

# Introduction to Proposed New

Oregon ISP

September 19, 2014

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This is a work in progress.

Changes are happening based on field test and ongoing feedback.

# Why one ISP?

- Oregon currently has 11 different ISP models used in various service settings
- Consistency for people supported and family members
- Assist in transitions across service settings
- Improved quality of plans

# Advisory Group

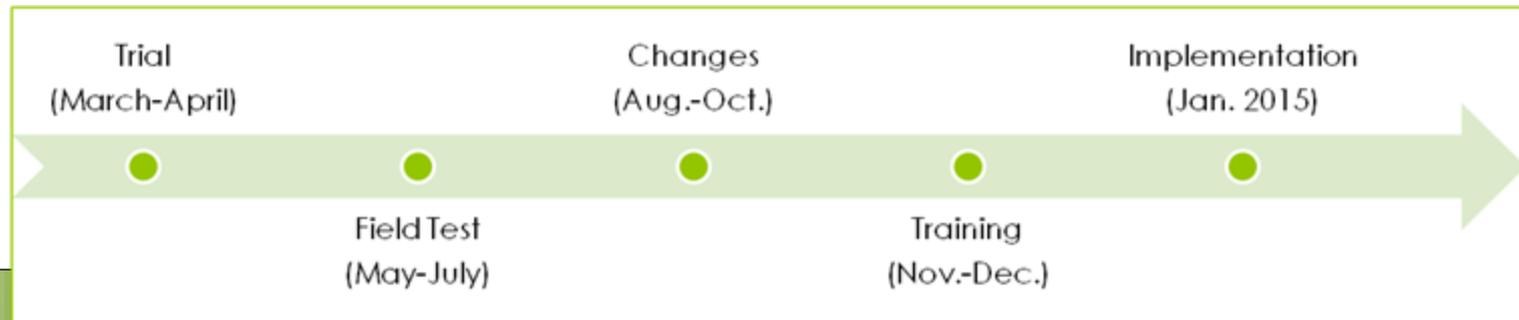
- Made up of stakeholders representing the array of service settings
- Reviewed each existing ISP in Oregon as well as ISPs from other states
- Responded to drafts developed by smaller work groups

# Partners in conversation

- eXPRS Plan of Care
- Employment First Implementation Team
- Medicaid Waiver Unit and Oregon Health Authority
- Licensing Unit
- ...and many others

# Where are we now?

- Field test concluded July 31
- We will continue to learn from what works and what needs improvement
- Statewide roll-out is anticipated by January 1 to coincide with implementation of new OARs



# Person Centered Information

Tool for gathering information from the perspective of **the person** and **others** that leads to the ISP

# Person Centered Information

Person's name:

Date of last update:

Use the space under each topic to describe what is currently happening in this person's life. If the person does not wish to discuss a topic, please note that. Seek perspectives from others that the person directs.

**Hopes and Dreams** *May reach beyond this current ISP, any timeframes for achieving hopes and dreams, things to include in this ISP to move toward these hopes and dreams, etc.*

**Person's perspective**

**Other's perspective, if different**

**Communication** *Describe how this person communicates including the person's preferences for expressing and receiving communication and how the person communicates their wants, needs, and pain.*

**Person's perspective**

**Other's perspective, if different**

**Life in Current Living Arrangements** *Where and with whom the person lives, who provides supports, meal planning, cleaning, personal care, opportunities to develop skills at home, hobbies, pets, safety, opportunities to contribute to the household, etc.*

**Person's perspective**

**Other's perspective, if different**

**Pre-Employment and/or Work** *Job exploration, job development for self-employment or paid work, job coaching, career goals, job satisfaction, developing job skills, planning for retirement, workplace safety, opportunities for continuity between work and home, opportunities to contribute to the workplace, financial concerns, childcare needs, lack of resume, etc.*

Person's perspective

█

Other's perspective, if different

█

**Employment-related skills** *Typing, answering phones, timeliness, organization, follow-through, friendliness, technical or computer skills, etc.*

█

+ **Employment-related preferences** *Hours, pay, location, etc.*

█

**School and Life-Long Learning** *Things this person would like to learn, opportunities for continuity of supports between school and home, continuing education, personal or professional development, understanding what I/DD services can offer, accessing school options, etc.*

Person's perspective

█

Other's perspective, if different

█

**Day Services** *Location, participation in chosen activities, attendance, relationships, safety, opportunities for continuity between day service settings and home, etc.*

Person's perspective

█

Other's perspective, if different

█

# Discussion Topics

- Hopes and Dreams
- Communication
- Life in Current Living Arrangements
- Community and Social Life
- Pre-Vocational and/or Work
- Day Services
- School and Life-Long Learning
- Relationships
- Health and Wellness
- Financial Life
- Protection and Advocacy
- Cultural Considerations
- Sexuality and/or Intimate Relationships
- Behavioral Health
- Mental Health
- Transportation
- Assistive Devices or Technology
- Environmental Modifications

# Risk Identification Tool

- Identifies known risks present in the person's life

Risk Identification Tool - 8.14.14 - DRAFT - NOT FOR USE

**Risk Identification Tool**      Date: \_\_\_\_\_

Person's name:     FirstName    LastName           No serious risk identified in this section (skip to HEALTH & MEDICAL section)

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**FATAL FIVE**

**1. Aspiration** (check all that apply)

a. Diagnosis of dysphagia, or been identified to be at risk for aspiration by a Physician, Speech/Language Pathologist, or Occupational Therapist

b. Ingests non-edible objects, places non-edible objects in mouth, or has a diagnosis of pica

c. Has a feeding tube

d. Diagnosed with gastroesophageal reflux (GER) and the physician has identified the person at risk of Aspiration.

e. Complain of chest pain, heartburn, or have small, frequent vomiting (especially after meals) or unusual burping (happens frequently or sounds wet) and the physician has identified the person at risk of Aspiration.

f. Someone else puts food, fluids, or medications into this person's mouth

***If the person experiences any of the following symptoms, a current evaluation by a qualified professional is required to determine if the person is at risk of Aspiration. (Check all that apply)***

g. Food or fluid regularly falls out of this person's mouth

h. Cough or choke while eating or drinking (more than occasionally)

i. Drool excessively

j. Chronic chest congestion, pneumonia in the last year, rattling when breathing, and persistent cough or frequent use of cough/asthma medication?

k. Regularly refuse food or liquid (or refuse certain food/liquid textures)

l. Need his/her fluids thickened and/or food texture modified?

m. Eat or drink too rapidly

**Evaluation results:**  Risk present     No risk     Declined eval     Other (see notes)

	Yes	Possible	No	History
Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# The ISP

## Individual Support Plan

Person's name:

*Complete this page based on communicating directly with the person. If additional information is needed, include information from people who have direct knowledge of the person's perspective.*

What people like and admire most about \_\_\_\_\_



How to best support \_\_\_\_\_

What is most important to \_\_\_\_\_



One page profile highlights the person's perspective and positive attributes at the front of the plan.

# The Plan

- Desired Outcomes are identified
- Based on what's important to the person

Individual Support Plan – DRAFT 8.18.14 – NOT FOR USE

## Desired Outcomes

<b>Desired Outcome</b> What is the desired result?	<b>Key steps to work toward the outcome</b>	<b>Who is responsible?</b>	<b>Timelines</b> Frequency or By When	<b>Where to record progress</b>	Check if written implementation strategies (Action Plans, Service Agreement, etc.) exist

Maintain instructions for staff to support identified risks (e.g. protocols, BSP, safety plans, etc.) where needed.

## Career Development Plan and Vocational Assessment (CDP)

**Students (age 18-20)** *If the person is under the age of 22 and still attending school, complete this section only.*

**Attending school and do not want to work now.** Expected date of exit from school:  Date by which the remainder of this Career Development Plan and Vocational Assessment (CDP) will be completed:

**Attending school and I do want to work now.**

**Working age adults (age 21-60) must choose one of the following statements:** *If the person is at least 18 years old and has exited school, complete this section instead of the "Students (age 18-20)" section.*

**Employed in integrated employment and wants to:** *Check all that apply.*

- Retain current job.
- Advance in current job (more hours, raise, new skills, promotion, etc.)
- Get a new job.
- Get an additional job.
- Retire – I am 60 or will be 60 this ISP year. *Employment Outcomes are not required.*

**Currently not working in integrated employment and wants to:** *Check all that apply.*

- Get a new job.
- Explore interests in integrated employment.
- Retire – I am 60 or will be 60 this ISP year. *Employment Outcomes are not required.*

**Choose not to work in integrated employment now and in the future:** *Check all that apply.*

- Does not believe he/she is able to work. *Employment Outcomes are not required.*
- Does not want to work. *Employment Outcomes are not required.*

**If the person chooses not to work in an integrated employment setting now and in the future, check at least one reason:**

- Transportation concerns
- Unable to find a job that matches my skills, interests and abilities
- Concern that I will lose my Social Security Disability and/or Medicaid benefits
- Behavior challenges
- Significant health problems and/or health-related needs
- Reluctant to change routine
- Other (describe):

**Must include notes from discussion guide for each box checked above.**

### Desired Employment Outcomes

Desired Outcome What is the desired result?	Key steps to work toward the outcome	Who is responsible?	Timelines Frequency or By When	Where to record progress	Check if written implementation strategies (Action Plans, Service Agreement, etc.) are expected
					<input type="checkbox"/>
					<input type="checkbox"/>
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Potential barriers to working in an individualized, integrated job

How will this obstacle be addressed?

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# The Plan

- Serious risks are identified and addressed

## Risk Management Plan

List risks identified through the assessment process and indicate the strategy to address each risk.

Risk	How is the risk addressed?	Check if written strategies are in place and note who is responsible	
		High risk	
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
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Maintain instructions for staff to support identified risks (e.g. protocols, BSP, safety plans, etc.) where needed.

# The Plan

- Connects assessed needs to specific chosen services (such as ADL and IADL support needs)

**Chosen K Plan Service**

Complete the following if the person chooses RESIDENTIAL services:

Service Setting	Service	Authorized dates (start and end)	Chosen provider type (Identify the PSW, independent contractor, provider or general business, etc.)
List needs identified	Chosen		

**Chosen K Plan Residential Service**

Service setting: \_\_\_\_\_

The K Plan services already included in my residential services are:

Attendant care – ADL / IADL     Skill training     Community Transportation

The additional K Plan services included in my residential services are:

Behavior supports     Nursing supports

Chosen provider type: \_\_\_\_\_

Authorized dates (start and end): \_\_\_\_\_

Person's preference on how service is delivered: \_\_\_\_\_

**Chosen K Plan Community Transportation Service** *Specific to travel to and from vocational program. Complete DD 53 budget.*

Transportation type	Authorized dates (start and end)	Chosen provider type or description of service
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**Natural Support**

Describe chosen services/supports

# The ISP

ISP - SPD 9.9.09a

## Action Plan

Person Receiving Services: \_\_\_\_\_

Meeting Date: \_\_\_\_\_

Desired Outcome: \_\_\_\_\_

Issue:	Where:			Who is responsible	How often or date due	Where to record	Notes
	H	W	O				
Measurable steps that will be taken to reach desired outcome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
A:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
B:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

## Action Plan:

Desired Outcome: \_\_\_\_\_

Name: \_\_\_\_\_

*\*Specific, measurable, and includes frequency*

Possible Roadblocks

Date: \_\_\_\_\_

Possible Solutions for Roadblocks



Various Action Plan tools will be offered

Step	Date Due	Who is Responsible	Where:			Where to Record	Notes/What We Learned	Completed <input type="checkbox"/> Date _____ Initials _____
			H	W	O			
	Frequency					Tried: _____ Learned: _____ Do Differently: _____	Completed <input type="checkbox"/> Date _____ Initials _____	
	Frequency					Tried: _____ Learned: _____ Do Differently: _____	Completed <input type="checkbox"/> Date _____ Initials _____	

# The Plan

- Authorized by person/guardian and SC/PA

## Authorization of this Plan

These people authorize this plan and must approve any needed changes to this plan.

Name	Relationship to this person	Present at meeting?	Signature	Date	Preferred method of contact
	Person Receiving Services	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	--Choose one--	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	Legal Guardian	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	--Choose one--	<input type="checkbox"/> Yes <input type="checkbox"/> No			

## Provider Signature Page

These providers agree to implement and provide the supports that have been designated as their responsibility in the ISP. A signed contract, job description, or service agreement may be used in lieu of this signature page.

Plan Effective Dates

Start Date: \_\_\_\_\_

Provider Agency Name	Provider Type	Name of Provider Representative	Date	Objections to the plan or support documents	Signature

Providers agree to implement and provide the supports that have been designated as their responsibility in the ISP.

# What's next?

- Visit [OregonISP.org](http://OregonISP.org)
  - Latest news
  - Sign up for email newsletter updates
  - Share feedback
- This Fall we will announce training schedule for November and December

Thank you!

[OregonISP.org](http://OregonISP.org)