

Guide for ISP Checklist

Please consider these factors when determining a “yes,” “no,” or “n/a” response to each item. The Services Coordinator or Personal Agent must use this checklist as a Q/A tool for all ISPs until further notice.

Person Centered Planning Process *(page 1 of checklist)*

1 The ISP meeting included the people chosen by the individual.

- ❖ The Services Coordinator/Personal Agent and Legal guardian must be present
- ❖ Was the individual asked who they wanted to participate in their meeting?
- ❖ Was anyone present that the individual did not want included?

2. The individual directed the ISP process to the maximum extent possible and was supported in making informed choices and decisions

- ❖ Did the individual contribute to the meeting?
- ❖ Was information provided to assist in decision making by the individual?

3. The ISP was timely and took place at a time and location that the individual chose.

- ❖ The ISP occurred within twelve months of the last ISP
- ❖ The individual chose the meeting location.

4. The ISP process and planning took into account cultural considerations that are important to the individual.

- ❖ Was consideration given to understanding and/or maintaining rituals and customs important to the individual?
- ❖ Was there a discussion about what groups, events or activities are important individual, and plans to support involvement?
- ❖ Was the individual asked if they are interested in exploring their heritage?
- ❖ Was the ISP conducted in the individual's native language?

5. The process includes strategies for solving conflict or disagreement, including clear conflict-of interest guidelines for all planning participants.

- ❖ Was conflict or disagreement voiced?
- ❖ Was the conflict or disagreement documented – including the person's perspective and the perspectives of those contributing to the ISP.
- ❖ If a decision is made, was it recorded? If no action was taken, is there documentation explaining why?

- ❖ Was conflict of interest explained? (Anyone that may benefit financially, emotionally, or when the family interest takes precedent over the individual's desires constitutes conflict of interest) .

- ❖ If conflict of interest was present, were parties advised that they can contribute to sharing information but not control the outcome of the ISP.

- ❖ Is there documentation of conversations to assist in helping the individual feel more confident as an independent decision-maker?
- ❖ Is there documentation of communication about this expectation family members?

6. **The individual was offered choices regarding the services and supports s/he receives and from whom.**
 - ❖ Was the individual asked if they wanted additional information about other services for which they might be eligible and interested.
7. **Includes a method for the individual to request updates to the plan.**
 - ❖ Was the individual reminded that they can request changes/updates to their plan at any time.
8. **Records the alternative home and community based settings that were considered by the individual**
 - ❖ Was the individual asked whether they wanted to discuss other service options?
 - ❖ If interested, were action plans developed to pursue other options?

Person-Centered Service Plan *(page 2 of Addendum)*

1. **The ISP reflects that the setting where (s)he resides is the one chosen.**
 - ❖ Was the individual asked if the service setting (home and work) are ones of their choosing?
2. **The ISP reflects the person's strengths and preferences**
 - ❖ Narrate strengths and preferences where it makes the most sense in the context of the ISP being used currently
3. **The ISP reflects the clinical and support needs identified using an assessment of support needs.**
 - ❖ If an ISP is scheduled prior to the roll out of the ODDS designated needs assessment, use the existing assessment of support needs (SNAP, SIS, Base Tool, etc).
 - ❖ Once a needs assessment has been conducted, the ISP needs to address how clinical and support needs will be addressed, in the context of the existing ISP.
4. **The ISP includes the goals and desired outcomes expressed by the individual.**
5. **The ISP includes the services and supports that will be provided and who will be providing those services and supports. In some cases, services will be provided by those who are naturally in someone's life. In those cases, these natural supports must also be identified.**
 - ❖ Natural supports cannot supplant needed paid services unless the natural supports are unpaid supports that are provided voluntarily to the individual in lieu of a paid staff.
6. **The ISP identifies risk factors and strategies and supports in place to minimize them, including individualized back up plans.**
 - ❖ Individualized back up plans are specific to actions and situations where paid or natural supports may become unavailable.
 - ❖ Document that information using whatever mechanism is familiar to the ISP in which you are planning.

7. The ISP is understandable to the individual and those providing supports

- ❖ Use clear language
- ❖ Verify that protocols, action plans, and discussion records are clearly written.
- ❖ Action plans need to be clear and easily understood by the person providing the supports and the individual.

8. The ISP identifies the individual or entity responsible for monitoring the plan

- ❖ A Personal Agent or Services Coordinator is the designated monitor of the ISP.
- ❖ This could be documented through the use of an action plan, until the One ISP rolls out

9. The individual has agreed to the final ISP and has signed it, with all others who are responsible for implementing the plan

- ❖ Documented on a signature page

10. The individual and the other members of the planning team have received a copy of the ISP.

- ❖ Document that all parties have received a copy of the ISP in progress notes.

11. Efforts are made to assure that unnecessary or inappropriate care is not in the ISP.

- ❖ Check in with the individual and the team through out the meeting whether the services and supports being discussed make sense or not.