



Division Directive Number
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Title: Discharge Planning Process – State Operated Programs

Application: Regional Office, Senate Bill 40 Boards, and Other Not-for-Profit TCM agencies State Operated Waiver Programs and Habilitation Center Campuses

Purpose: This policy outlines procedures and documentation requirements for State Operated Programs (SOPs), Senate Bill 40 Boards, Regional Office and Other Not-for-Profit TCM agency staff concerning persons who discharge from SOPs.

Definitions:

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

Interdisciplinary Team or Team: Those individuals (professionals, paraprofessionals, guardians, and/or family members) who know the individual well and who possess the knowledge, skills, and expertise necessary to accurately identify a comprehensive array of the individual’s needs and design a program which is responsive to those needs (Individual Support Planning Guidelines and Federal Standards ICF-MR W201 483.440(b)(4)(i), W202 483.440(b)(4)(ii), W203 483.440(b)(5)(i), W204 483.440(b)(5)(i), and W205 483.440(b)(5)(ii)). This includes all appropriate facility staff who know the individual, as well as staff from other agencies who serve the individual, or will serve the individual when discharged, the Regional Office, the individual, and legally responsible party (guardian) or other advocates chosen by the guardian or individual.

Individual Support 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 support planning process enables and assists the individual to access a personalized mix of paid and non-paid supports that will assist them to achieve personally defined outcomes and the training, supports, therapies, treatments, and/or other supports that become part of the plan. *Note: The Individual Support Plan may be referred to as Person Centered Plan or PCP at the Habilitation Center Campuses.*

Individual Support Plan/Transition Plan Document (SOPs): For individuals currently residing in a state operated program, the transition plan is the last portion of their Individual Support Plan, with a consent letter for those guardians who have already given consent for community placement, and a consent letter for those guardians who have not consented to transition into community placement.

DISCHARGE PLANNING PROCESS

1. The person and/or guardian shall be notified prior to the time of all meetings of their right to invite an advocate of their choice. Assessment or planning meetings shall be scheduled to accommodate the person, his/her guardian, and/or other advocate of choice, including evenings and weekends if needed. Individuals and/or guardians may request a meeting at any time, or to meet with Regional Office representatives at any time.
2. For all persons currently residing in a state operated program, as part of the regularly scheduled review and planning meetings held at least quarterly, the SOP interdisciplinary team shall review and assess the supports necessary for the person to live in a less restrictive setting based upon the individual's identified needs. The individual/family/guardian may register support or any objections to movement to the community. If permission to implement a placement plan is refused, SOP staff shall note this as part of the Individual Support Plan/Transition Plan document. In addition, a letter is also sent by the SOP to the parent/guardian for their acceptance or refusal of the ISP/Transition Plan; when the letter is returned, it is filed in the individual's record.
3. If permission is obtained, the appropriate Transition Coordinator/TCM Entity shall be notified and provided the individual's ISP/Transition Plan document. The individual's referral information will be submitted to providers in the geographical area identified by the individual or their guardian through the DD Consumer Referral System. The process described in Division Directive 4.270 for choosing a provider and transitioning the individual to the community will be followed. The Transition Coordinator/TCM Entity shall ensure a final Transition Plan is developed by the individual's interdisciplinary team which includes necessary information from the SOP ISP/Transition Plan document, prior to the discharge of the individual from the SOP.

The Transition Plan will contain the following documentation as appropriate:

- Specialized services, supports, accommodations, etc. required in order for the person to live in the community
 - Action plan that includes timelines for overcoming the barriers with responsible parties assigned
 - All follow-up meetings with dates, times and locations
 - Provider acceptance
 - Documentation that the person requires the ICF/MR level of care
 - Parent/guardians support or objections to community options
 - Medicaid eligibility status
 - Geographic area preference for community option
 - Social unit of more than one individual
 - Team review date
4. SOP interdisciplinary teams will continue meeting on a quarterly basis, or sooner, to review progress on developing the specialized services, supports, accommodations, etc. the individual requires for living in the community.
 5. SOP Superintendents are responsible for ensuring the following:
 - Ongoing education and opportunities for staff, families, and individuals living in a state operated program to learn about options available in the community including supported living, employment

services, Self-Directed supports, etc. (for example, could be a presentation at a staff and/or parent meeting by a Community Provider or a Regional Office Self-Directed Supports Coordinator).

- Interdisciplinary teams identify supports needed for community living for each individual living in a state operated program.
 - Each individual/family/guardian has the opportunity to make an informed choice regarding receiving services in the community on at least an annual basis.
 - The SOP ISP/Transition Plan documents the decision for all SOP residents regarding moving to the community.
6. Reviews will occur monthly for all people moved from a State Operated Program to a State Operated Waiver Program, documented in the person's file and attested to by the signature of the Support Coordinator involved. Regional Office review will be as outlined in the Individual Support Plan.
7. When multiple service options are available to meet a person's needs, health and safety are the primary considerations. Choice, cost, utilization review, quality and capacity shall also be taken into consideration.

Authority

Division Directive [3.020 - Service Monitoring](#)

Division Directive **4.060 -Individual Service Plan Guidelines, Training and Reviews**

Division Directive 4.270-Community Transition Process [4.270 Community Transition Process](#)

Federal Standards ICF-MR W201 483.440(b)(4)(i), W202 483.440(b)(4)(ii), W203 483.440(b)(5)(i), W204 483.440(b)(5)(i), and W205 483.440(b)(5)(ii)

Missouri Person Centered Planning Guidelines [PCP Guidelines](#)