

**DEVELOPMENTAL DISABILITIES WAIVER
& STATE GENERAL FUNDS**

**INDIVIDUAL SERVICE PLAN for ADULTS
INSTRUCTIONS**

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Instructions: Developing and Documenting an Individual Service Plan (ISP) for Adults with Developmental Disabilities

PREPARATION BEFORE THE ISP MEETING

Ensure all Team Members have Most Current Information about the Person

Prior to the ISP meeting, team members must complete functional and/or health assessments relevant to their discipline and role on the team that will contribute to effective planning.

- A written copy of these assessments, which includes both findings and recommendations, must be provided by each author to the Case Manager and other team members 14 calendar days prior to the ISP meeting so that everyone has a chance to review them in preparation for the meeting.
- The designated Healthcare Coordinator will work with the individual, family, and/or providers to determine the current status of medical and dental evaluations, testing, and implementation of medical treatment recommendations. (If it is an initial ISP and no healthcare coordinator has yet been designated, the case manager will collect information about current medical and dental evaluations, testing and implementation of treatment.)
- Case Managers in coordination with the designated Healthcare Coordinators must complete and Assessment Tracking Sheet and identify any gaps which need to be discussed by the team. Appendix 1, at the end of these instructions, is to be used for this purpose unless the case management agency has received approval from DDSD for an alternate format.
- Case Managers and teams may also use the Decision Justification Form to further document decisions regarding medical or other advice, which the IDT, Guardian, or Self-Advocate chooses not to follow. This is located in Appendix 2 of these instructions.

All adults must receive the following assessments on at least an annual basis:

- Physical check up
- Dental exam
- Health Assessment Tool (HAT) completed by a nurse on the team
- Updated Comprehensive Individual Assessment (CIA) completed by the case manager.
- Review of Guardianship status
- Other assessments related to the individual's diagnoses and support needs completed by the relevant discipline. (There must be an assessment for each type of therapy and service the individual has received in the prior year.)
- Medication Administration Assessment Tool completed by a nurse on the team (required if the individual receives community living, adult habilitation, employment or private duty nursing services – otherwise optional)
- In addition, the team should review any findings and recommendations made by medical specialists the individual has seen. If the team disagrees with such recommendations and therefore is not or will not be implementing them, a Decision Justification Document form (Appendix 2) must be completed and filled with the original document in which the recommendations are contained.

PITFALLS TO AVOID:

- *Waiting to review status of Medical Assessments and Reports at ISP Meeting*
- *Having outdated or incomplete reports from which to support planning*

ENSURE THE PARTICIPATION OF SPECIALISTS

- Per the DD Waiver standards, case managers must provide written notice of the annual ISP meeting date, time and location at least 21 calendar days prior to the meeting. Email is considered an acceptable form of written notice.
- The ISP regulations allow ancillary team members such as therapists and nurses to participate in the ISP process via written reports and recommendations prior to the actual meeting - with follow up support plans and strategies submitted after the meeting, if they cannot attend in person or by phone during the meeting.
- **However, if any team member believes that the presence** of one or more of such ancillary team members is critical to team planning, they should contact the case manager at least 5 working days prior to the meeting to request that arrangements be made for the therapist(s) and/or nurse to attend in person or by phone.
- Unless the individual or guardian objects, all efforts will be made by the case manager (CM) and specified therapist(s) and/or nurse to honor this request, including adjustment in the schedule if necessary and possible.
- For individuals who have been referred or have an open case with DVR, they must be invited to the annual team meeting (with the 21 days prior notice given to all team members). These invitations must be routed through the DVR Transition and Supported Employment Coordinator of Rehabilitation Services, Deb Hambel, at 1710 Rio Bravo SW; Albuquerque, NM 87105, or via email at Debbie.hambel@state.nm.us. For Jackson class members, DVR is obligated to attend if the class member has an open referral, open case or has been approved to receive a Vocational Assessment Profile (VAP) through DVR funding. For non-class members, DVR will attend at their discretion – resources permitting. Please send a copy of your invitation to DVR to your Regional Office Supported Employment Coordinator.

PITFALL TO AVOID:

- *No participation by a nurse for individuals with a Level 4,5,6 HAT scores*
- *Not arranging participation method with therapy providers*
- *Going to ISP meetings without current functional and medical assessments upon which to base effective planning.*
- *Not arranging for participation of key team members, including Individual, guardian, therapists and nurses when warranted based upon assessment results.*
- *Providing incomplete or inaccurate information which results in team members not knowing the person.*

PREPARE THE PERSON FOR HIS OR HER ISP

Before the annual team meeting, the CM must meet with the individual (and their guardian as applicable) to:

- Explain his/her rights, review client complaint procedures and dispute resolution process, share the Code of Ethics, and obtain signatures on the Addendum A form.
- Review results of assessments, helping the individual to understand their content and to add further related information or to state his/her disagreement with findings.
- Explore his/her long - term vision, (ideally the individual will develop draft long term vision statements prior to the meeting that are refined and finalized with the team.)
- Help him / her prepare for the ISP meeting, (including whether the individual wants to lead all or part of the meeting him/her self.
- Identify whom the individual wants to invite, in addition to core members required by the ISP regulations.

PITFALLS TO AVOID:

- *Reviewing rights, complaint procedures, dispute resolution process and Code of Ethics during the meeting instead of prior to the meeting.*
- *Not assisting the individual to prepare for their participation prior to the meeting.*

UNDERSTANDING THE ISP FORM:

The purpose of the remaining instructions is to assist case managers and inter-disciplinary teams in completing the ISP document. It is not intended for guidance on facilitating the person-centered planning process.

- For tips on planning and facilitating team meetings, please refer to training materials (e.g., *Promoting Effective Teamwork* handouts and resource pages) as well as "A Resource Guide for Independent Case Managers for the Developmental Disabilities Waiver" Chapters III & IV.
- It is the collective responsibility of the team to make certain that the content of each ISP reflects the unique desires and characteristics of the individual including health and safety and that supports described will logically lead toward successful achievement of the individual's vision.
- Each section of the electronic version of the form expands to accommodate information you insert, and will re-number pages and maintain headings. To utilize this feature, click in the gray space to insert information. In the footer, the space next to "Name" will automatically be filled with the name of the electronic file – therefore the individual's name should be used as the file name. This will assure that the individual's name appears on each page of the document. A "hard copy" version is available for those who want to take hand written notes during the meeting instead of using a laptop.
- Each section below includes an example from "Greg's" plan inserted into the relevant part of the form to help clarify the intended use of the form.



(Please note that a separate form & instructions are to be used for children / youth under age 21.)

THE FACE SHEET

INDIVIDUAL SERVICE PLAN (ISP)

FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY

IDENTIFYING INFORMATION	
INDIVIDUAL'S FULL NAME: Gregory A. Valdez	DOB: 7-3-76
ADDRESS: 1371 Fremont Ave. NE	
CITY AND ZIP: Albuquerque, NM 87106	PHONE: 505-777-1234
DIRECTIONS TO HOME: Take I-25 to Paseo Del Norte exit, go east to first traffic light, turn right, home is 3 rd on the left.	
INDIVIDUAL'S NATIVE LANGUAGE: English	INTERPRETER NEEDED: <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

↑ **In the top box complete** "Identifying Information" section, assuring that all items include the most current information.

DATE OF ISP MEETING: 12-15-06	DATE OF NEXT ISP MEETING: 4-23-07 to check on progress with employment & 4H requirements	
EFFECTIVE DATES OF ISP: FROM 2-3-07 TO 2-2-08	TERM OF LEVEL OF CARE: FROM 1-3-07 TO 1-2-08	
<input checked="" type="checkbox"/> DEVELOPMENTAL DISABILITIES WAIVER	<input checked="" type="checkbox"/> ANNUAL	<input type="checkbox"/> JACKSON CLASS MEMBER
<input type="checkbox"/> STATE GENERAL FUND	<input type="checkbox"/> REVISION (DATE:) (#:)	<input type="checkbox"/> NEW ALLOCATION
<input checked="" type="checkbox"/> WAIVER ID #: 96-01-2-323-32-3232	<input checked="" type="checkbox"/> LEVEL OF CARE: <input type="checkbox"/> I <input checked="" type="checkbox"/> II <input type="checkbox"/> III	<input checked="" type="checkbox"/> HAT SCORE: 4 HAT DATE: 11-29-06
<input checked="" type="checkbox"/> MEDICAID #: 96012323323232	<input type="checkbox"/> MEDICARE #: n/a	
<input checked="" type="checkbox"/> SALUD! PROVIDER: Molina	<input type="checkbox"/> MEDICAID FEE FOR SERVICE	

↑ **In the next box down**, indicate the date the meeting is held to develop the ISP, the tentative date of the next scheduled meeting, and for those individuals funded through the DD Waiver, the dates of the term of the ISP and Level of Care Packet as assigned by Medicaid Utilization Review and the Income Support Division respectively. If you are doing an ISP revision, indicate both the date of the revision and also the number of the revision (for example the first revision would be #1 and so forth).

CASE MANAGEMENT AGENCY: The Sky is the Limit ADDRESS: 2783 Skyline Dr. NE; Albuquerque, NM 87234	CASE MANAGER: Jenny Joseph E-MAIL: jennyjoe@earthlink.net	PHONE: 505-255-3377 FAX: 505-255-3388
RESIDENTIAL AGENCY: Home4U SERVICE TYPE(S): Supp. Lvg ADDRESS: 3457 Wesley Ave. NE; Albuquerque, NM 87123	CONTACT: Robert Simms E-MAIL: rsimms@home4U.org	PHONE: 505-277-8888 FAX: 505-277-8889
DAY SERVICES AGENCY: Desert View SERVICE TYPE(S): Supported Employment & Adult Habilitation ADDRESS: 203 Desert View SW; Albuquerque, NM 87266	CONTACT: Jerry Wills E-MAIL: jwills@aol.com	PHONE: 505-881-7777 FAX: 505-81-7778
DAY SERVICES AGENCY: to be chosen SERVICE TYPE(S): Comm Access ADDRESS:	CONTACT: E-MAIL:	PHONE: FAX:
GUARDIAN: Sophia Valdez (mother) AGENCY (IF APPLICABLE): n/a ADDRESS: 626 Gabaldon Rd. Belen NM 87002	<input type="checkbox"/> PLENARY <input checked="" type="checkbox"/> LIMITED <input type="checkbox"/> OTHER (SPECIFY):	PHONE: 505-861-3333 FAX: n/a E-MAIL: n/a
EMERGENCY CONTACT(S): Sophia or Martin Valdez ADDRESS: 626 Gabaldon Rd. Belen NM 87002	RELATIONSHIP: parents	PHONE 1: 505-861-3333 PHONE 2: n/a
FAMILY: ADDRESS:	RELATIONSHIP: E-MAIL:	PHONE: FAX:
FRIEND/ADVOCATE: Sam Fremont ADDRESS: 52 Second Ave. SW, Albuquerque NM 87111	RELATIONSHIP: co-worker E-MAIL: samF2@netzero.net	PHONE: 505-278-1111 FAX: n/a
REPRESENTATIVE PAYEE: Home4U ADDRESS: 3457 Wesley Ave. NE Albuquerque, NM 87123	E-MAIL: pburns@home4U.org	PHONE: 505-277-5555 FAX: 505-277-8889
PRIMARY CARE PHYSICIAN: Dr. Robert Miller ADDRESS: 203 Physicians Circle, Albuquerque NM 87224	E-MAIL: docmiller@familypractice.com	PHONE: 505-333-2222 FAX:
PHARMACY SUPPLIER: Medications R Us ADDRESS: 317 Paseo del Norte NE; Albuquerque, NM 87109	E-MAIL: medsRus@pharmacybiglots.com	PHONE: 505-371-4444 FAX:
MEDICAL SUPPLIER(S): n/a ADDRESS:	EMAIL:	PHONE: FAX:
MEDICAL PROVIDER 1: Sylvia Jones ADDRESS: 2889 North 4 th St NW; Albuquerque, NM 82279	E-MAIL: sjones@goodfood.com SPECIALITY: Dietician	PHONE: 505-887-6767 FAX: 887-6768
MEDICAL PROVIDER 2: ADDRESS:	E-MAIL: SPECIALITY:	PHONE: FAX:
OTHER: Jane England SERVICE TYPE(S): PT ADDRESS: 222 San Pedro St. NE; Albuquerque, NM 80004	RELATIONSHIP: PT E-MAIL: jengland@yahoo.com	PHONE: 505-366-8989 FAX: 505-366-8999
OTHER: Judith Pallice SERVICE TYPE(S): OT ADDRESS: 756 Second St NW; Albuquerque, NM 82227 OTHER: George Garcia SERVICE TYPE(S): n/a ADDRESS: 1400 Cattle Rd SW; Albuquerque, NM 82216	RELATIONSHIP: OT E-MAIL: jpallice@aol.com RELATIONSHIP: 4H sponsor E-MAIL: ggarcia@4HclubABQ.org	PHONE: 505-277-8844 FAX: PHONE: 505-213-5588 FAX: n/a

Add as many lines as needed to include all the doctors, therapists, etc

↑ **Current DD Waiver providers, Guardian, Emergency Contacts, PCP, Pharmacy, and other medical providers are listed in this section.** The "other" sections should be used for therapists, additional family members, additional friend advocates, additional healthcare professionals, Medical Equipment and Assistive Technology.

PITFALLS TO AVOID:

- *Copying outdated information off the prior ISP.*
- *Not listing current addresses and phone numbers*

THE NARRATIVE SECTION

This section documents the team's comprehensive discussion with the individual about his/her life experiences, strengths, dreams, preferences (likes and dislikes), medical history, health status, general types of supports needed from both natural and paid sources (specific support strategies will come later) and personal description of meaningful day.

- A description of self-advocacy efforts and/or leadership roles the person is involved with should be included under strengths and gifts.
- Assessments are not merely referenced in the Narrative section, rather relevant findings and recommendations are to be synthesized and summarized.
- The narrative sections capture what the individual wants for his/her future (long-term vision), progress towards reaching the long-term vision, and which outcomes the individual wants to work on in the near future, in relation to the vision.
- The team's discussion regarding these sections is the basis upon which action plans will be developed.



It is strongly suggested that the first time this format is used with any individual, a separate meeting is held for the narrative section of the planning process, so that sufficient exploration of the individual's history and future aspirations is facilitated. Then a separate meeting can be focused on the action - planning process, and individual specific training needs.

LIFE EXPERIENCES NARRATIVE

LIFE EXPERIENCES:

Provide background information, including successful past experiences and major life events. Describe what life is like now and important relationships. Include a description of the individual's values and beliefs that have resulted from these life experiences (e.g., personal, cultural, spiritual, political). Provide information regarding personal challenges when applicable. (Do Not duplicate information for upcoming sections on work, education, health and safety, strengths/gifts, preferences and hobbies, covered in later sections of this document.)

Significant Historical Information:

Greg was born in Belen, NM in 1978. He lived with his mother Sophia and father Martin on their small ranch until he was 21. He has no brothers or sisters, but is close with his Aunt Josie and two cousins, Justin and Jessica. He had many medical problems as a child (seizures, digestive problems and mild Cerebral Palsy). He had trouble learning to eat and needed help with his speech once he started pre-school. He loved the outdoors and spent lots of time tending horses with his father. He loved the rodeo and everything to do with ranch culture. He is proud of his Hispanic culture and attends St. Theresa's Catholic church with his family on religious holidays. He walks with a slight limp now, but does well with regular PT exercises.

He started pre-school at the local church at the age of 3 where he received SLP and PT services. He next tried a special education pre-school program and did not do well. His mother had him returned to his local church program. His therapists supported him at pre-school and home. He went to Meadowlark Elementary school where he attended both regular and special education classes. Greg's mother is a great advocate and pushed the system so that he could attend as many regular education classes as possible. He was well liked and had a good experience. He needed several surgeries on his feet during this time and missed a lot of school. He went to Jarales Middle School. He was behind from the surgeries he had during elementary years and required tutoring and attended more special ed classes, despite ongoing advocacy from his mother. This was a difficult period for Greg and he had to work very hard. His digestive problems became more severe and he had trouble getting enough nutrients. He had several evaluations and tests for this problem and finally discovered that he had a severe allergy to wheat, known as Celiac disease. Once he started a gluten free diet, he had more stamina and felt better. (Celiac disease causes the body to attack itself (allergic reaction) and keeps the person from getting nutrition and can cause irritability, tiredness and pain.) Greg worked hard to graduate from high school; he liked the volunteer work he did through the school. He graduated Belen high school when he was 20, along with several of his friends. They had such a great celebration he still talks about it. He lost touch with his classmates after his move to Albuquerque

Briefly describe progress made since last year:

Now employed in a job he likes; depression has resolved; know his way around his neighborhood and is ready to spend some time alone.

What life is like now (include where and with whom they live):

Greg currently has a part-time job working with horses, which partially satisfies his desire to be recognized as a rancher (see Work/Education/Volunteer section for details). Greg tires easily due to Celiac's disease. Greg attends 4-H meetings when he has transportation and

LIFE EXPERIENCES:

Provide background information, including successful past experiences and major life events. Describe what life is like now and important relationships. Include a description of the individual's values and beliefs that have resulted from these life experiences (e.g., personal, cultural, spiritual, political). Provide information regarding personal challenges when applicable. (Do Not duplicate information for upcoming sections on work, education, health and safety, strengths/gifts, preferences and hobbies, covered in later sections of this document.)

staff support available to him. He loves going to 4-H, which he associates with living the "cowboy life". He loved living in the country, but currently lives in a house in the city with other men. He is capable around the home and able to fend for himself, with minimal support from staff. Greg would like to live alone and talks a lot about having his own place one day. At this time he does not earn enough money to pay the bills and has not yet established credit. Greg takes pride in being a "man of his words" and is very motivated to do what it takes to have his own place. Although Greg has many interests, mostly associated with ranching and the "cowboy life", he does not have enough money to do what he wants and is hampered by having to share transportation with housemates who do not share his interests. He is organized and a good planner. He is very gentlemanly, easy to get along with, is a good listener and has a great sense of humor. He loves country music and is a great dancer. He has some spending money, but limited access to transportation and feels his style is cramped by having too many people around (he and his housemates go everywhere together). Greg has some skills on the internet and with help could learn to surf for sites that support his interests (rodeos, country music, etc.) and be more independent in sending emails.

Relationships: Include family and friends, community groups and staff with whom they are especially close. Also, clarify what relationships the person is interested in forming, maintaining, re-establishing, expanding, and/or ending:

Greg is very close to his parents. He talks to them weekly, spends his holiday with them and they visit him when they go to Albuquerque. He is also very close to his Aunt Josie and his two cousins Justin and Jessica. He talks to them once a month and sees them on holidays. They also visit when they drive into Albuquerque. Greg writes emails to Justin when he has free time. Justin is the same age and grew up with Greg. He attended the profile meeting the team had last year. Greg has grown close to his current job coach; Dave grew up in the same area as Greg. He has become close with his supervisors and co-workers and has attended a few work functions. Greg likes to be part of family and work groups. Due to his interests in horses and ranching, he attended three 4-H meetings, where he wants to volunteer, but has to attend more meetings to find out how. Finding a girlfriend is very important to Greg now. He had a girlfriend in high school, but has not found someone he gets along with since graduation although he knows what he wants in a girlfriend and would like to find that kind of a person to date. He sees his family occasionally, but would visit more often if he had transportation; He would also like to re-connect with his old friends from Belen.

Important Values/Beliefs:

Greg occasionally attends Catholic church with his parents

He is a proud Hispanic male and has trouble accepting help from people he doesn't know well

He is motivated to move to his own place and is willing to work hard to make enough money to "pay the bills"

Greg wants to meet the "right woman" and is motivated to look his best and save money to "go out"

↑ The "Life Experiences" section includes both historical and current significant events, and a description of what life is currently like for the individual including routines and activities that are important to him/her. This section also includes information about relationships that are important to the individual, existing and desired; including intimate personal relationships, and supports and/or education needed to express their sexuality.

PITFALL TO AVOID:

- *Duplicating information about strengths, preferences, work history etc. that will be covered in the sections that follow.*

IN THE NARRATIVE SECTION: BUILDING AN ISP THAT FOSTERS MEANINGFUL AND PURPOSEFUL DAYS

DESCRIPTION OF WHAT IS MEANINGFUL TO THIS INDIVIDUAL (Meaningful Day definition) – Summarize age appropriate choices and activities (with approximate frequencies) that the individual finds Meaningful in their life. Include such things as purposeful desired work, opportunities for optimal health, self-empowerment, memberships, desired skill development, social, educational and community inclusion activities, valued roles, new things to try and hobbies. This description may be broader than the individual's vision statements, but should support progress toward achieving the visions and desired outcomes.

Greg loves being around horses and wants the opportunity to do this every week. He gets up early every morning and tries to live what he refers to as the "cowboy life". He wants to be connected to the horse culture. He watches Bonanza every Thursday evening. He works part time at a stable on Wednesday, Thursday and Friday afternoons grooming horses and straightening up the stable. At this time he is looking for a full time job around horses or another part time job to increase both his income and time with horses. He listens to country music and likes to attend country western dances (at least monthly). He is looking for a new pair of cowboy boots. He enjoys being outside as much as possible. He is learning to surf the internet to further explore his interests. His is looking for affordable housing in the country. He wants to create a

budget so he can get his own place and have money to take girls on dates.

He attends as many rodeos as possible every year, especially that are part of the State Fair and the Santa Fe and Belen rodeos. He likes to attend the rodeo dances there too. Greg is beginning to volunteer with 4H and is looking to expand his role with this organization. He attends meetings once a month on the 2nd Saturday and will assist with the county fair this year.

Greg attends St. Theresa's Catholic church on holidays with his family. He spends all holidays with his parents and talks to them on the phone at least weekly. He enjoys time with his father at their ranch, even though his father had to sell the horses a few years back. He is also close to his cousins Justin and Jessica Lopez, whom he likes to call occasionally. He also likes to email Justin.

Greg wants to learn more about local politics and voting once he has his own place (he says "he's not too interested in politics but I know local politics will affect my property".)

Greg also is improving his shopping and cooking skills to support his gluten free diet.

Greg wants some time each week when he can be alone; therefore the team has arranged his Adult Habilitation schedule outside his work hours for all day Monday and Tuesdays, Wednesday and Thursday mornings – but not on Friday mornings.

Greg would like opportunities to try out new activities in the community without his roommates along.

Few of us spend all our waking hours working toward our visions for our lives, yet we do spend most waking hours on activities that are meaningful to us.

- Meaningful Day means *individualized access* for individuals with developmental disabilities to support their participation in activities and functions of *community life* that are desired and chosen by the general population.
- The term "day" does not exclusively denote activities that happened between 9:00 a.m. to 5:00 p.m. on weekdays. This includes purposeful and meaningful *work*; substantial and sustained opportunity for
 - *optimal health*,
 - *self empowerment*
 - *personalized relationships*;
 - *skill development* and/or maintenance; and
 - social and/or educational community inclusion activities that are directly linked to the vision, goals and desired personal outcomes documented in the individual's Individual Service Plan.
- Most Meaningful Day activities should help move the individual closer to desired outcomes identified in his/her *ISP*.
- The Meaningful Day description should include some language regarding opportunities to try new experiences so that this exploration can happen without constant *ISP* revisions. If such exploration identifies an important meaningful activity that the individual wants to keep doing on a regular basis, then it can be more formally added to the *ISP* via a revision (see *ISP* Revision instructions in the Appendix 1 to this document).

The *ISP* must include activities that support an individual to routinely explore, secure, maintain, build upon and/or change memberships, valued roles, and/or personal relationships in the community. Supports that comply with Meaningful Day expectations are age appropriate and provide a wide variety of planned opportunities to build personalized relationships and natural supports in the community. Such supports also include substantial and sustained opportunity for optimal health, self -empowerment, and skill development and/or maintenance.

Pitfalls to Avoid:

- Inserting the individuals' routine schedule rather than focusing in on desired meaningful activities.

WORK, EDUCATION AND VOLUNTEER HISTORY:

WORK, EDUCATION, AND/OR VOLUNTEER HISTORY:

Describe the individual's successes and goals in school (past and/or current), including his/her areas of interest (e.g., favorite subjects and activities) and particular learning style. Provide detailed information about the individual's complete volunteer and paid work history (e.g., length of employment, job responsibilities, strengths, preferences, and dislikes). Mention any awards or certifications the individual has received.

Volunteer and Work History:

Current Job Description Of Duties And Hours Per Week:

WORK, EDUCATION, AND/OR VOLUNTEER HISTORY:

Describe the individual's successes and goals in school (past and/or current), including his/her areas of interest (e.g., favorite subjects and activities) and particular learning style. Provide detailed information about the individual's complete volunteer and paid work history (e.g., length of employment, job responsibilities, strengths, preferences, and dislikes). Mention any awards or certifications the individual has received.

Horse grooming, 12 hours per week on Wednesday thru Friday afternoons – would like to be full time, in order to earn more money to “pay the bills”, “treat my girlfriend” and “buy new boots”.

Past Jobs/Duties:

fast food restaurant “fry guy”; bagging groceries

Length In Each Position:

fast food – let go after 3 months; bagging groceries – quit after 6 months

Reason They Left:

Did not enjoy work and did not like being indoors so much of the day.

Current And Past Volunteer Experience:

4 H – helped at state fair booth – wants to work with the kids in the program

Learning Style & Communication Mode Considerations:

Needs instructions broken down into small steps; needs time to process information; reluctant to ask for help of those he doesn't know well.

Related to Employment, what are the Individuals Interests, Strengths and Dislikes:

Prefers working outdoors in ranching related activities, likes animals. Greg is dependable and works hard when he enjoys the task.

Related to Education or Volunteering, what are the Individuals Interests, Strengths and Dislikes:

Interested in helping 4 H kids work with animals like he did on his Dad's ranch; needs information about requirements for volunteering with the kids versus just helping out at the state fair booth. Not as interested in the in-door craft project type activities..

Personal Connections/Contact People/Relationships Relevant to Work/Education/Volunteering:

Greg is making friends at the horse stable and attends some social functions associated with his job (annual company picnic, Christmas party, monthly birthday celebration for co-workers). Greg has grown especially close to his job coach Dave because they grew up in the same area and share an interest in horses and country-western dancing.

List Employment Service Options Discussed:

Individual Supported Employment to continue per Work/Education/Volunteer Action Plan.

Employment Desired?

YES - If yes, opportunities and supports go in work/learn vision, outcome and action plan. Also discuss strategies needed to protect the individual's benefits once employment achieved. If a current vocational assessment has been done, insert date: **9-19-06**

If individual doesn't have a current vocational assessment, make sure action plan includes steps and responsible party to obtain one.

NO - If no, develop work/education/volunteer vision, outcome(s) and action plan(s) for supports that may lead to work in the future. Consider whether the individual would like to participate in a VAP to more fully explore future vocational possibilities.

Give detailed of reason why work is not desired at this time here:

The Developmental Disabilities Supports Division's (DDSD) “Employment First” principle in the DD Waiver standards stresses the value of and preference for employment for adults; teams must assure that adults are making fully informed decisions regarding pursuit of employment.

- Therefore it is important to explore the individuals' interests and preferences with an eye toward potential career opportunities.
- If the individual is still in school, the team should still explore his/her ideas and preferences for a career so that learning can lead toward future employment.
- If the team thoroughly completes all sections of the Work/Education/Volunteer Narrative and associated Action Plans they should automatically be in compliance with the Employment First principle.



A critical question: How is the ISP moving this person toward competitive employment?

All adults served under the DD Waiver who express an interest in obtaining employment or *exploring* employment opportunities will receive a Vocational Assessment Profile (VAP). (See the DDSD website to review the Vocational Assessment Profile Policy and Procedures for details.)

- Once completed, information from the initial VAP must be integrated into the ISP in the Narrative and Action Plan sections, and then updated within the ISP annually. A responsible individual will be identified within the VAP Strategic Action Plan section to work with the case manager to assure this integration occurs.
- If at the time of the annual ISP meeting a VAP has not yet been obtained, or the interest in work is newly identified at the ISP meeting, then the ISP Action Plan should include steps and responsible party(ies) to arrange for a VAP to be conducted.
- To complete a VAP annual update within the ISP the team shall review the prior year’s VAP (whether it was a new one or an update in the ISP), discuss progress achieved on employment outcomes and reflect that progress in the Work/Education/Volunteer section of the Narrative, and then update the Action Plans and Teaching & Supported Strategies as appropriate to the individuals current circumstances. (For example, if the team discusses the individual’s desire to find a different job – then the narrative should reflect that desire and the Action Plan should include steps in supporting the individual to get a different job rather than just maintain the one they have – although they may maintain that job while they are looking for the new one.)
- If after completing the annual VAP review and update, the team determines that additional information is needed to support the individual’s desired outcome(s) related to employment, then a referral should be made to DVR (with a copy to the Regional Office Supported Employment Coordinator). If the individual is currently receiving supported employment services, the supported employment provider is responsible to make this referral, (if not the case manager is responsible to make the referral to DVR). In the meantime the team shall continue to work on any employment outcomes listed in the ISP Action Plan while arrangements with DVR are underway.

Who conducts the Initial VAP?

Jackson Class members	Non-Jackson Class waiver participants
<ul style="list-style-type: none"> • Facilitators approved through the DDSD/DVR process to conduct VAPs for class members, or • individuals who are being observed by a mentor approved through the DDSD/DVR approval process. (Such mentors may not work for the agency that provides employment services to the individual.) 	<ul style="list-style-type: none"> • Anyone approved to conduct VAPs for Jackson class members, or • identified supported employment providers with formal training in vocational assessment. (For a list of these individuals contact your Regional Office Supported Employment Coordinator.)

Who Conducts the Annual VAP update?

Jackson Class members	Non-Jackson Class waiver participants
The team, with DVR representative if the individual has an active referral or open case with DVR	The team (DVR should be invited and may attend)

What is DVR’s role on the team?

- To arrange for or conduct initial VAPs
- To provide technical assistance to the team related to employment

- To arrange appropriate short term employment supports for the individual (e.g. specialized training/education, equipment, uniforms).

What if the individual is not currently interested in employment?

- The team must assure that the individual's decision not to pursue or *at least explore* employment is an informed choice based upon discussion of employment opportunities and support options.
- The reason why work is not desired at this time must be documented under the "No" box in the Work/Education/Volunteer section of the Narrative.
- Individuals receiving Community Access and/or Adult Habilitation must include one or more of the following activities as part of their action plan(s) for Work/Education/Volunteer desired outcome(s).
 - Exploration or participation in post secondary educational activities;
 - Exploration of participation in volunteer activities;
 - Experiences with friends and peers and/or opportunities to make new friends;
 - Develop new hobbies or regularly participate in chosen hobby(ies);
 - Maintain contact with family members;
 - Engage in community events, education experiences and other activities and/or services where people without disabilities are involved;
 - Learn and develop new skills to support purposeful participation and independence in the community.

Pitfall to Avoid:

- Using "retired" as the justification for checking "no" under work if individual is not yet 62 years old.
- Not providing a **specific** reason why the individual is not interested in work at this time if "no" is checked.
- Forgetting to ask whether the individual would like to participate in a VAP, even if they are not yet ready to pursue work, in order to explore potential work opportunities further.

HEALTH AND SAFETY NARRATIVE:

HEALTH & SAFETY:

Provide summary information about **significant** health/ medical/ dental/ behavioral/ environmental concerns, (past and present), and diagnosis' that have implications for planning or impact on the individual's health and safety, including what has been done to date to address these concerns. If the person's health or skills are regressing, include that information here.

(Prompt: If outlier, Supported Living Awake and/or in-home Adult Habilitation will be required, justification should go here. Also, any issues not yet addressed should be included in Health and Safety Action Plan.)

Several medications have serious side effects – staff training and monitoring by agency nurse are in place. During visit to all doctors, all medications should be reviewed. Greg needs blood work every six months.

Greg had speech therapy services when he was a child – but this is no longer needed

To support Greg in having alone time on Friday mornings, the team has arranged for him to have his own key to the house and has programmed the "on call" number into his cell phone so he can call quickly for help if needed. During Friday morning alone time Greg will choose whether he wants to hang out at the house, take the bus to his favorite Village Inn for breakfast, walk down to the corner Starbucks or visit other nearby businesses.

Greg's health has been relatively stable the last couple of years by sticking to his gluten free diet.

↑ This section of the narrative is not intended to duplicate healthcare plans developed by the nurse, but rather to summarize health and safety related considerations that have implications for planning and implementing supports for the individual.

- Indicate if the individual's overall health status is better, the same or worse than last time the team met, and if the status has changed, indicate what has caused/contributed to that change (for better or worse) if known.
- Address issues of aging, if applicable.
- When an individual's skills are regressing, that can be an indication of an underlying medical condition – if regression has been noticed and medical conditions have not yet been ruled out, that should be noted here and then appropriate action steps listed on the Action Plan for Health and Safety Related Supports.
- Examples of other significant health information to include: risk for aspiration, chronic conditions that require ongoing management, issues of aging, allergies.

PITFALL TO AVOID:

- Listing medications or laundry list of diagnosis in this section
- Failing to document what team has done, with regard to Health Plans and Crisis Prevention/Intervention Plans
- Listing routine issues which are not significant for health and safety or planning
- Stating that the person needs "1:1" or "continuous line of sight supervision" within this section to justify outlier funding. (Wording should instead describe the reason that enhanced staffing is needed and leave the specifics about how that enhanced staffing will be carried out to Positive Behavior Support Plan, Healthcare Plan, and Teaching & Support Strategies pages as appropriate to the particular need.)

STRENGTHS, GIFTS AND PREFERENCES NARRATIVE:

STRENGTHS, GIFTS, PREFERENCES, AND HOBBIES:

Describe what makes the individual unique. Provide detailed information about each of the sections below.

TALENTS, HOBBIES, AND INTERESTS

Country music fan	Poet
Great dancer	Interested in meeting women with similar interests
Loves horses	Likes working with kids (wants to volunteer at the 4-H club)

STRENGTHS AND GIFTS

Hard worker	Very responsible
Great planner	Keeps his word
Organized	Gentleman
Experienced with horses	Easy to get along with
Good listener	Great sense of humor
Capable around the house	

PREFERENCES

Greg is accustomed to "cowboy" life and wants to continue to work and socialize in this setting.
 He prefers country music (dancing and listening) and actually does not like any other type of music.
 He would prefer to live alone with a little "paid help"

WHAT WORKS FOR AND MOTIVATES THE INDIVIDUAL

He needs to know what is expected of him and needs tasks presented in small steps; give him time to process information when giving instructions
 Greg is a man of his word and if promises are made to him, they need to be kept; he will do the same
 He considers himself a responsible adult and expects to be treated that way; lets people know if he feels they are not acting with respect
 Greg is sensitive to being treated as a child and does not like to do things that require help; he is more willing to accept help and teaching from individuals he knows well.

↑ **Be very thorough in describing talents, hobbies and interests, as this helps build a vision.**

- The strengths/gifts section must include SKILLS the individual has.
- Preferences should include the individual's FAVORITE activities, things, people, etc. For example, I may like desserts of all kinds, but ice cream is my preference. I may like to go to the movies, but I will always pick a scary movie given the choice.
- Remember to include what interferes with my success, if applicable, in the section on what works for and motivates the individual.



Helpful Hint: If team is stuck, go back and look at Meaningful Day for ideas.

VISION NARRATIVE, STATEMENTS:

VISION (WHAT I WANT IN MY FUTURE):

Describe what the individual desires for the future (i.e., dreams and aspirations without limits). Use relevant information from previous sections of the narrative (e.g., desires regarding relationships and potential jobs and roles), and team input. Describe what the vision means to the person in terms of how they define success.

LIVE: Greg wants his own place with some "paid help". He wants to establish credit so that he can someday own his own house, preferable with land so he can have horses of his own

WHAT DOES SUCCESSFUL ACHIEVEMENT OF THIS VISION LOOK LIKE?

Have his own place in the country; have a bank account, good salary, a credit card and be able to purchase some items on credit, have a phone or utility in his name, live where he wants and in the kind of house he wants, have some money saved and purchase a house, and hire help to assist with cleaning and yard work.

Which of the individual's strengths/talents and/or existing skills will contribute to the achievement this vision?

Greg takes pride in, and is independent at taking care of most chores around his house.

WHAT PROGRESS HAS ALREADY BEEN MADE TOWARD THIS VISION? (include relevant assistive technology already in use here)

He is capable around the home and able to fend for himself, with minimal support from staff.

WHAT STILL NEEDS TO OCCUR TO OVERCOME ANY BARRIERS AND ACCOMPLISH THIS VISION? (e.g. skill development/ needed, ASSISTIVE TECHNOLOGY needed)

Earn more money, Identify funding services to assist in purchasing house or renting his own place, find a place in the country he likes and can afford, Save for a down payment or deposit, Arrange to move, Arrange utilities, Identify and arrange needed supports

WORK/LEARN/ : Greg wants to work with or around horses on a full time basis; he considers himself a rancher and wants to be seen that way. He also wants to earn enough money to "pay the bills", go on dates and support his interests. He likes children and would like to volunteer with kids at the 4-H Club or a riding stable. Greg wants to be respected as a responsible adult and recognized as a dependable, hard-working employee.

WHAT DOES SUCCESSFUL ACHIEVEMENT OF THIS VISION LOOK LIKE?

Greg would be employed full-time, working with horses, and earning enough money to spend on his interests and pay his bills. Be recognized and appreciated as a dependable, hard-working employee.

Which of the individual's strengths/talents and/or existing skills contribute to achievement of this vision?

Greg is a hard worker, he has horse experience, he is organized, and a driven individual.

WHAT PROGRESS HAS ALREADY BEEN MADE TOWARD THIS VISION? (include relevant assistive technology already in use here)

He needs an adaptive brush and handles with palm straps to compensate for his weak grip and a wide based stool to help him with his balance. Greg currently has a part-time job working with horses, which partially satisfies his desire to be recognized as a rancher.

WHAT STILL NEEDS TO OCCUR TO OVERCOME ANY BARRIERS AND ACCOMPLISH THIS VISION? (e.g. skill development needed, ASSISTIVE TECHNOLOGY needed)

Earn more money, ask current employer to increase hours, learn required additional job duties

HAVE FUN/DEVELOP RELATIONSHIPS: Greg wants to have more connection with the "cowboy life" and wants to be a regular at the 4-H club and NM rodeos; one day he would like to attend the National Rodeo Finals in Las Vegas Nevada. He wants to find a girlfriend who "likes what I like". He wants to re-connect with his old friends from high school. He would like to spend more time with his family.

VISION (WHAT I WANT IN MY FUTURE):

Describe what the individual desires for the future (i.e., dreams and aspirations without limits). Use relevant information from previous sections of the narrative (e.g., desires regarding relationships and potential jobs and roles), and team input. Describe what the vision means to the person in terms of how they define success.

WHAT DOES SUCCESSFUL ACHIEVEMENT OF THIS VISION LOOK LIKE?

Greg would have become a regular at 4-H, and NM Rodeos, and would have attended the National Rodeo Finals. Greg would have expanded his friendships, and perhaps had or be involved in a relationship with a woman.

WHICH OF THE INDIVIDUAL'S STRENGTHS AND/OR EXISTING SKILLS CONTRIBUTE TO ACHIEVEMENT OF THIS VISION?

Greg is easy to get along with, a good listener, and has a great sense of humor. Has many interests, mostly associated with ranching and the "cowboy life". Organized and a good planner. Loves country music and is a great dancer. Had a girlfriend in high school and knows what he wants in a girlfriend now

WHAT PROGRESS HAS ALREADY BEEN MADE TOWARD THIS VISION? (Include relevant assistive technology already in use here)

Attends monthly 4-H meetings when transportation is available; loves going to 4-H, which he associates with living the "cowboy life".
Cousin Justin willing to help him track down his high school friends

WHAT STILL NEEDS TO OCCUR TO ACCOMPLISH THIS VISION AND OVERCOME ANY BARRIERS? (e.g. skill development, ASSISTIVE TECHNOLOGY needed)

Earn enough money to do what he wants.
Consistent source of transportation to attend 4H and other activities of interest, and visit his family which is not hampered by his roommates schedules.
To re-connect with his old friends from Belen High School; find out how to contact them (address, email or phone).
Arrange opportunities for Greg to participate in community activities he enjoys without always having to go along with both his roommates.
Learn to surf the internet and become independent in sending/receiving emails

HEALTH AND/OR OTHER: (Note – this section is for a health related vision the individual has for themselves, such as "stop smoking," "get in shape to run a marathon" or "learn to take my medication" or a vision that does not fit under one of the other 3 areas. It is optional.)

Greg wants to "get in shape", and be able to work for longer without getting tired.

WHAT DOES SUCCESSFUL ACHIEVEMENT OF THIS VISION LOOK LIKE?

Greg will increase his stamina so that he can be on his feet for longer, and not be too tired to go out after work.

Which of the individual's strengths/talents and/or existing skills contribute to achievement of this vision?

Greg is motivated to be active, he is enthusiastic, and goal oriented.

WHAT PROGRESS HAS ALREADY BEEN MADE TOWARD THIS VISION? (include relevant assistive technology already in use here)

Greg currently is employed in a part-time job that he enjoys. Has some spending money

WHAT STILL NEEDS TO OCCUR TO ACCOMPLISH THIS VISION AND OVERCOME ANY BARRIERS? (e.g. skill development needed, ASSISTIVE TECHNOLOGY needed)

Greg needs assistance with exercises which require balance, he needs transportation to the gym.
Train Greg's staff about his gluten free diet so they can support him in sticking to it.
Earn enough money to pay for gluten free foods
Make a list of foods to avoid, including foods that may "hide" gluten like sauces and soups with gluten based thickeners.
Make a list of restaurants that serve gluten free menu items.

↑ The Narrative Section: A Note about Supporting a Person's Long-Term Vision

When a person's life experience is limited, as is often the case with people with developmental disabilities, it becomes the mission of the team to:

- 1) Know the person really, really well
- 2) Introduce the person to as many life experiences as possible, because only after knowing what the world has to offer, can people build an informed vision for their lives.

The long-term vision statements must be future-oriented:

To the extent possible, use the individual's own words for his/her long-term vision statement for each life area. Then, describe the basic components that are necessary to fulfill that vision, irrespective of particular support needs. There are many different ways to achieve a particular vision.

PITFALLS TO AVOID:

- *Vision statements that maintain the status quo with no explanation as to why that is appropriate*
- *Vision statements that reflect team preferences rather than the individual's preferences*
- *Vision statements that contain jargon rather than the individual's own words – or words they are unlikely to understand if unable to communicate directly in their own words.*
- *Vision statements that do not relate to the individual's personal description of a meaningful day.*
- *Listing components necessary to achieve the vision in such a way that they either create a readiness trap – or are specific to a method rather than leaving multiple methods open for consideration.*
- *Vision statements that do not promote growth and development, or take place only in a paid service setting.*
- *Not specifying what progress looks like.*
- *Failure to clarify the true intent of the person's vision, (I may want to be president- what does being president mean to me?)*
- *Adding a health maintenance goal, where none is needed.*

Progress Towards Reaching the Long-Term Vision

After identifying “what does successful achievement of the vision look like,” the team needs to discuss what the person has and has not done to achieve the vision (i.e., what is already in place and what still needs to occur). In describing progress towards reaching the long-term vision, care should be taken to include aspects (including skills and assistive technology) already in place that can contribute to achieving the vision for all three life areas, what is missing, as well as barriers/personal challenges that must be overcome, skills they need to learn and assistive technology that may be helpful. **This is the baseline from which the individual and team are starting toward achievement of the visions.**

PITFALLS TO AVOID:

- *Failure to acknowledge skills and/or progress the individual already has in place that contributes to achieving the vision.*
- *Failure to clearly describe the gap between current status and desired status (vision)*
- *Failure to consider/identify what is most important to the individual about the gap between current status and his/her vision, including the need to learn new skills*
- *Failure to include assistive technology the person has and/or will need.*
- *Failure to include natural supports, as applicable.*

The next step is to brainstorm all the different ways possible for obtaining the basic elements not yet achieved or in place.

At this point the team is not evaluating or eliminating any of the ideas based on the particular individual's strengths, preferences and needs – but exploring **all** the creative options the team can think of. This list of options to consider does not need to be documented on the ISP form itself – however, it is strongly suggested that the team list all these ideas on a flipchart, so that the team can refer back to them when selecting Desired Outcomes and creating the Action Plan.



Helpful Hint: Refer to ISP Training / TA if having trouble with this.

PITFALLS TO AVOID:

- *Limiting ideas based upon perceived limitations of the individual or community.*
- *Limiting ideas that may be excellent for the individual but less convenient for support providers.*
- *Not writing all ideas down – no matter how unusual – for future reference (re: in order not to dampen creativity)*
- *Evaluating ideas as they are each stated instead of just listing all ideas out first.*

The brainstorming activity results in the individual and team being in a position to select measurable desired outcomes that can be achieved in, usually, the coming year.

DESIRED OUTCOMES SECTION :

DESIRED OUTCOMES:

Focusing on the individual's priorities, identify outcomes that the individual wants to achieve during the next 1 – 3 years. Areas to consider include future desires and anticipated achievements for each life area. Outcome statements need to include measurable criteria for determining success. If a life area will not include a desired outcome statement,) provide the rationale for this decision in the space provided. Work/Education/Volunteer outcome statements should include desired outcome(s) from the VAP if applicable.

LIVE: Greg will get his own home in a rural setting; Greg will establish credit

Criteria: Greg will either lease or purchase a home in an area he defines as rural; Greg will get and use a credit card or loan and pay off two purchases.

WORK/Education/Volunteer: Greg will work full time (with/around horses), Greg will earn enough money to "pay the bills."

Greg will volunteer with kids at the 4-H

Criteria: Greg works enough hours to earn money to cover his expenses and save toward a deposit or down payment on a place of his own.

Greg works with the kids at 4 H for at least one event this year.

HAVE FUN/DEVELOP RELATIONSHIPS: Greg will find a steady girlfriend, Greg will attend several NM rodeos, Greg will get a new pair of cowboy boots

Criteria: Greg goes on three or more dates with the same girl. Greg attends at least 5 rodeos in the area. Greg purchases new boots of his choice.

HEALTH AND/OR OTHER: Greg will improve his physical stamina to support an eight hour work day.

Criteria: Able to work an 8 hour shift at least one day per week.

↑ The Narrative Section: Desired Outcomes

Outcomes must relate to the individual's vision and personal description of meaningful day, and include a description of how the individual defines success of the outcome in measurable terms. "Measurable" means that it is obvious to anyone reading the plan when the outcome would be successfully achieved – it should be clear how the team will know they are done with that outcome.

- For example: the team clarified with Greg that his wanting his own place means to him that: Within 2 years Greg will move into his own place "in the country". He would prefer to own, but is okay with renting.
- In most cases there will be at least one Desired Outcome for each life area, but the individual may choose to have multiple Desired Outcomes for each life area, especially if more than one major step must occur to reach the vision.
- Outcomes typically take approximately one year to achieve. If a longer term or shorter term is needed to achieve a specific outcome, this should be clearly stated on the ISP in the Desired Outcomes Action Plan page (at the top). (No less than 3 months and no more than 3 years should be listed as a time frame for Desired Outcomes.)



Outcomes related to Meaningful Day, it should also be reflected in the Vision.

Desired Health Outcomes: In addition, individuals will often have visions related to their health, which do not directly lead toward achievement of their Visions / Desired Outcomes in other life areas. For example, "remove feeding tube and return to eating orally," "lose 20 pounds," "get in shape so I can go the whole way at the 10K Zoo Run." This would require the development of Desired Outcomes and Action Plans, as would any other life area.

VISIONS AND ACTION PLANS SECTION:

In rare instances, an individual may choose not to have a DD Waiver funded services or Desired Outcome for a life area where everything is going well and he/she prefers to prioritize outcomes for the other life areas.

- In this case, the rationale for not including a Desired Outcome for that particular life area must be stated in the Desired Outcomes box.
- This rationale should include a summary of the outcomes the individual has already achieved for that life area, including related valued roles and relationships. For example, if the individual is happy to continue living with his/her sister, and the individual does not desire, nor require any funding/services in that setting, then a rationale could be made for not having a Desired Outcome in the area of "Live". Part of the rationale should summarize the individual's valued role within the family and neighborhood and the outcomes already achieved in that home setting.

A Desired Outcome is required for each live area for which the individual receives paid supports through the DD Waiver. (See table above) Even if the individual does not receive paid supports in a particular life area, the individual may still choose to have a Desired Outcome based entirely upon natural supports included in the ISP. For example: LIVE Desired Outcome: I would like to host my knitting club at our house without my family present, once every three months. **(Bolded Services in the table require Action Plans in the areas listed, as per DD Waiver Standards).**

PITFALLS TO AVOID:

- *Although learning skills to complete activities of daily living (e.g. laundry, dressing, cooking, cleaning) may be action steps that contribute toward increased independence and therefore may lead to achievement of a particular Vision (e.g. living independently) and Desired Outcome (having staff-free mornings), activities of daily living shall not constitute the desired outcome itself.*

VISIONS AND ACTION PLANS				
	LIVE	WORK/EDUCATION/ VOLUNTEER	FUN/ RELATIONSHIPS	HEALTH/OTHER
SERVICES	Supported Living	Employment	Supported Living	
	Family Living	Adult Habilitation	Family Living	<i>*As Individual's</i>
	Independent Living	Community Access	Independent Living	<i>needs & preferences</i>
			Community Access	<i>require</i>
			Adult Habilitation	

- *Vague or excessively broad desired outcomes that are not easily measured.*
- *Conversely, desired outcomes that are too narrow or do not provide the individual with opportunities for skill building or personal growth.*
- *Desired outcomes the individual has already achieved, or are not relevant for the individual or that do not relate to his/her long-term vision.*
- *No desired outcomes that lead to inclusion of the individual as a valued member of his/her community.*

ACTION PLAN FOR A DESIRED OUTCOME IN THE LIVE AREA

ORIGINAL

UPDATE

NOTE: USE A SEPARATE FORM FOR EACH OUTCOME

DATE OF ACTION PLAN: 12-15-06

TARGET DATE FOR COMPLETION: 12-15-07

OUTCOME STATEMENT #_1_: Greg will get his own home in a rural setting;

PERSONAL CHALLENGES AND OBSTACLES THAT NEED TO BE ADDRESSED IN ORDER TO ACHIEVE THE DESIRED OUTCOME

Greg does not make enough money to support himself in a place of his own nor does he have enough savings for a deposit or down payment. By the end of a busy day Greg's feet hurt. If he does his PT exercises and has help to keep loose, he is able to walk with less pain. Greg has some budgeting skills, but not enough to pay all of his bills and budget his income well. Assisted living providers are few in areas outside of town. Greg takes several medications with potentially severe side effects; he still gets confused about which medication to take when.

ACTION STEPS <i>SKILLS TO LEARN AND TASKS TO DO</i>	FREQUENCY <i>HOW OFTEN, HOW LONG</i>	STRATEGIES NEEDED	RESPONSIBLE PARTY (IES)	TARGET DATE(S)	DOCUMENTATION AND REPORTING REQUIREMENTS
Make appointment with Home NM & call HUD to discuss supports for buying a home "in the country"	One to start with	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	Greg and his job coach Dave	By 4-1-07	Materials provided by Home NM & HUD; progress note summarizing what is learned
Greg will learn PT exercises he can do on his own	20 minutes daily	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	Greg and PT	Begin Feb 07; independent by June 2007	PT support plan; progress notes and bi-annual report
Greg will be transported and supported to purchase gluten free foods	weekly	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	Dietician will train Greg and SL staff	Begin Feb 07; ongoing	Training roster; house logs; Nutrition support plan & quarterly reports
Greg will learn to prepare gluten free meals at home	Each meal at least 3 time per week	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	Dietician will train Greg and SL staff	Begin Feb 07; ongoing	Training roster; house logs; Nutrition support plan & quarterly reports
Greg will create and monitor a budget for current expenses plus saving money for down payment or deposit	monthly	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	Greg and house supervisor	1 st done by April 07; review monthly	Copy of budget in house file – updated as he begins to earn more money
Monitor side effects of medication	Daily with nurse review bi-weekly & blood work every six months	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	Greg & AWMD trained staff plus nurse	Continuous from last ISP and ongoing	Daily logs; quarterly nurse report; six month blood work lab reports
Greg will learn which medications to take when	Daily	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	Greg & AWMD trained staff plus nurse	Able to self administer within one year	MAAT tool
Research affordable home locations; look around Belen first.	At least 3 days per month	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	Greg & SL staff & Adult Hab staff	Begin May 07 continue til home found	Quarterly SL reports
Greg will be "on his own" every Friday morning, taking his key and cell phone if he decides to go out.	Friday mornings 9-12	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	Greg	Ongoing	n/a
UNAVAILABLE SERVICES OR SUPPORTS			STEPS TO OBTAIN NEEDED SERVICES OR SUPPORTS		
n/a			n/a		

After implementing steps to obtain unavailable specialty services, if the services are still unavailable, complete a regional office intervention form and submit it to the local regional office.

THE ACTION PLANS :

Each Desired Outcome, including those developed for the Health/Other life area must have a separate Action Plan. In addition, there may need to be an Action Plan for Basic Health and Safety Related Supports, for health related issues, which do not relate directly to achievement of the Desired Outcomes for Live, Work/Education/Volunteer, Fun/Relationships or Health/Other. This is completed on a different section of the ISP form and will be explained in the next section.

It is important to build upon the individual's strengths when designing action steps; however, it is also important to acknowledge challenges and obstacles the individual and team will need to accommodate or overcome in order to be successful. These challenges and obstacles, including lack of necessary skills, should be identified and addressed prior to finalizing actions steps and listed in the appropriate section of the Action Plan.

Respite services do not need to be included in action plans, unless the respite provider is a responsible party for one or more action steps toward one or more desired outcomes. Otherwise it may be reflected solely on the face sheet, individual specific training section and the budget. Those providing substitute care are responsible to work on the desired outcomes in similar fashion to the family living provider.

PITFALLS TO AVOID:

- *Team uses challenges/obstacles to create a "readiness trap"*
- *Team ignores challenges in an attempt to be person-centered and strengths based, but thereby does not arrange necessary supports to achieve success*

The following list of Meaningful Day activities, may assist teams, in creating ISP Action Plans related to the individual's personal description of meaningful day. These examples include application of the DDS "employment first" principle, community inclusion as well as purposeful activities based on each individual's vision and choices.

1. *The individual is engaged in daily activities that lead toward his/her desired outcomes, as evidenced by:*
 - a. *The individual is trying new things, and learning and/or maintaining skills that are intended to result in the attainment of an identified outcome in his/her ISP.*
 - b. *The individual is doing things on his/her own to gain more confidence and skills.*
 - c. *The individual is choosing what he/she wants to do and is doing things in the community.*
 - d. *The individual is engaged in preventative health care activities/interventions as needed.*
2. *Support provided to an individual while he/she is engaged in work that is compensated under the Fair Labor Standards Act.*
3. *Work exploration in the community to learn about jobs that might match the individual's interests and skills.*
4. *Volunteer activities in the community, as long as the individual can be observed to have regular significant personal interactions with non-disabled peers or recipients of the volunteer service.*
5. *Instruction, when it can be demonstrated that learning or skill development is linked directly to the individual's vision and desired outcomes. (This includes, but is not limited to, instruction by direct care staff conducted under a structured plan developed by a therapist or time when the therapist, with the active engagement of the individual, is modeling, instructing or consulting with direct support staff on therapeutic interventions.)*
6. *The individual is engaged in exploring new interests and/or relationships or establishing meaningful social roles.*
7. *Retirement activities, as long as such activities are consistent with: 1) the DDS definition of Meaningful Day, 2) the individual's personal description of a meaningful day, and 3) activities undertaken by non-disabled retirees in the broader culture.*

PITFALLS TO AVOID::

- *Action steps that only talk about what the staff will do, but not what the individual will do – or vice versa*
- *Action steps that are vague, not measurable*
- *Action steps that are not specific to the individual's strengths and needs*
- *Action steps that do not directly contribute to achievement of the desired outcome or personal description of meaningful day*
- *Repeating the same action steps under multiple desired outcomes*

- *Activities that the general population would not engage in on a regular basis for extended periods of time (examples: going to the park every day for several hours; walking in the mall to “window shop” several times a week)*
- *Extensive time spent in skill building or leisure activities that isolate the individual from non-disabled peers (e.g. extensive TV viewing, volunteer work in isolated or congregate setting, sheltered work for longer than needed for specific skill development, engaging in a favorite activity only at the adult habilitation site)*
- *Activities which are not age appropriate (e.g. coloring in children’s coloring books, shoe-lace “sewing” cards)*
- *Action steps that simply reflect routine care and support that is expected as part of the service delivered but doesn’t directly contribute toward achievement of the desired outcome (e.g. staff reminding an individual to shower 3 times per week is not a legitimate action step in most instances)*
- *Focusing on IF rather than HOW. We are NOT asking IF a person wants to become a respected, contributing, active part of his/her community but asking him/her HOW we support him/her to achieve this universal outcome. A person’s vision should provide the guidance to his/her team for how s/he wants to do this.*

COLUMN 1 -THE ACTION STEPS:

Action Steps (first column) should describe steps the individual will take independently, skills that the individual wants to learn, as well as steps others will take to provide support, including natural supports, community supports and paid supports.

The number and complexity of action steps the individual is to complete must be tailored to meet his/her desires, abilities and challenges. The team must be careful to thoroughly break down the steps in order to avoid frustration/partial success. Action steps will also specify how the person will be actively and regularly engaged in community exploration so that the person’s experiences and expectations will expand.

Community Inclusion Services listed in the action plan must directly relate to each person’s desired outcomes consistent with his/her personal description of a meaningful day. All of these experiences should be planned, purposeful (not just “time fillers”) and reflected in daily schedules (schedules may be more specifically reflected in Teaching & Support Strategies developed to compliment the action plan).

COLUMN 2, FREQUENCY

The second column addresses how frequently the step will occur (e.g. one time only, daily, weekly, monthly, quarterly) as well as time devoted to the step (e.g. 30 minutes, an hour, before bedtime, after lunch) and if relevant, for how long (e.g. for the next 3 months, all year). Teams should be thoughtful about the required frequency for learning; if an individual only practices a skill 1x per month, it may impede skill acquisition. In general, the more frequently I practice a skill, the sooner I will learn it – this is especially important for new/complex learning.



Each action step must be stated in a way that makes it clear when the step is completed!

Pitfalls to Avoid:

- *Putting frequency without duration or vice versa.*
- *Not working on a skill frequently enough to make a difference.*

COLUMN 3, ARE STRATEGIES NECESSARY? _____ (MOST ACTION STEPS WILL REQUIRE STRATEGIES)

The third column is used to indicate whether strategies are necessary. Some steps are brief and self-explanatory; however, most steps will require expanded detail and strategies to be developed after the meeting in order to support implementation of the step (e.g., when the individual wants to learn a skill/task). Such detailed strategies should be developed on a “Teaching and Support Strategies” form and/or in the relevant support plan and are due to the case manager and other team members within 14 calendar days following the ISP meeting. Whether or not such strategies are due is indicated in the third column. The strategies should include all therapy recommendations and assistive technology relevant to learning/participating in the step. **In general, if an individual is learning a new skill or therapy recommendations are relevant to the completion of the step, strategies are required.**

PITFALL TO AVOID:

- *Failure to require detailed strategies when they are needed.*

COLUMN 4, RESPONSIBLE TEAM MEMBERS:

The fourth column lists the individual(s) responsible for carrying out the step, and can include the individual, one or more natural supports, and/or paid providers.

Pitfalls to Avoid:

- *Failure to consider and list natural supports*
- *Failure to let the individual complete action steps independently whenever possible*
- *Failure to list the individual as a responsible party in steps he/she will be participating in.*

COLUMN 5, TARGET DATE(S)

The fifth column identifies when the step is expected to begin and/or be completed (depending upon the nature of the action step). Please specify whether each date relates to a start date, or completion date. If steps are sequential, the first steps would logically start and be completed sooner. It is not acceptable to have all timelines for an action plan be the ISP year.

PITFALLS TO AVOID:

- *Putting start dates without completion dates or vice versa (when both are needed)*
- *The end date for all steps are the end of the ISP year.*

COLUMN 6, DOCUMENTATION

The sixth column identifies how objective data/documentation will be collected and reported regarding implementation of each action step. The purpose of data collection is to document the results of action steps and strategies completed and for the team to use that information to improve practice, make revisions to action steps and/or strategies as needed, and assure continued progress toward desired outcomes.

Specific data must be collected regarding progress in the context of the individual's personal description of a meaningful day, based upon staff observation of the person's response to purposeful daily activities. Documentation for some action steps may involve creation of a data collection form as part of the detailed strategies submitted following the meeting. In that case, just state that a form will be designed and submitted with the strategies. Other action steps may be documented on standardized data collection form (e.g. Community Participation/Exploration Form).

PITFALLS TO AVOID:

- *Listing documentation that doesn't directly measure progress toward and completion of each action step*
- *Listing excessive documentation beyond what is required to measure progress toward & completion of each action step*
- *Designing data collection method or form which interferes with integration in the relevant community setting*
- *Not quickly reporting to the team changes needed based upon lack of progress or realization that activities are not compatible with the individual's preferences.*

The Action Plan: Unavailable Services/Supports & Steps to Obtain

Below the Action Steps table is a place to list services/supports that the individual needs in order to achieve the desired outcome, but which are currently unavailable, and the steps the team will take to obtain those services or supports. This section can be used to list any type of service or support including:

- Natural supports and generic supports
- Specialty Services (e.g. therapy, medical specialists, durable medical equipment, medical supplies, augmentative communication devices, assistive technology)
- Environmental Modifications
- Private duty nursing
- Transportation

If the steps do not result in obtaining the needed service or support, the case manager or other designated team member must complete and submit a "Request for Regional Office Intervention" form to the local regional office for assistance (this form is included in the appendix of the Case Management Operations Manual and is available on the DDSD website).

PITFALLS TO AVOID:

- *Failure to consider and state need to develop natural and generic community resources*
- *Failure to seek Regional Office Intervention if unable to procure necessary resources*

ACTION PLAN FOR BASIC HEALTH AND SAFETY RELATED SUPPORTS:

Some individuals require supports to assure their health and safety that do not directly relate to achievement of their Visions and Desired Outcomes for Live, Work/Education/Volunteer, Have Fun /Develop Relationships (although health and safety is vital to all life pursuits). This page captures action steps related to assuring such supports will be put in place. This page is NOT intended to track routine medical appointments or duplicate an individual's Healthcare Plan, Crisis Prevention/Intervention Plan, Mealtime Plan, etc. Rather it is a place to list the need for such plans to be developed or updated and implemented. If support plans are already in place, just check the relevant box on the page titled "Individual Specific Training Requirements: Support Plans"

This page must be used to document what team is doing if:

- 1) An existing condition is worsening.
- 2) A new condition is emerging/new diagnosis.
- 3) There are new symptoms.
- 4) There are new medical tests or evaluations that are needed or that need to be discussed with the individual's physician.
- 5) There are any actions that are past due (i.e. MRI never scheduled, Blood work overdue, osteoporosis scan was canceled, but not re-scheduled). For example if the person has just discovered that they are allergic to bee stings, the action step could be "Create a Crisis Prevention/Intervention Plan to address Bob's allergy to bee stings", with appropriate responsibility and timelines completed as well.
- 6) If the team has noticed that an individual is losing skills, but they don't know the reason for this decline, some action steps should be listed to seek appropriate medical evaluation to determine if there is an underlying medical reason. *If any of the steps address an Assistive Technology device, it must state responsible party(ies) to both obtain and maintain the device.*

If the individual feels that certain health information needs to remain private and not shared with the full team, but support is still required for that issue or condition, the action plan step can refer to a private meeting with the individual's healthcare coordinator and/or nurse on the team to identify appropriate ways to address the concern.

PITFALLS TO AVOID:

- *Failure to address preventative healthcare measures that are needed*
- *Including detail that is better addressed through the Healthcare Plan and/or Crisis Prevention/Intervention Plan or other support plans*
- *Listing routine medical appointments*
- *Failure to determine results*
- *Demanding particular testing or treatment – usurping the physician's role in determining the most appropriate, least intrusive testing/ treatment to address the symptoms*

HEALTHCARE COORDINATION INFORMATION:

Please note: The Healthcare Coordination section of the ISP is not applicable for State General Fund participants.

This is the page to designate the member of the team who will assist the individual in coordinating their healthcare services. The designated healthcare coordinator can be any member of the team, including the individual, family member or other natural support, who is willing and able to arrange medical appointments and lab work, share results with appropriate team members, assure follow through occurs for physician orders and therapy treatments, and assure implementation of medication delivery supports. For individuals with a HAT score of 4, 5, or 6 if the individual wishes to be designated as their own healthcare coordinator, an additional member of the team must also be designated, to assist him/her in fulfilling that role to the maximum extent possible while still assuring coordination of the multiple and/or serious health issues that led to the higher HAT score.

There is also space to indicate whether or not the individual has an advanced directive in place and/or desires more information about creating or revising an advanced directive.

The level of support needed for medication delivery, as well as the responsible party(ies) for filling prescriptions and updating the Medication Administration Record (MAR) is to be described and may be a different team member than the designated healthcare coordinator.

- Be sure to include name and title of person who completed the MAAT, his/her recommendations, team decision and their rationale for making that decision.
- Please see the DDSM Medication Assessment and Delivery Policy and Procedures for details on determining the level of support needed for medication delivery.
- Some individuals may require different levels of support for different medications; for example, an individual may be able to self-administer oral medications, but require a nurse to administer injections. If this is the case, use the "rationale for this decision" section to describe the level needed for each type of medication.

INDIVIDUAL-SPECIFIC TRAINING REQUIREMENTS

INDIVIDUAL-SPECIFIC TRAINING REQUIREMENTS: SUPPORT PLANS

For each targeted area, document the urgency of training, as follows:	For each IDT member who must complete training, specify the type , as follows:			
<ul style="list-style-type: none"> • 1 – Prior to working with the individual • 2 – Prior to working alone with the individual • 3 – Within 30 days of working with the individual • 4 – Other (specify) 	<ul style="list-style-type: none"> • A – Awareness level (e.g., obtains basic familiarity with the plan) • K – Knowledge level (e.g., learns specifics strategies/techniques) • S – Skill level (e.g., demonstrates ability to implement the plan) 			
SUPPORT PLAN (ATTACH TO ISP)	WHO RECEIVES TRAINING	URGENCY	TYPE	WHO PROVIDES TRAINING
<input checked="" type="checkbox"/> MEALTIME PLAN Added 5/30/06	<input checked="" type="checkbox"/> Case Manager	3	A	Mary Chat, SLP (Eating technique) + Joe Muscle, PT (for positioning portion) + Jane Nojunkski, Dietician (for food texture and content)
	<input checked="" type="checkbox"/> Residential Staff	2	S	
	<input checked="" type="checkbox"/> Day Support Staff	2	S	
	<input type="checkbox"/> Ancillary Supports:			
	<input checked="" type="checkbox"/> Others: Sister	Prior to next home visit	S	
<input type="checkbox"/> TUBE FEEDING PROTOCOL (INCLUDING POSITIONING)	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input type="checkbox"/> BEHAVIOR SUPPORT PLAN <input type="checkbox"/> BEHAVIORAL CRISIS PLAN	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input type="checkbox"/> THERAPY PLAN (COMMUNICATION) <input type="checkbox"/> ASSISTIVE TECHNOLOGY <input type="checkbox"/> COMMUNICATION DICTIONARY <input type="checkbox"/> 24-HOUR COMMUNICATION SYSTEM <input type="checkbox"/> INTERACTIVE COMMUNICATION ROUTINES <input type="checkbox"/> OTHER:	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input checked="" type="checkbox"/> THERAPY PLAN (OCCUPATIONAL) <input checked="" type="checkbox"/> ASSISTIVE TECHNOLOGY <input type="checkbox"/> SENSORY ISSUES <input type="checkbox"/> THERAPEUTIC POSITIONING <input type="checkbox"/> GENTLE MOVEMENT OF LIMBS/ROM <input type="checkbox"/> OTHER:	<input type="checkbox"/> Case Manager			Larry Techsky, OT
	<input checked="" type="checkbox"/> Residential Staff	2	S	
	<input checked="" type="checkbox"/> Day Support Staff	2	S	
	<input checked="" type="checkbox"/> Ancillary Supports:	3	K	
	<input type="checkbox"/> Others:			
<input type="checkbox"/> THERAPY PLAN (PHYSICAL) <input type="checkbox"/> ASSISTIVE TECHNOLOGY <input type="checkbox"/> THERAPEUTIC POSITIONING <input type="checkbox"/> LIFTING AND TRANSFERRING <input type="checkbox"/> GENTLE MOVEMENT OF LIMBS/ROM <input type="checkbox"/> OTHER:	<input type="checkbox"/> Case Manager			
	<input type="checkbox"/> Residential Staff			
	<input type="checkbox"/> Day Support Staff			
	<input type="checkbox"/> Ancillary Supports:			
	<input type="checkbox"/> Others:			
<input checked="" type="checkbox"/> NUTRITIONAL/DIETARY PLAN Added 5/30/06 related to mealtime protocol	<input checked="" type="checkbox"/> Case Manager	3	A	Jane Nojunkski, Dietician
	<input checked="" type="checkbox"/> Residential Staff	2	S	
	<input checked="" type="checkbox"/> Day Support Staff		S	

	<input type="checkbox"/> Ancillary Supports:			
	<input checked="" type="checkbox"/> Others: Sister	Prior to next home visit	S	
<input checked="" type="checkbox"/> HEALTHCARE PLAN (REQUIRED IF HAT SCORE IS 4, 5, OR 6)	<input checked="" type="checkbox"/> Case Manager	3	A	Residential & Ancillary & Sister: Mary Heart, Nurse Day: Josh Jones, Nurse
	<input checked="" type="checkbox"/> Residential Staff	2	S	
	<input checked="" type="checkbox"/> Day Support Staff	2	S	
	<input checked="" type="checkbox"/> Ancillary Supports:	3	K	
	<input checked="" type="checkbox"/> Others: Sister	At next home visit	S	

↑ **Many ISPs require implementation of a variety of support plans.** The most common types of support plans are listed on the page titled "Individual Specific Training Requirements: Support Plans. Such support plans are due to all team members 14 calendar days after the ISP meeting and must be attached to the ISP when submitted to the regional office. In addition, the relevant team member must provide training on the support plan to designated team members.

The page titled "Individual Specific Training Requirements: Medical Crisis Prevention/Intervention Plans" provides space to address these individual specific training requirements. Please note that Behavioral Crisis Prevention/ Intervention Plans are included on the previous page with the Behavior Support Plan.

The next two titled "Individual Specific Training Requirements: Other Supports provide space to address a variety of other individual specific training.

If the "others" box is checked under "Who Receives Training," please list specific parties to be trained in the space to the right. Use the key at the top of the page to indicate the Urgency and Type of training needed by each of the various team members. In general, team members who provide direct support should be trained to "skill" level with support plans, crisis plans and ISP components. In the far right column state at least the title and agency that will deliver the training; include a specific name if possible. If different individuals will be conducting individual specific training for differing audiences (e.g. community living versus day service staff), this must be noted in this column.

The designated healthcare coordinator should be included in all individual specific training related to at least 1) support plans, 2) crisis prevention/intervention plans, 3) communication, and 4) medications. In some cases a healthcare professional will serve as the designated healthcare coordinator and may be delivering such training rather than attending as a participant.

Some topics are mandatory for all individuals served, although of course the specific information covered will be individualized. Mandatory topics are indicated by the fact that they are pre-checked in the Topic Area column. The one exception is Medications; in rare instances where there is an individual who does not take any medication (even vitamins or over the counter PRN medications) this box may be unchecked. However, teams are cautioned that should the individual become ill, support persons need to know what level of support is needed as well as purpose and side effects of any medication prescribed at that time.

Per DDS Policy, each provider agency is responsible for implementing a tracking system to prove staff completed individual specific training per each ISP. It is advisable for those who deliver trainings to also keep a copy of participant sign in sheets.

The following examples clarify what meets training requirements for each type of training,

- **Awareness:** the team member(s) could read through the SLP support plan and call the SLP if they have questions;
- **Knowledge:** the team member(s) would need to attend the SLP giving the in-service to the staff regarding use of the communication device;
- **Skill:** the team member(s) would need to demonstrate that they can assist the person in using their communication device.

PITFALLS TO AVOID:

- *Leaving out natural supports when considering who needs to be included in training*
- *Failure to address urgency and/or level of training*
- *Failure to be specific with regard to who will provide the training*

ISP MEETING PARTICIPANTS

This page documents the participants of the meeting to develop the ISP. If a team member was unable to participate in person, indicate the mode of participation in place of the signature (e.g. by phone, by input to individual and case manager prior to meeting).

THE ISP BUDGET:

Please note that in addition to the ISP and relevant support plans, a MAD 046 indicating the budget for Waiver funded services must also be attached. For detailed instructions on how to develop the budget and complete the MAD 046 budget form please refer to the Resource Guide for Independent Case Managers chapter VIII.

ASSESSMENT TRACKING SHEET

SEE **APPENDIX 1** AT THE END OF THESE INSTRUCTIONS, FOR ASSESSMENT TRACKING SHEET

This form is used as a place for the team to track which assessments and evaluations have been completed during the year, what the recommendations are from those appointments, and what are the implications for planning.

This form should **NOT** be used as a lifetime historical document, listing issues which have occurred in the past- and do not present any implications for planning. (example: "Jane had several bouts of tonsillitis until she had her tonsils out at age 9").

Please complete Therapist/Specialist information completely with address, phone and fax numbers.

DECISION JUSTIFICATION FORM

SEE **APPENDIX 2**, AT THE END OF THESE INSTRUCTIONS

This form is used to document IDT decisions to implement, not implement, or to modify recommendations from Specialists, Providers, and others- following a well-documented discussion and exploration of the facts and options presented.

ADDENDUM C ISP REVISION FORM

SEE **APPENDIX 3**, AT THE END OF THESE INSTRUCTIONS, FOR ISP REVISION FORM .

In some situations, the action plan does not need to be revised, but strategies for certain action steps do need to be revised to address lack of progress. Other times, one or more support plans need to be revised.

The case manager or parties responsible for changing strategies and support plans will need to complete a Revision Form (Appendix 3), attach revised pages of the ISP, and copy to all team members and the DDSD Regional Office.



IDT MEMBERS NEED TO HOLD IDT MEETINGS WHEN SIGNIFIGANT CHANGES OCCUR IN THE INDIVIDUAL'S LIFE. (SEE SERVICE STANDARDS).

PITFALLS TO AVOID:

- *Revising part of the ISP without revising related sections*
- *Losing previous versions*
- *Waiting until the annual meeting to make revisions, instead of doing them as soon as the need is identified.*
- *Failure to address lack of progress*
- *Assuming that lack of progress is the individual's fault (e.g. "not interested, too old, to disabled") rather than changing the steps and/or strategies to ensure success*

Failure to revise the action plan when all/most action steps are completed and the individual is ready for more action steps

ISP QUALITY ASSURANCE PROCESS

In order to ensure that ISPs promote health, safety, quality of life and appropriate support, quality assurance review is required. DDS staff assigned to review ISPs must complete training through the DDS training unit prior to performing this quality assurance (QA) function.

DDS requires that a quality assurance review is performed using the DDS ISP QA form for:

- ISPs for all Jackson Class Members
- A 10% random sample of each case manager's non-Jackson ISPs. For example, if a particular case manager has 20 non-Jackson individuals on his/her caseload, then the supervisor must randomly select 2 of those ISPs for review when the annual plan comes due.

Completion of the QA form requires:

- The designated ISP QA supervisor within the case management agency review of pre-meeting assessments and pre-meeting preparation via completion of the first page of the Quality Assurance Feed back Form
- DDS designated staff thorough and thoughtful review of each section of the ISP,
- Specific feedback on what is not currently adequate,
- Specific feedback on why a section(s) of the ISP is not adequate, and
- Clear instructions on how to correct the sections(s) of the ISP so it will become adequate.

The steps of the QA process must be followed in the order listed below:

1. The case manager and team develop the ISP.
2. The case manager completes the ISP form and submits it to the case management agency QA supervisor for review of the first page.
3. The agency QA supervisor puts the QA form with the first page completed on top of the ISP and sends both documents to the regional office for review and feedback.
4. The DDS reviewer adds his/her comments to QA form and returns the ISP and QA form to the case management agency director.
5. The case management agency QA supervisor reviews all feedback on the QA form with the case manager.
6. The case manager makes revisions to the ISP and sends the revised ISP back to the DDS regional office for review and approval or additional feedback within 14 calendar days. The case manager may request technical assistance from the regional office if help is needed to develop a quality ISP. In addition, regional office staff may request the opportunity to meet with the team to discuss ways to improve the ISP. Such requests will be made in advance through the case manager and will be handled as a separate agenda item to avoid the perception that DDS is leading the team meeting. If needed, an extension for an additional 14 days, may be granted to the timeline if such TA sessions are being held with the team.
7. The regional office has 14 calendar days to review the revised ISP and return it to the case management agency indicating approval or additional feedback. If the ISP is once again not acceptable, the regional office will provide technical assistance; the case management agency will be instructed to contact the regional office to schedule this session, preferable at a time that the case manager and the case management QA supervisor can both attend.

In order to assure no lapse in services, the case manager should not wait until the QA process is complete to distribute the ISP. The ISP must be distributed to NMMUR and team members according to timelines outlined in case management standards and ISP regulations.

PITFALLS TO AVOID:

- *Not completing requested revisions to ISPs after feedback is received.*
- *Not adhering to timelines cited above.*
- *Waiting for final approval before distributing and implementing the ISP.*

Appendix 1

The Assessment Tracking Sheet is a useful tool to assist teams to keep on top of required Health, Therapeutic and other assessments and evaluations as they occur during the year. This tracking sheet is not meant to be a detailed, exhaustive or historical account of the individual's medical or behavioral history.

Rather, it should include pertinent information which has current implications for planning.

For example, if an individual has seizures, the Neurologist would be listed, as well as when the person was last seen, and when they are due to be seen again. If the Individual had a febrile (fever related) seizure as an infant, twenty years ago- but not since, does not see a Neurologist- there would not be a reason to include this information on the Assessment Tracking Form.

Please see sample Assessment Tracking Sheet below:

Assessment Tracking Sheet

FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY

INDIVIDUAL'S NAME: John Sample		ISP DATES: <u>7/1/08</u> to <u>6/30/09</u>
Designated Healthcare Coordinator: Nurse June Allison R.N.		LOC DATE: <u>6/1/08</u> Date sent to ISD: <u>5/30/08</u>
Phone: 555-555-5555 x5	Fax: 555-5556	Year LOC Due to NMUR for review: <u>2009</u> Level: <input type="checkbox"/> I <input checked="" type="checkbox"/> II <input type="checkbox"/> III
Date of HAT: <u>5/01/08</u>	HAT LEVEL: <u>II</u>	Date of ABS: <u>5/01/08</u> Date of CIA: <u>5/01/08</u>
Clinical Assessment Areas:		
Assessments	Provider	Results / Implications for Planning:
Physical Exam: Date last done: 4/27/08 Date due Next: Call for lab appt. 9/08 Dr. appt to review lab results- 10/08	Physician: Dr. Ben Casey M.D. 555-5252 fax 555-5253 24 Elm Dr, Center City NM 87777	John is diagnosed with Downs Syndrome, Hypo-Thyroidism & High Cholesterol. His lab tests show his level of Synthroid is fine, and his cholesterol levels are slightly elevated, but within appropriate range (under 160). Dr. discussed raising John's level of activity, and maintaining a diet low in saturated fats. Re-test thyroid and cholesterol in six months. Weight is fine at 160 lbs.
Psychological / BT Assessment: Date last done: 4/10/08 Date due next: 10/08	Provider: Peter Worth, MA. 555-2222 Fax 555-2223 20 Feel Good Way, SFE, NM 87777	Ongoing BT supports, weekly. Current Behavior Support Plan in place, Annual Assessment completed. Peter supports John to express how he feels.
Psychiatric Exam: Date last done: 2/20/1998 Date due next: IDT does not rec.	Psychiatrist: Dr. Carl Jung 555-4444 Vienna Sausage Assoc. Santa Fe, NM 87777	Evaluation by Dr. Jung in 1998, no psychiatric follow-up needed. Mild Anxiety related to communication deficits.
Neurological: Date last done: n/a Date due next: n/a	Neurologist: n/a	No neurological issues requiring evaluation.
Dental: Date last done: 1/10/08 Date due Next: 7/09/08	Dentist: Dr. Steven Clean 222-8888 Fax 222-8887 Clean Dental 12 Smith Rd, SFE NM 87505	Routine cleanings, prophylactic antibiotics prior to dental work- call for prescription 10 days prior to appt. John has routine cleaning and periodic fillings as needed. Wisdom teeth out earlier this year.
Vision: Date last done: 1/24/08 Date due next: 1/09	Provider: Dr. Seeu 555-9999 Fax 555-9998 Seeu Associates 2020 Hwy 5, Espanola, NM 87555	John has Myopia-(nearsighted). He wears prescription glasses with transition lenses. Prescription generally increases every year or two. John needs assistance to keep his glasses clean, and clean them with special cloth to prevent scratches.

Auditory / Hearing: Date last done: 08/10/07 Date due next: 8/09	Provider: Dr. Kaufman 555-3333 Hearing Specialists, LLC 10 Hwy 2A, SFE, NM 87505	John has minor hearing loss in his right ear, Dr. Kaufman states John does not need hearing aids, and some deficit may be due to processing issues, follow every two years. Forward evaluation to SLP
Communication / Speech Therapy: Date last done: 4/08 Date due next: 7/08	Therapist: Julie Earring, SLP. 555-1111 Fax 555-1112 1332 Echo Valley Rd, SFE, NM 87555	John receives weekly SLP. Goals include pronunciation, and improving listening skills. Also, improving John's comfort level with expressing what he wants and needs, especially in group situations. Annual Assessment 4/08, Communication Plan in place.
Augmentative/Assistive Technology Date Reviewed: Due Next:	Therapist: n/a	n/a
Mobility/Adaptive Equipment: Date last done: Date due next:	Therapist: n/a	John has no Mobility issues, is ambulatory.
Physical Therapy: n/a Date last done: Date due next:	Therapist: n/a	John likes to walk, and participates in Special Olympics as well as a neighborhood softball league.
Occupational Therapy: n/a Date last done: Date due next:	Therapist: n/a	No need for OT services
Nutritional: Date last done: 3/1/08 Date due next: 3/09	Nutritionist: Sally Smith, Nutrition, Inc 555-7777 Fax 555-7778 PO Box 2222, SFE, NM 87777	Diet recommendations include healthy choices, which emphasize low-fat, low cholesterol foods, with lots of fiber. John likes fast food, but is learning which fast foods are better than others.
Vocational Assessment: Initial Assessment: 7/2002 Last update: 3/08	Facilitator: Steve Jobs 555-1111 Fax 555-0001 Your Jobs Inc 900 Apple Way, SFE, NM 87777	John had a vocational Profile update this year, as John would like to work more hours- not available at his current job. Also, he would like to work indoors, around computers. Current Voc Profile in place, incorporated into ISP.
Other: Date last done: Date due next	Received from provider: Frequency: n/a	n/a

Appendix 2

Decision Justification Form

A. Team Response to Expert Recommendations

Individuals served through the DD Waiver at times receive evaluations conducted by a variety of professionals. These evaluations typically include recommendations for the individual and the team to consider. This form provides a way to document that the team has given due consideration to the recommendations and either 1) created an action plan to implement the recommendation, or 2) made a thoughtful determination that the recommendation should not be implemented. This form should be filed with the evaluation report in which the recommendation (s) was made.

Recommendation & Source	Accept	Reject	Reason for Acceptance or Rejection	If accepted, Date ISP was revised

B. Other Decisions Requiring Documentation of Justification:

Use this section to document rationale for any decision for which the team feels it is important to maintain clarity (e.g. recommendation for change in guardianship status, appropriate support related to individual's informed choice associated with significant risk, measures taken to assure informed choice).

Decision	Rationale/Justification	Related Actions	Responsible Party	Timeline

Effective 2/1/0

Appendix 3

INDIVIDUAL SERVICE PLAN
For Individuals with Developmental Disabilities Living in the Community
ADDENDUM C ISP REVISION FORM

Name: <i>(Last, First, Middle Initial)</i>		WAIVER ID #: 96-__-6-__-__-__-__-__-__ (county) (social security number)	
<u>Date of Current ISP:</u>	<u>Proposed Revision:</u> <input type="checkbox"/> One Time Only <input type="checkbox"/> Permanent	<u>Effective Dates of Revision:</u> From: To:	
<u>Nature of Revision:</u> <input type="checkbox"/> Face sheet <input type="checkbox"/> Outcomes <input type="checkbox"/> Action Plan <input type="checkbox"/> Strategies <input type="checkbox"/> Providers <input type="checkbox"/> Other: _____			
<u>Nature of Revision:</u> <i>Be Specific</i> -- List all Provider changes (attach <u>Transition Plan</u>), changes in Services (note Additions, Deletions or changes in Intensity / Frequency, changes in Outcomes or other aspects of the <u>current</u> Individual Service Plan. Attach revised sections of the ISP. Please see Standards for when IDT meeting must be held.			
<u>Justification for change in ISP:</u>			
<u>Case Manager:</u>	<u>Case Management Agency:</u>	<u>Phone #:</u>	<u>Date:</u>

Revisions must be distributed to all IDT members, as well as the Regional Office.