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Bernard Simons

Bernard Simons, Director

Title: Individual Service Plan: Guidelines, Training and Review

Applies to: Targeted Case Management (TCM) entities, Habilitation Centers, and any provider agencies responsible for facilitating and/or writing individual plans for consumers eligible for Division of DD services.

Purpose:

- To describe the philosophy and the content of individual service plans for consumers served by the Division.
- To describe the processes used to ensure compliance with Medicaid Waiver requirements and the Division of DD Person Centered Planning Guidelines.

Definitions:

Action Plan Tracking System (APTS): A database utilized by the Division designed to track issues requiring resolution, as well as positive practices that are identified through Provider Relations and/or Quality Enhancement Functions. Issues tracked will be identified through indicators categorized by health, safety, rights, services, and money, in addition to the Missouri Quality Outcomes.

Division of DD Person Centered Planning Guidelines: Describe the philosophy and values that form the foundation of the planning process.

Missouri Quality Outcomes: A collection of positive outcomes identified by people with disabilities, family members, and friends outlined in the Missouri Quality Outcomes Discussion Guide <http://dmh.mo.gov/docs/dd/QualityoutMan.pdf>. The Discussion Guide document serves as a tool designed to assist the service delivery network to put these desired concepts into practice.

Individual Service Plan (ISP): A document resulting from a person centered process directed by the individual served, with assistance as needed by a representative, in collaboration with an interdisciplinary team. It is intended to identify the strengths, capacities, preferences, needs, and desired outcomes of the person served. The process may include other people freely chosen by the individual who are able to contribute to the process. The person-centered planning process enables and assists the individual to access a personalized mix of paid and non-paid services and supports that will assist the person to achieve personally defined outcomes and the training, supports, therapies, treatments, and/or other services that become part of the individual service plan.

Individual Service Plan Review Database: Division of DD database designed to collect data and analyze trends around CMS assurances related to service planning and level of care, in addition to quality enhancement.

Level of Care: A determination of whether or not an individual has a need for the level of care provided in an ICF-MR and if so, would this person require ICF-MR placement if not provided services under Missouri's Home and Community Based Waiver for persons with developmental disabilities.

Quarterly Review: A review conducted every three months on progress of the implementation of the plan. Reviews will be conducted for the plan year. For example, a plan with an implementation date of January 1 will be reviewed in April for the months of January, February, and March. In this example, quarterly reviews for this plan would be completed in April, July, October, and at the end of the plan year in order to determine needs for the next plan year. During the October quarterly review, the team may convene to review progress and develop a plan for the upcoming annual plan year.

State Quality Enhancement Unit: Staff designated within the Division of Developmental Disabilities that oversees and implements statewide Quality Management Functions.

Targeted Case Management (TCM) Provider: An agency, to include Regional Offices, SB 40 Boards and Not-for-Profit agencies, authorized through a contractual agreement to provide targeted case management services for persons eligible for services from the Division of Development Disabilities.

I. Person Centered Planning Guidelines <http://dmh.mo.gov/docs/dd/pcpguide.pdf>

- A. The values encompassed in the Missouri Quality Outcomes must be represented in the planning process.
- B. The Division’s State Quality Enhancement Unit shall ensure the Person Centered Planning Guidelines are reviewed annually and shall update as needed.

II. Individual Service Plan and Training Requirements

- A. All staff responsible for developing and writing individual plans shall receive training on the Division of DD Person Centered Planning Guidelines and Missouri Quality Outcomes. A curriculum and training tool developed by the Division will be provided to all trainers. If someone other than the TCM provider writes the plan, the TCM provider is responsible for ensuring all the required components are included in the plan.
- B. Each entity providing Targeted Case Management (TCM) services is responsible for presenting standardized training on future revisions or updates as identified by the Division.
- C. All persons receiving service coordination must have a current, comprehensive individual service plan (ISP), which meets the minimum following criteria (mandatory - topic is required; contingent - if appropriate to the person and situation, the topic is required; optional - topic is left to the choice of the person and/or guardian):
 - 1. Legal Issues: Include information about legal status, restrictions placed by the court system, and dated signatures of the person, legal guardian (if appropriate) and the service coordinator.

LEGAL ISSUES	
Legal Status	Mandatory
Guardianship (Name, address, phone number and relationship to the person of the person’s legal guardian)	Mandatory
Specific restriction placed by court	Mandatory
Specific restriction(s) to legal rights	Mandatory
Consent for Treatment	Mandatory

Signatures	Mandatory
Provider Choice	Mandatory

2. Demographics:

DEMOGRAPHIC INFORMATION	
Full Legal Name	Mandatory
Statewide ID	Mandatory
Personal Plan Meeting Date	Mandatory
Personal Plan Implementation Date	Mandatory
Regional Office/Hab Center	Mandatory
SB40 Board/ACSP	Contingent
Nicknames	Optional
Date of Birth	Optional

3. Contributors (information about this topic is mandatory):

- a. Who contributed to the plan through interviews, reports, letters, questionnaires, etc.?
- b. Who was present at the plan meeting? (If the person is not present at the planning meeting, list the reason why.)

4. Who is important to the person: It is important to know about the person's social support network. This includes who is important to the person, what the person likes to do with them and about how often. The detailed information is expected to vary significantly.

CONTRIBUTORS	
Information about the general topic of important relationships	Mandatory
Information from people who know and care about the person	Optional
Information about how to maintain/support relationships with family, friends, neighbors, community members, employers and/or supporters who are important to the consumer.	Optional

5. What is important to the person: This topic should include a description of what the person thinks is important to have a quality life. When reading the plan, it should be easy to distinguish what is important to the person from what is important to others.

WHAT IS IMPORTANT TO THE PERSON	
Hopes, Dreams & Wants	Mandatory
Needs	Mandatory

Likes & Dislikes	Mandatory
What the Person Would Like to Try	Mandatory
Support Preferences (e.g., Does the person prefer a female or male for specific tasks like bathing?)	Mandatory
Special Interests	Mandatory
Traditions	Optional
Ethnic Heritage	Optional
Cultural Events	Optional
Places That Are Important to the Person	Optional

6. What do we need to know in order to support the person: This information describes what “OUR” behavior needs to be to support the person. It may be helpful to develop a list of all of the items in the support section that need monthly follow-up to assist in providing support and to ensure that supports are being addressed and maintained.

WHAT WE NEED TO KNOW IN ORDER TO SUPPORT THE PERSON	
A description of how supports should be delivered.	Mandatory
Describe supports that are currently effective and need to continue to ensure consistency in the way supports are delivered.	Mandatory
Rituals and routines	Contingent
Primary Language Used (Required if the primary language is other than spoken English. If sign language is used, state what type of sign.)	Contingent
Method of Communication (Required if the primary mode of communication is other than speaking: communication boards, etc. see example in Appendix)	Contingent
How a person learns best.	Optional

7. What supports are needed for health (physical and mental): The plan MUST address the person’s health.

WHAT SUPPORTS ARE NEEDED FOR HEALTH – MENTAL AND PHYSICAL	
Prevention (e.g., healthy diet, exercise, weight management, stress management, counseling, etc.)	Mandatory
Maintenance of current health issues (Knowledge of diagnoses is important)	Mandatory
Improvement of current status of health	Mandatory

Medical, vision, hearing and/or oral care conditions and supports (per HIPS process 3.090 Health Identification and Planning System Process)	Contingent
Purpose of medications, treatments, or procedures (i.e., parameters for contacting physician – diabetes and hypertension)	Contingent
Dietary needs (not addressed by HIPS)	Contingent
Allergies/Sensitivities/Reactions	Contingent
Mental Health supports (counseling, therapy, medications, etc.)	Contingent
PRN psychotropic protocol	Contingent
Self-administration	Contingent
Adaptive equipment	Contingent
If specific supports are not in the plan, list where the information is located and that supporters must use this information to guide what supports they provide. (e.g., bowel and bladder management and other personal/private information)	Contingent
Family Medical History (if available)	Contingent
Diagnoses	Optional

8. What supports are needed for safety, if any: This information MUST be included when there is a need to highlight important or extensive safety issues. This information is contingent in that it is only required if the person has needs in this area. The Positive Behavior Support Guidelines explain more on how to develop supports for a person and are located at <http://dmh.mo.gov/docs/dd/PBSguide08.pdf>.

WHAT SUPPORTS ARE NEEDED FOR SAFETY	
Emergency Safety (emergency drills, plans in place, 911, stranger awareness)	Contingent
Support needed while cooking, away from home, answering the door, water temperature, toxic chemicals, having a key to their home, etc.	Contingent
Behaviors that put the person or others at risk http://dmh.mo.gov/docs/dd/PBSguide08.pdf	Contingent
Altered Levels of Supervision	Contingent
Sexual or Other Criminal Offenders (restrictions, supervision, contact person, pending charges, therapists, Probation & Parole)	Contingent

9. Transition:

WHAT SUPPORTS ARE NEEDED TO ASSIST THE PERSON WITH TRANSITION	
Career Planning & Job Development (career choice, changing jobs, loss of a job)	Mandatory
Onset of a disability (e.g. accident resulting in a brain injury)	Contingent
Change in marital status	Contingent
Change in day routine (i.e. retirement, graduation, etc.)	Contingent
Change in living environment (i.e. new home, new house mate, new staff, having a baby, etc.)	Contingent
Health-related issues (i.e. life altering illness such as breast cancer; end of life decisions)	Contingent
Self Directed Services (transition from a TCM provider directing services to directing own services)	Contingent

10. Requirements of family of minor child or guardian: If the person is a minor child, information from the parent(s) or guardian **MUST** be included in the plan. If the person is an adult with a guardian, information must be included if the guardian requests that it be included. The action steps should then describe how the guardian’s concerns are being addressed.

There may be situations where it is necessary to include information regarding what people need to know or do that the person disagrees with. Information such as this should be included in the plan but it needs to be made clear that the person does not agree with what is written. One way to provide clarity would be to include a section titled “Things the guardian thinks are important and that a supporter needs to know or do, even if the person does not agree.” Health or Safety issues that must be addressed to support the person in staying safe, but that the person does not consider important may be included here.

FAMILY OF MINOR CHILD OR GUARDIAN	
Parents of Minor Child	Mandatory
Guardian	Mandatory

11. Outcomes and Action Steps: Describe what the person would like to accomplish, learn or change and specifically how these outcomes will be achieved. It is crucial that the action steps reflect what priorities the person has identified as important. There should be a direct link between the information gathered in the profile and the action steps. This part of the action steps connects what is important to the person to the outcomes and action steps being developed. The action steps must include specific steps for each outcome as well as persons responsible for providing support and timelines for accomplishment. Those providing support should have access to the plan and use it as a guide for what activities need to be done with and/or on behalf of the person. Therefore, information regarding what is expected of supporters should be very clear so that individuals receive services in the type, amount, frequency, and duration specified in their individual service plan.

- a. What needs to be maintained/enhanced or changed/different?
- b. The action steps must describe strategies for providing the supports a person needs to work towards outcomes and to assure health, safety, and welfare.
- c. Action step must include the names of persons responsible for implementation of each action step and timelines for completion of each step.

Note: An outcome IS NOT a service, or service definition, such as “will receive residential habilitation”.

DEVELOPING OUTCOMES AND ACTION STEPS	
MO Quality Outcomes are utilized	Mandatory
Services Used To Support Outcomes – these should NOT be outcomes or action steps (e.g., <i>Personal Assistant</i> is a service one would use to go to YMCA for an outcome of person <i>belonging to the community</i>)	Mandatory
Rationale/Justification (for Outcomes)	Mandatory
Measurement of Outcomes	Mandatory
Action steps	Mandatory
Target Date/Timelines	Mandatory
Responsible person	Mandatory
Person’s definition of success	Optional
Support/learning strategies	Optional in plan*
Describe what the current situation is and list ideas to change the situation	Optional
*Planning team should develop consistent support/learning strategies to assist supporters in teaching skills (e.g., <i>developing relationships, finding a job, learning to cook, learning to budget money, etc.</i>). It is optional to include these in the plan but should be available at site of service delivery.	

12. Changing/Updating the Individual Service Plan (addendum/amendment): Reviews /updates need to occur through discussions/dialogues with the people and their circles of support, not just a review of their plan. Plans must be reviewed (and updated if necessary) on at least a quarterly basis. Review

and update of the plan must also occur when the person or the person's guardian requests that information be changed or added and/or when the need for supports and services change; significant changes always require dated signatures whereas informational changes do not. The plan should change as the person changes.

Note: Entities that provide service coordination for persons served by the Division must, at a minimum, follow required components of plans as identified in this directive.

III. Individual Service Plan Review (applies to TCM entities and Habilitation Centers)

1. Quarterly review of progress: All plans for consumers receiving purchased services will be reviewed quarterly by the assigned Service Coordinator.
2. Monitoring of plans (selected sample): Designated Targeted Case Management (TCM) and Habilitation Center staff who have received training in and have knowledge of the individual service plan required components shall monitor selected plans, including subsequent amendments, and all documentation of monthly progress for the past 12 months. The review is designed to be conducted on a sample of waiver participants and to ensure adherence to CMS waiver and Division of DD requirements. The review will include plans for all current Lopez, and Autism, and a statistically valid random sample of Comprehensive, Community Support and Prevention Waivers. Quarterly, the Division of DD Quality Enhancement Unit will provide a list of randomly selected consumers from the each of the waivers. As part of the Habilitation Center Quality Enhancement fidelity review procedures, a sample of non-waiver reviews is completed.
 - i. [Plan Review Form](#) - Hab Center
 - ii. [Plan Review Form](#) - Community
 - iii. [Level of Care Form | Instructions](#)
3. Reviews are entered into the Personal Plan Review database. Waiver review findings and remediation are entered into APTS.
 - i. TCM Entity database: <https://survey.dmh.missouri.gov/Survey.aspx?s=79919493f1714220bf19ed3d0015d202>
 - ii. APTS (Hab Center and Regional Office): <http://apts.dmh.state.mo.us/>
4. Trends are reviewed in each region.
5. If a plan does not meet criteria set forth in the required components, the reviewer shall share the appropriate information with a member of the planning team as well as document the follow up. The planning team shall be convened to discuss mandatory component(s) that were found to be absent from the ISP and to revise the plan so it is compliant.
6. If either of the above processes reveals a lack of meaningful progress (e.g., no progress, progress not related to the outcome, extreme length of time to complete strategies, same plan year after year) or maintenance of the current functioning level, this information shall be shared with appropriate members of the planning team for revision of the plan.

A. Implementation Review

1. Service Monitoring is completed to ensure the plan is being implemented as written.
2. Findings are entered into the APTS database.
 - a. Trends will be reviewed in each region/Hab Center and follow up on any issues will be completed.
 - b. The Division of DD State Quality Enhancement Unit will provide reports to Mo HealthNet as required in the waiver applications.

- #### **B. The Division of DD State Quality Enhancement Unit or designee will analyze the data and review statewide trends. Guidelines, as well as processes, will be reviewed and revisions may be recommended. Training and/or policy changes will be targeted to address issues and trends, locally or statewide as appropriate.**

Authority:

9 CSR 45-3.010: Individualized Habilitation Plan Procedures <http://www.sos.mo.gov/adrules/csr/current/9csr/9c45-3.pdf>

DD Services Catalog <http://dmhonline/admin/contracts/DDAttachmentB-ServiceDefintions-4-1-10.pdf>

RSMO 633.110 <http://www.moga.mo.gov/statutes/c600-699/6330000110.htm>

Technical Assistance Manual for Regional Offices, County Senate Bill 40 Boards, and Other Not-for-Profit Agencies