ISP Process, SIS Overview & SIS-ISP Policy

NC Innovations Waiver Stakeholder Meeting

Raleigh, NC

December 5, 2014

OBJECTIVES FOR THIS PRESENTATION

- Familiarize stakeholders with:
  - the Individual Support Planning (ISP) process,
  - the Supports Intensity Scale™ (SIS), and
  - the role of the Care Coordinator in the ISP process.

- Obtain feedback from stakeholders regarding the draft Supports Intensity Scale (SIS) Policy for ISP Planning

INDIVIDUAL SUPPORT PLANNING (ISP) PROCESS

NC INNOVATIONS INDIVIDUAL SUPPORT PLAN

- **Person-Centered Thinking**
- **Person-Centered Planning Process**
- **Person-Centered Assessment**
- **Preparing for the ISP Meeting**
- **Facilitating the ISP Meeting**
- **Developing the ISP**
- **Service Authorization / Service Implementation**
- **Updating the Individual Support Plan**

ISP PLANNING PROCESS

- Person Centered process lead by the individual/guardian
- Focus on supporting the person to realize their own dream/vision for their lives
- Collaborative process with the individual, guardian and others as determined by the individual and/or guardian
- Directed by the individual and identifies strengths and capabilities, desires and support needs
- A rich meaningful tool for the individual receiving supports as well as for those who provide the supports
- It generates actions—positive steps that the individual can take towards realizing a better, more complete life
- Ensure that supports are delivered in a consistent, respectful manner and offer valuable insight into how to access the quality of services being provided

ISP PLANNING PROCESS

Key Values and Principles Serving as the Foundation of Person-Centered Planning:

1. Builds on the individual's/family's strengths, gifts, skills, and contributions

2. Supports personal empowerment, and provides meaningful options for individuals/families to express preferences and make informed choices in order to identify and achieve their hopes, goals and aspirations.

3. Establishes a framework for providing services, treatment, supports and interventions that meet the individual's/family's needs, and that honors goals and aspirations for a lifestyle that promotes dignity, respect, interdependence, mastery and competence

ISP PLANNING PROCESS

Key Values and Principles Serving as the Foundation of Person-Centered Planning, cont.

4. Supports a fair and equitable distribution of system resources
5. Create community connections
6. Sees individuals/families in the context of their culture, ethnicity, religion and gender
7. Supports mutually respectful partnerships between individuals/families and providers/professionals, and recognizes the legitimate contributions of all parties.

ISP PLANNING PROCESS

- The umbrella under which all planning for treatment, service and support occurs
- Start with where the person is and their reasons for desiring services.
- Focus on identifying the person's/family's needs and desired outcome
- Plan is based on strengths and preferences as identified by the person/family which then supports good action and crisis planning
- Always consider natural and community supports

ROLE OF THE CARE COORDINATOR IN ISP DEVELOPMENT

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CARE COORDINATOR ROLE

- Provide information about the ISP process
- Provide education about Innovations waiver services/supports
- Work with the individual/family to determine needed assessments
- Complete and/or assist with arranging assessments
- Coordinate the ISP meeting
- Facilitate the ISP meeting
- Document the ISP
- Submit ISP to MCO Utilization Management for review/approval

CARE COORDINATOR ROLE

- Notify individual/family and provider when ISP approved

- Monitor services/supports

- Work with individual/family/provider to determine when adjustments to the ISP are needed and complete any needed ISP Revisions

ASSESSMENTS PROVIDE VALUABLE INFORMATION

ASSESSMENT

- Understanding the person's strengths and abilities, hopes and dreams, challenges and needs
- The quality of an ISP is directly related to the quality of the assessment process, both the gathering of person-centered information and of more formal assessment information.
- Information will continue to be gathered and added as more learning takes place

ASSESSMENT

- Three Components-
  - Gathering person-centered information,
  - Risk/Support Needs Assessment, and
  - Gathering information to support level of care
- Assessment is a dynamic, ongoing process based on the needs of the individual.
- Includes evaluating the impact of services/supports
- Important to determine the status of assessment information available prior to the annual ISP meeting in order to allow ample time to obtain any updates before the team ISP team meets

ASSESSMENT

Other assessment tools found to be particularly useful in helping to identify support needs, and supporting the level of care for persons with developmental disabilities:

- Adaptive Behavior Scales
- Psychological Testing

NC INNOVATIONS RISK/SUPPORT NEEDS ASSESSMENT

- Identify his/her health and safety risk factors

- Assists the ISP team to identify supports necessary to successfully participate in essential activities of life and significant risks regarding the individual's health/safety and the safety of others

GATHERING INFORMATION

The Supports Intensity Scale™ (SIS)

- Is a nationally recognized assessment that measures the level of supports required by people with developmental disabilities to lead independent, quality lives in their home community.

- It covers a number of support areas, including home living, community living, lifelong learning, employment, health and safety, social activities, protection and advocacy, as well as medical and behavioral supports needs.

SIS POLICY FOR ISP PLANNING

- The Supports Intensity Scale (SIS) Policy for ISP Planning:
  - Establishes the framework for incorporating SIS into the person centered planning process
  - Establishes various Administrative processes related to the SIS in the NC Innovations Waiver that ensures consistency throughout the state.

SIS POLICY FOR ISP PLANNING

The SIS Policy for ISP Planning includes four sections:

- An Overview of the SIS
- The SIS Assessment in NC Innovations
- Using the SIS for Planning

OVERVIEW OF THE SIS ASSESSMENT TOOL

SIS focuses on support needed for individual success.

- What type of support is needed
- How often support is needed
- How much support is needed

- Conducted in Interview/Conversational Format
- The SIS does NOT determine the number of hours a person receives or the type of services an individual needs.

OVERVIEW OF THE SIS ASSESSMENT TOOL

The **Individual**

AND

The **Respondents**

AND

The **Interviewer**

The SIS Interviewer or Care Coordinator review the SIS report with individuals and families.

SUPPLEMENTAL QUESTIONS (SQ)

- When the SIS is administered, certain responses in the Exceptional Medical and Behavioral Supports Sections may also require that a series of Supplemental Questions be asked.

- Responses to these questions help to identify exceptional levels of medical and/or behavioral support needs

- Such responses; however, need to be verified independently.

CATEGORIES OF SUPPLEMENTAL QUESTIONS (SQ)

- Severe Medical Risk

- Severe Community Safety Risk – Convicted

- Severe Community Safety Risk – Not Convicted

- Severe Risk of Injury to Self

THE SQ VERIFICATION PROCESS

Documentation to include but not limited to:

- The SIS Report

- Person's ISP/Psychological/Therapy Evaluations

- Current medical history/physical

- Progress reports/Quarterly Summaries

Conversations with individuals who know person:

- Individual

- Family or Guardian

- Care Coordinator

- Service Providers

THE SQ VERIFICATION PROCESS

There are 3 steps to the verification process:

Each LME-MCO Must:

1. Conduct a verification review for each person with supplemental questions indicating extraordinary support needs.

2. SQ Verification Committee will consider supporting documentation for exceptional needs

3. SQ Committee makes a final decision as to whether individual has exceptional support needs based on documentation

THE SIS IN NC INNOVATIONS WAIVER

- SIS Assessments are completed by certified AAIDD Interviewer:
  - Before individuals are approved for services through the NC Innovations Waiver
  - Major life changes for person resulting in different support needs
  - Disagreement with the SIS Results
  - Re-Evaluation
    - Every 2 years for Children (5 to 15 years)
    - Every 3 years for Adults (16 years and older)

THE SIS IN NC INNOVATIONS WAIVER

- Once the SIS is completed, the results are mailed and/or hand-delivered.

- The SIS interviewer or Care Coordinator then schedules a time to meet with the beneficiary and his/her family to review the results.

- The SIS is completed for each person served through the NC Innovations Waiver.

USING THE SIS FOR PLANNING

- A person's plan focuses on supporting individuals to realize their own vision for their lives.

- The planning process should identify the beneficiary's unique gifts, skills and capacities, and focuses on listening for what is really important to the person.

- Although the SIS is used to assess the types and levels of supports a person needs, not all areas of the SIS will be included in the ISP.

USING THE SIS FOR PLANNING

- The SIS provides the person's team with the information regarding their support needs in various areas.   The SIS highlights:
  - Areas of Strength for an individual
  - Areas where individuals require support
  - Areas that are identified for exploration
  - Areas of interest to person
- Prioritizing what will be developed into long-range outcomes is part of the person centered planning process.
  - The SIS is not the only source that the team considers.

WHAT WE NEED FROM YOU…

- Feedback related to the *SIS Policy for ISP Planning*
- What works?
- What doesn't work?
- Anything missing?

Thank you!