Policy Number:
1
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Subject: Person-Centered Planning

PURPOSE:

Camden County Developmental Disability Resources (CCDDR) shall implement a policy for person-centered planning.

POLICY:

It is CCDDR's policy to develop an Individual Support Plan for each client who receives Support Coordination services from CCDDR. Planning is a client/family-directed and person-centered process. Such plans shall be modified and updated, depending on the client's needs and preferences. Services authorized in all Individual Support Plans that are funded through the Department of Mental Health (DMH) billing system, including all Medicaid waiver plans, shall comply with Division of Developmental Disabilities (DDD) Service Monitoring guidelines.

DEFINITIONS:

DDD Individual Support Plan Guidelines: The DDD Individual Support Plan Guidelines describes requirements of Individual Support Plans, as well as information for maintaining and updating Individual Support Plans.

Missouri Quality Outcomes: Positive outcomes are developed to emphasize the quality of life for individuals receiving services through The DDD *Missouri Quality Outcomes: A Guide for Individuals and Families.* The *Guide* document serves as a tool designed to assist the user in discussions around important life areas and interests of the individual being supported that define quality of life. The Missouri Quality Outcomes can be found at https://dmh.mo.gov/media/pdf/missouri-quality-outcomes-guide-individuals-and-families.

Individual Support Plan: A document resulting from a process directed by the client served, with assistance as needed by a representative. It is intended to identify strengths, capacities, preferences, needs and desired outcomes of the participant. The process may include other individuals freely chosen by the client who are able to serve as contributors to the process. The person-centered planning process enables and assists the client to access a personalized mix of paid and unpaid services and supports that will assist them in achieving personally defined outcomes and goals.

I. Missouri Quality Outcomes

All plans developed by CCDDR Support Coordination staff shall be in accordance with the DDD's Quality Outcomes. There are fundamental values that form the foundation of the Outcomes, and these should be considered throughout the planning process.

II. Support Planning Process

A. Individual Support Plans:

The Support Coordinator, in conjunction with the client, family members, the client's legal representative (if applicable), and other team members shall hold a meeting to develop an Individual Support Plan within thirty (30) days of the individual being found eligible for services through the DDD. The plan must contain a description of immediate needs, especially needs relating to issues of health and safety. The plan must include information clearly identifiable to staff and others how to support the client and to ensure a client's immediate needs are met, especially needs relating to health and safety. The Support Coordinator ensures each item in the plan has enough detail and/or examples where someone new in the client's life can quickly understand what is meant and how to support the client.

B. Plan Components:

All Individual Support Plans developed by CCDDR Support Coordination staff shall contain at least the minimum information required to comply with the DDD's approved format. Accordingly, all Individual Support Plans developed by CCDDR Support Coordinators shall define desirable changes in the client's life and create personal outcomes and goals in six life areas as discussed by the client's support team. The six life areas are as follows:

- Daily Life
- Community Living
- Social Spirituality
- Healthy Living
- Safety & Security
- Citizenship & Advocacy

III. Updating Plans

Individual Support Plans are expected to change and develop over time as the CCDDR Support Coordinators and others get to know the client well and by spending time with the client in a variety of situations and environments. Plans must be reviewed (and updated if necessary) on a monthly or quarterly basis. However, review and update of the plan must also occur when:

- The client or the client's guardian requests that information be changed or added

- Others invited by the client to participate in the client's planning process provide additional information
- The need for supports and services change, i.e. the client's level of functioning may change requiring either a reduction or increase in services; the client's natural support system may expand, reducing the need for a paid service; or staff discovers another agency that will provide additional resources to the person
- Contact information has changed

When the CCDDR Support Coordinator makes major changes to a plan, the client supported and/or their guardian must be aware of and approve any changes made. Documenting this approval requires the signature of the client or guardian on the Personal Plan Authorization and Funding document. Major changes to a Plan include the following:

- Adding or changing a service. (e.g. client begins receiving respite, client moves to a group home, etc.)
- Proposing to restrict the client's rights
- Taking any other type of adverse action (e.g. canceling a service, termination from the waiver, etc.)
- Adding an outcome or goal

Minor changes (information only) may be made to a plan without prior consent/approval of the client or their guardian.

IV. Plans and Waiver Documentation

The CCDDR Support Coordinator shall ensure that information in the plan is consistent with and does not contradict information in other Medicaid waiver documentation. When developing a plan including waivered services, the CCDDR Support Coordinator shall consider what supports are needed in the areas covered by the Level of Care information from the most Missouri Adaptive Ability Scale Assessment (MAAS). The MAAS will identify adaptive functioning skills in life areas where a client might require support. These areas will be addressed in the client's plan.

V. Plan Monitoring/Reviews

The CCDDR Support Coordinator, in conjunction with the other team members, shall review every Individual Support Plan at least annually. The Health Risk Screening Tool (HRST) must be completed for all clients receiving Waiver residential support services (i.e. Individualized Supported Living, Group Home, Companion Home, and Host Home services). A HRST must also be completed for all other clients receiving Waiver services unless a client/guardian opts out of the HRST. Quarterly Reviews shall be completed for all clients, and Monthly Reviews shall be completed for clients receiving Waiver residential support services. The Quarterly/Monthly Reviews shall provide an overview of progress made toward plan outcomes and goals, recommendations for changes to plan,

Support Coordinator contacts, Service Monitoring notes, and other pertinent information relating to the client.

VI. Authorization of Services

All services to be paid by the DDD and/or CCDDR must be documented in a client's annual Individual Support Plan or amended Individual Support Plan before the services are authorized, delivered, and/or purchased.

VIII. Quality Assurance

The DDD's Targeted Case Management Technical Assistance Coordinator or other designee will evaluate a sample of plans from CCDDR on a quarterly and annual basis to ensure that the mandatory components of the Missouri Individual Support Plan Guidelines are implemented.

REFERENCES:

- CARF Standards Manual
- Missouri Individual Support Plan Guidelines
- Developmental Disabilities Waiver Program Manual
- RSMo 633.110
- Missouri Quality Outcomes: A Guide for Individuals and Families
- 9 CSR 45-3.010
- RSMo 630.655
- DDD Directive 3.020
- DDD Directive 4.060