

**STATE OF CONNECTICUT
DEPARTMENT OF DEVELOPMENTAL SERVICES**

Procedure No. I.C.1.PR.002.a

Subject: Components of an Individual Plan

Section: Services and Support, Case Management/Broker Services

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Effective Date: Upon release

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Revised: September 1, 2008

A. Purpose

The purpose of the procedure is to develop a consistent approach for the implementation of the Individual Planning Policy as it relates to individuals receiving supports and services from the department.

B. Applicability

This procedure shall apply to all individuals eligible to receive supports and services from the department who meet the requirements for the development of an Individual Plan.

This procedure shall apply to case managers, support brokers, private agency designees and all other DDS staff responsible for individual plan development and implementation.

C. Definitions

See Case Management Definitions at the beginning of this section.

D. Implementation

The individual planning process shall consist of the following components: preparing for the planning meeting, gathering a good understanding of the individual, developing an action plan to achieve desired outcomes, summarizing the plan of supports and services, identifying additional supports to assist the individual, addressing eligibility for Medicaid and for a Home and Community Based Services (HCBS) Waiver, documenting the plan, obtaining agreements and approvals with the plan, putting the plan into action, and monitoring and revising the plan as needed.

1. Prepare for the Planning Meeting

Prior to the meeting, the case manager or another team member should gather information from the person and his or her family to begin to update or develop the Information Profile, Personal Profile, and Future Vision. The case manager may provide a copy of "My Health and Safety Screening" to the individual or his or her family so they may identify health and safety concerns they want to be sure are addressed in the plan. Before the planning meeting, the case manager shall update the Level of Need Assessment and Screening Tool (LON) with input from the individual, the family, and providers and with information from the master file.

Individuals who are interested in self-directing their supports should be made aware of the opportunity to hire an independent support broker to assist with planning. If selected, the independent support broker would become a member of the person's planning and support team.

Providers of supports and services should share six month individual progress reviews with all team members and should share current assessments, reports, evaluations with the case manager at least 14 days prior to the scheduled meeting. The case manager should share the updated Level of Need Assessment and Screening Tool (LON) and the LON Summary Report with team members prior to the scheduled meeting and ensure all providers have copies of relevant assessments, reports, and evaluations. The case manager or another team member should provide an opportunity for the person

and his or her family to review the information in current assessments, reports, and evaluations that will be discussed at the meeting.

2. Gather a Good Understanding of the Individual

During the planning meeting, the individual and his or her planning and support team will complete a profile or assessment of the person's current life situation and future vision. The team should update and complete the information profile, personal profile, and future vision, and should review current assessments, screenings, reports, progress reviews and evaluations to identify important information to include in the plan and identify any additional assessments or evaluations that are needed. The team should review the LON and the LON Summary Report which identifies areas where the individual is likely to need support and areas where the person is likely to have the potential for risk. The planning and support team will review all aspects of a person's life such as significant past events, accomplishments and strengths, relationships, current home, work, day, retirement, or school situations, leisure interests and community life, health and wellness, and finances. The team will complete an assessment and analysis of the person's preferences, satisfaction with services, desired outcomes, and support needs.

The Planning and Support Team shall complete the Aquatic Activity Screening form annually at the time of the annual Individual Plan. The Aquatic screening shall be filed as an addendum to the plan. All staff whom provide supports to the individual shall refer to the individual's Aquatic Activity Screening to ensure safe participation and supervision in aquatic activities, including activities proximal to water.

3. Develop an Action Plan to Achieve Desired Outcomes

Based on the individual's preferences, desired outcomes, and support needs, the individual and his or her planning and support team will develop an action plan to assist the individual to move toward his or her desired outcomes. The action plan should include the person's desired outcomes, needs or issues to be addressed, actions and steps, responsible person(s), and timeframes. During the development of the action plan, the team should consider the individual's choices and preferences. When areas are identified in the LON Summary Report as having the potential for risk, they must be addressed in the person's Individual Plan. The action plan should reference any teaching strategies, programs, protocols, guidelines, or treatment plans that will be developed and/or implemented to assist the individual to achieve desired outcomes.

When an individual plan identifies the use of behavior modifying medication or aversive programming, PRC (Programmatic Review Committee) and/or HRC (Human Rights Committee) policies and procedures must be followed, unless there is a valid waiver from such review in accordance with applicable policies and procedures.

4. Summarize the Plan of Supports and Services

The case manager should ensure that the individual and his or her family or guardian have sufficient information available to make informed selections of support providers, and information to make informed decisions regarding the degree to which the individual and his or her family or guardian may wish to self-direct supports and services.

The planning and support team shall summarize the supports to be provided to address needs including DDS HCBS waiver and state funded supports, Medicaid state plan services, generic resources and natural supports provided. The team shall identify the specific agencies and/or individuals that will provide the supports and services identified in the Action Plan. The planning and support team shall include the amount of services to be provided and the planned frequency.

The team shall also identify and document in the plan the planned amount and extent of case management services and contact the individual will receive. To be enrolled in a waiver, it must be determined and documented in the plan that the person requires at least one waiver service and requires waiver services at least monthly, or, if less frequently, requires monthly monitoring by the case manager to assure health and welfare. The need for monthly monitoring by the case manager should be documented in the plan and monthly case notes should be completed for those individuals enrolled in the waiver who do not receive at least monthly waiver services.

5. Identify Additional Supports Needed to Assist the Individual

The case manager and planning and support team should identify any additional and specific qualifications or training that an employee must have to support the individual to achieve the specific outcomes and strategies in the plan. For individuals who receive waiver services in their own or family home or other settings where staff might not be continuously available, the team should also describe a backup plan to address contingencies such as emergencies, including the failure of an employee to appear when scheduled to provide necessary services when the absence of the service presents a risk to the individuals health and welfare. The team must describe the specific protocols to follow in the event that these needed supports and services are not available.

During the planning meeting, the case manager and team should review the person's ability to make important decisions and possible need for a guardian/advocate/legal or personal representative. They should also describe the person's participation in the planning process and planned efforts to enhance the person's future participation in planning, as well as the team's efforts to involve the person's family, guardian, advocate, or legal or personal representative in the planning process. The team should also discuss plans to ensure that implementation of the Individual Plan will be evaluated and monitored as needed.

6. Address HCBS Waiver Eligibility

On an annual basis, during the Individual Planning process, the case manager and the planning and support team should complete a Level of Care Re-determination for continued waiver eligibility. The Level of Care re-determination must be completed no more than 365 days from the previous Level of Care determination.

7. Document the Individual Plan and Obtain Agreements and Approvals

The case manager shall ensure that the individual plan is documented on the form(s) designated by the department. At the time of the meeting the case manager shall ensure that the person's Information Profile, IP.1, is updated and shall ensure updated information is documented in the master file and/or automated data system as appropriate.

At the end of the meeting, the case manager will document who participated in the planning process and obtain signatures on the Signature Sheet, IP.11. The individual, parent, guardian or advocate, should contact the case manager within two weeks of receipt of the written plan if they do not agree with the plan as written.

New individual plans with individual budgets that are within the amount allocated by the regional Planning and Resource Allocation Team (PRAT) may be considered approved by the department once the individual budget is reviewed and approved by the case management supervisor and Resource Management. Renewed individual budgets that do not include a change in services and are within the amount allocated by the regional PRAT have a streamlined approval process. Actual services must be authorized by Resources Management in line with renewal procedures.

8. Put the Plan Into Action

Supports and services are expected to be implemented within 60 days of plan development, 30 days in licensed settings, and should be provided as described in the Individual Plan.

9. Monitor and Revise the Plan as Needed

The individual and his or her planning and support team will identify the nature and minimum frequency of plan reviews to monitor progress and to evaluate whether the supports are helping the person to reach desired outcomes. At a minimum, the team shall meet to review and update the individual plan annually, when there are any significant changes in the individual's life situation requiring a change in the plan, or more frequently as required by state or federal regulations.

On a six month basis at a minimum, service providers should submit specific individual progress reviews to the case manager and other team members detailing progress on specific personal outcomes and actions for which they are responsible. Case managers should review the individual progress reviews completed by support providers to assess if desired outcomes are being addressed by support providers, and should sign and date the reviews and file them in the Master File.

Staff hired directly by the individual or family to provide support will document the individual's progress on specific goals. The support broker or case manager should review this documentation to assess if desired outcomes are being addressed by self-directed support staff.

The case manager will monitor progress on plan goals on an ongoing basis through review of individual progress reviews, contacts, site visits, Quality Service Reviews (QSRs), and, if applicable, self-directed service documentation. The case manager's ongoing review will include the following:

- Determination that needed supports and services in the Individual Plan have been provided
- Review implementation of strategies, guidelines, and action plans to ensure specific needs, preferences and desired outcomes are being addressed.
- Review of the individual's progress and accomplishments
- Review of the individual's satisfaction with supports and providers
- Identification of any changes in the individual's needs, preferences and desired outcomes
- Identification of the need to change the amount or type of supports and services
- Identification of the need to revise and update the individual's plan of services.

The case manager may convene a team meeting at any time to update the plan. The team shall be convened when:

- The individual, family or guardian requests a meeting, for example to plan a different outcome, new service, or different provider
- The person's needs change resulting in an increase or decrease in services
- One or more new service is added or discontinued
- There is a change in a service provider.

The individual plan should be updated and revised within 90 days when an individual receives new residential or day supports and services or experiences a major change in one or both of these services. The individual plan should accurately reflect the individual's current life situation and address their specific supports and services. Individuals who live in licensed settings must have their plans updated within 45 days of a change in services, and individuals in ICF/MR settings must have their individual plans updated within 30 days of a change.

E. References

1. Individual Planning Policy
2. Planning and Support Team Procedure
3. Individual Progress Review form
4. Aquatic Activity Screening
5. Human Rights Committee Procedure
6. Program Review Committee Procedure
7. Programmatic Administrative Review Procedure
8. Risk Management Procedure

F. Attachments

Attachment A: Individual Plan

Attachment B: Individual Plan Short Form

Attachment C: Aquatic Activity Screening

Attachment D: Individual Progress Review Form