Planning for the Individual Support Plan (ISP): Preparing for a Successful Meeting

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Agenda

01 Fundamentals of Individual Support Plan (ISP) Development: Mandatory Elements of the ISP Specifically Described by Center for Medicaid Services (CMS)

02 Federal Policy and Practice: And Increased Focus on Person-Centered Planning

03 Data and Insights: What We Learned From National Core Indicator Fiscal Year 2019 (FY19)

04 Closing the loop – ensuring the goals reflect what the person wants
Fundamentals of ISP Development:
Mandatory Elements of the ISP Specifically Described by CMS*

In accordance with 42 CFR §441.301 (b)(1)(i)
Fundamental Requirements of ISP Development

- The individual has the opportunity to engage and direct the process.
- Meaningful information and supports are available to support the individual's engagement.
- Needs are assessed and services identified to meet the individual's needs.
- The individual wishes to attend and participate in the ISP get adequate notice.
- The planning process is timely.
- Responsibilities are identified.
Choice of Available Providers

**Information about qualified providers**

- The individual is...
  - Helped to get information about approved DBHDD providers
  - Provided information in a format accessible to them

**Selecting a provider**

- The individual is supported in selecting provider to the level they choose
Frequency of ISP Review and Update

• The individual support plan (ISP) is the fundamental tool for assuring the participant’s health, welfare and quality of life to include goals. The ISP must be reviewed and updated no less than annually
  - The ISP is subjected to periodic review and update
  - Reviews determine the ongoing appropriateness and adequacy of the services and supports identified in the plan
  - Check to ensure the services continue to be responsive to the individual’s needs
How Can Providers Support the ISP Process

• Support the individual to make choices about their goals and preferences
• For new enrollees, provide previews of the services and supports provided
• Report on milestones reached and any changes in the participant’s needs
• Maintain engagement with the family and friends of the individual
• Attend the planning meeting
• Coordinate with other providers supporting the individual
Federal Policy and Practice: An Increased Focus on Person-Centered Planning
## Home Community Based Services (HCBS) Settings Rule & Best Practices for Person-Centered Practices

| The planning process... | - Is driven by the individual  
|                          | - Describes employment and self-directing options |
| The planning meeting... | - Takes place in a location convenient to the individual, is conducted in plain language, and materials are accessible  
|                          | - Is conducted in plain language and materials are accessible |
| The ISP...               | - Takes into account cultural considerations  
|                          | - Includes goals important to the individual  
|                          | - Includes people chosen by the individual  
|                          | - Provides necessary information and support to assist the individual to direct the process |
HCBS Settings Rule & Best Practices for Person-Centered Practices

- Includes strategies for solving disagreements
- Offers choices of services and providers
- Provides method to request updates
- Ensures health and welfare
- Identifies strengths, preferences, needs, and desired outcomes of the individual
- Defines whether and what services are self-directed
- Includes risk factors and plans to minimize them
Three Pioneers of Person-Centered Planning

- Michael Smull

Essential Life Planning emphasizes more than “a service life” and stresses that plan include services that are important to the individual as well as important for the individual.
Three Pioneers of Person-Centered Planning

• John O’Brien
  Planning Alternative Futures with Hope – focuses on individual’s vision and includes graphic representations (Forest, Pierpoint & O’Brien)
Three Pioneers of Person-Centered Planning

• Beth Mount
  Advanced Person-Centered Principles:
  o See people first, rather than as diagnostic labels
  o Use ordinary language and images, rather than professional jargon
  o Actively search for a person's gifts and capacities in the context of community life
Chapter 03

Data and Insights:
What We Learned From NCI in FY19
What is National Core Indicators (NCI)?

- NCI is a voluntary effort by public developmental disabilities agencies to measure and track their own performance
- Collaboration began in 1997
- Currently 46 states and Washington D.C. represented plus 22 non-profit regional centers in California
- Coordinated by Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services
NCI Tools and the In-Person Survey

• **In-Person Survey**
  - Individuals who receive at least one service in addition to case management from the IDD agency
  - Face-to-face survey with the person receiving services
  - Survey includes three main parts:
    - Background information – largely collected from state records
    - Section I – Subjective questions only the person can answer
    - Section II – Objective questions can be answered by a proxy when needed
Person-Centered Questions

• In 2018-19, NCI added additional questions to assess person-centered practices
• Questions added to background information section to better assess person-centered planning
• New Section I and II questions include information on relationships, learning and service planning
## Service Planning

100%  
Participated in Last Planning Meeting

96%  
Meetings Included Individual

87%  
Choice or Had Input In Choosing Services in Service Plan

82%  
Understood What Was Being Talked About at their Last Planning Meeting
Closing the Loop:
Ensuing ISP Goals Reflect What the Individual Wants
Georgia Data on Relationships Goals

54% have a goal in service plan to create, expand, strengthen and/or maintain friendships and relationships (*requirement is 1 person centered goal*)

Has Goal by Residence

- 63% own home
- 55% group home
- 50% family home
National Data: Friends and Relationships

- 87% have friends
- 48% want more help to make or keep in contact with friends
- 7% often feel lonely

Has friends | Wants more help to make or keep in contact with friends | Often feels lonely
Georgia Data: Individuals have friends, want help to make or keep in contact with friends, feel lonely...

...and has a relationship goal in ISP to create, expand, strengthen and/or maintain friendships and relationships

- 58% Has friends
- 66% Wants more help to make or keep in contact with friends
- 65% Often feels lonely
National Data: Community Participation Goals

- 63% have a goal in service plan to increase participation in activities in the community
- Has Goal by Residence
  - 63% group home
  - 55% own home
  - 50% family home
Satisfaction With Level of Community Activity

Wants to Go Out More, Less or About the Same

- Go Out Shopping: 67% More, 3% Less, 31% The same amount as now
- Go Out for Entertainment: 50% More, 2% Less, 49% The same amount as now
- Go Out to Eat: 41% More, 3% Less, 56% The same amount as now
- Go Out to Religious Service or Spiritual Practice: 20% More, 2% Less, 79% The same amount as now

The Georgia Collaborative ASO | DBHDD
Wants to Go Out More Often….

....and has a goal in service plan to increase participation in activities in the community

62% Shopping

61% Entertainment

61% Eat

64% Religious service or spiritual practice/ Faith based
Overall Average of Need for Support for Activities of Daily Living

• 63%
  have a goal in service plan to increase independence or improve functional performance in activities of daily living (ADLs)
    o 33% said they need at least some help with ADL
    o 73% of those who said they need help with ADLs, want to learn to do more activities on their own
Has Support With Activities of Daily Living
Support and Goal

81%
Report they need at least some help with ADLs

...and has goal in service plan to increase independent performance of activities of daily living

89%
Of those who help with ADL, want to learn to do more activities on their own

...and has goal in service plan to increase independent performance of ADL
11% have employment as a goal in service plan

13% have a paid community job

41% are not employed, and want a community job (competitive employment)
Employment and Goals

14% want a job and have an employment goal in their plan...

27% take classes or training to help get a job or get a better job and has an employment goal in their plan....
What We’ve Discussed . . .

- Fundamentals of service planning
- Federal perspective on planning
- Using data to learn and prepare
Resources

• Charting the Life Course, at: https://www.lifecoursetools.com/

• National Association of Directors of Developmental Disabilities Services publications on case management and service planning
  https://nasddds.org/resource-library/case-management-support-coordination/

• AAIDD, Webinar: Next Steps in Quality Measurement for Person Centered Planning, recording at:
  https://www.aaidd.org/education/event-details/2018/12/05/default-calendar/next-steps-in-quality-measurement-for-person-centered-planning

• CMS, Systemwide Person Centered Planning, PPT at:

• National Center for Person Centered Practices and Systems, at:
  https://ncapps.acl.gov/
Thank You

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