must be discussed in the ISP in the Safeguards Section or in the attached Plan for Protective Oversight if the person lives in an Individualized Residential Alternative (IRA). This is a reasonable and thought out approach to keeping the person safe in case of fire.

- Does the Medicaid Service Coordinator **ensure there is a current and reasonable assessment** of the individual'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 an **OPWDD certified site** (e.g., IRA, Family Care or Supportive/Supervised CR), the site is responsible for the person's fire safety and an assessment of each person's capacity to evacuate the home in the event of a fire emergency. **The Service Coordinator is responsible for ensuring that this assessment is current and reasonable based on the Service Coordinator's knowledge of the person.**

  If a person lives in a **non-OPWDD certified site**, the Service Coordinator discusses and reviews with the person or family his/her fire safety needs, but a formal written fire safety assessment is not required. Results of this discussion

  and review should be summarized in the Safeguard Section of the ISP and should include any actions taken based on the identified needs.

- Does the Medicaid Service Coordinator ensure that actions and recommendations relative to addressing an individual's assessed fire safety needs are specified in the ISP and does the Medicaid Service Coordinator advocate that these recommendations are implemented?

  Service Coordinators are not required to routinely read fire drill reports or be present for fire drills. However, if the Service Coordinator determines that the
  person is in imminent danger due to lack of a current fire safety assessment or actions needed for fire protection, the Service Coordinator should contact his/her supervisor, as well as the individual responsible for fire safety at the residential site.

Transition to step 5. State the previous steps and explain that they culminate to this step which is the concrete step of the process.

Step 5: Develop Next-Step Strategies and a Personal Network of Assistance (Individualized Service Environment)

Refer to Participant Manual Pages #32, #33 and # 34/ Show Slide #24

Explain and Discuss the following:

- The purpose of this step is to bring to reality a very personal network, or Individualized Service Environment (ISE), of supports and services that helps the person to live a successful life in the community and pursue personal outcomes. It is the culminating step for all the discussions, decisions, and discoveries made so far. It is the time to decide what has to be done, who will do it, and how it well be accomplished. Next-step strategies hold people accountable and encourage commitment to helping the person.

- The completion of this step results in an ISE that consists of a variety of resources that are compatible and work in collaboration with each other and the person. The ISE is a blending of unpaid and paid supports.

- As you design the person's ISE, the first and most important area to consider is help from friends, family, and community resources. Funded resources should complement rather than replace natural supports and community resources.

- Review existing supports and services and decide which ones may not work for the person anymore and may need to be changed or replaced.

- Some resources may need to be created or organizational changes made.

- It's important to identify next step strategies that can be completed in a short period of time like making a referral, requesting an assessment, locating transportation, contacting a family member, or immediate safety measures.

- The resulting list of service and supports will be documented in Section 2 of the ISP. We will review the specifics of these entries in the next section of this training.

Ask:

"What are some resources or creative supports and services that you have used?"
Encourage sharing and networking.

Transition from the ISE to the next step strategies – the what, who, how and when after the planning process.

Say:

The following questions are asked and decisions are now made that result in next step strategies and the person's Individualized Service Environment. During a planning meeting, decisions should be written on a simple 4-column chart:

What	Who	How	When

What needs to be pursued and accomplished? This is the time to set priorities with the person and family.

- What are the person's desired outcomes? (Step 3 of the planning process)
- What are the person's needed safeguards? (Step 4 of the planning process)
- What additional assistance does the person need that may not be a personal valued outcome? For example, pain management or needed transportation.
- What clinical assessments are needed, if any?
- What community inclusion strategies should in place?

Who will help the person? Identify the natural support or paid service/provider. This is the time to obtain commitments. Multiple people can agree to help the person with the same outcome or need.

- What people or services are already in place?
- Consider new opportunities and ideas discovered during planning.
- Consider replacing existing supports and services that may not work for the person anymore.

How will it be accomplished? What action steps are needed?

- Consider how outcomes and other additional assistance will be pursued. Consider what skills should be taught, what supports should be given, and what new experiences should be explored. Acknowledge any barriers or obstacles that need to be overcome but avoid an emphasis on procedural problems that will be encountered

When will it be accomplished? This is a timeframe for a specific action, if needed.

- For example, in the next 6 months, the next month, or by a certain date. Timeframes help people to be accountable and help ensure progress is being made.

Trainer should ask participants for examples of next step strategies. Explain that they have just identified themes and developed some outcomes. Using these or examples form their caseload, they should give some examples of how an outcome will be brought to life, what services will support this outcome (who will do what, when, how and how often). Participants need to solidify the whole process with a "product" they can refer to during class and/or when they get back to the office or are working with someone on their ISP.

Transition/Summary:

You might say:

So far today we focused on planning from a person-centered perspective. The amount of time spent reinforces how critical it is to writing a personal plan or ISP.

Trainer should briefly re-describe what makes planning person-centered (mention the main elements). He/she should also repeat the planning steps before proceeding.

You might say:

Now we will learn how to assemble an ISP after the planning has begun.

Remember:

This is a lot of information that was given to participants. At this point they may be overwhelmed. It is a good idea to help them to refocus.

Module 4:
Writing the ISP

Refer to Participant Manual Page # 35 / Slide #25

Purpose of this module:
To understand how to assemble a person's ISP.

Objective of this module:
How the ISP is assembled while meeting the requirements of OPWDD.

Specifically we'll cover:

- An Overview of The ISP Format and Instructions
- Specific Components of the ISP
  - The ISP Header
  - ISP Section 1: The Narrative: profile, person's valued outcomes, safeguards
  - ISP Section 2: The Person's Individualized Service Environment (ISE): Natural Supports and Community Resources, Medicaid State Plan Services, Federal, State or County Funded Resources, HCBS Waiver Services, Other Services or 100% Funded Supports and Services
  - Signatures
  - Attachments
- Reviewing and updating the ISP
  - Changes to the ISP
  - Reviews of the ISP
  - Documentation of the ISP Review
- Maintenance, Retention and Distribution of the ISP

Method:
Presentation and discussion

Materials:
Participant Workbook
PowerPoint Slides (Optional)

Time
Approximately 1 hour, 45 minutes

Module Four
Topic One: Overview of the ISP Format and Instructions

Refer to Participant Manual Page # 36

Show Slide # 26; also refer to the ISP format beginning on Page # 55 of the Participant Manual

- **Explain that we will review** the ISP form briefly page by page, section by section, to familiarize everyone with the format of the ISP and why this format is to be followed. We will first go over the sections of the ISP and the categories under each section. So, if you have any questions about signatures, please ask them during the appropriate segment. This helps to keep the material and the presentation organized.
- After reviewing the ISP format, we'll discuss attachments, reviews, updating the plan, and the maintenance, retention, and distribution of the ISP.

Say:

This module focuses on how to write an ISP. In writing the ISP, there are three goals:

1. To assemble an ISP as a person's personal plan
    - An ISP is written for everyone enrolled in MSC or the HCBS Waiver regardless of where they live or what services and supports they receive.
    - The ISP is assembled, implemented, and maintained by the person's service coordinator.
    - It is ongoing, not stagnant, and is modified as temporary setbacks and accomplishments occur.

2. To meet OPWDD requirements
    - **Make this point: The requirements that we are reviewing this afternoon are STATEWIDE RULES that meet expectations of both MSC and the HCBS Waiver. Knowing statewide expectations will help you to separate out local agency or DDSO rules.**

3. To keep the person well and safe

Discuss:

The ISP has two primary sections

Section 1: **The Narrative: Profile, Outcomes, and Safeguards**
Section 2: **Individualized Service Environment (ISE).**

- **The basic format of the ISP must be adhered to, including all sections of the plan and the sequence of each section.** Service coordinators may add their agency name or logo, transfer the form to word processing, or add additional sections.

- **The first ISP is written within 60 days of the HCBS Waiver enrollment date** (which can be found on the HCBS Waiver Notice of Decision form) **or within 60 days of the MSC enrollment date, whichever comes first.**

  Sometimes planning has just begun by the time the first ISP is due. Assemble the ISP with the available information. Since the ISP is kept current, it can be updated at any time.

Summary/Transition:

Provide a transition to the next topic: Specific Components of the ISP

You might say:

Now that we have an overview of the ISP format, we'll continue with discussion on the specific components of the ISP. We'll review what should be indicated in each ISP section.

Module Four
Topic Two: Specific Components of the ISP

The Header

Refer to Participant Manual Page # 37 / Show Slide #27

Say:

These must be in the header of the form:

- **The date of the ISP**

The ISP date is the date of the face-to-face ISP review meeting or the non face-to-face ISP review which results in a written or rewritten ISP. This date does not change unless the ISP is rewritten by the service coordinator.

For the very first ISP, which is completed within 60 days of the MSC or HCBS Waiver enrollment date, a review of the ISP must occur within 6 months of the date of this first ISP. We will discuss more about ISP review timeframes after we review the form.

- The **name of the person**

Additional information can be added at the discretion of the service coordinator or service coordination agency. For example, TABS number, date of birth, etc.

- **Medicaid Number or CIN Number:**

The person's Medicaid number, also known as the person's Client Identification Number (CIN).

- **The Dates the ISP was Reviewed, the MSC Initials and whether the ISP review was a face-to-face meeting.**

List each date the ISP was reviewed. ISP reviews must take place at least twice annually. One of these reviews must be a face-to-face review meeting with the individual and major service providers. Use the check boxes to indicate whether the review was a face-to-face meeting. The annual face-to-face review meeting must occur within 365 days of the prior face-to-face meeting or by the end of the calendar month in which with 365th day occurs. It is suggested that, at a minimum, an ISP review occur every six months.

ISP Section 1: The Narrative

Refer to Participant Manual Page #38 / Slide # 28

Say:

Section 1, the Narrative, gives a clear understanding of the person and his/her valued outcomes for receiving supports and services. This includes information to keep the person safe and well.

Section 1, the Narrative of the ISP, is divided into three parts:

a) **Profile**
b) **The Person's Valued Outcomes**
c) **Safeguards**

a) The Profile

Refer to Participant Manual Page #38 / Slide # 29

Say:

- **The Profile is a narrative about the person.**

It summarizes some or all of what was learned during the planning process and tells the reader about the person and his/her current needs and wants.

The profile assists those people helping the person to provide supports and services with an understanding and sensitivity to what is important to the person to successfully put the plan into action.

- **The profile must include selected person centered information about the person discovered during the planning process.**

  This information can include life themes, valued social roles, preferences, capabilities, friends and relationships, personality, capabilities, pertinent clinical information, needs, health, talents, skills, fears, cultural traditions, or other information that impacts our understanding of the person and how supports and services will be provided.

Ask: "What do you usually put into a profile?"

Discuss the answers and give recommendations.

Some common answers are:

- **History.** A brief overview of history may be needed but do not give a lengthy and detailed account. Pscyho-socials and Social Work evaluations contain history.

  For example: John spent his youth at home with his parents until age 18 and then lived in 3 successive family care homes before moving to his current home (an IRA) 3 years ago.

- **Medical information.** Brief and direct information is recommended. Again, a summary of the person's detailed medical condition is not expected.

  For example: John has seizures at least once a month and has asthma. He takes medications for both. Otherwise, he is in good health.

- **Diagnosis.** This information is important to understand the person. However, it should not be the centerpiece of the profile. Please refrain from stating the person's diagnosis at the beginning of the profile. The person should be seen as a person first and not a grouping of disabilities.

Say:

You have to use your professional discretion when deciding what goes in a profile and what is left out. Keep in mind what the person wants in his/her own profile, what parents or advocates may want, and what information will make a difference in how services and supports are designed and provided.

Also focus on what the profile hopes to accomplish at the time. For example, if the person is in transition, and many referrals are being made, then some information may be included for now and taken out later.

Tell a story of someone close to you. Give examples of what you would put in his or her profile.

Review the following:

- **Highlight abilities and avoid a needless discussion of disabilities that do not relate to the person's valued outcomes or health and safety.**

- **Use plain English and avoid labels, acronyms, or professional jargon.**

Avoid terms like "non-compliant"; "attention-seeking", or "behavior problem". These labels can be misunderstood or encourage a negative reputation of the person. Instead, describe the person's actions in simple ways.

For example, instead of writing "Joe is non-compliant with dressing himself" write "Joe requires patience and a lot of encouragement to dress himself independently"; or instead of writing "John is attention-seeking" write "John likes to be around others and often seeks their company". In addition, describe behaviors that necessitate a behavior management plan rather than using professional jargon.

- **Avoid changeable information as height, weight, or dosage of medication.**

This information is more accurately communicated on a medical or nursing report.

- **Profile contents may vary depending on the service coordination agency or supervisory requirements.**

Always refer to the "Key to Individualized Services" or the "MSC Manual" to clarify the distinction between statewide policy and agency requirements.

- **Don't let the length of a profile measure its value or effectiveness.** Each service coordinator has a different writing style, some more concisely, others need more words. Some profiles are more comprehensive than others depending on the person and his or her current life situation.

- **The profile is not a comprehensive clinical report or assessment, or a complete social history.**

Though clinical and historical information may be relevant and therefore included it must not dominate a profile. For example, though there may be a medical condition or certain life experience that impacts the person's life, it is not necessary to specify all the details of the experience or condition.

- **The ISP is not a repository of all information about the person and not a stand-alone document.**

If the ISP becomes a repository of too much information the essence of the ISP as a personal plan is lost and the person's valued outcomes may be overshadowed. The ISP complements rather than copies detailed and comprehensive information about the person that can be found in supporting documentation such as clinical assessments, various types of information sheets, habilitation plans, historical summaries, etc.

Review Workbook page # 39 / Show Slide # 30

b) The Person's Valued Outcomes

The person's valued outcomes are listed in this section. These outcomes will be linked to supports and services. **There must be at least one outcome listed in this section for each waiver funded service the person receives (e.g. residential, day, prevocational, and supported employment).**

Refer to Participant Manual page #40 / Slide #31

c) Safeguards

Review and Discuss the following:

- **The person's significant safeguard needs that generate from the planning process are identified directly after the outcome section.**

  Safeguards briefly describe the individual health and welfare needs of the person and actions to be taken (safeguards) to keep the person safe and well.

- **The Habilitation Plans will provide greater detail about how safeguards are ensured within the context of the respective service.**

  Service providers and others, based on information in the safeguard section, must be prepared to prevent or respond to those issues when providing services or supports.

Discuss the importance of safeguards: Staff and service providers all have a primary responsibility to make sure that the person is safe. Give some examples of safeguards if they were not given before.

- **"See attached Plan for Protective Oversight" can be written in the safeguards section for people who live in an IRA**

  People who live in Individual Residential Alternatives (IRAs) must have an Individual Plan for Protective Oversight, which is attached to the ISP. The operator of the IRA, using information learned during the collaborative planning process, writes this plan. The information from the Individual Plan of Protective Oversight is not repeated in the Safeguard section of the ISP. Simply write "See attached Plan for Protective Oversight". However, the service coordinator must add any safeguards to the ISP that are not included in the Individual Plan of Protective Oversight.

- **Fire safety must be discussed in the safeguard section of all ISPs unless it is discussed in the attached Individual Plan for Protective Oversight for people who live in IRAs.**

Summary/Transition

You might say:

We've reviewed Section 1 of the ISP (Profile, Valued Outcomes and Safeguards). Now we'll continue with Section 2: The ISE (Individualized Service Environment) and how to list supports and services in the ISP.

Section 2: Individualized Service Environment (ISE)

This section is further broken down into categories of assistance which include natural supports and community resources, Medicaid State Plan services, Federal, State, or County services, HCBS Waiver Services, and other services and 100% OPWDD funded supports and services.

Refer to Participant Manual Page # 41 / Show Slides #32 and #33

Say:

- **Section 2 of the ISP lists all the supports and services received to help the person live a successful life in the community and pursue his or her valued outcomes.**

It is intended to document supports, services, and resources and not be an extension of the profile.

- **Section 2 of the ISP clearly sets accountability for who will assist the person to pursue his/her valued outcomes.**

This is demonstrated by the required information for all funded services that we will review shortly.

- **It also demonstrates the coordination between these supports and services.**

An Individualized Service Environment is a uniquely designed blending of paid and unpaid supports and services that work in harmony to help the person live a successful life in the community and pursue his or her valued outcomes. It is developed as part of planning in Step 5.

- **A well-developed and documented network keeps the person healthy and safe from harm.**

- **Section 2 of the ISP must "fit" with or complement the profile.**

The two sections of the ISP must logically "fit" together. Activities, Supports and Services must be consistent with the person's needs and personal valued outcomes. The information in the narrative is linked to the supports and services in Section 2.

The ISE Categories

Refer to Participant Manual Page # 42/ Show Slide #34

Say:

- Section 2 of the ISP is broken down into **categories.**
- Each support and service that is part of the person's ISE is entered under one of the categories.
- All of the categories except Natural Supports and Community Resources are related to a funding source. Therefore, service coordinators must know how the service or support is funded in order to enter the information correctly.

Briefly Review the categories:

- **Natural Supports and Community Resources** are resources for supports and services that exist in the community for everyone.

Natural supports and community resources are those routine and familiar supports that actively 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. This can include family, friends, neighbors, associations and community centers, religious or school groups, continuing education, self-help groups, health club, reading clinics, hobby or collectors clubs, volunteers, transportation, etc.

- **Medicaid State Plan Services** are those medical services that a person can access with his or her Medicaid card (except to HCBS Waiver Services).

These services include Medicaid Service Coordination, physician, pharmacy, laboratory, hospital, clinic, dental, physical therapy, audiological, personal care, certified home health care, durable medical equipment, day treatment, psychology, etc. Medical, nursing or dental State Plan Service provided in an Article 16, 28, or 31 Clinic should be described in this section.

- **Federal, State, or County Services** are government services funded by agencies other than OPWDD.

These include Vocational and Educational Services for Individuals with Disabilities (VESID), State Office for the Aging (SOFA), Housing and Urban Development (HUD), Board of Cooperative Educational Services (BOCES), Department of Health (DOH), Department of Social Services (DSS), public schools.

- **HCBS Waiver Services** are those services funded by the Home and Community Based Waiver.

Examples of these are Residential Habilitation, Day Habilitation, Community Habilitation, Prevocational Services, Supported Employment, Respite (including free standing respite), Assistive Technologies, Environmental Modifications, Family Education and Training, Plan of Care Support Services, Consolidated Supports and Services, and Intensive Behavioral Services.

- **Other Services and 100% OPWDD Funded Supports and Services** are services that do not fit in the other categories or are solely funded by OPWDD and have no Medicaid funding.

Examples are Family Support Services, Individualized Support Services, and some Community Service Plan services such as mirrored service coordination. Private Medical Insurance can be listed in this section.

a) The Information Needed for Each Supports & Services Category Entry

Refer to Participant Manual Page # 43 / Show Slide #35

Present and Discuss the following:

NATURAL SUPPORTS AND COMMUNITY RESOURCES:

The Information needed for each entry for natural supports and community resources should include:

- **People, places, or organizational affiliations that are an active resource to the person by providing supports or services.**

This is not intended to be an exhaustive list of all-generic community activities, places, or relationships experienced by the person such as extended family, grocery stores, parks, shopping centers, and restaurants. **Only those that provide a support or service**. A description of day-to-day community involvement is more appropriately included in the profile. Be sure to consider supports provided by family members, including the potential support of reunited members.

- **A brief statement or summary of what the support is doing to help the person. Be sure to include any relevant details that coordinate these supports with the rest of the network such as how often the support is provided, where, and extent of involvement.**

For example, "John's neighbor, Harry Smith, helps John with his grocery shopping at Wegman's every Saturday"; or "John is a member of the Red Hook fire department and attends most of the scheduled activities with his friend Sam, especially the Tuesday night meetings."

Refer to Participant Manual Page # 44 / Show Slide #36

Present and Discuss the following:

ALL FUNDED CATEGORIES:

Entries for all Medicaid State Plan Services, Federal, State and County Funded Resources and other 100% Funded Services must include the information below:

- **Name of the provider or agency** (e.g., Dr. Smith, Community General Hospital, VESID, Housing and Urban Development, Sunshine County ARC, or DDSO).

- **Type of service** (e.g., physician, cardiologist, educational, residential habilitation, housing, day treatment, or Medicaid Service Coordination).

Refer to Participant Manual Page # 45 / Show Slide #37

For HCBS Waiver Services

- **Name of the Waiver service provider or agency**

- **Type of provider or type of service** (e.g. residential habilitation, supported employment, consolidated supports and services, respite).

- **Frequency of the support or service** (must correspond to the billing unit of service (e.g. day, month, hour, or one time expenditure). See the frequency of HCBS Waiver Services Appendix attached to ISP instructions and included in this manual.

Refer to ISP Format & Instructions for Frequencies for HCBS Waiver Services

Units of service are billing units. For example, the unit of service for Waiver Supported Employment is a month, and the frequency of this service should be listed as "month" on the ISP.

- **Duration of the support or service.** This means for how long, as a whole, the assistance is expected to last. If the service does not have an expected end date, write "ongoing".

For example, "until 5/1/11" when the service has an end date; "on-going" if there is no end date; or a specific date or anticipated purchase/completion date for a one-time service such as an environmental modification.

- **Effective date of the Service.** This is the date the current provider began to provide the service. **Note that an authorized waiver provider's billings will be jeopardized if the date the service provider actually billed for the service is prior to the effective date shown on the ISP.**

HCBS Waiver Services must have the exact and correct effective date. Contact the business office of the agency providing the service to determine the first day the service was billed.

This effective date does not change if the person chooses a new service coordinator employed by the same agency or changes homes operated by the same agency.
If the person changes his or her service provider, then there is a new effective date that corresponds to the date the new service provider began to provide the service.

NOTE:

THE ABOVE INFORMATION (NAME AND TYPE OF PROVIDER, OUTCOME, FREQUENCY, DURATION, AND EFFECTIVE DATE) MUST BE ACCURATE FOR HCBS WAIVER SERVICES SINCE THE ISP DESCRIBES THE PAYMENT OF THESE SERVICES.

It is required that HCBS waiver habilitation services (e.g. residential, day, prevocational, and supported employment) help the person to pursue at least one of the person's valued outcomes. This outcome(s) is repeated on the habilitation plan. There must be a "match" between at least one outcome(s) for a waiver habilitation service in the ISP and the outcome(s) in a habilitation plan.

NOTE:

It is not necessary for the valued outcomes in habilitation plans to match word for word with the valued outcomes as stated in the ISP. It is only necessary that there be an obvious connection.

Frequency for HCBS Waiver Services

Residential Habilitation
- IRA or Community Residence ……Month
- At Home……..Hour
- Family Care…….Day

Day Habilitation
- Group ……Day
- Individual Hour

Community Habilitation……...Hour

Supported Employment (SEMP)……..Month

Pre-Vocational Services…….Day

Respite…….Hour

Adaptive Devices……...One Time Expenditure

Environmental Modifications…….One Time Expenditure

Plan of Care Support Services…….Once Every 6 Months

Family Education and Training…….1 or 2 Units per Year

Consolidated Supports and Services …….Month

Community Transitional Services ……One Time Expenditure

Agency with Choice/
Financial Management Services…… Month

Intensive Behavioral Services……..Product/Hourly

Additional Information:

Present the following:

- **For a one time service or purchase, such as environmental modifications, the anticipated purchase/completion date is used as the effective date.**

When the ISP is rewritten (which requires a new ISP date in the masthead), some effective dates of services could predate the ISP effective date.

- **ISP entries for funded services must only include the information listed above (name and type of service provider).**

Further specificity about how the service will be delivered is located in complementary plans (waiver residential and day habilitation plans, waiver prevocational and supported employment plans, day treatment plans, or service coordination activity plan)

- **Include Medicaid State Plan Services if used as secondary insurance to private coverage.**

Some families use Medicaid State Plan Services as secondary insurance to private coverage. If this applies, so state under Medicaid State Plan Services and list the primary insurance under the last category "Other". The name of the insurance company or program is all that is necessary.

c. Signatures

Refer to Participant Manual Page #47 / Show Slide # 38

Present the following:

The last page of the ISP requires four signatures as follows:

- **Service Coordinator**
- **Service Coordinator Supervisor**
- **the Person**
- **Advocate (if the person is not self-advocating),**

If the person is unable to sign, state this fact on the line for his/her signature. If the person is a self-advocate, so note on the line for the advocate's signature.

It may be necessary to mail a copy of the ISP to a family member or advocate in order to obtain signatures. Briefly explain on the original ISP, maintained by the service coordinator, that a copy has been sent for the advocate's signature. Do not leave any blanks.

Signatures attest to the agreements and informed choices made during planning about what the person's needs and wants and who will assist the person to pursue his/her valued outcomes.

Explain any difficulties in obtaining signatures in the service coordinator's notes.

Summarize what was discussed in this section and transition to attachments to the ISP.

5. Attachments

Refer to Participant Manual Page # 48 / Show Slide # 39

Present the following:

Attached to the ISP are copies of the following plans, as applicable:

- Any Waiver habilitation Service Plans including residential habilitation, day habilitation, prevocational services, supported employment plan, community habilitation, consolidated supports and services.
- Individual Plan for Protective Oversight if the person lives in an IRA
- Medicaid Service Coordination Activity Plan (if the person has requested one or is a Willowbrook Class Member).
- Clinic treatment plan recommendations for long-term therapies provided by Article 16 Clinics.

Transition/Summary:

Provide a transition to next topic: Reviewing and updating the ISP.

You might say:

Now that you have an ISP written, there are times when things will change for the person and the ISP will need to have revisions or be re-written. The ISP needs to be reviewed on a regular basis (twice yearly) and updated when changes occur. In the next section we'll talk about updates and reviews.

Module Four
Topic Three: Reviewing and Updating the ISP

Changes to the ISP

Refer to Participant Manual Page # 49 / Show Slides #40 and #41

Say:

The service coordinator ensures that the ISP is kept current (up-to-date), adapted to the changing outcomes and priorities of the person, as growth, temporary setbacks, and accomplishments occur.

Present and Discuss:

- **Changes are made by attaching an addendum**

The addendum should include the name of the person, the date of the ISP to which it is attached, the date of the change, the new or changed information, and the signature of the service coordinator.

Addendums require only the signature of the service coordinator. A note must be written in the MSC record indicating the change was discussed with and agreed upon by the individual and/or advocate. Addendums are filed with the current ISP and distributed to all appropriate parties.

- **Changes in the ISP must be communicated to day treatment providers and HCBS Waiver service providers (e.g. residential habilitation, day habilitation, prevocational services and supported employment). If an addendum is used, distribute copies.**

It is not necessary to rewrite the ISP every year. It can be rewritten when the content is not clear (too many addendums) or the plan is not effectively meeting its purpose. Anytime the ISP is rewritten new signatures are required.

Reviews of the ISP

Refer to Participant Manual Page # 50/ Show slides # 42, # 43, #44

Say:

Reviews of the ISP are part of the collaborative planning process and can follow the Five Steps to Planning. These reviews are critical to determine if the ISP is effectively implementing decisions made during personal planning.

Refer the participants to "The ISP Review" in their Workbooks.
This can be used as a resource when preparing and holding reviews.

The ISP Review

- Follow the person's agenda and discuss what the person wants to talk about.
- Gather new information and determine if the strategies identified to help the person live a successful life in the community according to his/her valued outcomes worked or didn't work.
- Determine if the person is successfully pursuing his or her valued outcomes, if outcomes need to be clarified, or if new outcomes need to be identified.
- Discuss any new themes in the person's life that may be cues or indicators for planning.
- Review the person's positive vision of the future for any changes, clarifications, or added details.
- Determine if the person is healthy and safe and, if not, what clinical assessments may be needed, what supports and services must be provided, or what safeguards need to be in place.
- Determine if planning and the ISP are encouraging community life and, if not, strategies to do so.
- Determine if the person is receiving services and supports according to the ISP and is satisfied with those services.
- Identify any obstacles to pursuing the person's outcomes and actions to deal with them.
- Develop any changes to the person's network of assistance (Individualized Service Environment) as needed or requested by the person.
- Determine if habilitation plans, or other plans, need to be changed.

- Identify next step strategies or action steps and who will follow-up with each.

Refer to Participant Manual Page # 52

Present and Discuss the following:

- **The service coordinator is responsible for coordinating a review of the ISP with the person, advocate, and major service providers, making any needed changes to the plan as the result of the review.**

- ISP reviews must take place at least twice annually

- At least annually, the ISP review must be a face-to-face meeting with the service coordinator, individual, advocate and major service providers (i.e. residential habilitation, day habilitation, prevocational, supported employment, or day treatment). Each of these major service providers must send a representative.

At least annually the habilitation plan must be reviewed at the ISP meeting with the service coordinator, person, advocate, and all other major service providers in attendance. This is a joint review of the ISP and all habilitation plans.

An effective review of the ISP also requires mutual sharing of information between the service coordinator and major service providers.

It is also important to **hold meetings at a convenient time** for everyone involved. For others a more informal approach is best. It may involve meeting with the person and his or her family in their home. However, input must still be received from the person's network (including major service providers) to effectively review the plan.

Documentation of the ISP Review

Refer to Participant Manual Page # 52/ Show Slide #45

Say:

Documentation that a review of the ISP occurred is recorded in the **service coordinator's notes.**

This may include (a) the date, (b) the signature of the service coordinator and (c) a brief summary of the review and (d) names of the people who attended the review.

ISPs are updated as a result of the review.

Summary/Transition:

Provide a transition to the next topic: Maintenance, Retention, and Distribution of the ISP.

You might say:

We discussed updates and changes to the ISP. The next section will focus on maintaining, retaining and distributing the ISP.

Module Four
Topic Four: Maintenance, Retention, and Distribution of the ISP

Refer to Participant Manual Page # 53 / Show Slide #46

Say:

- **The signed ISP (with attachments) is maintained by the person's service coordinator and filed in the service coordination record.**

The ISP must be maintained, according to Medicaid rules, for at least 6 years but not necessarily in the "active" record. If the service coordination agency changes, a copy of the current ISP is forwarded to the new service coordination agency and the original is kept by the former agency.

Show Slide #47

- **Copies of the signed ISP (with attachments) are forwarded by the service coordinator to:**
  - **The person,**
  - **His/her advocate, and**
  - **All waiver service providers**
  - **Day Treatment**
  - **Article 16, 28, or 31 Clinics**
  - **Other providers and individuals with the consent of the person and/or advocate**

- HCBS Waiver habilitation providers have 30 days from the date of the ISP review to make any necessary revisions to the habilitation plan and send the completed and revised plan to the service coordinator.

The service coordinator has 60 days from the date of the ISP review to send the full ISP or addendum and any revised habilitation plans to the individual, advocate and appropriate service providers. The service coordinator must show proof of distribution indicating the parties to whom the ISP was sent and the date of distribution. This may be done on the ISP itself or a note in the service coordination record. If the 60 day time frame cannot be met because of delays in obtaining the signature of the individual and/or advocate, the service coordinator should still sign and send copies of the ISP to all appropriate parties without the individual and/or advocate signatures. The ISP must be sent with a note indicating that the original document with the required signatures can be found in the individual's service coordination record.

If the habilitation service provider fails to send the habilitation plan to the service coordinator within the allowed time frame the service coordinator should still distribute the ISP without the habilitation plan so as to not exceed the required distribution time frame for the ISP. In this case the habilitation provider is then responsible for distributing the habilitation plan to the service coordinator and all other required parties.

Show Slide #48

The ISP with any addendums or revisions and the services described remain in effect until a new ISP is written.

Show Slide #49

The ISP format and detailed instructions can be found on the OPWDD website.

Summary:

In this section we learned:

- How to assemble an ISP as a personal plan.
- To use information from the profile to come up with the person's valued outcomes. This is the part that makes it a personal plan.
- OPWDD's requirements for the ISP (such as writing the ISP, signatures and distribution timeframes).
- How the ISP helps to keep the person well and safe.

Wrap-Up

- Briefly review the course objectives and summarize the main sections.
- Thank everyone for their participation.
- Perhaps send them out with a last word/message/relevant inspirational story related to a person's ISP.
- Remind them that further questions regarding the ISP can be directed to their supervisor.

End of Course