The Oregon ISP

Welcome to the Oregon Individual Support Plan (ISP) instructions. The Oregon ISP is the written details of the supports, services, and other resources a person will use to meet support needs and reach personal goals and outcomes. The ISP is created by the person’s Services Coordinator or Personal Agent (SC/PA) following a person-centered approach to planning.

The planning process begins well before the ISP gets written. The SC/PA and others invited by the person begin by seeking to understand what is important TO the person from his/her perspective, including those things the person wants to do, learn, try, or have. These priorities and additional details the person chooses to share are recorded on the Person Centered Information document.

Support needs are assessed following a functional needs assessment process and any known, serious risks in the person’s life are identified. Conversation between the person and their SC/PA includes the person’s preferences for how support is delivered and who or what will provide the support.

The SC/PA brings this information together in the ISP to create an outline of the person’s desired outcomes, the person’s career development plan, any chosen services or community resources that will support the person to work toward their desired outcomes or meet assessed needs, as well as information about how any known, serious risks will be addressed.

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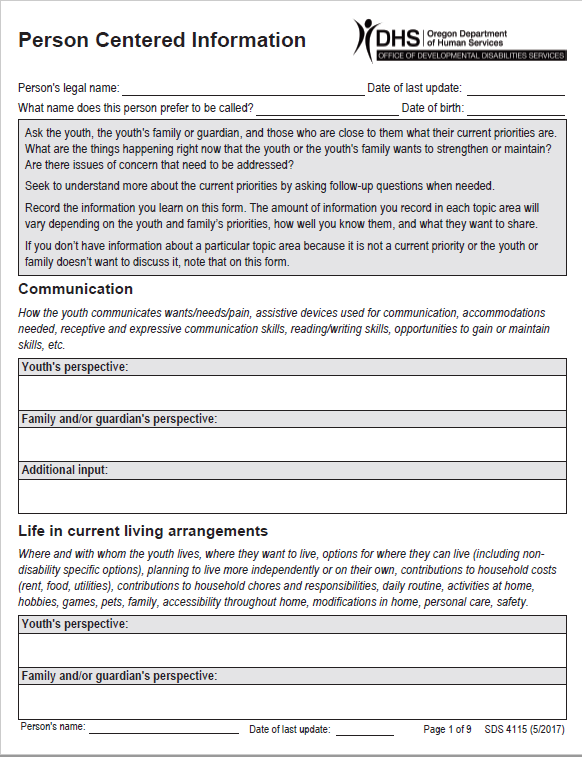
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| *Each chapter of this manual highlights “What to expect in your role” for people with ISPs, families, legal or designated representatives, providers, services coordinators, and personal agents.* |

Person Centered Information

# Gathering and Recording Person Centered Information

Gathering Person Centered Information is one of the foundations of the ISP process. Person Centered information can help us understand what is important To and For a person, what priorities they have, what they want their life to look like and how they want to be supported. The Person Centered Information form provides a place to record information gathered from the person and others who know and care about the person.

Once complete, this document serves as a valuable record of perspectives gathered from the person and invited participants on a range of important topics. This information contributes to the development of an ISP that is meaningful to the person and reflects what they want their life to look like.

Information gathered here may result in powerful action in the ISP, such as:

* Desired Outcomes that the person wants to pursue
* Community resources and other informal supports the person may access
* Chosen services, including both paid and unpaid services.

These are just some examples of what to do with information recorded here. Not everything written on the Person Centered Information document must be recorded in the ISP. ISP teams should carefully review the information gathered and work together to decide what needs to be included in the ISP.

## Adult and Youth versions

The Person Centered Information document is available in both Adult and Youth versions. The Youth version has supporting questions under each topic that are designed to address issues relevant for those under age 18. The youth version also includes a field to record the young person's date of birth.

## Perspectives

The form includes space to record multiple perspectives from those participating in the person-centered information gathering process.

### Person's perspective

This is the place to capture the person’s perspective. The person’s perspective includes those things that are important To the person. Things that are important To the person might include the things they like and love, the things and people they want and don’t want in their life, and the things that work and don’t work for them.

The person’s perspective is learned over time in a variety of ways:

* The person’s words (spoken words, signs, written word, assistive device), if any
* Actions that we observe
* Information shared by others who know the person well.

### Family and/or guardian's perspective

This section appears automatically on the Youth version of this document. It can be toggled on for adults who have a guardian or who choose to have family involved in planning, or their perspectives can be recorded in the "Additional input" sections of this form.

If the person has a legal guardian, include their perspective in this section. For adults, the legal guardian's perspective may also be recorded in "Additional input," if desired.

Family relationships take many different forms and are not limited to blood or legal relations. It may include anyone the person chooses to identify as family.

## Additional input

This is the place for all other perspectives from people the person chooses to have involved in planning. This includes paid support providers or other professionals in the person's life such as counselors, therapists, medical professionals, behavior professionals, and more.

When there are multiple perspectives on a similar issue, consider recording from whom each perspective was shared. Attributing information to its source can make it easier to follow-up if more information is needed later.

# What to expect in your role

## The person & their legal or designated representative

### Prior to the ISP Meeting

You can expect to be asked to share your perspective about a number of topics in your life. You are in charge of who you share this information with and how much information you share. If you don't want to talk about a particular topic, you don't have to. You may invite anyone else to contribute information, such as friends, family, or providers.

Your SC/PA will ask you, your legal or designated representative (if any), or the people you've chosen to help you plan, to share perspectives about your life.

### If you are supported by a provider in a residential setting

Your residential provider will ask you to share your perspective. Your provider will also record their perspective on this document in the section marked Additional input.

### If you need help sharing your perspective

You can choose someone else to help you communicate your perspective. If you are unable to choose someone, your ISP team may choose someone who knows you well to help you. They will indicate who helped you in the space provided at the end of the form.

## Provider organizations & Foster providers

### Prior to the ISP Meeting

Residential providers must gather information, then review and update this document at least every twelve (12) months prior to the ISP meeting. Share the updated copy with the person's SC/PA prior to the ISP meeting.

Gather information from the person's perspective and from others that the person chooses. If you don't have information about certain topics or the person declines to discuss, note that.

Carefully record the person's perspective in the space provided. Whenever possible, include the person's own words.

If the person needs support to communicate their perspective, ask the person who they want to help them communicate their perspective. If the person is unable to identify someone to support them, the ISP team may identify someone who knows the person well to contribute their knowledge of the person's perspective.

If you have been asked to assist the person to record or communicate his/her perspective, you must record the person's perspective faithfully. This is true, even if you disagree with the person’s perspective or feel the things that are important to them are unsafe or unhealthy.

Accurately record who contributed to this document in the space provided at the end of the form.

Use the information shared by the person and by others to identify areas of focus for the coming year. Consider drafting action plans toward desired outcomes that are meaningful to the person.

### Throughout the Year

Keep a copy of the updated Person Centered Information document in your files.

Use the information on the Person Centered Information to tailor the services you provide toward the person's priorities. When new support staff are hired, train them on the contents of this document.

Watch for any circumstances where supports you provide are in conflict with something that is important to the person. If this happens, take steps to adapt your supports to the person's preferences. If you're unable to do this, discuss this with the person and their SC/PA.

You may update the information contained in this document any time during the year. When you make changes, follow the documentation procedures in place at your organization. No change form is needed to change this document.

## SC/PAs

### Prior to the ISP Meeting

Information must be gathered and this document must be reviewed and updated at least every twelve (12) months prior to the ISP meeting.

Ask the person, his/her guardian, or the people they have chosen to help plan to share perspectives about the topics on this document.

Gather information from the person's perspective and from others that the person chooses. If you don't have information about certain topics or the person declines to discuss, note that.

Carefully record the person's perspective in the space provided. Whenever possible, include the person's own words.

If the person needs support to communicate their perspective, ask the person who they want to help them communicate their perspective. If the person is unable to identify someone to support them, the ISP team may identify someone who knows the person well to contribute their knowledge of the person's perspective.

If you have been asked to assist the person to record or communicate his/her perspective, you must record the person's perspective faithfully. This is true, even if you disagree with the person’s perspective or feel the things that are important to them are unsafe or unhealthy.

Accurately record who contributed to this document in the space provided at the end of the form.

**If the person is supported by a provider in a residential setting,** the residential provider must complete or update this document with information they have available to them. You should receive a copy of this document from the residential provider prior to the scheduled ISP meeting. If the person invited other providers to contribute, you may receive additional documents. If there are multiple documents from different providers, they do not need to be merged, but can be filed together with the completed ISP in your records.

Review the person centered information. Consider the following points as you review:

* Identify priorities or topics that the person may want support to work toward over the next ISP year.
* Make sure the person's perspective is carefully and accurately recorded even if others disagree with the person’s perspective or the things that are important to the person are unsafe or unhealthy.
* Look for situations where there may be conflict between the person's perspective and someone else's.

Watch for issues to include in the new ISP, discuss at ISP team meeting, or have a separate conversation with those involved.

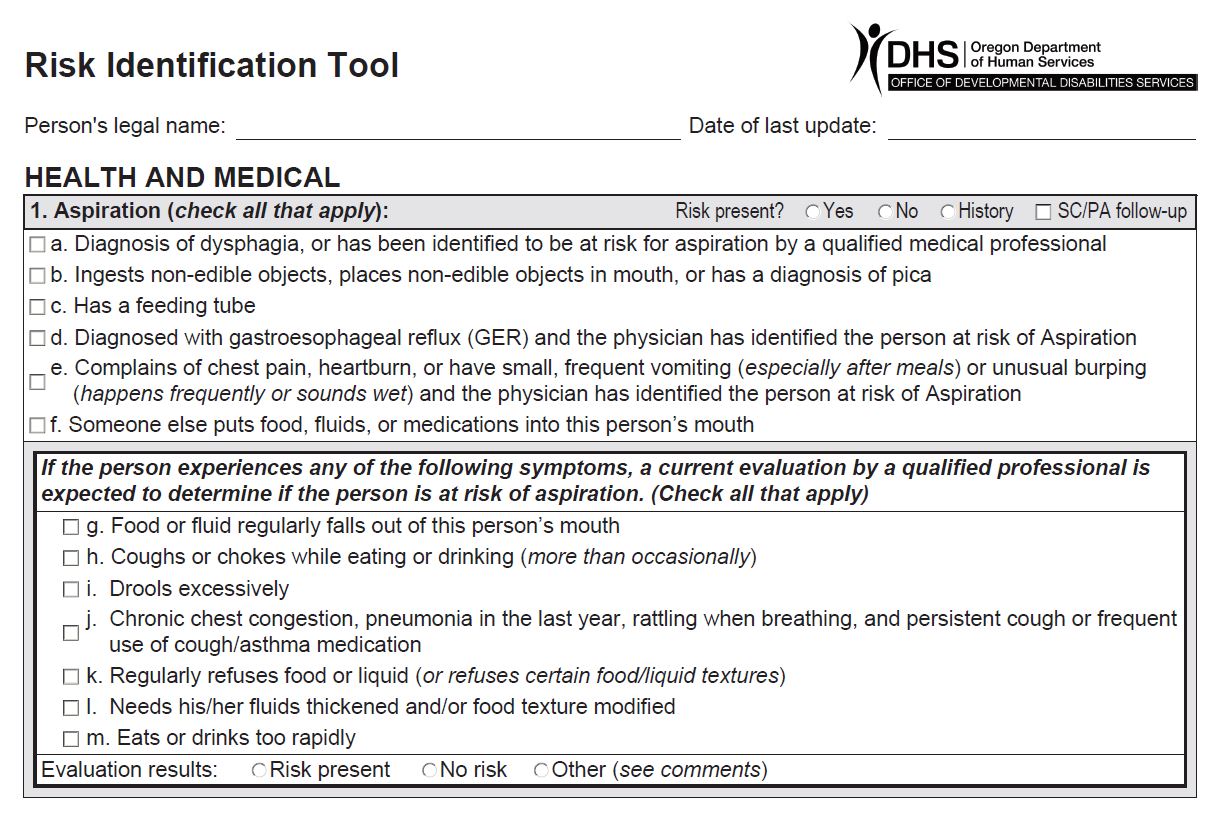
### Throughout the Year

Keep a copy of the updated Person Centered Information document in the person’s file.

Familiarize yourself with the information on the Person Centered Information. When monitoring or checking in on the person throughout the year, listen and observe for evidence that the person's perspective is being recognized and addressed.

You may update the information contained in this document any time during the year following documentation practices common at your organization. No change form is needed to change this document.

Risk Identification Tool

The Risk Identification Tool is designed to assist teams in identifying any known, serious risks that are present in the person's life. The tool includes many common risk factors or warning signs in order to help teams recognize when a risk is present.

**Serious Risk** For purposes of this tool, serious risks are considered things that would likely result in hospitalization, institutionalization, serious financial hardship, legal action, or place the person or others in imminent harm unless specific, individualized support is necessary to address it.

Once any risk is identified, the SC/PA discusses it with the person and his/her ISP team to identify the best way to address it. Every risk marked 'Yes' will be listed by the SC/PA on the person's ISP Risk Management Plan along with a description of what supports are available in the person's life to address it. Read more about the ISP Risk Management Plan on page .

This document is best completed or reviewed near the time of the needs assessment as similar information is covered. However, be mindful of changing risks throughout the year. While this tool must be completed initially prior to the ISP meeting, it must also be updated throughout the year if known risks change.

The complete Risk Identification Tool is kept in the person’s file at the CDDP or brokerage.

# What to expect in your role

## The person & their legal or designated representative

You can expect to be asked to share your perspective about any serious risks that you believe are present in your life.

### If you are supported by a provider in a residential setting

Your provider will also share information they are aware of with your SC/PA.

### If you need help sharing your perspective

You or your legal or designated representative can choose someone else to help you record your perspective. Let your SC/PA know if you want help sharing your perspective.

## Provider organizations & Foster providers

### Prior to the ISP Meeting

Familiarize yourself with the risks and risk factors in the Risk Identification Tool. You must share information with the person's SC/PA about any known, serious risks in the person's life. Communicate any evidence of known, serious risks promptly to the SC/PA. Maintain documentation about this communication.

Talk with the SC/PA to find out the best way to share that information.

### Throughout the Year

Prepare and maintain a “Provider Risk Management Strategies” form specific to the location where you support the person. This should include all of the risks listed on the Provider Service Agreement or ISP Risk Management Plan that are directed to you to support.

If the SC/PA disagrees or does not include a risk on the ISP Risk Management Plan that you believe may be a serious risk, discuss it further with them. Provide evidence of the issue you are concerned about and document any discussions you have with the SC/PA. Follow your agency’s policies or guidance for resolving issues and disputes between agencies as needed if you feel the difference of opinion puts the person’s health and safety at risk or does not respect the person’s preference.

Notify the person's SC/PA if you observe new or changing serious risks in the person's life. Identify strategies you can offer to help address these risks and discuss those strategies with the person and the SC/PA.

## SC/PAs

SC/PAs have the responsibility for the accurate completion of the Risk Identification Tool based on available information.

Complete this form based on information learned through conversations, file review and your knowledge of the person.

Upon entry into services, identify serious risks during or near the time of the needs assessment. That way, you can use the information that was discussed during the needs assessment and you don’t have to repeat conversations that may feel intrusive to the person or their family.

### Prior to the ISP Meeting

This document must be reviewed at least annually prior to the ISP meeting.

* If the person lives in his/her own home or their family home, ask the person, his/her legal or designated representative, or the people they have chosen to help plan if there are any changes in serious risks in the person's life. If you are also conducting the needs assessment for the person, check in on this information at the same time to avoid redundant conversations with the person and his/her designated representative(s).
* Providers are expected to share any updates they have about changes in risks in the person's life. Communicate with the provider to make agreements about how that information should be shared with you.

### Throughout the Year

* Provide a copy of this tool to the person or his/her designated representative. Keep a copy of the most current Risk Identification Tool in the CDDP or brokerage files.
* Familiarize yourself with the known, serious risks present in the person's life. When monitoring or checking in on the person throughout the year, listen and observe for evidence that those risks are being effectively supported.
* If this document needs to be updated, you may do so by completing a change form. Other team members may also initiate a change form and send it to you for review.
* Continue to keep this form up-to-date throughout the year if you learn about changes in risks in the person's life.

# Completing the form

Final responsibility for completing this document rests on the SC/PA. Providers who support the person are expected to communicate with the SC/PA promptly if they observe any changes related to serious risks in the person’s life.

Based on your knowledge of the person and their support needs, as well as conversations with the person and/or their designated representative, respond to each risk by marking 'Yes', 'No', 'History', or 'SC/PA follow-up'. If you know that all risks in one section will be marked 'No', you may check the box provided to skip ahead to the next section.

## 'Yes'

Mark 'Yes' if there is evidence of the identified risk.

### Expected action for SC/PA

Record the risk on the Risk Management Plan in the ISP and note how the risk is addressed. See Risk Management Strategies for more information about addressing identified risks.

## 'No'

Mark ‘No’ if there is no available evidence of the identified risk. This response is also indicated if the person declines to discuss the issue and there is no available evidence that the risk exists.

Risks marked 'No' are not listed on the Risk Management Plan in the ISP.

## 'History'

Mark 'History' if there is no available evidence of the identified risk being a current issue and supports are not needed BUT there is evidence that the identified risk did occur or needed supports within approximately the last five years.

The history designation is for informational purposes only. If you mark a risk as ‘History,’ it is not recorded on the Risk Management Plan in the ISP and no support strategies are put in place to address the issue.

Typically, if a risk is changing from ‘Yes’ to ‘History,’ leave it marked History for approximately five years. Circumstances may warrant changing the response from ‘History’ to ‘No’ in less than or more than five years. Consider if there are other documents available in the person’s file that provide information about the past issue, the person’s and family’s preference on how it is recorded, and the likelihood the risk will be present again.

## 'SC/PA follow-up'

The SC/PA may choose to mark this box to indicate intent to follow-up on that issue.

Follow-up may be helpful if the SC/PA has reason to believe the issue may be present, but information is inconclusive or the person declines to discuss the issue.

### Expected action for SC/PA

* Note the issue and planned follow-up on the ISP in the Chosen Case Management Services section of the ISP, as an anticipated case management activity
* Follow-up within established timelines to see if the issue is changing or additional information becomes available.
* Provide information about available community resources (e.g. county health department, medical professionals, etc.) for assistance assessing or addressing the issue.
* Document actions taken in a progress note.

## Comments

There is a field provided in each section for comments. Use this space to record any useful information about why a risk was marked 'Yes', 'No', 'History', or 'SC/PA follow-up'. Comments are considered optional and are not required.

When marking a risk 'Yes', the comments section can be used to describe what the risk looks like for the specific person you are planning with. You might use this space to explain how the particular risk affects the person, which can be useful when developing support strategies.

Avoid using the comments space to record specific support strategies for any identified risk. That information belongs in the Risk Management Plan in the ISP or in support documents, such as safety plans, protocols, financial plan, etc.

## Contributors

List anyone who contributed information to assist in completing this tool. Signatures are not required on this form.

Think about who has information and who may be able to help identify known, serious risks. It may be the same people who are involved in the needs assessment. Are there others who have knowledge of the person who should be consulted? Consider family, nurses, behavior professionals, and providers.

## Evaluations

The risks of aspiration, choking, dehydration, constipation, and seizures have a series of risk factors or observable symptoms listed to help identify whether a serious risk may be present. Some risk factors (e.g. letters “g”-“m” under Aspiration) may warrant additional evaluation or discussion with a qualified professional to determine the level of risk present. Unless the risk has already been determined “Yes” by a preceding risk factor (e.g. any of “a”-“f” were already marked under Aspiration), seek an evaluation to determine whether a risk is present.

|  |  |
| --- | --- |
|  | **Risk is present. Supports are needed.**  **Evaluation is not expected.**  Note: Even when not expected, an evaluation can always be sought to help identify effective support strategies. |
|  | **Evaluation is expected in order to determine whether risk is present.**  Consider the need for interim supports while waiting for evaluation |
|  | **Risk is present. Supports are needed.**  **Evaluation is not expected.**  Note: Even when not expected, an evaluation can always be sought to help identify effective support strategies. |

If an evaluation is needed, consider professionals that are already in the person’s life. If the person has a nurse, ask the nurse for input. If the risk is related to the person's behavior and the person has a behavior consultant, start there. In addition, consider if the person has already received an evaluation from a qualified professional that is still current.

Even when an evaluation is not expected, teams can always seek an evaluation to help them rule in or rule out a risk or to get advice on the best way to support the risk.

**For SC/PAs supporting people in an In-Home setting,** encourage the person or family to discuss the issue with his/her primary care physician. Help them in a way that works for them to encourage follow-through. Use progress notes to indicate how follow-through is working or not working. If you have concern for the person’s immediate health and safety due to this issue and an evaluation is not available or possible, seek your supervisor’s guidance and use your professional judgment in determining whether immediate intervention is necessary.

Record information about any completed evaluations in the "Evaluations" section provided at the end of the tool.

# Considering other supports in place

As you review each risk, think about any supports that might already be in place or that might be necessary in order to help the person be safer around this issue. If the person relies on specific supports from someone in their life in order to avoid serious harm, mark that risk as 'Yes'. This is an important step, even if the supports currently in place are working well.

## When supports are provided by a provider organization or foster provider

*This additional guidance applies to #6) Unsafe Medication Management, #10) Lack of access to medical care, and #20) Safety and cleanliness of residence.*

These risks do not need to be marked 'Yes' simply because the person lives in a residential setting and relies on a provider to provide basic supports with these activities of daily living. The Functional Needs Assessment identifies basic support needs in these areas. If a provider is expected to provide support around these needs, list the identified need under the appropriate service code in the Chosen Services section of the ISP.

If the only support necessary for one of these risks is provided by a provider organization or foster provider following their policies or applicable administrative rules, the risk may be marked 'No'. Consider marking 'Yes' to any of these risks if the person requires individualized supports beyond the provider’s policies or applicable administrative rules.

# Considerations when planning with children

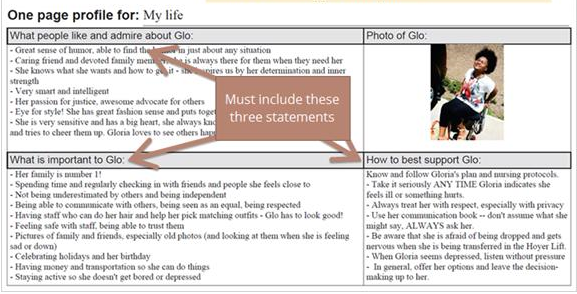
This tool is intended to identify risks beyond typical childhood development and parental responsibilities.

Do not include supports provided based on a child’s developmental level that are not as a result of the disability, such as needing to cut a child’s meat or hold a child’s hand when crossing the street.

One Page Profiles

The ISP includes a One Page Profile.

A One Page Profile provides a positive introduction to the person. The One Page Profile(s) in the Oregon ISP can be in any format, as long as it includes responses to the following three questions:

* What people like and admire about the person
* What’s important to the person
* How to best support the person

**What people like and admire about the person** includes the person’s positive qualities; this is a place the person can “shine.”

**What’s important TO the person:** Think about what matters most to the person in general or within the environment or situation the One Page Profile is being written for, such as employment, school, or home. One Page Profiles can be especially powerful if they are tailored to a specific setting.

**How to best support the person:** What supports help create balance between what’s Important TO and Important FOR the person, what helps make a good day or turns a bad day around?

## Common Errors

When creating One Page profiles there are some common errors to avoid.

### Mixing Important FOR in with Important TO:

One common error is including things that are important FOR a person mixed in with the things that are important TO them. Or, including things that are important to the person, but going on to explain why some of those things are unsafe or not possible. These can be thought of as “yeah, but…” statements.

Things that are important **TO** a person are those things that make a person feel ***happy, content, and fulfilled.***

Things that are important **FOR** a person are those things related to a person being ***healthy, safe, and a valued member of the community.***

For example, the person’s One Page Profile says, “likes to walk around the house naked, but roommates don’t like it and this causes problems with their relationships.” Or, “likes to pick up sticks in the roadway, but doesn’t look both ways and should.” These statements talk about what is important TO the person, but then go on to explain why what is important TO the person is not safe or appropriate. Make sure the things listed in the “important TO” section are purely those things that are important TO the person.

### Short, cryptic phrases:

Another common error is using short, cryptic phrases. If a person’s One Page Profile says that ‘music’ is important TO them, that doesn’t tell others enough about what music means to the person.

Does she like to perform music? Listen to music? Collect music? What kind of music does she like?

With lack of information, we put our own perspective on things, so give a little more information about what loving music means to the person.

### Including only the basics

Another common error found with One Page Profiles is writing the same, generic information on everyone’s profile. The basics should be assumed.

We all want and deserve to have our basic needs met, like food, clothing, shelter, and freedom from abuse. Unless the person is telling you these things are a particular priority in their life, it’s okay to leave them out, in favor of including more details that are unique to the person.

For example, if a person has experienced homelessness and they want their supporters to know that they never want to be in that situation again, then of course include it. Follow the person’s lead on what to include and what to leave out.

The point here is that the One Page Profile should be specific enough to know that it is the person’s One Page Profile and not someone else's.

Learn more about One Page Profiles at [www.OregonISP.org/1PP](http://www.OregonISP.org/1PP).

# What to expect in your role:

## The person & their legal or designated representative

### Prior to the ISP Meeting

* Give information to your SC/PA about what is important TO you and how you want to be supported. Include information about what your strengths and skills. Others you invite will share what they like and admire about you. Tell your SC/PA if you’d like help inviting others to help you create a One Page Profile.
* If you or others you invite are interested in creating a One Page Profile on your own, you can find templates and other available resources to support you online. www.OregonISP.org/1PP is a good place to start.

### Throughout the Year

* Tell your SC/PA any time you want to update your One Page Profile(s) so it continues to reflect who you are right now.

## Provider organizations & Foster providers

### Prior to the ISP Meeting

*Residential providers have additional requirements to contribute information relevant to planning prior to the scheduled ISP meeting date.*

* Communicate with the person and the SC/PA well in advance of the person’s ISP renewal date to clarify what information is expected, in what format, and in what timelines.
* Develop a One Page Profile for the specific environment where you support the person.
* At a minimum, update the One Page Profile(s) annually in preparation for the ISP meeting.
* Provide a complete One Page Profile to the SC/PA prior to the ISP meeting following agreed timelines.
* Train staff on the One Page Profile for your setting.

### Throughout the Year

* Review and update One Page Prolife anytime throughout the year, as needed.
* Changes may be made to local copies of the One Page Profile(s) at any time following local documentation practices, without an ISP Change Form.

## SC/PAs

### Prior to the ISP Meeting

* Ensure that there is at least one One Page Profile included with the ISP.
* If the person or family is interested in creating a One Page Profile themselves, offer templates and other available resources to support them. A good place to start is the website, [www.OregonISP.org/1PP](http://www.OregonISP.org/1PP).

#### In-Home settings

* Develop a One Page Profile in a manner that works for the person and/or family.
* Review One Page Profiles submitted by others, like the person and their supporters.
* Watch for the “Common errors in One Page Profiles” listed on page and share feedback with the providers.
* At a minimum, update the One Page Profile(s) annually in preparation for the ISP meeting.

#### Residential settings

* Review One Page Profile(s) submitted by providers and include them with the final ISP.
* Ask questions, if needed, to clarify any information.
* Watch for the “Common errors in One Page Profiles” listed on page and share feedback with the providers.
* Contribute additional information when needed.

## Throughout the Year

Review and update the One Page Prolife(s) anytime throughout the year, as needed.

Changes may be made to local copies of the One Page Profile at any time following local documentation practices, without an ISP Change Form.

Desired Outcomes

Desired outcomes are the things the person is interested in doing, learning, trying or accomplishing in the next year or beyond. A desired outcome is what a person wants their life to look like. It is the transformation that others can see once a person has taken specific steps or achieved goals. A person’s desired outcome might be to have a pet to care for or own a home. There might be several smaller goals involved in gaining the skills to care for a pet or saving the resources to buy a home. These smaller goals or steps can work together to achieve the person’s desired outcome.

Creating meaningful desired outcomes starts with having a conversation with the person and listening for the things that are important TO them, from their perspective and from the perspective of others who know and care about the person.

This process of gathering person centered information is central to developing desired outcomes. Gathering person centered information will help you discover what’s important TO the person and what they want to do, learn, try, or accomplish in life.

Once you know what’s important TO the person, you’ll ready to begin developing some meaningful desired outcomes!

# Guiding Action

Desired outcomes drive a person’s ISP by guiding the action people will take to help them achieve the things they want out of life.

They are based on information gathered from the person and others who the person has chosen to contribute additional input.

Desired outcomes give meaning to the person’s ISP by highlighting the goals the person has for achieving the life they want. Support needs, risks, and other health and medical issues inform what support the person may need to achieve their desired outcome, but it’s the desired outcome itself that tells us what we’re working toward.

A meaningful desired outcome must reflect what is important TO the person.

That is not to say that desired outcomes don’t include the things that are important FOR a person.

What’s important FOR a person (such as for the person’s health, safety, or to be seen as valued member of his/her community), may also be considered when developing meaningful desired outcomes, but be sure that the outcome itself is based on what the person would like to do, try, learn, or achieve.

People won’t always be using a Medicaid paid service to help them achieve their desired outcomes, but when they are, this is indicated by selecting the service that supports the outcome from the drop down.

Desired outcomes can encompass both long and short-term goals. Describe timelines within the desired outcome for when key steps will be completed or reviewed.

# Being Specific

Desired outcomes should be as specific as possible so supporters will know what is important to the person and what is expected of them in their role.

A specific Desired Outcome should tell us:

* What the person will be working toward
* What the person wants to accomplish
* What the person will do, learn, try, or achieve

Will the person do an activity, take a course, make a new friend, play baseball, make dinner, or go on a vacation? The more we know exactly what the person wants to do, learn, or try, the quicker we can start building the steps we’ll take to get there.

Even after gathering person centered information, the person and the team might not always know exactly what it is the person wants to do.

The person may know she wants to take a class at the community college, but might not be sure if she wants to take pottery or accounting, or something else.

Try to be as specific as possible, but when the person and the team aren’t sure, start with what you know and update the desired outcome as new things are learned and the person discovers what they want.

It is important that the desired outcome includes information about where and when it will happen and who will help.

* Where will the action take place? Is there a particular time of day or day of the week when steps will take place?
* What works best for the person and their schedule or routine?
* Is this something that will be done at home or somewhere in the community?
* Are their particular environments that work best for the person? Do we know that quiet spaces without a lot of hustle and bustle work best, or is it a social and crowed place that the person prefers?

Include any details that will help the desired outcome to be a specific as possible. So we know the WHO, WHAT, WHEN, and WHERE.

A specific Desired Outcome should NOT:

* Describe someone else’s goals for the person
* Specify provider’s compliance goals or requirements

# Transformation

When a desired outcome has been achieved, we will be able to see the change. Some sort of transformation will have taken place in the person’s life that others will be able to observe. The person will do something they had not done before, like take a class or make a cake. They will have something they did not have before, like a job or an apartment.

Using action verbs when writing desired outcomes will help describe what will take place to create that transformation; we should be able to see the transformation because of the action that was taken. You can use action verbs like to meet, to take, to visit, to play, and to make, in order to describe action.

Here are some other examples of using action words in the Desired Outcome.

* Danelle will rent an apartment.
* Michelle will get a dog.
* Susie will take a violin class.

When we are done, we will know the action took place because we will see that transformation. Danelle is living in her own apartment now. Michelle has that new dog she wanted and Susie is playing her violin.

# Making sure it is connected to Important TO

In order to check and make sure the desired outcome is meaningful to the person and connected to something that’s important TO them, we can ask,

“Why are we doing what we are doing?”

Is this something the person is interested in, or is it something we’ve added purely for compliance purposes?

Is it something that is based in the person's values, or is it only included for the convenience or wishes of others?

Asking ourselves, “Why?” will help ensure the desired outcome is connected to something that’s important TO the person.

# Getting at the WHY

It can help us get at the WHY if we use phrases like “In order to, so that, or because” to make sure the outcome is related back to something that is important TO the person.

Writing the WHY into the desired outcome not only helps us to know if the outcome is connected back to something that is important TO the person, but also helps providers know how to help the person achieve the outcome. Knowing the why helps providers know the things that they can focus on when supporting the person.

Here are some examples: Reggie’s desired outcome says, “Reggie has a job in an office in order to work on computers and meet people.”

Without knowing the WHY, Reggie's job coach might focus too much on helping him find a high paying job, when he really might first prefer some support making friends at work.

Marvin wants an apartment in Dallas because he wants to be closer to his family and his girlfriend.

We now know a bit more about why Marvin wants to live in Dallas.

Brea has a garden in her backyard so she can have fresh cut flowers and a quiet place to sit and think.

Brea’s providers know they’ll focus on supporting Brea toward the flowers she wants in her garden rather than jumping in with a full vegetable garden.

The more specific a Desired Outcome is, the more it is connected to what is important TO the person; and the more we know what the person aims to achieve, the better equipped supporters will be to help the person achieve the life they desire!

# Monitoring progress

In order to be successful in achieving desired outcomes, it is important to monitor and record progress so we know when things are working or not working. Think about how and where progress will be recorded.

Would the person or their family like to track their own progress toward this goal? Consider tools such as a checklist, calendar, or diary where they could record their own progress.

If the person has providers who will be supporting them toward a desired outcome, they might want to record progress on tools like learning logs, progress notes, or checklists. Providers should be prepared to report back progress to the person’s SC/PA during the year.

The SC/PA could check-in on progress and record in progress notes or use other tools like a learning log as well.

Tools like learning logs can be useful in keeping track of what should change and what should stay the same.

# What to expect in your role:

## The person & their legal or designated representative

### Prior to the ISP Meeting

Tell your SC/PA if there are things you are interested in doing, learning, trying or achieving. Include anything that will help your SC/PA and the people helping you achieve your goals know how you want to be supported.

Think about how you would like to track your progress toward this outcome. Would you like support to keep a checklist, calendar, or diary where you can record your progress? Talk to your SC/PA if you’d like support with this.

### Throughout the Year

Tell your SC/PA any time you want to update your Desired Outcomes so they continue to reflect your current priorities and what you want to do, learn, try, or achieve.

## Provider organizations & Foster providers

### Prior to the ISP Meeting

Share person centered information gathered from the perspective of the person and include additional input where needed.

Participate in the development of Desired Outcomes as requested by the person. Share any information you know about what the person wants to work toward and strategies you can offer to support progress toward these outcomes.

### Throughout the Year

Implement agreed Desired Outcomes, as requested by the person and directed in the ISP or Provider Service Agreement. This may include creating Implementation Strategies, like Action Plans, that include the steps providers will take to support a person in achieving their desired outcome.

Employment providers providing services funded through ODDS can expect to receive a copy of the person’s Career Development Plan and Desired Employment Outcomes. Develop implementation strategies to indicate what your organization will be doing to support the person toward their identified career goals and outcomes. Refer to administrative rules for employment providers for further details (OAR 411-345-0140).

Communicate progress toward achieving Desired Outcomes with the SC/PA and others the person chooses as needed throughout the year.

## SC/PAs

### Prior to the ISP Meeting

Identify what is important TO the person. Discover things the person wants to learn, do or achieve through gathering person centered information or by reviewing person centered information collected by others and shared with you.

Facilitate the development of Desired Outcomes with the person and others in the person’s life, if applicable (e.g., guardians, providers, family, friends, and others the person may wish to involve).

Record Desired Outcomes in the ISP.

Make sure to identify the services, if any, the person will use to help them achieve their desired outcomes.

### Throughout the Year

Monitor the progress toward achieving the Desired Outcomes and make changes as appropriate in response to what is working and not working as reported by the person, the legal or designated representative if applicable, and the providers working with the person.

Revise Desired Outcomes as needed throughout the plan year using a Change Form.

Career Development Plan

# Completing the Career Development Plan

The Career Development Plan is the part of the ISP that includes the person’s plan, if any, for gaining or maintaining competitive, integrated employment.

The Career Development Plan begins by selecting if the person has no Career Development Plan, is Transition Age, or is a Working Age Adult.

When filling out the form on a computer, there is purple help text on the screen to help you decide which option to select.

# No Career Development Plan

The No career development plan option is available to people who meet the criteria described in purple text. This purple text will show on the screen when you are completing the form on a computer. If the person does not want a Career Development Plan, there is still a place to indicate the highest education level the person has completed. If you are not sure, choose “unknown.”

Then, choose the reason No Career Development Plan was selected by marking box A or B.

Select option A, if the person is under age 14 and does not want a Career Development Plan at this time.

Select option B, if the person is at least 60 years old or will be 60 this ISP year, does not want to access any ODDS Employment Services, and does not want a Career Development Plan at this time.

# Transition age

After selecting the Transition age option, choose the highest education level the person has completed from the drop down.

Check all boxes that apply to indicate what is currently happening in the person’s life.

* Is the person currently attending school and wants to work now?
* Is the person attending school and wants to maintain and advance in their current job?
* Is the person attending school and receiving employment supports elsewhere?
* Does the person have an IEP post-secondary goal with employment or training focus?
* Is the person attending school and not receiving any employment supports?
* Is the person currently receiving or requesting pre-employment transition planning services through Vocational Rehabilitation (VR)?

Record any known barriers and the plan to address them in the space provided.

When Desired Employment Outcomes are expected, the Desired Employment section will appear on the form.

# Working age adults

Be sure to indicate the person’s highest education level from the drop down provided.

Select the person’s status with VR by choosing one of the three following options:

* Currently receiving VR services
* Wants a referral to VR, or
* Other or not applicable

Notes can be added as needed to add any additional details about current VR services or the plan to refer the person to VR.

Next, describe the person’s current employment status and what they want to do now by selecting A or B.

**Select A** if the person is currently working in competitive, integrated employment and/or small group employment.

**Select B** if the Person is currently not working in competitive, integrated employment and/or small group employment.

## Selecting option A

Indicate the number of hours per week the person is currently working and how many hours per week the person wants to work in both competitive, integrated employment and/or small group employment.

Once the number of hours is selected, indicate what the person wants to do this year by selecting all the following options that apply.

Does the person want to:

* Retain their current job
* Advance in their current job
* Explore interests in competitive, integrated employment through an employment path, discovery or other time-limited service
* Get a new job
* Get an additional job
* Retire
* Or does the person choose to no longer continue in individual, integrated employment and/or small group employment. If so*, complete the "Decision not to explore employment" section. This section will appear on the form, if required.*

When Desired Employment Outcomes are expected, the Desired Employment section will appear on the form.

We encourage you to review each of the sample Career Development Plans, including the sample Desired Employment Outcomes by clicking on the Examples tab above.

## Selecting option B

Option B is the appropriate choice for adults who are currently not working in competitive, integrated employment and/or small group employment. Indicate what the person wants to do this year by selecting all of the following options that apply.

Does the person want to?

* Get competitive, integrated employment? For how many hours per week?
* Get small group employment? For how many hours per week?
* Explore interests in individual, integrated employment through an employment path, discovery or other time-limited service?
* Retire if they are at least 60 years old or will be this ISP year? If the person chooses "Retire," they are not eligible to receive ODDS employment services
* Not explore integrated employment at this time. If so, *complete the "Decision not to explore employment" section. This section will appear on the form, if required.*

# Desired Employment Outcomes

Desired Employment Outcomes appear automatically on the ISP form anytime an option is selected that requires them.

Desired Employment Outcomes are structured the same way as Desired Outcomes that appear earlier in the ISP document. They are located with the Career Development Plan so it is easier to extract them from the person’s ISP to share them to an employment provider, VR, or others the person wants to receive support from to reach their employment goals.

Please review the instructions provided on screen in purple text as well as additional resources such as the Employment Discussion Guide, available at www.OregonISP.org/CDP.

Just like in the other Desired outcomes section in the plan, you can use the buttons provided on the screen to add additional outcomes, remove outcomes, add/remove key steps, or reorder key steps.

We encourage you to review each of the sample Career Development Plans, including the sample Desired Employment Outcomes, by clicking on the Examples tab above.

# Decision not to explore employment

The Decision not to explore employment, or DNE, section of the Career Development Plan will appear automatically if a selection is made above that requires it.

This section records the details of a conversation that occurred about employment with working age adults who end up deciding not to work in or even explore an integrated employment setting now and who do not want a waiver-funded employment service at this time.

For more detailed instructions on how to complete the DNE or the Career Development Plan, visit [www.OregonISP/cdp](http://www.OregonISP/cdp).

# What to expect in your role:

## The person & their legal or designated representative

### Prior to the ISP Meeting

Tell your SC/PA about your current employment priorities and your employment goals for the future. Tell your SC/PA if you are currently working in competitive integrated employment or small group employment.

* If you are working, tell your SC/PA if there is anything you want to change or strengthen with your work.
* If you aren’t working, tell your SC/PA if you want to pursue competitive integrated employment or small group employment.

If you are not interested in even exploring competitive integrated employment, talk to your SC/PA about the reasons why so they can include this information in your ISP.

### Throughout the Year

Tell your SC/PA any time you need a change in your Career Development Plan.

## Provider organizations & Foster providers

### Prior to the ISP Meeting

Contribute any information you know about what is important to the person, their employment goals, and their desired outcomes, when asked by the person to do so.

If you are an employment provider, obtain a copy of the Career Development Plan and Employment Desired Outcomes.

### Throughout the Year

Support the person toward achieving their Desired Outcomes, as defined in the key steps.

If the Desired Outcome indicates that you are responsible for implementation strategies such as action plans or other documents, be sure to develop them and train caregivers on how to follow them.

Track progress throughout the year and report progress back to the SC/PA.

## SC/PAs

### Prior to the ISP Meeting

Facilitate conversations about employment and ensure accurate completion of the Career Development Plan section of the ISP following published guidance from ODDS.

Ensure that the employment-related supports that service providers will be responsible for are discussed, written into the person’s plan, and understood by the responsible parties.

### Throughout the Year

Update the Career Development Plan as needed throughout the year.

Chosen Services

Chosen services are the paid and unpaid services a person (or their legal or designated representative, if any) has chosen to meet their assessed support needs.

The ISP chosen services section includes:

* Case management services
* Informal supports, community resources
* State plan personal care
* Family support plan
* K Plan services
* Waiver services
* K Plan residential services
* Additional chosen services

If there are services sections that are not applicable, or the person has not chosen to use them, they can be removed from the plan and added back later, if needed.

# Common fields

**The Service element and service code** indicate what service setting and what service within that setting a person will use. If a service is not listed, the form allows the user to type directly into the field.

**The Units, Unit type, and Per.** fields indicate how often the person will receive the service over time.

**The authorized dates** indicate the start and end date of the plan. If authorization dates match the ISP effective dates, check the box provided. Otherwise, indicate the start date and end date of the service by entering the dates in the space provided.

When a person needs a service authorized for multiple start and end dates throughout the year, this can be indicated by clicking the “add a date range” button. This might be useful when a child will receive a different number of service hours in the summer months than in the months they are in school.

**The chosen provider and current rate** indicates what type of provider the person will use to provide the chosen service. This might be a Provider Organization, Foster Provider, PSW, or another qualified service provider. The rate refers to the rate that was current when the plan was written.

**The needs that the service will address** are listed in the section, “List needs identified by the needs assessment that this service will address.” The information in this section tells service providers what assessed needs they will be responsible to support. Writing “ADL supports” in this section is not enough. There should be enough detail in this section so providers are clear on what they should and should not be helping the person with.

# Case management services

In the **chosen case management provider** field, enter the chosen case management service provider. This is the name of the Community Developmental Disabilities Program, Brokerage, or other State Agency, like CIIS, where the person receives case management services. Your agency should be listed in the drop down. If not, you can type into the field.

***Children in the CIIS program***

Children and families who receive case management services through the Children’s Intensive In-home services (CIIS) program may also choose case management services through their local county developmental disabilities program in addition to their CIIS case management provider. This additional case management service can be added in the Case Management service section by clicking to add an additional case management service. The additional anticipated case management services that will be provided throughout the year can be included in this section.

In the **required frequency of case management contact that will occur**, choose the frequency by selecting monthly, quarterly, or other from the drop down. To learn more about requirements for case management monitoring and contact, see OAR 411-415.

In the **Authorized Dates** field, enter the dates the service will be authorized. If authorization dates match the ISP effective dates, check the box provided. Otherwise, indicate the start date and end date of the service by entering the dates in the space provided.

In the **Prime Number** field, enter the person’s prime number.

The information in the **anticipated case management services** section indicates what case management services will be provided throughout the year.

In the space provided, include any **preferences the person has for how case management is provided**. Preferences might include information about with whom monitoring will occur, like the person or their legal or designated representative. It might also include information like what time of day and in what manner the person prefers to be contacted. The manner of contact might be by phone, email, in person, or whatever the person prefers and is permitted by rule and policy.

# Informal supports

Informal supports and community resources are the services and supports available to the person, which are not funded by Medicaid. These services and supports might include family, friends, privately paid medical professionals and therapists, or other paid or voluntary services.

Informal supports and community resources help people live the life they want in the community they choose. Identifying and strengthening informal support systems is essential to the planning process. Knowing who and what is available in the community to help people meet their assessed support needs and achieve their desired outcomes provides people more options so they don’t have to only rely on Medicaid services and can build community on their own terms.

Family, friends, and neighbors can be helpful resources. They might provide transportation and support with medication; they might help with meals and budgeting; they keep us company and much, much more. When a family member or friend is providing help with an assessed support need, this is called an “informal support.” Other community members and community resources can also act as informal supports. All of the following resources could be considered informal supports if the person is using them to meet an assessed need.

* The bank and bank teller for paying bills
* The checker at the grocery store for counting change
* Library for help with reading and find additional resources
* Senior centers for rides to medical appointments
* Family advocacy groups, like FACT or ASO, for family training
* YMCA or Boys and Girls Club for community activities and learning social skills
* Supplemental Nutrition Assistance Program (SNAP) for nutrition education
* Employment Department or community employment center for job support
* SSI for benefits counseling
* Church for transportation

All support needs identified by the functional needs assessment must be included in the ISP. If the person is not using a Medicaid funded service to meet an assessed support need, use the Informal Supports section to describe how the need is being met.

# State plan personal care (SPPC)

If the person is eligible for and has chosen this service, authorize SPPC in this section.

# Family supports

The family support services section can be used if the person receives services through the Family Support program and chooses to have an Oregon ISP. If the person and their family do not choose to have an Oregon ISP, a separate document known as the Family Support Plan can also be used. To learn more about the Family Support program see OAR 411-305.

If the person chooses to have their Family Supports services outlined in the Oregon ISP, the SC/PA will complete the entire Oregon ISP process, including gathering Person Centered Information and completing a risk identification tool.

**Person’s preferences on how this service is delivered** tells a service provider how the person prefers to be supported. This section should reflect what is important TO the person and include known information about how best to support the person.

# K Plan residential services

If the person chooses to live in a residential setting, you will use the K Plan residential services section to authorize the service.

The Service setting drop down includes all the residential service settings available in Oregon.

You will notice that choosing a residential setting will prompt the user to answer two additional questions in the Risk Management Plan related to HCBS settings. Review the Risk Management Plan section of these instructions for more information on these questions. These questions will only appear if the person has chosen a provider owned or operated residential setting. All of the residential settings options are considered provider owned or operated except Supported Living (own home). So, if the person choses Supported Living (own home), these two additional questions will not appear.

The K Plan residential services section includes an important question about the person’s choice of bedroom. This question must be answered for each person who chooses to live in and receive services in a residential setting. Indicate here if the person has chosen to have their own private bedroom or to share a bedroom.

If the Residential provider’s rate includes additional K Plan services like behavior services or nursing services, check the appropriate box in this section. If these services are funded separately, authorize them in the appropriate section of the ISP, such as the Chosen K Plan services or Additional Chosen Services.

Use the space in the Chosen K plan transportation services section to authorize transportation to or from work.

# Additional chosen services

The Additional chosen services section is used to record any service that has not been included in another section. Examples might include Nursing Services for a person living in a foster setting or assistive technology purchases for a person living in a 24-hour residential group home.

# What to expect in your role:

## The person & their legal or designated representative

### Prior to the ISP Meeting

Tell your SC/PA:

* What services you want to help meet your assessed support needs
* Where you want your services provided
* Who you want to help provide services to you
* Your preferences on how supports are provided

### Throughout the Year

Tell your SC/PA any time your assessed needs change or you need changes to the services you are using to meet those needs.

## Provider organizations & Foster providers

### Prior to the ISP Meeting

Contribute information towards the development of the ISP, including information about what service you provide and what you know about the person's support needs.

### Throughout the Year

Follow any instructions directed as your responsibility in the chosen services section of the ISP or Provider Service Agreement.

## SC/PAs

### Prior to the ISP Meeting

Complete the chosen services section based on the direction and choices of the person and their legal or designated representative, if applicable.

Complete the Chosen Services section accurately and according to established timelines.

Ensure that relevant information gathered through assessments and provided by others is included accordingly.

Ensure the ISP chosen services section follows the established ISP process and that expenditures for services follow published guidelines.

### Throughout the Year

Revise Desired Outcomes as needed throughout the plan year using a Change Form.

Risk Management Plan

The risk management plan provides space to record information about emergency preparedness, abuse prevention, and what to do if the person cannot be reached. It also provides space to list all the known, serious risks in the person’s life and how those risks are being addressed. If the person has any safeguarding intervention or equipment in place, or an individually based limitation to an HCBS freedom, the ISP Risk Management Plan is the section in the ISP where this information is recorded. The Risk management plan also includes space to describe the back-up plan for when the person’s primary support is unavailable for any reason.

Let’s look more closely at each section of the Risk Management Plan.

# Emergency Preparedness

The Emergency Preparedness section of the Risk Management Plan is a space to indicate what plan the person has in place for staying healthy and safe during emergencies.

An important part of planning is being prepared for natural disasters, power outages, community disasters, and other events that could leave people without shelter, food, or electricity for a period of time. In some situations, it could take 3 to 5 days or longer for community services to be restored. Does the person have a plan and supplies in preparation of such an event? Do they have access to a basic disaster supply kit? Do they have a plan for where they would go if they were unable to return to their home? To help a person plan for an emergency event, think about items such as durable medical equipment, assistive technology, food for special diets, prescription medicines, diabetic supplies, hearing aids and batteries, a TTY, manual wheelchair, or supplies for a service animal.

There are more resources available to plan ahead for emergencies at [www.ready.gov](http://www.ready.gov).

# Preventing Abuse

The Preventing Abuse section of the ISP provides space to indicate what measures are in place to help prevent abuse or neglect in the person’s life.

Abuse, neglect, and exploitation are serious issues. People who experience intellectual/developmental disabilities are more likely to experience neglect or abuse than people who do not experience intellectual or developmental disability. Because of this, most people who are paid to work with people who experience developmental disability are required to be mandatory abuse reporters.

Consider any measures needed or available to help prevent abuse of all kinds. This might include advocacy skills the person has or trusted supporters that are in the person’s life and are mandatory abuse reporters.

# If the person can’t be reached

The next section of the ISP provides space to indicate what others should do if the person cannot be reached.

At times there may be circumstances where the person cannot be reached. This may be for a number of reasons, from the person simply not answering phone calls to a more serious issue like being lost or injured. When the person cannot be reached, others should have some idea about what they can do in response.

Is there a plan in place? What should others do if the person is missing?

Some people might have a formal missing persons plan in place, while others might have a phone number of a friend or relative who typically knows the person’s location. This section can reference other documents, like a missing persons plan on file at a provider location, the names and numbers of others who should be called if the person is missing, or how long a person should be looked for before calling 911.

Check out some of the sample plans to get more examples of what information might be useful in this section of the ISP.

# Risks and how they are being addressed

The next section of the Risk Management Plan provides space to list all the known, serious risks in the person life and the plan to address them. Known, serious risks are risks that, without support, would likely result in hospitalization, institutionalization, legal action, or extreme financial hardship, and place the person or others in imminent harm. These risks are first identified using the Risk Identification Tool. Then all risks marked ‘Yes’ on the Risk Identification Tool must be recorded in this space on the ISP.

Use the space provided to briefly describe the issue and how it is addressed. If separate written documents are in place for providers to follow, note that here. If others are paid to provide supports to address a risk, the expected supports must be written down.

The plan to address each risk should clearly indicate who is responsible. If a risk is present at one provider location, and not another, that should be clearly indicated in the ISP risk management plan. This is an important detail so that providers are clear about their responsibility and are not creating risk management strategies for risks they are not expected to provide support to prevent.

# Risk Management Strategies

Risk Management strategies are the specific supports in place to address a known, serious risk. They are written with a specific person in mind, taking into account what is important TO the person and their preferences for how they want to be supported.

The goal is not to eliminate risk. Risk is a part of life. It helps us learn and grow and each person has a right to take risks. This human right is often referred to as the “dignity of risk.” Knowing how important risk is in a person’s life will help supporters develop strategies that work to prevent known, serious risk without infringing on a person’s right to take risks.

Some examples of risk management strategies include:

* Education
* Informal and/or paid supports
* Assistive technology or devices
* Environmental modifications
* Written support documents (protocols, safety plans, financial plans, etc.)
* Specific written instructions in the Provider Service Agreement
* Case management tasks such as providing information and/or referral, as well as monitoring

## Assessing High Risks

After listing all of the identified serious risks, the SC/PA assesses each risk to determine if it meets the threshold of high risk. To determine if the risk is a high risk, consider the supports that are in place to address the issue. If the SC/PA believes the person or others are likely to experience significant harm as a result of this issue -- even with the listed supports in place -- mark the risk as a high risk.

If there are three or more high risks, the SC/PA must be contacted at least monthly to monitor the high risks

## Provider Risk Management Strategies Form

The Provider Risk Management Strategies form is prepared by provider organizations and foster providers who maintain written instructions such as protocols, safety plans, and other support documents for their staff or substitute caregivers to follow. This form is typically not used with PSWs, unless specifically directed by the SC/PA.

Residential support providers must use the Provider Risk Management Strategies form to list the known, serious risks they are responsible to address at their location.

The Provider Risk Management Strategies form must match what is written in the ISP Risk Management Plan or the Provider Service Agreement related to the risks the provider is responsible to address.

Providers list what documents they have in place at their location for each risk they are responsible to address. There is also space to include the person’s name, the provider site, the date of the support document, and where it is kept at the provider location.

# Safe-guarding interventions and equipment

After listing known, serious risks, assessing high risks, and recording how each risk is addressed, the next section of the Risk Management Plan includes a few additional questions that must be answered for all people who have an ISP.

In this section, the SC/PA indicates if there are any safeguarding interventions or safeguarding equipment used to address a known, serious risk.

The answer will either be ‘Yes’ or ‘No.’

If the answer to either of these questions is ‘Yes,’ an Individually Based Limitations (IBL) form must be completed and attached to the plan.

For more information about safeguarding interventions and/or safeguarding equipment, visit Oregon’s HCBS web page at [www.oregon.gov/dhs/seniors-disabilities/HCBS/Pages/Resources-Oregon.aspx](http://www.oregon.gov/dhs/seniors-disabilities/HCBS/Pages/Resources-Oregon.aspx)

# Individually Based Limitation to HCBS residential settings protections

If the person has chosen to receive their services in a provider controlled residential setting, two additional questions will be asked about any individually-based limitations on Home and Community Based residential settings protections.

If the answer to either of these questions is ‘Yes,’ an Individually-based limitations form must be completed and attached to the ISP.

For more information about individually-based limitations to HCBS protections, visit Oregon’s HCBS web page at: [www.oregon.gov/dhs/seniors-disabilities/HCBS/Pages/Resources-Oregon.aspx](http://www.oregon.gov/dhs/seniors-disabilities/HCBS/Pages/Resources-Oregon.aspx)

# Nursing Care Plan

The Risk Management Plan also includes a question asking if the person has a nursing care plan. A nursing care plan is a plan developed by a registered nurse telling supporters how to address a specific health or medical issue.

If the person has a nursing care plan, it is indicated in this section of the ISP along with a note of where it is kept.

If the person’s assessed needs qualify them for a Medicaid-funded nursing service, authorize that service in the appropriate chosen services section in the ISP.

If the team feels a nursing care plan is needed but one is not currently in place, mark “needed.” Note within the plan what follow-up will be done on this issue.

# Back-up Plans

A Back-up plan is a contingency plan. It is a plan put in place for when the continuity of services and supports needed to be healthy and safe is interrupted. In short, a back-up plan tells supporters what to do when a person’s primary care providers are unavailable either temporarily or permanently.

The person’s circle of support is a place to look for people who can be part of the backup plan. For example, If a person lives with their parents (mom and dad) and suddenly mom and dad are no longer able to support the person, where does the person want to live? Look among the person’s circle of support to identify people who can help temporarily or permanently. Is there another family member that is willing to help out, like a brother or aunt? Is a neighbor or coworker able to help?

For people without a lot of unpaid connections, help the person think about what they want to happen if their current supporter is suddenly unable to provide them with services. If the person currently lives in a 24-hour residential group home and could no longer live in their current home, where would they want to live? If the person’s PSW gets a new job, are there other providers who they know of that they might want to take the position?

Back up plans don’t only need to be back-up plans for where the person lives. If the person shows up for work one day and no one is there, who should be called? What should the person do or where should they go.

Finding out these details ahead of time can make a big difference for a person while going through a transition that might already be painful. Include any information about who will help the person if their current, primary support provider is suddenly unavailable.

# What to expect in your role:

## The person & their legal or designated representative

### Prior to the ISP Meeting

#### Emergency Preparedness:

Share any plan you or your family have in place for responding to an emergency situation.

* Does your family have a disaster kit?
* Do you have an agreement on where to meet if you, your family, or your housemates are not able to return home?
* What support do you need to respond to emergencies?

#### Preventing Abuse

Share anything you do to prevent abuse in your life. This may be things like skills you have for advocating for yourself, or the support you get from others.

#### When the person can’t be reached

Share anything you want your SC/PA to know about what to do if they can’t reach you. If you can’t be reached, who do you want your SC/PA to contact, if anyone, in order to find you?

#### Risks and how they are addressed

Share information about known, serious risks in your life.

Share your preferences about what support, if any, you want for preventing and responding to risks.

#### Back-up plans

Tell your SC/PA if you or your family has a back-up plan. What is the back-up plan? What are the names and phone numbers of the people you want helping you if the people who help you now are not available for some reason? If you don’t have a back-up plan, work with your SC/PA to create one.

### Throughout the Year

Tell your SC/PA anytime you need something in your plan to change, including changes needed to the Risk management plan.

## Provider organizations & Foster providers

### Prior to the ISP Meeting

#### Emergency preparedness:

* Maintain your own emergency preparedness plans.
* Share the contents of the plan with the SC/PA, so that they can review it and reference it in the ISP.

#### Preventing abuse:

* Share anything you know about measures in place for preventing abuse and neglect.
* Ensure all staff have Mandatory Abuse Report training.

#### When the person can’t be reached:

*Providers supporting someone who lives in a residential setting:*

* Maintain your own emergency preparedness plans.
* Share the contents of the plan with the SC/PA, so they can review it and reference it in the ISP.

#### Risks and how they are addressed

*All Providers:*

* Communicate any evidence of known, serious risks promptly to the SC/PA. Maintain documentation about this communication.
* Before signing the ISP or Provider Service Agreement, carefully review the ISP Risk Management Plan or the Provider Service Agreement. Be sure that it includes all known serious risks that you have agreed to address.
* If the SC/PA disagrees or does not include a risk on the ISP Risk Management Plan that you believe is a serious risk, discuss it further with them. Provide evidence of the issue you are concerned about and document any discussions you have with the SC/PA.

*For Providers supporting a person who lives in a* ***Residential setting****:*

* Prepare a “Provider Risk Management Strategies” form specific to the location where you support the person. This should match the risks listed on the ISP Risk Management Plan that you are directed to support.

### Throughout the Year

Communicate with the SC/PA anytime you are aware of a change in risks or how risks are being addressed.

## SC/PAs

### Prior to the ISP Meeting

#### Emergency preparedness:

Facilitate a conversation about any emergency plans in place with the person, their legal or designated representative, and others the person has chosen to contribute.

* When necessary, support the person and their family to develop a plan or refer them to other resources that can help them create one.
* In the ISP, record the emergency plan or reference other documents that contain more details about the emergency plan, if any.

#### Preventing Abuse:

Facilitate a conversation about any measures in place to prevent abuse with the person, their legal or designated representative if any, and others they have chosen to contribute to planning.

* Record any measures in place to prevent abuse. Reference any other documents that contain more detailed information about abuse prevention.
* In addition to completing this section of the Risk Management Plan for all people who have an ISP, if the person is known to be at significant increased risk of abuse or exploitation, mark this risk on the Risk Identification Tool and list it on the ISP Risk Management Plan along with strategies in place to address the issue.

#### When the person can’t be reached

* Record what steps would be taken if the person cannot be found or contacted as usual. Reference any other documents, like a Missing Persons Plan, that exist.
* Consider any timelines the team expects for notifying others and who is expected to be notified.

#### Known, serious risks

*In-Home settings*

* Seek information from the Person and others in order to complete the Risk Identification Tool accurately. List each identified risk (those marked “yes” on the Risk Identification Tool) on the ISP Risk Management Plan.
* If a risk is only addressed in one setting but not another, state that explicitly on the ISP Risk Management Plan.

*Residential Settings*

* Carefully review the information submitted by providers and other available documentation. Seek further information where necessary in order to complete the Risk Identification Tool accurately.
* List each identified risk (those marked “yes” on the Risk Identification Tool) on the ISP Risk Management Plan.
* If a risk is only addressed in one setting but not another, state that explicitly on the ISP Risk Management Plan.

*Back-up Plans*

* Talk to the person, their legal or designated representative if any, and providers about what the back-up plan will be in the event that the primary support provider is unavailable. If the person does not already have a back-up plan in place, help to identify those people who could potentially be counted on to help if the primary supporter was unavailable. Record the back-up plan or what is being done to develop the back-up plan in the person’s ISP.

### Throughout the Plan Year

Update the ISP any time during the year as appropriate.

Other Sections in the ISP

# Differences

The Differences Section in the ISP is a place to include any differences or disagreements with what is in the plan and what the person or any other team member wants.

If there are no known differences, this can be indicated by selecting the ‘no known differences’ box and the section will collapse.

# Legal Relationships

The Legal Relationship section provides a place to indicate any legal relationships in the person’s life that the SC/PA is aware of. The dropdown includes many common legal relationships people might have in Oregon.

Add as many legal relationships, as needed, by clicking the plus button.

Some legal relationship types ask for additional information. For example, if the person has a legal guardian; the SC/PA will be prompted to indicate that person’s name and what scope of authority the guardian has. This information is located in the Guardianship paperwork that should be in the person’s file at their Case Management entity. As another example, if the person has a representative payee, select that option and then enter the Payee’s name in the space provided.

If you have questions about guardianship, other legal relationships, or the rights of people with disabilities, Disability Rights Oregon (DRO) is one available resource. You can review their guardianship handbook and other resources by visiting their website at <https://DROregon.org/>

If there are no known legal relationships, check the box provided and the section will collapse.

# Acknowledgments

The Acknowledgments page in the ISP includes a series of questions that affirm the person was given information about their rights in the ISP process and as a recipient of Home and Community Based Developmental Disabilities services.

The person receiving services has the right to make an informed choice about where to live and receive services, to choose which services to use, and to select from available providers to deliver those services.

The Acknowledgments page provides check boxes for the SC/PA to indicate they have made the person and their legal or designated representative, if any, aware of these rights and includes space to record the choices that were offered.

The Acknowledgments page also includes space to indicate if the team agrees that the ISP reflects:

* Independence (Having control and choice over one’s own life.)
* Integration (Living near and using the same community resources and participating in the same activities as, and together with, people without disabilities.)
* Productivity (Engaging in contributions to a household or community; or engaging in income-producing work that is measured through improvements in income level, employment status, or job advancement.)

If the answer to any of the questions in this section is NO,the SC/PA must describe the reason why and the plan in place to address it in the box provided.

# Agreement to the plan

The last page of the ISP is a place to sign in agreement with the plan.

The plan must be signed by the person receiving services, their legal or designated representative, if any, and the SC/PA.

If the person is hiring providers to deliver services outlined in the ISP, the provider or a representative of the provider organization must sign either the ISP or a Provider Service Agreement.

If the person is hiring a Personal Support Worker (PSW), that provider must sign a Provider Service Agreement.

Providers should have time to review and ask for any clarity needed before signing the ISP or the Provider Service Agreement.

With their signature, the provider is agreeing to implement the parts of the ISP that have been designated as their responsibility. If the provider is signing a Provider Service Agreement, it must contain all of their responsibilities.

# What to expect in your role:

## The person & their legal or designated representative

### Prior to the ISP Meeting

If there is something in your plan that you disagree with, tell your SC/PA and make sure this is recorded in the ISP Differences section.

Tell your SC/PA if you have any legal relationship in your life.

If you need support understanding your plan, tell your SC/PA who will help you.

Review the ISP to make sure it included the things you agreed upon, this includes reviewing the Acknowledgments page and ensuring it reflects the information you have been given by your SC/PA.

### Throughout the Year

Once the ISP is complete, sign the ISP if you agree that the plan reflects your strengths and preferences, support needs as identified by the needs assessment, and the services and supports you have chosen to meet your support needs.

Tell your SC/PA anytime you need something to change in your ISP.

## Provider organizations & Foster providers

### Prior to the ISP Meeting

Communicate any disagreements you have with the contents of the plan. Ensure any disagreements are recorded in the Differences section of the ISP.

Communicate information you have about any known legal relationships the person has in their life.

If requested by the person and his/her ISP team, provide any support needed to help the person understand the contents of their plan.

Advocate for the person by supporting them to understand their rights in the Acknowledgments section of the ISP, as requested by the person.

Review and sign the ISP or a Provider Service Agreement if you agree to implement and provide the supports that have been designated as your responsibility in the ISP.

### Throughout the Year

Communicate the need for any necessary changes to the ISP throughout the year by completing a change form and providing it to the SC/PA. (See Making Changes section).

## SC/PAs

### Prior to the ISP Meeting

Record any differences between the contents of the plan and what the person or any other team member wants.

Ensure the legal relationships you are aware of are reflected in the ISP.

Provide any support needed to help the person or their designated representative, if any, understand the contents of the plan.

Complete the Acknowledgments section and facilitate any discussions necessary to complete this page.

Sign the plan if you agree that it meets the person’s current support needs and complies with requirements for the chosen service setting(s) and associated funding.

### Throughout the Year

Make updates to the ISP throughout the year by completing a change form (see Making Changes section)

Making Changes

In order to ‘keep the plan alive,’ adjustments to the ISP will often be needed throughout the year. This helps to ensure the plan continues to meet the person’s assessed support needs and reflects what is important TO the person and how they want to be supported.

The Change Form is used to track and record changes to the ISP or related documents. It provides space to:

* Record the reason for change
* Describe what is changing
* Indicate the effective date and date initiated
* Note the name of person initiating change and the name and title of persons approving change
* Record the date approval was given
* Include signatures or note of how approval was obtained, when needed.

A change form may be initiated by the person, legal or designated representative, family, provider, or SC/PA.

To streamline the change process, some changes, such as changes to provider implementation strategies which don’t change the scope of the document, may be made immediately with notification to appropriate ISP team members. Other changes, such as adding or discontinuing services, require approval.

Completed Change Forms are filed with the ISP at the CDDP or Brokerage. Providers must be notified of changes that affect the services they are expected to deliver.

A copy of the Change Form is provided to the person, if desired; legal or designated representative, if desired; SC/PA; any service provider impacted by the change.

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of change** | **Change form initiated by** | **Approval or Notification?** | **Notes** |
| **Revised, added, or discontinued desired outcomes** | SC/PA or Provider org./Foster prov. | **Approval** |  |
| **Added or discontinued chosen services** | SC/PA | **Approval** | Adding or removing a service requires the signature of the person receiving services, legal or designated representative (if any), the SC/PA, and the provider agreeing to implement the new service. Changes within an authorized service may be made with the documented, verbal approval of the individual, their legal or designated representative. |
| **New or discontinued Risk** | SC/PA or Provider org./Foster prov. | **Approval** |  |
| **Change in a risk management strategy that is described in the ISP Risk Management Plan** | SC/PA or Provider org./Foster prov. | **Approval** |  |
| **Revision to provider support documents that changes the scope of the supports provided** | SC/PA or Provider org./Foster prov. | **Approval** | Examples include attempting to implement restrictions or limitations on the person’s rights or discontinuing supports that are written into the person’s ISP. |
| **Revision to provider support document that does not change the scope of the supports provided** | Provider org./Foster prov. | *Notification only* | Examples include reasonable adjustments to support documents that honor the person’s preferences and remain consistent with supports that are written into the person’s ISP.  \*Send copy of changed document including Change Form to SC/PA |
| **Revision to provider’s implementation strategies, such as Action Plans** | SC/PA or Provider org./Foster prov. | *Notification only* | \*Send copy of changed document including Change Form to SC/PA |
| **Revision to One Page Profile or Person Centered Information** | *Local changes may be made by any ISP team member following local documentation practices. No formal approval or notification is required.* | | |

# Approval or notification

When approval of a change is required it must be sought and obtained from (or attempted to be obtained from):

* the person,
* the person’s legal or designated representative, if any, and
* Services Coordinator/Personal Agent.

Approval may be given verbally or in writing.

The signature, email, or verbal acknowledgement is expected from any service provider impacted by a change.

If approval is not required for a specific change, notification of the change must still occur. Examples of notification options include telephone call, email, or fax.

Record how the approval or notification was obtained in the space provided on the ISP Change form.

## Progress notes

The SC/PA should also describe the change in progress notes. When approval is required, note how approval was given.

## When a signature is required

When adding a new service to an existing ISP, the person (their legal or designated representative, if applicable) and the SC/PA must sign the ISP Change form agreeing to the change.

The provider who will deliver the service may sign the ISP Change Form or a Provider Service Agreement agreeing to implement the service. The form they sign is directed by the person and how they want to share information with the service provider.

When a Provider Service Agreement is used to share information with a provider, the person (their common law employer, if other than the person) must also sign the Provider Service Agreement in addition to the ISP Change form.

# What to expect in your role:

## The person & their legal or designated representative

### Throughout the Year

* Notify your SC/PA about any changes needed to your ISP.

## Provider organizations & Foster providers

### Throughout the Year

* Ensure necessary changes to the ISP and related documents are communicated to the SC/PA in a timely manner.
* Take action on needed changes according to the chart provided.
* Notify the SC/PA about needed changes
* Obtain approval from the SC/PA as required
* When initiating a Change Form, keep a copy and send the original to the SC/PA.

## SC/PAs

### Throughout the Year

* Ensure necessary changes are made to the ISP in a timely manner.
* Take action on needed changes according to the chart provided.
  + Notify the Person about needed changes, as applicable
  + Obtain approval from the person as required
  + Obtain signatures when required.
* Review and file Change Forms received from provider organizations or foster providers.
* File completed Change Forms with the ISP at the CDDP or Brokerage.
* Ensure providers impacted by the change are appropriately notified of the change. For example, this may require revising a PSW’s job description or completing a new service agreement.
* Monitor the plan throughout the year to ensure it is meeting the person’s satisfaction and the plan is being carried out as agreed.

Resources

Access all of the required forms and training resources at [www.OregonISP.org](http://www.OregonISP.org).

For the latest instructions on the Career Development Plan, please visit [www.OregonISP.org/cdp](http://www.OregonISP.org/cdp) and <http://www.oregon.gov/dhs/employment/employment-first/Pages/index.aspx>.

To stay informed about the latest Oregon ISP news subscribe to the ISP Pipeline email newsletter published by OTAC at [www.OregonISP.org/pipeline](http://www.OregonISP.org/pipeline).

Find definitions of many terms used in the ISP process at [www.OregonISP.org/glossary](http://www.OregonISP.org/glossary).

If you have questions or need support with the ISP forms or process, submit a support request at [www.OregonISP.org/support](http://www.OregonISP.org/support).