

# Partners in Recovery

## Individual Service Planning

<b>CMC or Department Name:</b> Partners in Recovery Direct Care Clinics								
<b>CMC or Department Procedure Name and Number:</b> Individual Service Planning								
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### PROCEDURES

The Direct Care Clinics support a recovery model for service planning and service delivery that is outcome driven, strength-based, family friendly, culturally sensitive and clinically sound. The model is based on the Principles of Person-Centered Planning that are required for behavioral health assessment and service planning. Services:

1. are developed with the understanding that the system has an unconditional commitment to individual's served.
2. begin with empathic relationships that foster ongoing partnerships, expect equality and respect throughout the service delivery process.
3. are developed collaboratively to engage and empower individuals, include other individuals involved in the person's life, include meaningful choice, and are accepted by the person.
4. are individualized, strength-based and are clinically sound.
5. are developed with the expectation that the individual is capable of positive change, growth and leading a life of value.

The **PNO** through the case management teams has responsibility for the development, implementation and monitoring of the ISP. The case manager will coordinate and provide oversight of the ISP process.

This approach is based upon a coordinated, flexible, person-driven process that supports and helps the individual to attain an optimum level of functioning, develop healthy interpersonal relationships, experience recovery, and become a self-determined and productive member of society by:

- Managing and eliminating the debilitating symptoms of a mental illness;
- Promoting the ability to live a productive and satisfying life;
- Improving the ability to function in social, educational and vocational roles;
- Emphasizing every individual's unique strengths, recovery process and culture and
- Increasing participation in the greater community.

The team works to enhance the person's engagement in services, improve customer satisfaction and treatment outcomes by involving family members, peer and other natural supports, and involved provider's service systems in the design, development and oversight of the individual's service and "recovery" plan.

In tandem with the assessment process, service planning should be an ongoing process resulting in an individual service plan for the behavioral health person that is a living clinical document continually being changed to meet the

needs of the person and his/her family. *The ISP drives treatment.* The ISP should be viewed as the person's service plan not the provider agency or clinician's plan. So, the ISP should be written so that the person and their family can easily understand objectives and their responsibility to follow through with the plan.

While ongoing, the service planning process is also short term with the life of any single service plan being brief in its operation. Technically, the service plan is good for one year; however, staff are encouraged to set objectives that can be readily achieved and celebrated within a shorter time frame. The goal is to stop reinforcing failure and to encourage involvement, achievement and success, continually building on the strengths of the person and his/her family.

**Purpose:**

To establish the Provider Network Organization's guidelines for service planning for adults with a serious mental illness based upon all identified regulations in the following documents which are referenced/summarized as an Appendix in this protocol.

**Service Planning Standards:**

1. An ISP will be developed by the clinical team and each behavioral health recipient.
2. The ISP must include the most appropriate and least restrictive services, consistent with the behavioral health recipient's needs and preferences, as identified in the assessment, without regard to the availability of services or resources.
3. The services identified will maximize the recipient's strengths, independence, and integration into the community.
4. Natural supports and community services available to the general public should be utilized to the maximum extent possible, when adequate to meet the person's needs.
5. The service plan should address all needs identified in the core assessment and that the type of service, level of care and frequency of the service is sufficient to meet the needs of the person.
6. Recommendations made should support the accomplishment of the long term goals in living, learning/working, and social/leisure.

This protocol takes the approach of developing, implementing and monitoring the ISP through the Appendix C criteria.

- I. **C-2** A full clinical team should be involved in the development of the assessment/ISP to include the person, case manager, nurse, doctor and vocational specialist, unless the person is over 62 and chooses to be retired.
  - A. Each required member of the team must document their clear, professional input /recommendations for the assessment and ISP in the medical record and those recommendations must be incorporated into the ISP. This may also include other individuals who are needed to identify and address the recipient's treatment needs, (e.g. housing specialist, substance abuse specialist, etc.)
  - B. The case manager may conduct a home visit to facilitate the development of the ISP with the person's input.
  - C. Recommendations made should support the accomplishment of the long-term views in living, learning/working and social/leisure.
  - D. There should be documentation that the specific clinical team members attended the ISP meeting and assisted in establishing goals and making service recommendation; and documentation of team discussion in progress notes.
  - E. Each member of the clinical team must clearly document progress towards the goals and objectives of the ISP and provide clear justification or rationale for important decisions.
- II. **C-3** All ISPs for new recipients should be completed within 90 days with an adequate functional assessment and long-term view.
  - A. The case manager is responsible for ensuring that a functional assessment and long-term view are completed with the initial ISP.

- B. Recommendations made should support the accomplishment of the long term goals in living, learning/working and social/leisure based upon the person's preferences not based on what is available.
  - C. If the person is not able to articulate a long term view in any of the areas listed above, there must be documentation that the case manager and clinical team are working to engage and develop a relationship with that person as evidenced by home visits, outreach in the community, follow up with commitments made on behalf of the person, utilizing peer support, etc...
  - D. The case manager will ensure that all needs identified in the assessment are reflected in the ISP.
  - E. The case manager must personally deliver and review the completed ISP with the recipient and provide the recipient with a copy of the ISP.
- III. **C-4** A review of the ISP must be completed every six months at a minimum.
- A. ISP reviews will be held within six months of the date that the ISP was accepted by the person, or more frequently as needed.
  - B. The purpose of the review is to ensure that services continue to be, to the maximum extent possible, appropriate to the person's needs and least restrictive to the person's freedom.
  - C. The case manager will document on the plan the measure(s) the person has achieved at the time of the review.
  - D. The review will be conducted with the fullest participation of the person and any designated representative/guardian. Participation should include the case manager, the person, family members with the permission of the person, the clinical team, representatives from each service provider, and anyone whose participation is requested by the person and whom the clinical team feels will contribute to the ISP review.
  - E. The case manager will prepare an updated ISP based on the progress made, or lack of progress, and any changes in the person's circumstances.
  - F. The case manager must personally deliver and review the completed ISP with the recipient and provide the recipient with a copy of the ISP.
- IV. **C-5** Whenever there is a substantial change in the person's life, the ISP is modified to incorporate that change.
- A. The case manager will modify the ISP when there is a change in service provision which causes a significant modification in the recipient's daily routine and activities and/or the level/type of supervision and support provided – this includes a change in the level of case management. (e.g. move in/out of residential treatment, inpatient settings, movement from a Supportive team to an ACT team, getting/losing a job, etc.)
  - B. Requests for modifications may be initiated by the recipient, designated representative or guardian, a Direct service provider, or any member of the clinical team.
  - C. No modifications of an ISP will be made without the acceptance of the recipient or their guardian unless the change is required to avoid a serious or immediate threat to the health or safety of the recipient or others.
- V. **C-6** Every recipient with a serious mental illness has signed the Grievance and Appeal form advising him/her of their rights and the form is in the medical record.
- A. The case manager is responsible for reviewing the rights with the recipient, obtaining the signature on the form and placing it in the medical record and documenting that activity in the progress notes.
- VI. **C-7** All behavioral health needs of recipients who are priority classmembers are met in three domains - living, learning/working and social/leisure. The needs must be reflected in the assessment and ISP with services delineated and provided which would reasonably meet the identified need. The current plan will be reflective of the person's choice of areas in which s/he chooses to focus.
- A. The service plan will address needs in the area of living.
    - 1. The case manager will assist the recipient in formulating their desired living arrangements.

2. If the recipient is living in a supervisory care home (SCH), the case manager will work with the consumer to identify a safe and sanitary living environment and assist the recipient with moving from the SCH.
  3. The case manager must ensure that needed living services/supports are included in the ISP and all needed living services/supports planned for in the ISP are actually being provided to the person.
- B. The service plan will address needs in the area of learning/working.
1. The case manager will assist the recipient in exploring their educational and vocational interests.
  2. If the recipient is over 62 years old and chooses to be retired it should be clearly documented in the ISP and in the medical record.
  3. The case manager must ensure needed learning/working services/supports are included in the ISP and all needed learning/working services/supports planned for in the ISP are actually being provided to the recipient.
- C. The service plan will address needs in the area of social/leisure.
1. The case manager will help the recipient explore their current or potential social network.
  2. Wherever possible, normal social activities, rather than treatment base socializing, should be identified
  3. The case manager must ensure that needed social/leisure services/supports are included in the ISP and all needed social/leisure services/supports planned for in the ISP are actually being provided to the recipient.
- D. The service plan will address other basic needs of the person identified in the assessment. The presence of the functional assessment in the revised ISP form should replace the requirement to include an objective and intervention for each identified need.
- VII. **C-8** All behavioral health needs of recipients who are non-priority classmembers are met in living and learning/working. The needs must be reflected in the assessment and ISP with services delineated and provided which would reasonable meet the identified need.
- VIII. **C-9** The recipient served actively participates in the development of their ISP.
- A. The case manager may conduct a home visit to the recipient's home as part of the assessment/ISP development process to discuss the recipient's goals and document the conversation that took place during the home visit in the medical record.
  - B. The case manager will explain Partners in Recovery and options for services and treatment to the recipient.
  - C. The case manager will explain that the ISP is designed to drive their treatment services.
  - D. The case manager will ensure that the recipient is given a copy of their ISP.
- IX. **C-10** Each recipient's need for special assistance must be assessed and documentation must be present in the ISP indicating whether the recipient requires special assistance.
- A. The case manager will adhere to the Policy on Special Assistance to make the assessment of whether the recipient is able to participate in the ISP or grievance and appeal process due to physical or cognitive deficits, or language difficulties that interfere with the recipient's ability to communicate effectively.
  - B. The decision on whether the recipient is in need of special assistance must be documented in the ISP and in the medical record.
  - C. How the special assistance is provided must be documented in the medical record.
  - D. The clinical team is responsible for ensuring that special assistance is provided to identified recipients.

- X. **C-11** Each recipient must give informed consent to take all medications prior to starting the medications. The recipient must also give informed consent for ECT or other surgically related procedures to address mental health concerns. The signed consent form must be present in the medical record.
- XI. **C-12** In the event that a recipient had an inpatient stay for more than seven days, an Inpatient Treatment Discharge Plan (ITDP) must be developed with participation of the outpatient clinical team and incorporated into the ISP.
  - A. The person, guardian – if applicable, case manager must participate in the development of the ITDP. The case manager must meet with the recipient during his/her inpatient stay at a minimum of every 72 hours.
  - B. The ITDP should reflect and incorporate the goals and services of the ISP.
  - C. The ITDP must be developed by the 10<sup>th</sup> day of an inpatient stay.
  - D. The case manager must obtain a copy of the ITDP and file in the outpatient medical record.
  - E. The ISP must be revised if clinically indicated to reflect any additional services/supports required to address the reason for the inpatient hospitalization.

### **Attachment 1**

The documents listed below serve as the foundation for the action steps delineated below.

ADHS/DBHS Instruction Guide for the Assessment, Service Plan and Annual Update  
R9-20 Licensure Rules  
R9-21 SMI Rules  
Arnold vs. ADHS Case Review Instrument Version 22.00  
ADHS/DBHS Provider Manual 3.9 Intake, Assessment and Service Planning

- I. **Preparation of the ISP**
  - A. The case manager will solicit and actively encourage the participation of the person, the guardian, if applicable, the assigned clinician, the psychiatric nurse and the vocational specialist, unless the person is over 62 years old and retired. Each required team member must document their clear, professional input/recommendations for the assessment and ISP in the medical record and those recommendations must be incorporated into the ISP. Recommendations made should support the accomplishment of the long-term views in living, learning/working, and social/leisure.
  - B. The case manager will conduct a face to face visit to gather the person’s input and will document the activity and conversation in the medical record.
  - C. The case manager will inform the person of the right to have a designated representative throughout the ISP process and to invite family members, guardian and any other individual the person feels can contribute to the development of the ISP.
  - D. The case manager will seek out a representative for persons who need special assistance to articulate their own preferences in the ISP and will follow the Policy on Special Assistance for those persons determined to need special assistance.
  - E. The case manager will assess and document if the person needs communication assistance in a preferred language other than English in order to effectively communicate with the person. The person’s cultural preferences and language needs are assessed, considered, and incorporated into the person’s service plan and thereby further customizing treatment to the person’s unique cultures, faith, traditions and priorities.
  - F. For person’s who are inpatient as a new referral, the case manager will incorporate the Inpatient Treatment Discharge Plan (ITDP) into the ISP and include community services and, if needed, alternative housing and residential supports to be provided when the person leaves the inpatient facility.
  - G. For person’s who are case managed, upon an inpatient stay, the case manager will ensure that the goals and services of the current ISP are reflected in the ITDP.

- H. In developing the ISP, the case manager will conduct a thorough record review and gather information and recommendations for treatment and services from the person, guardian, and clinical team – to include at a minimum the person or guardian, the assigned clinician, the psychiatric registered nurse, the case manager, the vocational specialist and any identified potential service providers. This may also include other individuals who are needed to identify and address the person’s treatment needs. (i.e. substance abuse specialist, behaviorist, housing specialist, rehabilitation specialist, etc.)

## II. Development of the ISP

- A. After having reviewed and updated all relevant assessments, the case manager will pull that information together in the development of the ISP. The assigned Clinical Liaison provides clinical oversight to ensure that the plan is clinically sound. The initial ISP must be completed within 90 days. The case manager should ensure that a functional assessment and long-term view are completed with the initial ISP. Utilizing the Part D: Behavioral Health Service Plan, information should be documented as follows.
1. Enter the name, CIS ID#, Program, today’s date, and the names and titles of the individuals at the service planning meeting.
  2. Recovery-Goal/Person-Family Vision(Long Term View): The case manager and clinical team should assist the person in articulating a long-term view based on the person’s preferences not based on what is available in the three areas listed below:
    - a. The case manager should assist the person in formulating their desired living arrangements – if necessary, a Housing Needs Assessment can be completed to assist in determining areas of need.
      - i. If the person is living in a Supervisory Care Home (SCH), the case manager will work with the person to identify a safe and sanitary living environment and assist the person with moving from the SCH.
    - b. The case manager/clinical team should assist the person in exploring the person’s educational and vocational interests. The case manager/clinical team should identify activities that are most meaningful to the person and potentially productive to the community. A rehabilitation or vocational assessment should be completed. If the person is 62 years of age or older and does not desire to work, this should be documented by the case manager or the rehabilitation specialist in the medical record.
    - c. The case manager/clinical team should help the person to explore their current or potential social network. This includes availability of family, friends, neighbors, and other natural supports in the community. Wherever possible, normal social activities, rather than “treatment-based socializing” (partial care, clubhouse) should be identified. The person’s desires for/satisfaction with intimate or romantic relationships should also be explored.

If the person is not able to articulate a long-term view in any of the areas listed above, there must be documentation that the case manager and clinical team are working to engage and develop a relationship with that person as evidenced by home visits, outreach in the community, follow up with commitments made on behalf of the person, utilizing peer support, etc. The ISP must have evidence that the case manager/clinical team is providing strategies and options for the person to explore possible life Partners in Recovery to achieve this outcome.
  3. Person’s Strengths: The case manager should summarize the person’s strengths that have been identified throughout the assessment process. Strengths may include internal strengths or supports/support people available to the person in times of distress.
  4. Review Date: The review date should reflect the date when the person’s service plan will next be reviewed by the clinical team. This date should coincide with the date that the person is expected to have met the specific objectives listed on the plan.

5. Identified Needs and Specific Objectives: The case manager/clinical team will pull **all identified needs** from the assessment process, the person, and their knowledge of the person, and insure that there is an objective and an intervention for each need. The case manager should help the person prioritize needs so that emergent or safety factors are addressed first. Each need identified in the assessment must be addressed in the ISP.
  - a. As soon as needs of the person for particular services are identified through the assessment process, the person, case manager and the clinical team shall begin considering and choosing potential service providers to participate in the development of the person's individual service plan.
  - b. The case manager will complete referrals to the identified service providers to determine their ability to serve the person.
  - c. Generic services (natural supports) available to the public should be utilized, to the maximum extent possible, when adequate to meet the person's needs.
  - d. Those providers who have the ability to serve the person will be invited to the ISP meeting.
  - e. The person, case manager and the clinical team will determine which provider(s) are the most appropriate to serve the person. Providers/services identified should maximize the person's strengths, independence and integration into the community.
  - f. If services identified in the ISP are not currently available, the case manager and clinical team will develop an alternative plan for alternative services.
  - g. If the case manager and clinical team determine that a service is unavailable or does not exist, the case manager will forward a description of the unmet need to the Manager of Unmet Needs and follow the existing process for resolving unmet needs.
  
6. Measure (Current, Desired and Achieved): A quantifiable means to measure each service plan objective needs to be established. On the service plan, the case manager should indicate the current measure (where the person currently is in terms of meeting his/her need and desired outcome) and in collaboration with the person establish what the measure should be ( used to determine that the service objective has been met) and the target date for achieving each of these objectives.
  
7. Interventions to Meet Objectives: In this section of the service plan, the case manager should describe how each of the service objectives is going to be met. While this should include identification of covered behavioral health services, including type and frequency, it is also important to identify natural/community resources that might be drawn upon to help meet the service plan objective, (AA group, parks and recreation departments, etc). Strengths the person has to motivate himself or herself to achieve the goal should be identified, including outside supports such as a neighbor or probation officer who has been identified in the assessment. There should be documentation that the specific clinical team members attended the ISP meeting and assisted in establishing goals and making service recommendations and documentation of team discussion in progress notes. The documentation should be in the ISP itself and in progress notes in the medical record. Finally, it is necessary to identify where the person is at in terms of their readiness for change. Services should be provided which meet the person where they are at in their readiness.
  
8. Discharge Plan: Like the rest of the service plan, the discharge plan is a living plan that can be changed as appropriate to the person's situation. This section should also be used to plan for goals or objectives that are not a focus or priority for this planning session but will need to be addressed at a review or a later update.

B. The service plan must also include the following information:

1. Identification of any need for alternative housing or residential setting, including the support and monitoring to be provided after any change in housing or residential setting.
2. The person's capacity to:
  - a. make competent decisions on matters such as medical and mental health treatment, finances and confidential information.
  - b. participate in the development of the ISP
  - c. independently exercise his/her Rights.
3. The person's need for guardianship or other protective services or assistance.
4. The person's need for Special Assistance.
5. The person's right to make an Advance Directive.

### **III. Implementation of the ISP**

- A. The service plan should reflect the balance of strengths and needs identified in the assessment. The appropriate covered services and supports are included based on the person's needs as identified in the Core Assessment and Addenda.
- B. The case manager will convene an ISP meeting to present information gathered during the development process at a convenient time and place for the person, guardian, clinical team and potential service providers. The person will make the decision on whether they choose to attend the ISP meeting.
- C. The case manager will arrange for the person's transportation, if needed, to the ISP meeting.
- D. The case manager will provide notification to all involved parties of the date and time of the ISP meeting.
- E. The case manager will make arrangements, if needed, to have qualified interpreters or other reasonable accommodations for persons who cannot converse adequately in spoken English.
- F. During the ISP meeting, the case manager should facilitate a discussion around the following:
  1. The person's strengths, skills and supports necessary to obtain the person's long term views in living, working/learning and social/leisure.
  2. The conclusions of the assessment process.
  3. Any existing ITDP.
  4. The person's preferences regarding services.
  5. Recommended long term or alternative services.
  6. Current or proposed service providers.
  7. Recommended dates for starting each service or the date each service started.
  8. The methods and persons to ensure that services are provided as presented in the ISP, adequately coordinated and regularly monitored for effectiveness.
  9. The procedure for completion and implementation of the ISP process, including the procedures for accepting, rejecting, or appealing the ISP.
  10. The procedure for the person or service providers to request changes in the ISP.
- G. Signatures:
  - a. The case manager must ensure that the person/guardian signing the plan clearly understands what is being agreed to and how they will achieve these goals within a reasonable amount of time (target date for meeting objectives). The person/guardian must indicate whether they agree or disagree with the service plan and the types and levels of services included. If the person/guardian checks no, a Notice of Action (PM Form 5.1) must be provided to the person if the disagreement concerns a Title XIX/XXI covered service. If the disagreement pertains to a Non-Title XIX/XXI covered service and the person has been determined to have a serious mental illness, the person must be given the Notice of Decision and Right to Appeal (For Individuals with a Serious Mental Illness) PM Form 5.5.1.
  - b. The case manager will inform the person of their right to appeal eligibility and treatment decisions and obtain their signature on the form which will be placed in the medical record.
  - c. The case manager should print their name, indicate their credentials/position, and date the bottom of the service plan, along with the behavioral health professional reviewer,

- if the Clinical Liaison is not a behavioral health professional. Any other individuals participating in the service planning session should also sign the service plan.
- d. If the service plan is completed via telemedicine, the person/guardian should affix his/her original signature where appropriate. The behavioral health practitioner accompanying the person should note on the appropriate lines requiring the case manager's signature (e.g. Tom Jones, certified professional counselor, via telemedicine) and initial. At the clinician's site, the case manager should include a statement in the progress notes "service plan completed via telemedicine" and sign the progress note to complete the documentation process.
- H. Upon acceptance of the ISP by the person, services will be initiated according to the timeframe indicated in the ISP.
  - I. If all, or a portion of, the ISP is rejected by the person or guardian, the plan will not be implemented and services will not be provided unless the person or guardian consents to specific services.
  - J. For each person identified as needing alternative housing, a new residential setting, or a residential support service, the case manager will inform the person of the need for an alternative living arrangement and will use the case manager's best efforts to obtain appropriate housing or residential supports. These efforts may include showing the person the house or apartment in which the person could reside, introducing the person to the other residents of the residential setting, as appropriate, and permitting the person to live in the alternative setting on a trial basis. All person's should be informed that they may choose to move at any time in the future subject to the terms of any lease, mortgage, contract, or other legal agreement between the person and the housing provider.
  - K. For at least the first two months after a person moves to a new residential setting, the case manager will coordinate and monitor support services, as identified in the person's ISP, in order to foster the maintenance of the person's key relationships with others, to provide necessary orientation and to ensure a smooth and successful transition into the new setting.

#### **IV. Distribution of the ISP**

- A. Once all signatures are obtained on the ISP, the case manager is responsible for copying and distributing the ISP. Each ISP must pass a quality review completed by the Clinical Coordinator. The Clinical Director will review the work of the clinical coordinators.
- B. The Clinical Director will enter the completed ISP into the tracking system currently utilized.
- C. The case manager must deliver and review the ISP with the person face to face and provide the person with a copy of the ISP.
- D. The case manager will mail, or otherwise distribute, copies of the ISP to all other involved parties.
- E. The case manager will forward the completed ISP to the clinic chart room for filing in the ISP section of the medical record.

#### **V. Monitoring of the ISP**

- A. The case manager is responsible for ensuring that services are actually delivered in accordance with the ISP.
- B. The case manager will monitor the delivery of services rendered to the person. Monitoring will consider, at a minimum, the consistency of the services with the goals and objectives of the ISP.
- C. The case manager will accomplish the monitoring by initiating and maintaining close contact with the person and all service providers.
- D. The case manager will provide support and assistance to the person consistent with the individual's needs and the minimum contact requirements for the person based on their assigned level of care according to the Protocol on Case Management Contact Requirements.
- E. The case manager will obtain, at a minimum, monthly reviews of progress from each provider delivering services. The case manager should attend all treatment/service meetings at the provider agency whenever possible.
- F. The case manager will assess progress toward and identify impediments to, the achievement of the person's goals and objectives identified in the ISP. This information must be

documented in the medical record. Progress notes should contain a justification or rationale for important decisions. Examples include, but are not limited to, the decision to petition or not petition for court ordered evaluation or treatment, the decision to discharge from an inpatient setting, the decision to recommend a restrictive level of care, etc. Any decision which may have significant consequences for the person should have a written justification in the record.

- G. The case manager/clinical team will assist in resolving any emergencies concerning the implementation of the ISP. Additionally, when there is evidence of imminent risk of danger to self or others, or imminent risk of loss of housing, employment, income or entitlements, or incarceration, then subsequent documentation should show rapid and effective actions likely to remedy the situation. The same holds true if there are early warning signs of relapse. The progress notes need to reflect any modifications needed to the ISP as determined by all the issues noted above.
- H. If a case manager is assigned to a person who, at any time, is admitted to an inpatient facility, the case manager will ensure that the ITDP reflects the goals and services of the ISP.
- I. The case manager will attend all periodic reviews of the ISP and ITDP meetings to share feedback and progress towards goals.

## **VI. Reviews/Updates of the ISP**

- A. Where an ISP includes residential, vocational or other primary service providers that do not currently serve the person, the first ISP review shall be held within 30 days from the date on which all such providers have initiated services currently in effect for the person.
- B. Where the ISP includes only primary service providers that currently serve the person, the first ISP review will be held within six months of the date the ISP is accepted by the person or the date on which any appeal is concluded.
- C. Thereafter, ISP reviews will be conducted at least every six months and more frequently as needed. The case manager will facilitate the ISP reviews.
- D. The purpose of the ISP review is to ensure that services continue to be, to the maximum extent possible, appropriate to the person's needs and least restrictive to the person's freedom.
- E. During reviews of the service plan, the case manager will document on the plan what measure(s) the person has achieved at the time of the review.
- F. The review will be conducted with the fullest participation of the person and any designated representative/guardian. The case manager will invite, in writing, the person and any designated representative/guardian, family members with permission of the person, the clinical team, representatives from each service provider, anyone whose participation is requested by the person and any other person whose participation is not refused by the person and whom the clinical team feels will contribute to the ISP review.
- G. The review will consider the following information:
  - 1. any change in the clinical, social, medical, vocational, educational, and personal needs of the person;
  - 2. whether the person needs any further assessment or evaluations;
  - 3. whether the services provided to the person continue to be appropriate to meet the person's needs, least restrictive of the person's freedom, consistent with the person's preferences and as integrated as possible in the person's home community;
  - 4. whether there has been progress towards the attainment of the long-term view and each of the goals and objectives stated in the ISP;
  - 5. whether to reaffirm, modify or delete each goal and objective, together with the reasons for these actions;
  - 6. whether there has been any change in the legal status of the person, in the necessity or advisability of having a guardian or conservator appointed or removed or in the person's need for special assistance;
  - 7. whether any change in the person's circumstances should result in a modification of the person's priority of need for services not currently provided; and
  - 8. whether there has been any change in the availability of services formerly determined to be needed but not then available.

- H. The case manager will prepare an updated ISP based on the summary of items listed above in G. 1-8.
- I. The case manager will personally meet with the person or guardian to explain the updated ISP. The updated ISP will be mailed or otherwise distributed to the other participants of the review meeting.

**VII. Modifications of the ISP**

- A. When there is any change in service provision which causes a significant modification in the person's daily routine and activities and or the level/type of supervision and support provided - this includes a change in the level of case management - the ISP must be modified to reflect that change.
- B. Other reasons for modifying the ISP include:
  - 1. the person withdraws consent to the ISP or any portion of the ISP;
  - 2. the person agrees to services that are more suitable to his/her needs that they previously refused;
  - 3. the needs of the person have changed due to progress or lack of progress towards goals and objectives;
  - 4. the proposed change will allow the person to receive services that are more consistent with the person's needs, less restrictive of the person's freedom, more integrated into the community or more likely to maximize the person's ability to live independently;
  - 5. the person wants to change their long-term view and the focus of the ISP or no longer needs a service or services.
- C. Requests for modifications may be initiated at the ISP review or at any other time by the person, designated representative and/or guardian, a service provider or any member of the clinical team.
- D. Requests for modification of an ISP will be directed to the case manager.
- E. No modification of an ISP will be made without the acceptance of the person or their guardian unless the change is required to avoid a serious or immediate threat to the health or safety of the person or others.
- F. The steps listed Section VI above should be followed to modify the ISP.