ND Developmental Disabilities Section- Overall Service Plan Instructions

Revised
Revisions are indicated in RED

Provides a description of the OSP process in the web-based application; concepts of the OSP; terminology; timelines; different types of OSPs, and roles and responsibilities of Program Coordination and DD Program Management in the development of the OSP.

Introduction to the OSP Updates

- Updated the requirements for goals with the service plan type of Annual no-pcsp (pg. 90).
  - *Please note, this plan type is completed by the DDPM and is not used for services provided by DD licensed providers.*
- Added new instructions for documenting the use of Virtual Supports (pg. 60).
  - Updated to include the Virtual Supports Checklist (SFN 1522) to the attachment section of the OSP.
  - Added Virtual Supports to the Appendix OSP Sample Checklist (pg. 119)

Overall Service Plan (OSP)

Table of Contents

ND Person-Centered Planning Definition

Every person should have the opportunity to define **their happiness** and the life they desire. A person's life is realized when family, friends, community members, and service providers **actively listen** to what matters to a person, by **respecting** and honoring their values, strengths, culture, hopes, and dreams. Person-Centered Practices occur through the development and implementation of services and supports that are **informed** by a person's preferences, strengths, and choices.

Emphasize Person First, with Customized Supports and Services

Focus on the Person's Strengths

Balance Choice and Risk

Meet the Person Where They Are

Regularly Review Goals

Build Equity of Voice

Equip the Person to Make Informed Decisions

Be Kind

ND Person-Centered Planning Guiding Principles

Emphasize Person First, with Customized Supports and Services – The person directs their plan and is at the center of the planning process, rather than the conditions/diagnosis, agency, or system. The person's desires and experiences should be heard, honored, prioritized, and reflected in the services received. People who are important in the person's life should be part of the planning process, helping to ensure the person's vision for their life is realized.

Focus on the Person's Strengths – Recognize the individual's positive attributes and what they can or hope to do. Listen to the person and those who know them well, to understand their talents, unique skills, gifts, competencies, and sources of pride. Utilize and build upon the person's strengths to support them in realizing their desires and to develop/enrich life-long skills.

Balance Choice and Risk – Show dignity and respect by identifying what is important to and for the person. What's important to the person is usually related to comfort, happiness, contentment, satisfaction, and often revolves around what is critical to maintain the individual's health and safety. People have the right to take risks which are essential for dignity and self-esteem, to learn from mistakes, and grow through these learning opportunities.

Meet the Person Where They Are – Seek to understand the person's values, beliefs, culture, and community to foster appreciation and respect for how the individual feels, works, and lives their life. This includes acknowledging how a person's past experiences impact their life today. To ensure a person's vision for their life is realized, listen to their story with humility. Humility—which is about personal reflection and being open to and thoughtful about other peoples' experiences—should be shared by everyone participating in the service process, including those receiving and providing services or supports. Many cultures see health, well-being, and community as one in the same. Respect and compassion for all people as valued community members are integral to success of the whole. Acknowledge cultural similarities and embrace the differences, but do not impose beliefs and values on others.

Regularly Review Goals – Recognize that desires and needs evolve over time and may change. Take the time to review the person's life goals to ensure that supports and services are designed to help realize the person's vision for their life is imperative. Supports and services should be flexible, and any changes/updates made timely.

Build Equity of Voice – Empower the person to actively participate and make decisions that are consistent with their goals and values and support the individual's voice. Create equity in engagement by reaching out to people who may not traditionally be engaged in self- and system-advocacy, and make sure underrepresented groups feel welcome and supported to engage.

Equip the Person to Make Informed Decisions – Clearly explain what options, education, and choices may be available to the person. Ensure that the person understands the options and has all necessary information, including potential benefits and consequences, to make informed decisions.

Be Kind – Take the time to show genuine care, concern, and compassion. This builds trust and ensures that quality services and supports are being

Overall Service Plan (OSP)

Section I: Overview

Introduction

The Overall Service Plan (OSP) is the individual service planning process in North Dakota for individuals with intellectual disabilities and related conditions. The OSP concept was introduced when the State implemented the Therap computer web-based application in 2012 that combined the State's eligibility determination, service authorization and planning process with the person-centered service planning process entered by private DD licensed providers into one shared plan.

The Overall Service Plan (OSP) types are located on the Provider Side in Therap DDD-ND in the Overall Service Plan module.

The types of OSPs are: Initial, Admission, 30 Day Comprehensive, Annual, OSP Update, Annual no PCSP, and Annual no PCSP Update. These types will be described in their respective sections.

What does the OSP contain?

The OSP consists of two (2) sections:

1. **State Individual Service Plan (ISP)** which is the pre-authorization of payment for DD Medicaid Waiver and State Plan Services. The ISP is completed by the DD Program Manager, a representative of the State Medicaid agency. This section can only be edited and entered by the DDPM.

   The ISP lists Title XIX Medicaid funded services that will be provided to the person including the amount, type, frequency, service provider, funding source, and start/end dates. It also lists the generic non-Medicaid funded services the person is receiving.

   The ISP is the document that authorizes Medicaid payment for DD Title XIX services in the Medicaid payment system. An ISP must be completed in order for payment to be made.

2. **Person Centered Service Plan (PCSP)** is the portion of the OSP which is entered by the primary program coordinator employed by a provider of licensed DD services. The PCSP describes the person's preferences, identified risks and mitigation strategies to manage those risks, and goals and learning and support objectives that will assist the person in achieving their desired outcomes and assure

health and safety. The PCSP is individualized based on the person's unique needs, interests and aspirations. It also addresses the person's healthcare status, benefits and safeguards.

The PCSP is developed at the team meeting by the team, including the person, legal decision maker, DDPM, provider, and other members. The provider, whom acts in a clerical manner, enters the plan as it was developed during the team meeting.

The OSP is approved by the DD Program Manager as a representative of the State in order for authorized services on the ISP to be submitted to the Medicaid payment system for reimbursement. The DDPM is responsible to review the OSP to ensure that the plan has been developed as discussed in the team meeting and in accordance with applicable policies and procedures. Only OSP's that meet the requirements will be approved. Approved OSPs cannot be edited. If any change is to be made, a new OSP must be created and the DDPM must approve the revisions.

The Person-Centered Service Plan (PCSP) section of the OSP will be completed in Therap in the OSP module for people receiving the following services:

- *ICF/IID community group home*
- *Residential Habilitation*
- *Independent Habilitation*
- Day Habilitation (includes Day Habilitation in combination with any other services)
- Prevocational Services
- Small Group Employment Support
- Individual Employment Support
- In Home Supports (provider managed and self-directed)
- Family Care Option
- Parenting Supports
- Extended Home Health Care (provider managed and other non-DD licensed providers)
- People screened to the Medically Fragile Waiver

The IFSP/ISP will be used for:

- Children under the age of 3
- DDPM's are the service coordinators who assist in the access, coordination, and facilitation of early intervention services.
- If a child under age 3 does not receive Infant Development services or ICF/IID services, the DDPM is responsible for the development of the IFSP.
- Most current ISP will be attached.
- Intermittent Risk Assessment SFN 866 sfn00866.pdf (nd.gov).
- Self-Assessment not applicable

**Refer to Appendix "Transition Between OSP/PCSP/IFSP" for when people transition between the plan formats in Therap, based on the services and waivers they choose and their age.*

Legal Reference/Authority

The legal references and authority for the service plans for persons receiving services for individuals with intellectual and developmental disabilities are as follows:

- 42 CFR 441.301 (b)(1)(i) Medicaid Waivers 1915(c) (CMS HCBS Final Rule)
- 42 CFR 483.440 – ICF/IID
- North Dakota Century Code 25-01.2-14. Individualized habilitation or education plan – Contents
- North Dakota Administrative Code (N.D.A.C) 75-04-01 and 75-04-02.
- 42 CRF 441.301(c)(1)(i-ix) Medicaid Waivers 1915(c) Person Centered Planning Process
- 42 CFR 441.301(c)(2)(i-xiii) Medicaid Waivers 1915(c) The Person-Centered Service Plan

Monitoring and Compliance

OSP requirements are monitored through the Department of Health and Human Services, DD Section. The Case File Review process will be completed on a quarterly basis so trends can be identified, errors corrected, and proactive steps can be taken. Ongoing, data will be reviewed and analyzed for quality assurance purposes, system performance, and Waiver Program Measure reporting to CMS.

Case File Review will evaluate the following areas:

- Timelines
- OSP updates being completed based on changing needs

- Correct service amount, frequency, and funding used
- ISP signatures
- Per the OSP Instructions, the OSP addresses the persons risks, reflects strengths/preferences, reflects support needs, persons desired goals, emergency back up plans, right restrictions, and choice in setting.

When an OSP timeline is not met, the DD Program Manager must document the reason(s) and any efforts by the DDPM to meet the timeline e.g., reminder, contacts with the assigned program coordinator.

- This information will be documented by the DD Program Manager in the "**DDPM final review and discussion" section of the OSP on the provider side.**
- If documentation indicates that the OSP timeline is not met because the provider did not meet their timelines or due to a legitimate extenuating circumstance, the DD Program Manager will not receive a citation. However, if documentation is missing or the plan is late without a legitimate reason, the DD Program Manager will receive a citation.

If errors are discovered within the Case File Review, the DD Program Manager will receive a citation and will be required to submit remediation to come into compliance. The DD Program Manager will collaborate with the provider on remediation activities. If providers did not fulfill their responsibility, it will be addressed within the context of quality assurance and licensing of the DD licensed provider responsible for program coordination and development of the OSP/PCSP section.

At the regional level:

- Provider agency designees should notify the Regional DD Program Administrator if there are questions or concerns related to the roles, requirements or timelines of the DDPM.

- The Regional DD Program Administrator should notify the Provider agency designees if there are questions or concerns related to the roles, requirements or timelines of the Program Coordinator/agency.

If issues cannot be resolved at the regional level, the DD Section shall be contacted.

Section II: Principles and Values of the OSP Process

The OSP is a Person-Centered Plan.

People in Medicaid HCBS programs under section 1915(c) must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The format of the OSP may be standardized but the content of the plan is *individualized* for each person.

The planning process and plan should put the person in front and center, not the system. Person-centered planning encompasses the idea that the person is at the heart of all decisions about services and supports and lead the planning process where possible. The focus should be the goals, wants, needs, and strengths of the person. Plans should not only capture and reflect the true nature of agency services, but also the story of the person's life and the spirit of the person. The planning process and plan should discover and describe what is important to a person in everyday life and what others need to know and do. What is important to each person is reflected while any issues of health and safety are also addressed.

The plan reflects the services and supports that are important for the person to meet the needs identified through assessments, as well as what is important to the person regarding their preferences and priorities. This planning process and the OSP will assist people in achieving personally defined outcomes and community integration, ensuring delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare.

The individual self-assessment is required and should drive the planning process. The written plan should clearly address the person's preferences, dreams, non-negotiables and personal goals as captured in the Self-Assessment. Although the CQL personal outcome measures can be used as a guide to stimulate discussion on individual outcomes and goals, the self-assessment and plan will reflect *individual outcomes that are unique and specific to the person.*

The risk assessment is a vital component of the overall service planning process, but it should **contribute** to the planning process, **not overshadow** it. The presence of risks does not mean that the person should not live in the community or that the person should not have decision making authority over their services. The identification of risks and development of strategies to mitigate such risks are integral to enabling people to live as they choose in the community while trying to assure their health and welfare.

***The OSP should contain information so anyone, even someone unfamiliar with the person, can review the plan and implement it to assure that basic health and welfare for the person and assistance is provided in accordance with the person's preferences. This also includes entering the plan with no professional jargon and in language that is meaningful and easy to understand.**

Plain Language
Plain language is written or verbal communication that considers the person's age, profession, education, and skills, and uses language that is easy to read, understand, and use.

Tips
- Use simple words and phrases
- Use everyday words
- Use pictures
- Avoid jargon, legal, and technical terms
- Avoid abbreviations
- Organize the content so that it flows logically

Life-Long Learning Concept

There is not a set formula for the number of learning or support objectives for each person that should be included in their person-centered service plan. The purpose of the plan is to assist the person in identifying what could be better for this person and how the team will support him/her to improve their quality of life. It is expected that services in the DD service delivery system promote community inclusion, self-sufficiency and natural supports. One of the main goals is to provide people with the opportunity to learn throughout their life span so they can become as independent as they can be and experience satisfaction and fulfillment.

The assessment process should help the person and the teams identify the person's Overall Goals. Most people will have Overall Goals in the areas of living, working (daytime hours if the person is retired), and leisure/recreation. In some cases, the assessment process might tell the team that the person's biggest priority is to explore some options in these major life areas (i.e. explore new recreation options, learn about jobs, or volunteer opportunities in an area that they have shown some interest etc.)

A foundation value of person-centered services is that attaining Overall Goals is a combination of learning new things (learning objectives) and supports (support objectives). Not having a skill should not limit the person's access or dreams – that is when supports are provided. But the

team should also address strategies to support the person in learning new skills that will lead to increasing their independence and ability to lead a self-directed life. With rare exception (i.e. a person with dementia) the person's plan will include a combination of learning objectives and support objectives that are designed to systematically assist the person in attaining these Overall Goals.

Since services are provided for this reason, each authorized DD licensed service program will have goals associated with the service listed in the PCSP section of the OSP.

The OSP is a Dynamic and Ongoing Process

Each person who receives services from DD licensed providers will have a single plan including those who receive services from multiple DD licensed service providers. **It is important to note that the person's plan and the record belong to them. Providers of services and supports, as well as the DDPM's, assist in the development of the plan and access the record for documentation and monitoring purposes to support the person.**

The DD Program Manager enters the ISP section of the plan which must address all services the person is receiving and include Medicaid and non-Medicaid funded services along with informal supports that are necessary. The ISP section also lists the rights and responsibilities of the person receiving services. The DD Provider has the responsibility to enter the PCSP, which documents the process and detail of the services and supports provided by the agency(s) involved.

Federal regulations require that an OSP for waiver and ICF/IID services be developed prior to the start of services, reviewed at least annually and updated whenever the person's needs change**.** A person and/or their legal decision makers may also request verbally, or in writing, to their DDPM or Program Coordinator for an update to the plan as needed. Refer to the OSP update section for the process.

The **"Active"** OSP is the current working plan and the plan that is being implemented. Therap is designed so that when the plan is "Active" it cannot be edited. If changes occur for the person that warrant revisions to the plan between annual reviews, the current Active OSP will be copied forward so that changes can be made within the new document. The plan will then be reviewed (the information from the previous plan can be retained in the new

plan if it is still accurate or old information deleted) and the new information added to the appropriate section of the OSP.

Every OSP must be submitted to the DDPM for review and approval.

All OSPs are maintained for historical purposes and can be accessed for review. Tracking of OSP changes and historical information will be possible through review of the OSP types.

People Choose Their Services, Providers and Settings

As part of the planning process, the DDPM will provide the person with information about the services and supports available, the providers available, and setting options. The DDPM should take into consideration the person's needs, preferences, and goals. Setting options considered should include options that are not exclusive to people with the same or similar disabilities. Individual services and supports are to be provided in the most integrated setting and ensure full access to the benefits of community living.

By being provided with the necessary information and support, people will be informed of all the possibilities from which they may choose, as well as the results of those choices, in a manner that is meaningful and easily understood to them. This process truly puts the person in the center, facilitated to make informed choices. Ideally, this should occur prior to the person's initial service plan, annually thereafter prior to the team meeting, when service needs change, or when requested by the person. A list of all available services and providers will be shared with the legal decision maker if applicable.
At times, the choice made may not be agreeable to some participating in the process. There will also be circumstances due to situations beyond one's control, the options are limited, which may affect this choice making process (e.g. limited housing options due to availability; finances; not able to establish housing assistance, etc.)

The person's choice in their home, work, and/or day services, along with the other options and different settings considered, will be documented in their plan. The person-centered planning process considers individual needs and preferences. For residential settings, the person's resources are also factored in with the available options, room and board costs, and opportunity for a private bedroom. If the person is sharing a bedroom, they are provided choices regarding their roommate.

Needed services and supports are discovered through the planning process and must be identified within the ISP and PCSP sections of the OSP. Not

only does the process and plan identify services, but it should also assist in preventing the provision of unnecessary or inappropriate services and/or supports. The mission of DD services in ND is to assist people in becoming as independent as they can.

Engaging People, Family Members and Legal Guardians

The plan is developed by the person along with others chosen by them and the legal decision maker, if applicable. Person-centered planning engages the person and those close to the person as primary authorities on the person's life direction, leading the person to drive the process. Family members, even if they are not the legal decision maker, typically have a vested interest in and play a significant role in the individual's life. Family members have a great deal of influence in the lives of people supported. As such, they are valued team members and have information and ideas to share. The team planning process and services must be designed to promote and utilize natural and informal community supports, including family, friends and others.

The person and others they select to participate must be empowered to lead and direct the design of their service plan. Providing necessary information and support ensures the people directs the process to the maximum extent possible and is enabled to make informed decisions and choices. With skillful facilitation, people can express themselves at the level in which they desire or are able to participate. People and their legal decision makers should determine when and where they would like the meetings to be held and to determine what information they wish to share and discuss at the meeting.

Additionally, the planning process should take into account the cultural considerations of the people, conducted by providing information in a language that is understandable to them, no professional jargon, and accessible to those who are limited English proficient. People should also have the opportunity and option to have their plan in an alternative format that is understandable and meaningful to them. This is individualized and may incorporate such things as a personal "book", pictures, using their own words, interpreter, etc.

Cultural considerations should not only be based on a person's language, country, or heritage, but also includes a person's learning style, beliefs, values, etc.

Family members and legal guardians can become most effectively involved when they function as partners in the planning process. Information should be shared reciprocally as opposed to merely giving information to family

members. A two-way communication where the person, family members and guardians contribute their ideas, concerns and possible solutions increases the effectiveness of the planning process. Open lines of communication are essential.

There may be times when there is conflict between the person or legal guardian, family members and other members of the team. When conflict does occur, it should be addressed immediately in a neutral and respectful manner. The provider and DD Program Management staff are paid professionals and are expected to have the skills to understand behavior and manage conflict. Here are a few suggestions to be successful in managing conflict:

- Remaining neutral;
- Eliminating negative perceptions;
- Not personalizing the situation;
- Listening and trying to understand the other point of view;
- Remaining open and honest;
- Recognizing areas of understanding and areas of difference;
- Being flexible and willing to negotiate whenever possible;
- Making sure the well-being of the person supported is the focus.

This does not mean that staff cannot discuss their concerns and express a different point of view. It simply means that we are held to a higher standard in terms of our ability to manage conflict and can skillfully facilitate the discussion to move the plan forward.

It is important to document the discussion and decisions that are reached in the OSP/PCSP and review it with all parties before it is finalized and implemented.

Access to Information and Assuring Health and Safety

Medicaid law requires states to ensure the health and welfare of waiver recipients and to develop strategies to reduce the potential risks. This requirement applies to both traditional and self-directed/participant directed services.

Individual records pertaining to a person are essential for effective planning and implementation; for establishing and maintaining a personal history; and for protecting the legal rights of the person, agency and the agency's

staff. Most importantly, having information is critical to assuring the health and safety of the person receiving services.

At a minimum, the following information and assessments will be obtained in order to develop the person-centered service plan:

- Risk Assessment/RMAP;
- Release of Information/authorization to disclose information with health care providers and if the child is of school age, the school system;
- Most recent history and physical examination;
- List of medications, which may include dosages and side effects;
- Current diagnoses;
- Name, address and phone number of the person's physician or health facility providing medical care;
- Emergency contact information;
- Emergency backup plan; and
- Level of supervision

Primary Program Coordination Responsibilities

Staff employed by the licensed DD provider who are responsible for individual program coordination must meet the qualifications of a Qualified Developmental Disability Professional (QDDP).
http://www.nd.gov/dhs/policymanuals/816/816.htm

The Primary Program Coordinator (QDDP) responsibilities for the OSP includes but are not limited to: assisting the person and/or legal decision maker in scheduling and facilitation of the plan; entering of the plan; timely completion and distribution of the plan; implementation of the plan; training of direct support staff relative to the individual plan; review and compilation of data; completion of periodic monitoring reports; follow up to recommendations for services, equipment or programs; convening of the team for revision of the plan based on individual need and performance. The Program Coordinator serves as the primary contact for DD Program Managers.

The residential programs for the following services have primary program coordination responsibilities for entering of the OSP/PCSP.

- ICF/IID group homes
- Residential Habilitation
- Independent Habilitation

The Residential Program Coordinator is responsible for program coordination and completion of the annual Risk Assessment and coordination of the PCSP process. If additionally receiving Day Habilitation, Prevocational Service, Small Group Employment Support, and Individual Employment Support, those staff are responsible to:

- Participate in the completion of the annual Risk Assessment with the residential Program Coordinator
- Prepare a written assessment including current status and review of progress made over the past year and submit to the residential Program Coordinator.

Day Habilitation, Prevocational Services, Small Group Employment Support, and Individual Employment Support only

Staff of these services are responsible for program coordination including completion of the annual Risk Assessment, assessment including current status and review of progress made over the past year and coordination of the PCSP process.

If the individual is receiving day services with more than 1 provider, individuals/legal decision makers and agencies may make decisions regarding Program Coordination responsibilities. If there is not agreement as to which agency will be responsible, the provider who is authorized to provide the most hours per week will be responsible unless the individual/legal decision maker requests the other agency and the agency agrees to it.

- Levels of support in the programs may change over time, but Program Coordination responsibility will be determined only once a year and the designated Program Coordinator will be responsible for the year.
- The arrangement can continue indefinitely unless one or both providers make a request to revisit the issue.
- If the person receives a combination of Day Habilitation and a secondary service provided by a qualified service provider (Adult Foster Care, AFC respite, Homemaker or Personal Care) which does not have program coordination, the Day Habilitation will take on the primary coordination responsibilities completing the OSP and RMAP.
    The DDPM will continue to develop the Individual Care Plans, Personal Care Service Plans, and authorizations that serve as the care plans for the services provided by a QSP. Qualified Service Providers should be invited to attend the OSP meetings but are not required to do so as independent contractors. Since the DDPM is responsible to enter the individual care plans for the services provided by a QSP, they can bring information to help synthesize the plans for the person in the different settings.

Outcomes/Goals (may use the overall goal/outcome from the assessment narrative) for the services provided by a QSP should be added to the OSP and will be monitored by the DDPM.

In-Home Supports, Parenting Support, Extended Home Health Care, and FCO only (DD licensed provider)

Staff of these services are responsible for program coordination including completion of the annual Risk Assessment, other assessments, including current status and review of status/progress made over the past year and coordination of the PCSP process.

Combination of Day Habilitation, Prevocational Service, Small Group Employment Support, Individual Employment Support and In-Home Supports, Parenting Support, Extended Home Health Care, and FCO

Individuals/legal decision makers and agencies may make decisions regarding Program Coordination responsibilities. If there is not agreement as to which agency will be responsible, the provider who is authorized to provide the most hours per week will be responsible unless the individual/legal decision maker requests the other agency and the agency agrees to it.

- Levels of support in the programs may change over time, but Program Coordination responsibility will be determined only once a year and the designated Program Coordinator will be responsible for the year.
- The arrangement can continue indefinitely unless one or both providers make a request to revisit the issue.
- All programs are responsible to participate as a team member, provide assessment information, participate in the development of goals/objectives and provide monitoring updates relative to their program/service.

*When an individual is receiving IHS self-directed or EHHC non-DD provider in combination with a DD licensed provider service - the DD licensed provider is responsible for the program coordination and should obtain information from the other service and incorporate into the plan.

*When the individual is receiving a combination of Day Habilitation, Prevocational Service, Small Group Employment Support, Individual Employment Support, and In Home Supports, Parenting Support, Extended Home Health Care, and FCO - the provider who has primary Program Coordination responsibilities will enter the OSP on the provider side and is responsible to enter the PCSP section of the OSP and Risk Assessment.

In Home Support self-directed, Extended Home Health Care provided by a non-DD licensed provider, and Medically Fragile Waiver

These services are not provided by a DD licensed provider and do not have a DD provider program coordinator. Therefore, the DD Program Manager is responsible to complete the PCSP portion of the OSP.

Secondary Providers

A secondary provider is when an agency provides services as part of the individual plan but does not have primary Program Coordination responsibility (e.g., Day Habilitation would be considered the secondary if an individual was receiving a residential DD authorized service as the residential service provider would already have the primary program coordination responsibility).

The term secondary or tertiary provider should not take away from the role and importance of the provider. All providers involved in services are **joint partners** and should contribute equally toward the input and delivery of services. The Primary Program Coordinator is responsible for coordination of activities among all providers, however, development and collection of information is a collaborative team effort and expectations for all providers include, but are not limited, to the following:

- Ongoing communication among all providers pertaining to the person's status, significant events, successes, lack of progress, day to day situations, GERs related to health/safety/programming, etc.
    - Inform the Primary Program Coordinator of any significant issues or concerns that the team needs to address in either service setting.
- Provide copies of any assessments and assist in the completion of the RMAP prior to the OSP meeting. Assessment information should be summarized at team meetings from all involved providers.
- Attend team meetings and participate in the development of the OSP which includes, but is not limited to, risk management strategies and goals and objectives to be implemented in their program and across settings.
    - Secondary providers have firsthand information on programs they implement and can provide insightful information toward methods, strategies, etc. The Primary Program Coordinator ensures goals/objectives are developed appropriately.

  - Primary Program Coordinator ensures that program training is being completed at all programs (providers may decide how and who is responsible to train staff).

- Collect program data and provide information regarding the person's status and data collection for programs they are responsible for implementing (progress or lack thereof).
  - Provide the data/information to the Primary Program Coordinator as requested. It is best practice for the Primary Program Coordinator to visit people at their day programs and observe program methods are consistent with implementation.
  - Provide current status and review of progress made over the past year. Secondary providers should be aware of the data, how programs are being implemented, and if there is progress or not.
- The OSP should include adequate information and documentation that incorporates all services and service settings, therefore being reflective of all providers.
- Share information, assessments, and other documents.

Staff Training on the OSP

The overall service plan team consists of the person, their legal decision maker, family, friends, other natural community supports, and paid employees including the DDPM and provider(s) of service.
In many instances, the Direct Support Professional (DSP) is the person who works directly with the person and knows that person best, particularly if natural supports are limited. Most importantly many times they are responsible for implementing the person's plan on a daily basis and provide the services and supports an individual need to reach their desired outcomes. The DSP is clearly an important part of the person's life and must know the person, understand what is important to the person, understand the person's communication style and the person's likes or dislikes, wants, needs, hopes, dreams and desires.

Therefore, it is critical that the DSP(s) who know the person best are involved in the planning process and trained on the complete OSP for each person they work for so they can effectively provide the guidance and support needed to reach their outcomes and health and safety in accordance with the OSP. Abbreviations/cheat sheets may be utilized for staff reminders, documentation purposes etc. However, it is expected that all direct staff supporting the person are thoroughly trained on the entire OSP.

All staff providing services and supports must be trained on the person's plan prior to the person beginning services or prior to the implementation of a new plan or component of a plan. Training of staff must be documented.

The OSP should contain information so anyone, even someone unfamiliar with the person, can review the plan and implement it to assure that basic health and welfare for the person and assistance is provided in accordance with the person's preferences. This also includes entering the plan with no professional jargon and in language that is meaningful and easy to understand.

The OSP is significant to the person and should be reviewed with and provided to other entities involved in the plan. The plan will be critical to those who may provide services on a temporary basis (e.g. hospital, swing bed, nursing facility) and in the event of an emergency relocation, such as in the event of a natural disaster or other emergency situation, when people familiar with the person may not be readily available and others may be providing them with assistance.

OSP Meeting Format

Admission, 30-day Comprehensive, and Annual OSP meetings should be conducted primarily in-person to promote active participation, collaboration, and personal connections. However, some team members may participate via phone, virtually*, or other means if they are unable to attend in-person. Circumstances for not being in-person may include the team member is out of town/state or infection control measures. If the majority of the team members are unable to attend in-person, the meeting should be rescheduled unless it's an emergent situation.

**Meeting virtually does not equate to an in-person meeting.*

There may be situations where minor OSP updates are needed and can be communicated to the person and other team members via phone, email, virtually, or S-Comm. If there is a significant change in the person's medical, behavior, impact the service setting, health/welfare, or discharge, an in-person meeting may be more conducive to better address the issue and the needed OSP update. The team should use their professional judgement in determining the best format based on the circumstances,

situation, topic, preferences, and what method would be most effective. An in-person meeting should occur if a team requests that format.

The OSP Format will Serve as the Meeting Agenda

It is not necessary to complete the PCSP checklist. The OSP format has incorporated the checklist into the plan.

The OSP format and document is not intended to be used as a checklist or the sequence of discussions for the PCSP meeting. However, it does contain the topics for discussion. The PCSP meeting should be focused around the person, their interests, tell the story of their life, describe who they are, what they want, and their desire to participate/facilitate to the greatest extent possible. Meetings that are open to creativity, fun, personal connections, and meaningful to the person are encouraged and part of person-centered planning.

The Primary Program Coordinator may create a draft or outline of the PCSP component of the person's OSP in preparation for the team meeting. This is acceptable as long as the team has the opportunity to discuss issues and to provide input into the planning process during the meeting.

It is expected that the team will have the opportunity to discuss any areas of the RMAP that may need to be revised and to provide input into the development of risk mitigation strategies for the identified risks. If changes or revisions need to be made to the RMAP as a result of the team discussion, the Program Coordinator will make revisions to the RMAP following the team meeting and attach to the plan before the OSP is approved.

The team is available to assist the person/legal decision maker in identifying and prioritizing desired goals and objectives. **It is not expected that the team will word smith and finalize the OSP during the team meeting.** However, the team will actively participate in the planning process and by the end of the meeting will have a good understanding of what the plan will consist of as it relates to the person's desired goals, learning and support objectives and strategies to manage health and safety.

Information in the PCSP plan will be documented, utilizing the format provided in Therap, but the Person-Centered Service Planning process must respect the person and/or legal decision maker's right to decide what information they want to share and with whom. It is essential that the person and/or legal decision makers are contacted prior to the meeting by the Program Coordinator to complete the Self- Assessment and to determine

if there is information they do not wish to have discussed at the meeting, or if they choose not to participate during a time an issue is addressed. It is essential that these matters are approached with sensitivity and the discussion and decisions reached are documented.

People and their legal decision makers may waive some assessments in consultation with the licensed provider and DD Program Manager. However, this must be balanced against the provider and State's ability to help assure the health, safety and protection. Assessments for the purpose of identifying service type, amount and frequency, or assessments required to authorize services cannot be waived.

Documentation of Team Discussion and Decision Making

The team discussion and decision-making process must be documented.

It is essential that team discussion at the OSP meeting is documented to:

- Reflect the discussion points of the team meeting
- Capture the meaning of meeting conversations
- Document important or divisive issues
- Serve as a reminder of issues that were discussed, conclusions that were drawn and any follow up that is needed.

Documentation of team discussions ensures that critical decision making is recorded and provides reference as to why certain proposals or actions were accepted or rejected. The documentation should accurately reflect the interpretation of the issues discussed and what, if any, conclusions were reached. The documentation of the team discussion should not be a verbatim record of the discussion word by word, but should outline major points of the discussion, conclusions, recommendations, and follow up as applicable.

This team discussion should be documented in each of the appropriate Assessment Areas of the OSP. If additional space is needed to document the team discussion, the additional documentation should be continued in a separate document entitled Team Meeting Minutes that is attached to the OSP document.

Signature Page for OSPs

The signature page for the OSP meetings is located on the website http://www.therapservices.net/northdakota/ at the right-hand side of the

page under the module/support page for Overall Service Plan (OSP) for Linked Providers titled "Service Plan Signature Page".

- The page can be downloaded and printed.
- The signature page must be attached to the OSP.

A copy of the plan is shared with the person, legal decision maker and other team members involved in the plan that do not have access to Therap and the electronic document.

Approval of the OSP

The OSP is the person's plan and is contained in the electronic record in the web-based application that is shared between the licensed DD provider and the State.

The plan is developed by the person along with people chosen by them and legal decision maker, if applicable. Typically, this involves family members, legal decision makers, provider staff who know the person well, the QDDP and the DDPM. It may also include friends, neighbors, and advocates invited at the request of the person and/or legal decision maker.

The responsibility to enter the plan as it was developed during the team meeting and implement the plan lies with the internal Program Coordinator (QDDP) employed by the DD licensed agency.

As representatives of the State Medicaid agency, the assigned DD Program Manager (DDPM) is responsible to ensure that the plan has been developed as discussed in the team meeting and in accordance with applicable policies and procedures, and that the plan addresses the health and welfare.

Although each has their own role(s) in the planning process, the outcome is the same for Program Coordinators and DDPMs - the development of a person-centered plan that meets the person's needs and preferences and contains the requirements set forth in policy as required by the Centers for Medicare and Medicaid.

Review-Revision-Approval Process

Once the Program Coordinator has finished entering the OSP they will select "Submit" and at that point the OSP will show up on the count for the DDPM "Approve" under the Overall Service Plan box.

Once the plan is submitted by the Program Coordinator, the DDPM is responsible as the representative for the Medicaid agency to review the plan

to verify that applicable policies and procedures associated with service plan development are carried out. Only OSP's that meet the requirements will be approved. (Refer to the specific OSP type instructions and format)

It is also important the planning process reflected the following:

- Person has opportunity to engage and/or direct the process to the extent they wish;
- Those whom the person wishes to attend and participate in developing the service plan are provided adequate notice;
- The planning process is timely;
- Needs are assessed in all appropriate areas and services meet the needs including health care needs;
- The providers of secondary services (those who do not have program coordination responsibilities) have submitted applicable assessment information and participated;
- Responsibilities are identified;
- The plan reflects the team discussion generated at the team meeting as well as the agreed upon decisions and strategies developed as part of the team planning process;
- The plan reflects all services the person is receiving regardless of funding source which includes, but is not limited to, education services, natural supports, counseling, physician, nursing, dental, WIC, behavioral consultation, Home Health Care, etc.

After reviewing the plan, the DD Program Manager will either approve the plan as entered or contact the Program Coordinator to discuss recommended revisions to the plan before it is approved. The DDPM will not make any changes in the document prior to contacting the Program Coordinator. However, DDPM's may make the necessary changes but must inform the Program Coordinator. The contact by the DDPM can occur via s-comm, T-Note, or a telephone call. Both the Program Coordinator and DD Program Manager are able to edit the plan document in the web-based application before it is approved. Approved OSPs cannot be edited. If any change is to be made, a new OSP must be created and the DDPM must approve the revisions.

Between the two, they will decide who is responsible to make the requested revisions before approval. It is extremely important to maintain the integrity of the team planning process. Any information added to the plan and not discussed at the team meeting must have a notation acknowledging this fact.

It is anticipated that the Program Coordinator and DD Program Manager will reach agreement on the revisions. If they are not able to reach agreement, the plan will be reviewed at the next level within the DD licensed provider agency and the regional DD Program Administrator. If an agreement is not reached at the regional level, the plan will be submitted to the state DD Section who has final decision-making authority.

The goal is to work together on ensuring the contents of the plan reflect the needs, preferences, strengths, desired outcomes, supports and services provided. It is important for team members to not become choosy with such items as spelling errors and word preferences; or let personalities contribute to the loss of the integrity of the plan and person-centered process.

Upon the DDPM approving the plan, the plan will become "active" once the start date on the plan is reached (which is typically the start date for the service of DD Program Management). The system will change the status of the plan from Approved to Active through a nightly batch job that is run in the early morning hours and based on the start date.

**Refer to Appendix "OSP Terms and Concepts"*

Section III: OSP Types and Descriptions

OSP types:

- **Initial**
- **Admission**
- **30 Day Review Comprehensive**
- **OSP Update**
- **Annual**
- **Annual No-PCSP**
- **Update Annual No-PCSP**

**Refer to Appendix "How to complete the OSP for Prevocational Services, Small Group Employment Support, and Independent Employment Support"*

****Refer to Appendix "How to complete the OSP for IHS, FCO, Parenting Supports, EHHC, MFW"***

Initial OSP

- Completed for people over the age of 3 on the provider side who are newly eligible for DD Program Management.
- Completed only at the time of an approved eligibility.
- Can only be initiated and entered by the DD Program Manager.
- Consists only of the ISP section of the OSP. There is no PCSP section as the person is not yet enrolled in any DD authorized service.
- The only authorized service on the initial ISP section of the OSP is DD Program Management.
- The start date for the service of DD Program Management is the date of the approved Eligibility Determination.
- All generic services the person is receiving, regardless of funding source, must also be entered on the ISP portion of the OSP (e.g., physician services, psychiatric services, education, counseling, WIC, counseling etc.)
- The DDPM can determine if they wish to add an outcome in the initial OSP but it is not required.
  For example: If the person is receiving Psychiatric services or other services that need to be listed on the HSC Treatment Plan an outcome may be added.
- The DDPM will "Approve" the Initial OSP immediately.
- ISP PDF print will list only the DD authorized services.
- OSP PDF print will list authorized services and all generic services.

Admission OSP

The Admission OSP is completed when a person has selected their service and qualified service provider:

1. Initially enrolling in an ICF/IID or DD waiver (**DD authorized)** service provided by a DD licensed provider for the first time. (There is not an existing plan or service and the person is not currently authorized with any primary provider.)

   Example: The Admission OSP is initiated by the DDPM when a person is just enrolling in a service and a basic plan must be developed prior to the start of the service and in place for the first 30 days of service (from date of admission to start date of 30 Day comprehensive plan).

   Start and End Dates:
   The Admission OSP begins from the date of the person's admission to service(s) and the end date of one year minus a day. The DDPM start and end dates from the previous active OSP will be changed to align with the start and end dates of the service(s).

   Example: A person begins DDPM services on 6-1-18. The start and end dates of the Initial OSP are the same start and end dates of DDPM and are one year minus a day (6-1-18 to 5-31-19). The person then begins DD Authorized services on 7-1-18. The start date of DDPM from the Initial OSP will be changed in the Admission OSP to align with the service start date beginning 7-1-18. Therefore, the start and end dates for the Admission OSP will be 7-1-18 to 6-30-19.

2. Starting a **DD authorized** service with a <u>new</u> Primary Provider responsible for Program Coordination.

   Example: The Admission OSP may be initiated if a person has been receiving Day Habilitation and then starts a <u>primary service</u> of Residential Habilitation. The new Residential provider will be assuming primary program coordination duties and the DDPM will copy the active OSP to allow the primary provider to complete an Admission OSP in the template on the Therap Provider side DDD-ND. The Day Habilitation program will become a secondary service and that plan will be integrated into the Admission OSP.

   Start and End Dates:
   There are 2 options that can be completed, and the team can decide what works best for the person's situation.
   <u>Option 1:</u> The DDPM and any current service(s) start and end dates from the previous OSP will remain. The person's admission date to the new provider service(s) will be the start date for those services with the end date of DDPM. Therefore, using this option, the OSP period from the previous plan will remain.

   Example: An Annual OSP is currently in place for Residential Habilitation and Day Habilitation with start and end dates of 1-1-18 to 12-31-18. On 5-1-18, the person begins

Residential Habilitation with another provider. The Admission OSP will terminate Residential Habilitation with provider A on 4-30-18, add Residential Habilitation with provider B on 5-1-18 to 12-31-18, and keep Day Habilitation and DDPM 1-1-18 to 12-31-18.

Option 2: The person's admission date to the new provider service(s) will be the start date for those services with the end date of one year minus a day. The start and end dates of DDPM and any current service(s) from the previous active OSP will be changed to align with the person's admission date to the new provider service(s).

Example: An Annual OSP is currently in place for Residential Habilitation and Day Habilitation with start and end dates of 1-1-18 to 12-31-18. On 5-1-18, the person begins Residential Habilitation with another provider. An OSP update will be created to terminate Residential Habilitation with provider A and Day Habilitation on 4-30-18. The Admission OSP will remove the services that were terminated in the OSP Update, add Residential Habilitation with provider B and Day Habilitation with the start and end dates of 5-1-18 to 4-30-19. DDPM dates will be changed to 5-1-18 to 4-30-19.

The annual OSP will either be based from the Admission OSP or the previous Annual OSP dependent on which option is chosen.

Both the ISP and PCSP sections of the OSP are completed.

The Admission OSP meeting must occur prior to the start date of the new service(s).

The Admission OSP must be developed, entered and submitted, and approved prior to the start date of services and staff must be trained prior to the person's admission and prepared to support them when they arrive.

Initiating the Admission OSP

The DD Program Manager must initiate the Admission OSP to preauthorize the DD provider services. (The Provider is unable to initiate this OSP type).

The DDPM will work with the Program Coordinator to establish a mutually agreed upon date for the OSP meeting and a start date for services with the person/legal decision maker and provider.

- The DDPM will select the Admission OSP type and select the Primary provider in the first section of the OSP document.
    - The Primary Provider is the provider responsible for Program Coordination.

- Once the OSP type, primary provider and the ISP section has been completed, the DDPM will select the "send to provider" button.
    - The DDPM can select the "save" button to save the document if additional work needs to be done by the DDPM at a later time. However, selecting "save" will only save the document to the DDPM's work list and does not send it to the provider.
- Once the OSP is sent to the Linked provider, the status changes to Pending for Provider Input and under the OSP section it shows a count.
- The Primary provider will be able to open the document and begin their work in the PCSP section of the Admission OSP.

Program Coordinator responsibilities to the Admission OSP

- Arrange to have all other necessary provider staff, including direct support professionals attend the Admission Meeting.
- The Admission OSP is submitted to the DDPM for approval at least 5 days prior to the start of the service(s).

DDPM responsibilities to the Admission OSP

- The DDPM will assure that Money Follows the Person (MFP) has been accessed for eligible individuals.
- DDPM will review the information on the Individual's Home page on the State Side of Therap (View Details). This needs to be completed prior to a new plan being started in order for the changes to be reflected. Edit, if necessary, to assure the information is correct including:
    - The person's address/phone
    - Involved Individuals – names, address, phone numbers,
    - Guardianship status – make sure this is up to date
- Assist Program Coordinator to obtain any updated information that is available e.g., medical, programmatic that was not included in the referral packet and not in the transferred Therap information. This is most applicable when a person is being admitted and has been previously served by another DD licensed provider.
- DDPM will enter the ISP section of the Admission OSP and print the ISP section to bring to the Admission meeting for signatures.
- If the person is receiving individually authorized services, the DDPM will complete the Authorization. The authorization should be approved by the provider, regional DDPA and DD Section prior to the initiation of services.

For a client who enters services without a completed assessment, the DDPM will document the discussion and the planned staffing hours (FTE not necessarily the authorized service hours) in the DDPM Final Review Comment Section.

Agenda for Admission OSP Meeting and Requirements for Admission OSP

The referral information provided by the DD Program Manager and any additional information provided by the person and/or legal guardian will serve as the basis for the Admission Plan. This includes any previous plan that has been developed for that person and a current RMAP that has been completed by the DD Program Manager or a previous provider as part of the referral information.

The Admission OSP may not be as comprehensive as other plans because the provider is typically just getting to know that person and to understand their support needs and preferences**. However, if the person has recently been served by another service provider, the previous plan should offer the team a great deal of information to complete the Admission OSP**. **The use and carryover of this information not only will provide a starting point but should also assist with the transition and consistency of services for the person.**

At a minimum, the PCSP section of the Admission OSP will include the following:

- Review of the previous plan if there is one (including OSP, PCSP, IFSP, IEP etc.) *
- Review of the initial RMAP completed by the DDPM or by a previous provider. All identified risks to the person's health and safety must be discussed and the team must mitigate the risks in the appropriate PCSP section of the OSP. The OSP must describe how the risks will be managed.

  Key areas of support include individual care, adaptive skills, and significant risks that are likely to occur or lead to involvement with medical intervention, legal or other systems.
- Review of the person's health information including diagnoses, medication, treatment needs and any strategies to assure health needs are met.

  This information must be addressed in the PCSP and describe how this will be managed.
- Review of Guardianship information and status
- Review of Guardianship name, address, phone numbers, email
- Review of Emergency Contact Information including names, address, phone numbers, email
- Review of benefits including clear assignment of responsibility for notifying and completion of applications needed (Medicaid, Social Security, SNAP-food stamps, Housing Assistance etc.)

- Review of person's anticipated daily schedule (weekday and weekend). Some flexibility will be required.
- Identification of other assessments or information needed prior to the 30 Day Comprehensive OSP
- Specific issues or requests of person and/or legal decision maker.
- Establish date for 30 Day Comprehensive Meeting.
  The 30 Day Comprehensive OSP meeting will be held within 30 calendar days following the start date of service.

*As best practice, if there is a previous plan, goals, objectives and supports may be carried over as applicable, to provide consistency, or to establish a new baseline. However, learning objectives are not required for an Admission OSP.

Attachments Required

- Current RMAP in PDF format
- Behavior Support Plan, if applicable
- Medical protocols that receive specialized training, are very specific/unique to that person, or for procedures that pertain to an outlier. For example, seizure protocols, catheter procedures, trach cares/procedures, nursing care plan. **Protocols that are typical, everyday care (e.g., toothbrushing, toileting, medications, tube feedings) are not required to be attached.**
- OSP Signature page
- Assessment Results Form (ARF) if applicable (most current version)
- Individual Service Plan (ISP) (include all ISP's associated with the plan period)
- SFN 1800 Employment Readiness Assessment (only applicable to those receiving Prevocational Services)
- EHHC: Nursing Plan of Care, nursing assessment, physician order for Home Health Care/Skilled Nursing Care
- Virtual Support Checklist SFN 1522, if applicable

Combining Admission and Discharge Meeting OSPs

If an individual is being discharged from one agency and admitted to another DD licensed service agency upon discharge, the Admission and Discharge meetings can be combined, if desired, and approved by the individual and/or legal decision maker, so that the sharing of information and transfer is as seamless as possible for the person. The Program Coordinator and other staff as appropriate from the discharging agency will participate in the Admission meeting.

This is particularly appropriate in situations where the discharge is voluntary e.g., the individual has requested a transfer.

When the discharge is involuntary, the discharging provider is required to provide a 30-day notice and the individual may choose to hold a separate Discharge meeting with the team to specifically address the involuntary discharge and their right to file a grievance. In these situations, the discharging provider will arrange for the discharge meeting prior to the 30-day notice and develop the Discharge Summary to attach to the existing OSP within 10 working days of the meeting.

The discharging agency will:

- Ensure the current OSP is up to date;
- Develop the Discharge Summary in a word document and attach to the Admission OSP if entering services with another provider.

The DDPM will:

- Terminate the service for the discharging agency through an OSP Update;
- Approves the plan;
- Copy the plan forward;
- Select the Admission OSP type and new primary provider.

*If the discharging agency did not attach the Discharge Summary to the previous OSP Update, the Discharge Summary can be attached to the Admission OSP.

30 Day Comprehensive OSP

The meeting for the Comprehensive 30-day OSP will be held within 30 calendar days following the start date of the DD authorized service(s) in the Admission OSP.

The 30 Day Comprehensive OSP is an all-inclusive plan that reflects the person's individual goals, dreams, preferences, functional abilities, strengths, support needs, and risks based on the new, revised or updated assessments, and observations conducted during the first 30 days of the person's receipt of service(s).

The agenda and requirements for the Annual plan are utilized for the 30 Day Comprehensive OSP type. Refer to the appropriate section for details.

Program Coordinator responsibilities prior to the 30-Day Comprehensive Meeting

- Arrange for necessary assessments/ evaluations identified at Admission OSP meeting.
- Review the RMAP with direct support professionals and secondary service staff if applicable and person and/or guardian if they desire to participate, and update and approve the RMAP during the initial 30 days so that it is available at the 30-Day Comprehensive.
- Complete the individual Self-Assessment with the person and others who know the person well, so the assessment is available for the 30 Day Comprehensive OSP.
- **Optional:** Complete the IPOPS and select "Approve" so the IPOPs are available to view.

DDPM responsibilities to the 30-Day Comprehensive meeting

- Complete pending ISP section of the OSP to bring to meeting for signatures, as necessary.
- Review rights and document.
- Review the IPOP's, Self-assessment, and RMAP prior to the meeting. DDPM acknowledges the RMAP and IPOP's. **(IPOP's are optional)**
- For a client who enters services without a completed assessment, the DDPM will document the discussion and the planned staffing hours (FTE not necessarily the authorized service hours) in the DDPM Final Review Comment Section.

Start and end date for 30-day Comprehensive OSP

The start and end dates for DDPM service on the ISP determines the start and end dates for the OSP. The start and end dates contained within the Admission OSP will remain the same and are NOT changed.

Example: The start and end dates of the Admission OSP are 7-1-18 to 6-30-19. The 30 Day Comprehensive OSP start and end dates will be 7-1-18 to 6-30-19, which is the same as the Admission OSP. The Annual OSP is due on or before 6-30-19.

The Program Coordinator will have 10 working days to enter the 30-Day PCSP section of the OSP and to submit it to the DD Program Manager for approval. The DD Program Manager will have 5 working days to review and approve the PCSP section of the plan or to work with the Program

Coordinator to make any necessary revisions prior to approval (working days does not include provider/state holidays).

Attachments to 30-Day Comprehensive OSP

- Current RMAP in PDF format
- Behavior Support Plan if applicable
- Medical protocols that receive specialized training, are very specific/unique to that person, or for procedures that pertain to an outlier. For example, seizure protocols, catheter procedures, trach cares/procedures, nursing care plan. **Protocols that are typical, everyday care (e.g., toothbrushing, toileting, medications, tube feedings) are not required to be attached.**
- Self-assessment in PDF format
- OSP Signature page
- Assessment Results Form if applicable (most current version)
- All ISP's associated with the plan period
- SFN 1800 Employment Readiness Assessment (only applicable to those receiving Prevocational Services)
- EHHC: Nursing Plan of Care, nursing assessment, physician order for Home Health Care/Skilled Nursing Care
- Virtual Support Checklist SFN 1522, if applicable

OSP Update

The OSP changes need to follow the person and at times OSP updates may need to occur as often as monthly. The OSP Update type is used to:

- Update or revise the OSP (ISP and/or PCSP sections) between annual plans. For example, an OSP Update may be completed to
  - Reflect Team discussion and necessary updates based on the changing needs of the person
  - Start or re-start a new service or change services or new service location with the same provider. *
  - Reflect changes requested by the person/legal decision maker
  - Life changes or medical changes
  - Level of supervision
  - Revise behavior plan, etc.

**If a secondary service is added to an OSP, the OSP Update type will be selected. In this situation the start and end date of the OSP will not change).*

Example 1: Person has an OSP and receiving Independent Habilitation services from a provider and will now be starting a primary service of Residential Habilitation with the same provider. An OSP Update will be completed to terminate Independent Habilitation, start Residential

Habilitation on the ISP and revisions entered as needed to the PCSP section to mitigate new risks if identified in the new setting, update goals/objectives etc.

Example 2: Person has an OSP and has been receiving Residential Habilitation services. Now the person will be starting Day Habilitation. An OSP update will be completed to add the service of Day Habilitation to the ISP and to update the PCSP section of the plan to reflect the change as well.

The OSP Update type has a narrative box at the top of the document. This must be completed to describe:

- Why the plan is being reviewed
- Brief summary of changes that will be made to the OSP with reference to the appropriate Assessment sections of the PCSP or the ISP that were updated.

The actual changes to the OSP and team discussion regarding the changes, along with the date the change was made, should be reflected in the applicable Assessment sections of the PCSP and/or the ISP must be updated as well to reflect the changes if needed.

There may be situations when a team meeting is called in anticipation of the need to update the OSP but following the team discussion it is determined that actual changes did not need to be made to the OSP (ISP/PCSP sections). This can be reflected in the narrative box. However, if there are changes made, the narrative will describe why the plan is being reviewed and a brief summary of changes. The actual discussion and changes that are made will be documented in the applicable Assessment sections of the PCSP and/or the ISP must be updated as well to reflect the changes/updates.

Note: If the discussion and changes are only reflected in the narrative box of the OSP and not actually documented in the appropriate section, this information will be lost as future updates to the plan are completed.

To create an OSP update: Select "copy"; Select OSP type "OSP Reason for Review".

The PCSP Meeting date will be updated to reflect the date of the team review-OSP Update or if a team meeting is not held but the Program Coordinator enters updates to the goals or objectives, the date the PC makes the change will be recorded. Changing the PCSP Meeting date will not change the Annual OSP dates.

The attendance list will be updated to reflect the names of the participants at the team review.

Reasons for Review for OSP Update

There is a drop down of "Reasons for Review" when the OSP Type **OSP Update** is chosen.

OSP Update Reason*

- Add DD Authorized Service
- 30 Day Review of New Service
- Discharge from Service or Provider Voluntary
- Discharge from Service or Provider Involuntary
- Change in Medical or Behavioral Status
- Change in Outcomes or Supports Provided
- OSP Revisions

  The person/legal decision maker, provider and DDPM must be informed and sign the plan when there is a change in the following circumstances to ensure that everyone is aware of the proposed changes relative to service provision and to ensure that the appropriate appeal rights to the person are provided:
  - service start date or end date; and/or,
  - a change in funding source (MA to private pay or vice versa; and/or
  - change in amount or frequency of a DD authorized service that results in a direct impact to the person; and/or
  - significant changes in the PCSP section of the plan regarding changes in the person's health or mental status.

  The OSP update does not require a team meeting or signatures to make typographical corrections or correcting of errors that do not impact the person. However, the reason for OSP update will be explained in the narrative box as well as the selection for Reasons for Review and a copy of the plan will be provided to the person upon request and the legal decision maker.

Timeline for submission and approval of OSP Update

The written OSP Update documenting the meeting and/ or updates and revisions must be submitted to the person and/or legal decision maker within 10 working days or before the changes need to begin. This will allow the Program Coordinator 5 working days to enter the updated information from the team meeting and submit to the DDPM and 5 working days for the DDPM to approve.

- *If there are updates that need to occur sooner due to health and safety concerns, the PC and DDPM may discuss prompter submission timelines.*
- *If teams meet frequently or on a scheduled basis, the PC and DDPM will need to collaborate on the submission dates to ensure that the OSP update is completed timely and prior to the next meeting.*

The DDPM will notify the Program Coordinator via s-comm or by phone if any changes are made to the OSP due to changes in the ISP. The DDPM will be aware of any changes made by the Program Coordinator through the OSP approval process.

State/DDPM approval of OSP Update Approved OSPs of any type cannot be edited. If a change is to be made, a new OSP must be created. The DDPM will need to approve the OSP once the changes have been made.

Attachments required for the OSP Update

- Current RMAP in PDF format
- Behavior Support Plan if applicable
- Medical protocols that receive specialized training, are very specific/unique to that person, or for procedures that pertain to an outlier. For example, seizure protocols, catheter procedures, trach cares/procedures, nursing care plan. **Protocols that are typical, everyday care (e.g., toothbrushing, toileting, medications, tube feedings) are not required to be attached.**
- Self-assessment in PDF format
- OSP Signature page
- Assessment Results Form if applicable (most current version)
- All ISP's associated with the plan period
- SFN 1800 Employment Readiness Assessment (only applicable to those receiving Prevocational Services)
- EHHC: Nursing Plan of Care, nursing assessment, physician order for Home Health Care/Skilled Nursing Care
- Virtual Support Checklist SFN 1522, if applicable

**If updates were made to these documents, the updated version should additionally be attached.*

Reasons Selected for OSP Update

Team Review Reason 1 – Add DD authorized Services

This reason for Team Review will be selected when:

1. A secondary DD authorized service is added to an existing OSP e.g., person is receiving Residential Habilitation and has an existing OSP and now the service of Day Habilitation will be added to the OSP and team is meeting to discuss the start of this service; Person has an OSP and receiving Independent Habilitation services from a provider and will now be starting Residential Habilitation with the same provider; OR

2. This option will also be utilized when a person has been temporarily absent and is now returning to DD authorized services (e.g., admitted to a swing bed or NF and DD authorized services were temporarily terminated).

A team meeting is required if it is proposed that a person transfer from one DD service to another DD authorized service or location, even if it is within the same provider agency. In addition, the person and/or their legal decision maker must be given advance notice and their right to file a grievance if they do not agree with the transfer. The Active OSP and RMAP must be reviewed and revised to reflect any necessary changes in risks, risk remediation strategies etc. due to the change in service location/environment.

The DDPM must be notified of any planned service or location changes prior to the move to the new environment, as the DDPM will need to approve the change and revise, if necessary, the ISP section of the OSP and/or the Case Action Form screening document to authorize payment of services. Medicaid payment will not be made without prior authorization for a service.

In addition, the person and/or their legal guardian must be informed of any change that may impact their benefits or payment due to the change in service or location e.g., recipient liability, SNAP, room and board etc. prior to the move. For example: In some situations when a person or setting switches from one living arrangement e.g., individual setting to group setting, their SNAP (food stamp) is calculated differently and reduced to reflect other house members in the group setting, while in an individual setting the SNAP benefits are received on an individual basis. Also, the purchase of groceries in a group setting is different than in an individual

setting as well as room and board. People and guardians need to be aware of potential changes in benefits, room and board etc. when a change in services is being considered. This must be documented in the team discussion in appropriate assessment section.

Team Review Reason 2 - Discharge from Services Voluntary

The person and/or their legal guardians have the right to choose to participate in services and to select between services and providers. When a person chooses to exit services and/or choose another provider, this is considered a Voluntary Discharge.

"Discharge from Services Voluntary" is also the reason selected when a person is deceased (death).

In these cases, the services will be terminated on the OSP for payment purposes and the provider will discharge the person in Therap.

A team meeting will be offered by the Program Coordinator prior to the termination of services. The person and/or their legal guardian will be invited to attend although they may choose not to.

If a meeting is held, the following agenda items will be covered, and any discussion documented. In any event, the DD licensed provider will write a "Discharge Summary" addressing the following areas:

- Brief recapitulation of findings, events and progress during the period of service to the person;
- Reasons for the discharge;
- Potential impact the discharge may have on the person;
- Specific recommendations and arrangements for alternative services;
- Termination of services on ISP/OSP.

The licensed provider agency from which the person is terminating services is responsible to prepare/author the discharge summary information described above. If the "discharging" agency does not have primary coordination responsibilities, they will work with the primary program coordinator to arrange for the team meeting and the primary program coordinator will assist in updating the OSP as needed and include the discharge summary information in the OSP document or as an attachment.

** In the event of a death, there should be a case closure note documented by the DDPM in Admin or Progress Notes denoting dates*

of service, services received, summary of progress, and reason for death etc.

Discharge from Provider agency in Therap

When a person's services are permanently terminated from a provider, that Provider agency must unenroll them from the programs they are associated with at the agency and then "discharge" the person from the provider account in Therap within 30 calendar days of service termination. The discharge must be completed so the provider no longer has access to the person's Therap file and information after the date of discharge from the provider.

*(Refer to instructions for Discharging an individual. Users with Individual Admit/Discharge Role or the Individual Administrative Role for the DD licensed provider are able to discharge people from the system. A person can be discharged directly from his/her individual Data page. If the provider is using ISP Programs in Therap, the ISP Reports should be run **before** the person is discharged in Therap. It is recommended that the reports are run for the last month and saved in Therap and then run again for the year and saved in Therap before the person is discharged).*

*The state user (DDPM or RDDPA) can check to determine if the person has been discharged from the provider agency by selecting the **Switch Provider*** link to review the Individual Data form.

Other examples that fall under Voluntary Discharge

- **Temporary termination of services**
  There may also be circumstances when a person is temporarily admitted to another level of care such as a Nursing Facility, Swing bed, the Life Skills and Transition Center, the North Dakota State Hospital or other institution to treat mental illness such as the Stadter Center, Prairie St. John's etc.
  The current DD authorized services and ICF/IID level of care Case Action must be terminated when the person is not receiving the authorized community DD services and is in another service setting receiving services through another level of care and/or Medicaid eligibility is impacted.
  It is considered a voluntary discharge as long as the person and the provider agree that it is expected that the person will return to services.

Even though DD authorized services are temporarily terminated on the ISP, the person is not discharged from the provider's census in Therap.

The DD Program Manager must update the ISP section of the OSP to start the institutional service and terminate the community DD authorized services and ICF/IID level of care Case Action Form.

Example: The person is admitted to a nursing facility or swing bed, the DD services must be terminated the day prior to the admission to the nursing facility because the person is screened to the nursing facility level of care upon admission. The nursing facility level of care screening will "step on"/terminate the DD ICF/IID level of care screening.

If the person is admitted to an acute rehab unit or acute care hospital, the DD services can continue because the admission to the rehab or hospital does not result in a screening to another level of care.

If a person is being institutionalized, even temporarily, it is best practice for the Program Coordinator, DDPM and key team members to meet or
conference call with the admitting facility e.g., Nursing Home, Basic Care, hospital etc. to help orient the person and to review the needs and preferences with the new staff that will be working with that person to assist in the transition. This can be done in person or via conference call with key members of the team and admitted facility.

When the person returns to the DD authorized services a team review will be held to review and update the OSP and RMAP, document the person's return, incorporate any new information and to make any necessary revisions to the RMAP, PCSP or ISP sections of the plan. The ISP will be updated to restart the DD authorized services and the ICF/IID level of care will be updated to restart the screening on the Case Action Form.

- **Planned extended absences from DD services**
  There may be also situations when it is known that a person will be absent from services for a period of time. This might be due to an extended vacation with family; person is unable to attend due to medical or temporary accessibility issues for a period of time etc. but is not receiving services through another agency or screened to a different level of care during that time. In these situations, services

will be terminated on a temporary basis while the person is not receiving services. Services will be re-instated when they return.

The person is not discharged from the provider in Therap during this time.
A Team Review may be held to discuss any revisions during their time away and when they return. Typically, the time to consider temporary discharge is 30 days.

- **Incarceration**
  Under Medicaid law, states do not receive federal matching funds for services provided to people in jail. When a person is incarcerated, the Human Service Zone responsible for administering the Medicaid case should be contacted to determine the status of the person's Medicaid eligibility. DD authorized services should be terminated and the ICF/IID level of care (Case Action Form) terminated when a person is in jail.

Team Review Reason 3 - Discharge from Services Involuntary

Involuntary discharge is when the person is discharged from services against his/her own wishes or will. The provider and/or State has made a decision to discontinue services even though the person has not requested the termination of services and does not have a choice in the matter.

People receiving services and/or legal decision makers have the right to select the service and provider of their choice. Written notice must be provided and include reason for discharge, the effective dates, and the right to file a grievance with the provider agency.

The DD licensed provider must have written policies and procedures that define the conditions of discharge and transfer. A copy of the policy is provided to all person's/legal decision makers at the time of admission to the provider agency and again when discharge is being considered. When the discharge is involuntary, the discharging provider is required to provide a written 30-day notice, schedule a team meeting, and complete a written discharge summary.

Any opportunities to prevent discharge should be explored prior to the discharge by the provider. Contact with the regional Behavior Analyst and CARES team to request formal consultation and technical assistance must be made in an effort to preserve the person's placement. CARES' consultation is available due to challenging behavior and/or medical conditions. The request should be made early and as soon as the provider and team members are aware that the placement may be compromised and additional

assistance is needed to support that person. Seeking services from the CARES team when concerns have been ongoing and discharge is imminent is not acceptable.

In the case of an involuntary discharge, the DD licensed provider must schedule a team meeting and the meeting must be held before the provider issues the written 30-day discharge notice.

It is the responsibility of the Program Coordinator to schedule the meeting. Participants must include the person and/or legal decision maker, DD Program Manager and other team members.
The following agenda items must be covered, and discussion and decisions documented in the OSP.

- Brief recapitulation of findings, events and progress during the period of service to the person;
- Reasons for the discharge;
- Potential impact the discharge may have on the person;
- Opportunities to prevent discharge, specific recommendations and arrangements for alternative services;
- In the case of an involuntary discharge, the provider must inform the person and legal decision maker of their right to file a grievance with the provider agency.

The licensed provider agency from which the person is terminating services is responsible to prepare/author the discharge summary information described above. If the "discharging" agency does not have primary coordination responsibilities, they will work with the primary program coordinator to arrange for the team meeting and the primary program coordinator will assist in updating the OSP as needed and include the discharge summary information in the OSP document or as an attachment.

Discharge from provider agency in Therap

When a person's services are permanently terminated from a provider, that Provider agency must "unenroll" the person from the identified program(s) enrolled in at the provider and then discharge them from the provider in Therap within 30 calendar days of service termination. The discharge must be completed so the provider no longer has access to the person's Therap file and information after the date of discharge from the provider.

(Refer to instructions for Discharging an individual. Users with Individual Admit/Discharge Role or the Individual Administrative Role for the DD licensed provider are able to Discharge people from the system. A person can be discharged directly from his/her individual Data page. If the provider

is using ISP Programs in Therap, the ISP Reports should be run before the person is discharged in Therap. It is recommended that the reports are run for the last month and saved in Therap and then run again for the year and saved in Therap before the person is discharged).

Combining Admission and Discharge Meeting OSPs

If an individual is being discharged from one agency and admitted to another DD licensed service agency upon discharge, the Admission and Discharge meetings can be combined, if desired and approved by the individual and/or legal decision maker, so that the sharing of information and transfer is as seamless as possible for the person. The Program Coordinator and other staff as appropriate from the discharging agency will participate in the Admission meeting.

This is particularly appropriate in situations where the discharge is voluntary e.g., the individual has requested a transfer.

When the discharge is involuntary, the discharging provider is required to provide a 30-day notice and the individual may choose to hold a separate Discharge meeting with the team to specifically address the involuntary discharge and their right to file a grievance. In these situations, the discharging provider will arrange for the discharge meeting prior to the 30-day notice and develop the Discharge Summary to attach to the existing OSP within 10 working days of the meeting.

The discharging agency will:

- Ensure the current OSP is up to date;
- Develop the Discharge Summary in a word document and attach to the Admission OSP if entering services with another provider.

The DDPM will:

- Terminate the service for the discharging agency through an OSP Update;
- Approves the plan;
- Copy the plan forward;
- Select the Admission OSP type and new primary provider.

*If the discharging agency did not attach the Discharge Summary to the previous OSP Update, the Discharge Summary can be attached to the Admission OSP.

*The state user (DDPM or RDDPA) can check to determine if the person has been discharged from the provider agency by selecting the **Switch Provider** link to review the Individual Data form.*

Team Review Reason 4 - 30 Day Review of New Service

This reason is selected when the team meets to review the addition of a secondary service within 30 days of starting the service

Example: An OSP was in effect for a person receiving the primary service of Residential Habilitation and later the secondary service of Day Habilitation was added to the OSP through a Team Review of Annual. The team is now meeting to review the new service and to determine if there are updates or revisions to the plan based on that review.

Team Review Reason 5 – Change in Medical or Behavior Status

The team will review the RMAP, current OSP, functional behavioral assessment and behavior support plan, and other current information to determine if the assessment and OSP needs to be revised to reflect any changes in health protocols or behavioral strategies to mitigate new health and/or safety concerns. The team discussion will be documented in the appropriate assessment areas of the OSP/PCSP or if necessary, attached to the OSP.

Minor and temporary health issues such as treatment for a cold, bronchitis, etc. do not warrant revisions to the OSP or a team meeting and team members can be notified via s-comm, email or telephone. However, if the issue becomes chronic or severe, then the team must meet to review the OSP and assessments and revise them accordingly.

Team Review Reason 6 – Change in Outcome or Objectives

Revisions may be needed to address if the person has achieved or is not progressing with their outcomes and objectives. The OSP will be revised to reflect the changes and will then be submitted to the DDPM for review and approval.

Team Review Reason 7 – OSP Revisions

OSP revisions include editing the PCSP portion of the plan for typographical and grammatical errors; omissions, correcting information on the ISP section of the plan (disposition of service, funding source, start or end date); addition or deletion of a generic (non-DD) service, etc.

Annual OSP Requirements

Annual OSP is developed on an annual basis. Overall Service Plans, including the ISP and PCSP sections, must be reviewed at least annually. Annual is defined as one year minus one day.

* Refer to Appendix "OSP Sample Checklist"

*Refer to Appendix "How to complete the OSP for Prevocational Services, Small Group Employment Support, and Independent Employment Support"

***Refer to Appendix "How to complete the OSP for IHS, FCO, Parenting Supports, EHHC, MFW"**

OSP annual meeting date

The person's team must meet each year(annually) to review and update the Overall Service plan.

The due date for the annual OSP is determined by the start and end dates for DD Program Management. The annual plan must be developed and approved on or before the review date of the current OSP (which is one year minus one day from the start date of DDPM) to meet the required timeline.

Start and End Dates of OSP

The start and end dates of the OSP are determined by the Start and End date of DD Program Management on the ISP section of the OSP.

The end date for DDPM and the OSP cannot exceed one year minus one day but can be shortened to reflect a new review or due date.

Example: If the dates for DDPM on the ISP are 7-5-18 to 7-4-19, it is expected that the annual PCSP meeting for 2019 will be held, the OSP entered and approved by the DDPM on or before 7-4-19.
The Start Date for DDPM on the new ISP will start 7-5-19 and end 7-4-20 which means that the following OSP will start on 7-5-20 and end 7-4-21 unless the end date of DDPM is changed.

It is expected that staff are trained before the start date of the OSP and the PCSP plan is implemented on the Start Date.

The Annual OSP must be submitted to the DD Program Manager for approval at least 5 working days prior to the End Date of DD Program Management on the ISP.

It is expected that staff are trained before the start date of the OSP and the PCSP plan is implemented on the Start Date.

PCSP Meeting Date Notice

This notice is generated by the Therap system 90 days prior to the end date of the current OSP to remind the Program Coordinator and DD Program Manager that the OSP is coming due. It is generated only for the Annual OSP type and the Annual no PCSP type.

The Annual PCSP meeting notice will appear 90 days prior to the end date of the current active Annual or Annual-No PCSP OSP (end date of DDPM). This alert appears on the dashboard of the primary Program Coordinator and on the First Page of Therap for the DD Program Manager in the "PCSP Meeting Notice" folder in the Overall Service Plan box. The (number) next to the folder indicates the number of OSP's due within 90 days.

The alert will provide notice for the Program Coordinator to schedule the PCSP meeting with the person/legal decision maker and team members, send a notice regarding the date and time of PCSP meeting two months prior to the meeting date, complete the IPOPS **(optional)**, RMAP and Self-Assessment and make available two weeks prior to the meeting.

The alert will disappear/close when a new Annual or Annual No PCSP OSP is active. The alert is generated when a new Annual or Annual No PCSP OSP type is activated but does not appear in the folder until 90 days before the active OSP's End Date.

**Programming in Therap is currently updating the alert folder when any OSP type is activated. Currently Annual and Annual NO PCSP alerts are being removed when any OSP is activated.*

Search function – The user can also utilize the Search function to search by individual to find the OSP.

Timelines for Meetings

The due date schedule is not determined by the date of the annual OSP team meeting. However, if a provider wishes to have a reasonable assurance that they will have enough time to have the team meeting, enter the plan, submit the plan to the DDPM for approval and train their staff prior to the start of the next plan, the provider may wish to schedule annual team meetings at least 15 working days prior to the end date of the current OSP. That will give the Program Coordinator 10 working days to enter and submit

the OSP and allow the required 5 working days for the DDPM to approve it (working days does not include provider/state holidays).

The OSP meeting can be held less than 15 working days prior to the end date of DDPM. However, it means the Program Coordinator has less time to enter the OSP and submit it to the DDPM as the DDPM will always have the 5 working days to approve it; otherwise, it may not meet the timelines.

The provider may choose to schedule the annual meeting 4 to 6 weeks before the next OSP is due (end date of DDPM on ISP). This will allow the PC more time to enter the OSP, train their staff and submit it to the DDPM at least 5 days before the plan must be approved. It is recommended that annual OSP meetings not be scheduled more than 6 weeks in advance as circumstances can change and information can become outdated before the plan is implemented.

ICF/IID Meeting Timelines

To comply with ICF/IID federal regulations, team meetings should not be scheduled, if possible, more than 3 weeks before the next OSP is due (end date of DDPM on ISP). Best practice would be to arrange the meeting within the 3-week timeframe each year and schedule in advance the next yearly planning meeting. If for some reason the timeline exceeds the 3 weeks, the reason(s) should be documented by the DDPM in the DDPM Final Review Section.

The guidance for W249 states *"There should be no delay in the development and implementation of the IPP. To promote a team process and meaningful discussion, IPP development should take place during IDT meetings. Any IPP objectives or modifications that is critical to the health and safety of any client should be implemented immediately following IDT discussion."*

Change in Annual OSP dates

OSPs must be reviewed and updated annually (one year minus one day). However, the schedule for the plan can be revised as long as the new OSP is scheduled before the existing OSP is due and the person and/or legal decision maker has requested the change and/or are in agreement.

> *Example 1: The annual OSP was most recently held in February but the legal decision maker has requested the schedule be changed to the summer months. The team can determine when the annual meeting will be held and when the next annual plan is due provided it is completed and approved by the end date of the existing OSP. The team meeting should be held within 6 weeks of the new start date of the plan.*

Example 2: The Program Coordinator has 8 OSPs that are due in the month of December. The PC asks the person and/or legal decision maker if they would mind rescheduling their annual plan so that h/she will not have so many OSPs due within the same month. They agree and in consultation with other team members it is determined that the annual plan will be changed to the next April. The team can determine when the annual meeting will be held and when the next annual plan is due provided it is entered and approved by the end date of the existing OSP. The team meeting should be held within 6 weeks of the new start date of the plan.

Example 3: The annual OSP was held on November 15th and the new OSP start date is December 15th. It was determined that there are new or changes in supports that need to be implemented prior to December 15th due to health and safety concerns. The team may decide to change the plan date to be earlier then the new start date of the plan so implementation is not on hold.

Initiating the Annual OSP

Both the Program Coordinator and DDPM can start the annual OSP process by searching for the Active OSP to copy it forward.* Since it is a shared plan, both should search for the OSP before initiating a new one and notify the other if they intend to initiate the plan.

Program Coordinator responsibilities prior to the Annual OSP Meeting

1. **Written Notice of Annual Meeting**:
   At least two (2) months prior the Primary Program Coordinator will send out written notice of the meeting date and time.
   The Primary Program Coordinator will contact the person and/or legal decision maker and DDPM to select a mutually convenient date and time prior to setting the meeting date and time.

   If the person is receiving more than one service from a DD licensed provider, **one** OSP will be developed for the person. The Primary Program Coordinator is responsible to assure the secondary DD provider is invited to the OSP team meeting.

   Example: The person is receiving Day Habilitation services and In-Home Support services and the provider of Day Habilitation has Primary Program Coordination responsibilities. The Primary Program Coordinator of Day Habilitation is responsible to send the notification of the OSP meeting to the In-Home Support staff.

2. **At least two (2) weeks prior to the annual meeting date the Primary Program Coordinator will assure that the Risk Assessment (RMAP), Self-Assessment and IPOPs (optional) are completed with a new assessment date and available to all**

team members prior to the team meeting. These assessments are updated at least annually or as needs change significantly.

Involvement and gathering input from the person, their legal decision maker, and other team members in the assessment process is vital to a person-centered approach. It is expected that all team members will review the assessments prior to the annual meeting and come prepared to participate in team discussion relative to risk mitigation strategies, goals and supports.

- **Risk Assessment (RMAP) - the Primary Program Coordinator will complete the Risk Assessment in Therap and "Approve" it so the RMAP can be seen by the DDPM and other team members.** The RMAP is an assessment completed as part of the overall service planning process and utilized to identify known and potential risks to an individual so that appropriate mitigation strategies can be incorporated into the Person-Centered Service Plan.

The RMAP to be completed is, **"Risk Management Assessment and Plan" (Version: DHS-ND-2016.10)**BETA
If there is an existing RMAP in Therap the document will be copied forward, reviewed, updated and approved.

For EHHC and IHS, use Intermittent Risk Assessment SFN 866 sfn00866.pdf (nd.gov).

A new completion date should be reflected on the annual RMAP to align with the annual OSP dates.

RMAP Selection Buttons:

- **Save**-document is still being worked on and not fully completed.
- **Approve**-document has been reviewed and updated by the provider prior to the OSP meeting. Once "approved" the document will show up for the DDPM to "acknowledge".
    - Reviewer Comments section-DDPM can add any comments before selecting "acknowledge".
- **Copy as Draft**-select when you are creating a new RMAP if there is already an existing RMAP. This feature will be used for the annual RMAP or when risks change between the annual reviews. This creates a whole new RMAP.

- **Update**-use after the document has been "approved" to correct any errors or complete updates/additional information that resulted from the team meeting. Note-do not use this option for annual RMAPs or when risks change between the annual review. This will result in the original past versions within the RMAP module not being available for comparison or to show what has changed year to year.
- **Discontinue**-select this for any previous RMAP that is no longer current. Current is defined as the RMAP that is associated with the active OSP. Past versions will still be accessible but will show up as "discontinued" which is similar to how OSPs are displayed. Note-in order to work off or make updates using the previous RMAP, it must be copied over as a draft first before discontinuing. Once an RMAP is discontinued, it cannot be copied forward.

The RMAP is used to **identify** the risks, but the risks **must be mitigated** in the **PCSP** section of the OSP. The RMAP document has a section to document which specific section of the OSP contains the strategies to mitigate the risk, but the RMAP is not the document in which the risks are mitigated. The mitigation strategies are contained in the PCSP. The RMAP should list the specific section of the PCSP in which the mitigation strategy is located (e.g., Residential, Outcomes, Nutrition, PT, Rep Payee, etc.). Just listing "OSP" is not sufficient.

Consideration should be given to both the risks associated with current activities of the person as well as potential risks which inhibit the person from pursuing his/her goals and fully participating in integrated settings.

There is **a section in the PCSP section of the OSP titled "Review the Risk Assessment".** In this section the Program Coordinator will provide a high-level summary all risks identified in the RMAP.

**Refer to Risk Assessment Instructions on how to complete the document.*

The RMAP will be completed by the Primary Program Coordinator with input from all DD licensed service providers who are providing services to the person.

Example: The Day Habilitation provider has primary program coordination and the person is receiving In Home support

provider managed. The Day Habilitation Program Coordinator will work with the in-home support staff to complete the RMAP.

** Note: the INITIAL RMAP is completed (if one does not already exist) by the DD Program Manager as part of the referral packet.*

Gather information from a variety of sources. The person and legal decision makers will also be given the opportunity to participate in the completion of the RMAP if they wish to. Direct support professionals, observation, record review and assessor direct knowledge of the person are good sources of information.

When completing the RMAP, the Program Coordinator will **review GERs from the previous year** to determine whether there are new risks that correspond to GERs and need to be documented on the RMAP and mitigated in the OSP/PCSP.

The RMAP will be shared with the person and/or legal decision maker, including other team members. If the person, legal decision makers, and/or other team members do not have access to Therap, a hard copy will be shared.

The Primary Program Coordinator will send a Secure communication (s-comm), courtesy email or phone call to the DDPM to inform the DDPM that the assessment is ready to view. **The DDPM will "acknowledge" the RMAP**. Acknowledging means the DDPM has reviewed and is aware of the risks identified.

Once the RMAP has been reviewed by team members and finalized, a copy of the RMAP will be attached to the OSP prior to submission to the DDPM for approval. **Each annual OSP type will have a current RMAP associated with the OSP which is attached.**

Self-Assessment The Self-Assessment is a personal interview conducted with the individual prior to the service plan meeting and is an integral part of the person-centered service planning and should drive the planning process.

The Primary Program Coordinator will complete the Self-Assessment with the person and others who care about and know the person the best to identify the person's desired outcomes; goals; dreams; based on the individual strengths; interests; values; aspirations; and choices.

The self-assessment should very clearly describe what makes this person unique; what makes them happy; what is a good day for the person; what is a bad day; what should be avoided; are there tasks that need to be done in a specific order for the person. It provides information about the person's life story; describes who they are; and what they have indicated as their likes; dislikes; dreams; favorite things to do; desired community involvement; goals they wish to work on; things they want to learn and do; things they would like to change in their life; and who and what is important to them. This information should also be included in the appropriate Assessment section in the OSP/PCSP.

Self-Assessment Requirements

The State does not have a prescribed format for the self-assessment, providers will use their own format(s). In addition to describing the person, the self-assessment must address individual experiences that incorporate the CMS HCBS Final Rule regulations to ensure on-going compliance with the requirements. This self-assessment will capture this information initially and on an annual basis. The Council on Quality and Leadership (CQL) Personal Outcome Measures may be utilized for this purpose. The self-assessment must address the following:

- People are living and regularly participating in integrated environments (e.g., using and interacting in the same environments by people without disabilities; regularly accessing the community; having the ability to come and go from the setting; access to public transportation; etc.)
- People have opportunities for employment and to work in competitive integrated settings (e.g., choice and opportunity to experience different work and/or day activities, support to look for a job if interested, meaningful non-work activities in the community, etc.)
- Control and access of their money. (e.g., able to buy needed items, use own money when choose to, accessibility of money, have their own bank account, etc.).
- People have options and choices in where they live, work, and attend day services (including do they continue to be satisfied, choice in their own bedroom, and choice in whom they live with/share bedroom).
- People experience privacy, dignity, and respect (e.g., have time alone, privacy during personal assistance, confidentiality of information, respectful staff interactions, being listened to and heard, ability to close/lock bathroom door, access to phone, etc.)

    - In provider-owned or controlled residential settings, people are provided the right to have lockable bedroom doors.
- People have choice and control in daily life decisions, activities, and access to food (e.g., they understand their rights, they practice rights important to them, individual choice/control in schedule and routines, availability of food, choice in when/what/where to have meals, etc.)
- People have the freedom to furnish and decorate their room/home (e.g., choose decorations, arrange furniture, hang pictures, change things if want to, décor reflects personal interests and preferences, etc.).
- People have access to all areas of the setting (e.g., kitchen, break room, laundry room, community rooms, etc.)
- People have visitors of their choice and at any time.
- People exercise their rights to freedom from coercion and restraint (e.g., give informed consent, know who to talk to if not happy, least restrictive methods utilized first, etc.)
- People choose their services and supports (e.g., choice in providers, service options, opportunities for meaningful non-work activities, opportunity to update/change preferences, etc.)
- People are involved in their own planning process to the extent desired (choice of meeting location, people to invite, desired level of participation, development of plan, etc.)

Refer to the CQL "A Toolkit for States" for more information on how to use the Personal Outcome Measures with the HCBS requirements. Or refer to the document titled "CMS Home and Community Based Settings Final Rule Requirements located on the following website: *https://www.hhs.nd.gov/human-services/hcbs*

Since the Self-Assessment is not in Therap and providers continue to use their own formats, it will be necessary to send the Self-Assessment via s-comm or hard copy to team members two weeks prior to the annual meeting. Again, risks are not mitigated in the self-assessment but are managed within the OSP/PCSP.

- **IPOPs – "Individual Plans of Protective Oversight" – (USE VERSION-ND-2012.1)**
  *The IPOPs are not required but are optional assessments. The information contained in the IPOP's may be already captured in either the RMAP, self-assessment, or other sections of the OSP. Providers may also choose to complete other provider specific assessments to supplement the IPOP's information.

The Primary Program Coordinator will complete the residential and general IPOPs in Therap prior to each annual meeting. The IPOP modules record and update both general and residential assessments and needs.

When the annual plan comes due, copy the IPOP forward and update the information in the new IPOP so that the historical information is maintained from the previous IPOPs and can be accessed.

Once the updated IPOP is completed, the Program Coordinator will select "Approve". This will enable the DDPM to view the IPOPs. The Program Coordinator will send an s-comm or call the DDPM to inform the DDPM that the IPOPs have been entered.

The DDPM will have the opportunity to read the IPOPs and assure that they have been completed, but the DDPM is not expected to approve or evaluate the IPOPs. Once the DDPM has reviewed the IPOPs, the DDPM will select "Acknowledge".

The IPOPs are assessments but are not attached to the OSP.

- **Other Assessments**
  The Primary Program Coordinator will assure that other necessary and appropriate assessments and reports are obtained and available at the annual meeting. These may include but are not limited to Medical and Physical Exams, Nursing, PT, OT, Speech, Nutrition, Functional Analysis, Vocational or Day Service assessments etc. The Program Coordinator may choose to send these additional assessments out to the team prior to the team meeting, but the only assessments required to be sent out prior to the meeting are the Self-Assessment and Risk Assessments (RMAP).
  Assessments which are not provided to team members are available to the team upon request.

SIS and ICAP Assessment

The DDPM should follow up with the person and/or legal decision maker to determine if a team meeting is necessary to make any updates/changes to the person's plan based on the assessment results.

The information documented in the Support Intensity Scale (SIS) and the Inventory for Client and Agency Planning (ICAP) may be utilized as

another tool or resource for the person-centered service planning process. These assessments should not take away from the plan but may provide supplemental information toward how paid and non-paid supports can provide support.

**Refer to Appendix "The SIS for Overall Service Planning"*

Providers of secondary DD licensed services are responsible to provide the Primary Program Coordinator with a copy of their assessment prior to the Annual OSP meeting. Secondary service providers are expected to attend the team meetings and participate in development of the OSP, specifically as it relates to their services, including goals, objectives, and risk management strategies in their program. In addition, the secondary service provider will provide the Primary Program Coordinator with periodic written updates regarding the person's progress or lack thereof in their program and of any significant issues or concerns that need to be addressed by the team.

DD Program Manager Responsibilities prior to Annual OSP

Prior to the annual OSP the DD Program Manager will:

1. Review and update the "Individual Home" page under "View Details Show Individual" on the State Therap side. This needs to be completed prior to a new plan being started in order for the changes to be reflected.
    - Involved Individual's addresses, phone contacts, email etc.
    - Demographic information
    - Guardianship information
2. Review and "acknowledge" the RMAP
   Completion of the RMAP by the Program Coordinator includes a review of the GERS for the past year.
3. Review Self-Assessment to assure through the OSP process that individual outcomes are being realized, services meet the person's needs, people have experiences in line with the HCBS requirements, and plans are developed according to needs and preferences.
4. Review and acknowledge IPOPs – for informational purposes only. DDPMs are not responsible to "approve" the IPOPs. **(optional)**
5. Review the service options and their choice of service providers with the person prior to the team meeting, annually and as needed. People will be informed of all the possibilities from which they may choose, in a manner that is meaningful and easily understood to them. This process truly puts the person in the center, facilitated to make informed choices.

6. If the person is receiving a Traditional Self-Directed waiver service: develop outcome/goals and objectives to include in the PCSP at the annual meeting. The DDPM can enter this information into the PCSP section of the OSP or send the information to the Program Coordinator to request that it be entered.
7. Prepare Release of Information/Authorization to Disclose forms to bring to the annual meeting.
8. Complete the pending annual ISP section of the OSP and print the PDF form to bring to the meeting for signatures.
9. Review ISP rights, including their right to appeal, in a manner that is understandable to the person with no professional jargon and document.

   The ISP will remain in pending status until the PCSP section is entered and submitted by the Program Coordinator and approved by the DD Program Manager.

   Once the DD Program Manager has approved the OSP, a copy of the signed and dated ISP will be distributed to the person and/or legal decision maker and each DD licensed provider providing a service. A signed copy is retained in the HSC file.

Annual OSP Meeting: Requirements, Discussions and Expectations

Medicaid Redetermination Date

Since the majority of DD authorized services require Medicaid participation or private pay, it is important to ensure that the person maintains their Medicaid eligibility. Typically, Medicaid benefits must be renewed and re-determined every 12 months.

List the date when the next or future Medicaid re-determination is due, if available.

Demographic Information

This information is entered by the DDPM and transfers from the Stateside View details page as well as from the Shared Contacts within the Individual Demographic Form (IDF)-this found within the Individual Demographics Module on the Dashboard page.

These sections should be reviewed by the DDPM at least annually and updated whenever necessary.

*Enter this before the new plan is created otherwise updated information will not carry over into the OSP.

"State" ISP section of the OSP

The ISP section is entered by the DDPM and is the authorization for payment of DD authorized services. The ISP must list all services the person is receiving regardless of funding source, including Medicaid and non-Medicaid funded services, the provider in which the person is receiving services, and informal supports that are necessary. This includes DD authorized services to be reimbursed through the Medicaid waiver, state plan services, generic and community services and natural supports that are not authorized through the DD Section. e.g., Education, Individual Counseling, Psychiatric, WIC, and other non-DD services the person utilizes or accesses. When the natural/informal supports and non-waiver services and supports are needed to meet the needs of the person, their provision must be addressed in the service plan.

The ISP also contains information regarding the disposition of services, provider of services, funding source, start date and end date of services, termination date of services, location, setting, and amount/unit/frequency. The ISP must be updated anytime the DD authorized service changes.

**DDPM's should refer to the Service Grid for the list of service information to enter into the ISP. The Service Grid is to assist the DDPM in completing the ISP.*

In addition, the ISP contains a list of rights and responsibility statements for the person receiving services. The annual rights/responsibilities printed in the ISP will be reviewed at the team meeting in a manner that is understandable to the person with no professional jargon. If the person/legal decision maker is not available to sign the ISP at the meeting, the DDPM will ensure they are reviewed and explained prior to signing of the ISP.

The signature on the ISP denotes that the person and/or legal decision maker is aware of their rights and responsibilities.

Service reimbursement and payment

The ISP also serves as the preauthorization document for payment of Medicaid funded DD authorized services. The ISP is the document that

authorizes Medicaid payment for DD Title XIX services in the Medicaid payment system. An ISP must be completed in order for payment to be made.
Federal financial participation (FFP) from Medicaid may be claimed only for services that are included in the plan and may not be claimed for services furnished prior to the development of the service or for services not included in the plan. There must be a current OSP (including the ISP and PCSP components) before reimbursement will be made for services.

The ISP section of the OSP is printed by the DD Program Manager prior to the meeting and is signed and dated by the person/legal decision maker, one representative from each provider and the DD Program Manager. A copy of the signed ISP is distributed to the person and/or legal decision maker and each provider agency and a copy is attached to the OSP.

The DD Program Manager will make every effort to obtain the signature of the person and/or legal decision maker and the efforts will be documented in the individual record. In the event the document is not signed and returned, services will continue to be provided as long as the person meets the eligibility requirements and the service is appropriate or the person/legal decision maker is given advance notice in writing of the intent to terminate the service(s) and includes the person's right to appeal that determination.

The OSP (ISP and PCSP sections) is subject to the approval of the State Medicaid agency. DD Program Managers are responsible as representatives for the Medicaid agency to approve each plan. The plan will not be approved unless the appropriate person-centered service plan meets the requirements set forth in policy as required by Centers for Medicare and Medicaid.

Virtual Supports

Select services within the Home and Community Based Services (HCBS) Waiver can be provided using virtual supports, which is an electronic (live real-time video and audio) method of service delivery.

Services available for virtual supports include:

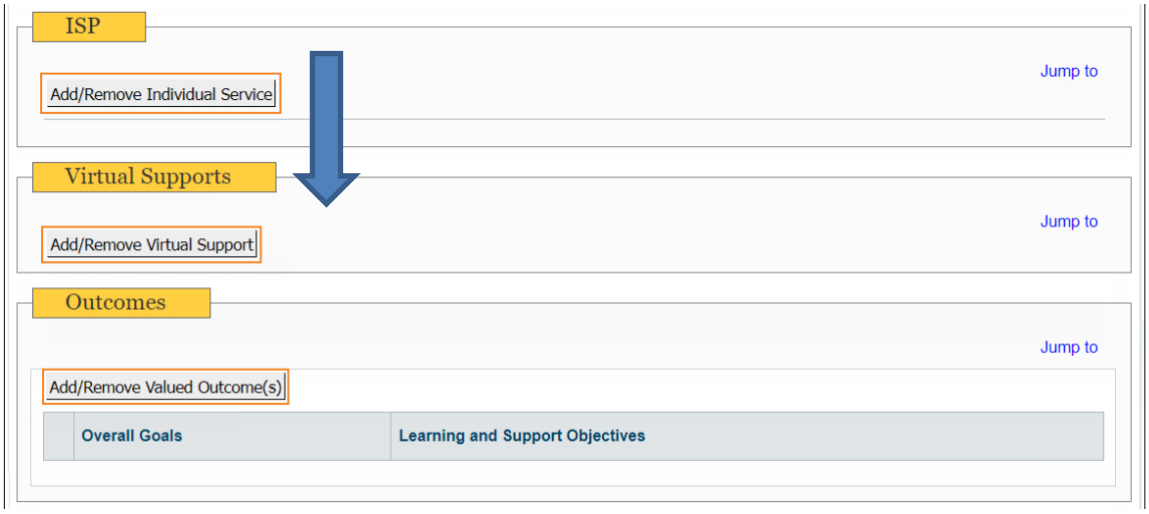
- Behavioral Consultation
- Independent Habilitation
- Individual Employment Services
- Parenting Supports

If the person and/or their legal decision maker are interested in receiving virtual supports and the team agrees, a Virtual Supports Checklist (SFN 1522) will be completed by the DDPM and team during the OSP planning process to determine if the person meets the criteria and if so, the estimated number of hours and how virtual supports will be implemented.

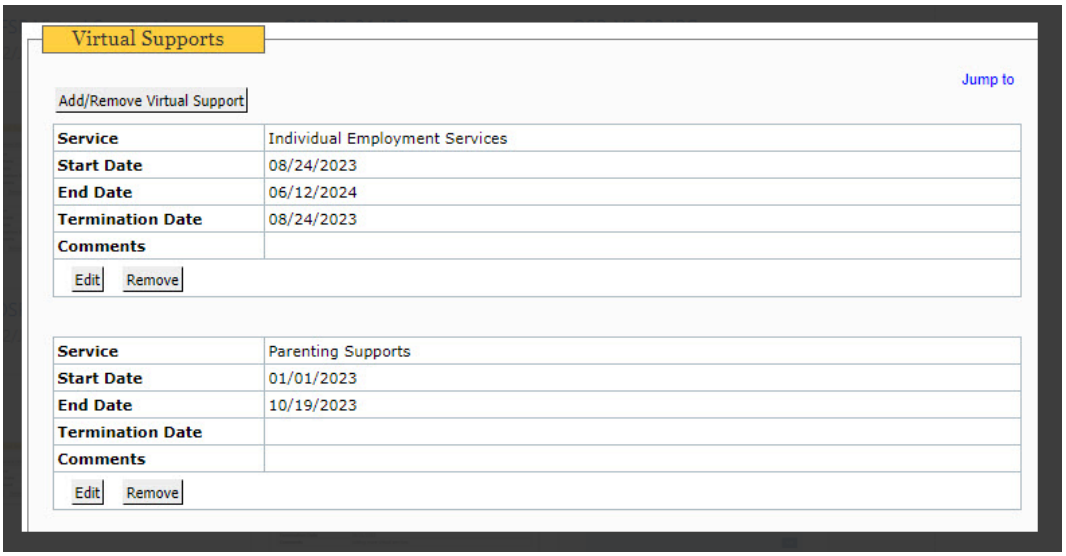
The Virtual Supports Checklist will be completed prior to the start of virtual supports, annually and be attached to the OSP.

> *Refer to the DD Virtual Support Policy for more information pertaining to the requirements, limitations, and utilization.*

The OSP contains a section to document the use of virtual supports (located between the ISP and Outcome sections) **This section will be entered by the DDPM.**



- Click on the Add/Remove Virtual Support button to add Virtual Support(s).
- Select the Service, Start Date, and End Date.
- Select a Termination Date, if applicable.
- Enter required information in the Comments field.
- Clicking the Done button.
- Click the Add/Remove Virtual Support button to include any additional service(s).



The comment box area will describe the pre-planned activities that will be provided virtually. This includes:

- The tasks, supports, and objectives that can be delivered remotely.
- Identify the technology platform used to deliver the virtual supports.
- Estimated number of hours that will be delivered virtually.
  - Services may not be delivered via virtual support 100% of the time.
- Any other team discussions and decisions.

Additional Instructions

- The service that will be provided using virtual supports will be selected from the drop-down list, along with the start and end date.
- Each service using virtual supports must be listed separately.
- The end date cannot be past the end date of the OSP start and end dates.
- If any virtual supports will be discontinued prior to the OSP end date, the OSP will be updated in the virtual supports section to enter the termination date along with reasons for termination in the comment box. An OSP Update may be used to complete this.
- At least annually, or more frequently if needed, teams will review the quality and effectiveness of virtual supports to meet the person's needs and preferences. The DDPM will review and document satisfaction and progress of virtual supports in the satisfaction section of the QER document.
- If health and safety concerns arise, the team shall meet to determine if tasks, estimated number of hours, and virtual supports need to be updated. An OSP Update may be used to document this.

Outcomes

Overall Goals	Learning and Support Objectives
List 1st priority overall goal/valued outcome **List 2nd priority overall goal/valued outcome** **Etc.**	**Label and list Learning Objectives that relate to the 1st priority goals/valued outcomes.** **Label and list Support Objectives that relate to the 1st priority goal/valued outcome.** **Label and list Learning Objectives that relate to the 2nd priority goals/valued outcome.** **Label and list Support Objectives that related to the 2nd priority goals/valued outcome.**

Goals and objectives are individualized, meaningful, and specific to the person. Goals should be written in words familiar to the person and/or legal decision maker.
Each DD licensed service program will have at least one goal and one learning objective associated with that service listed in the PCSP section of the OSP per state law (ND Century Code 25-01.2-14).
Goals and learning objectives should be tied to the provision of services. DD services are provided because a person has specific goals they want to achieve and support needs that must be addressed to ensure health and safety, quality of life for that person, and promote independence and learning.

There is not a set formula for the number of learning or support objectives for each person. **Through the person-centered planning process and based on individual needs, the team will determine the goal, learning and service objective(s).** The team should factor in health and welfare safeguards; opportunities and encouragement to grow to the highest attainable level; and individual needs are being met taking into consideration the person's age, self-management, and opportunities for choice. **All people should be actively involved in their daily activities.**

Not having a skill should not limit the person's access or dreams. A foundational value of person-centered services is to support the person's dreams and in learning new skills that will lead to increasing their independence and ability to lead a self-directed life. With rare exception (i.e., a person with dementia*) the person's plan will include a combination

of learning objectives and support objectives that are designed to systematically assist the person in attaining these Overall Goals.

> **People with dementia may have goals/learning objectives/supports that focus on skill(s) or health maintenance. People who are at retirement age, may explore areas related to social roles or focus on what retirement will look like for that person.*

Goals and learning/support objectives can be implemented across multiple programs particularly if it is a priority and is important to address in more than one setting. Goals and objectives will be implemented and monitored on an ongoing basis.

It is expected that data is collected and analyzed in each service program for the purposes of monitoring and accountability. The Primary Program Coordinator should gather data monthly and provide a summary to the team members at a minimum quarterly to monitor the progress of the programs **(SFN 1414 progress summary for prevocational services are sent quarterly).** The secondary service provider will provide any information on the person's status and data collection for programs they are responsible for implementing. The team should identify who receives this information, such as the DDPM and any other team members, in order to keep the team informed and to assist in monitoring and planning. The review provides data and progress on the individual's goals and learning objectives/supports. The review may also include other items such as medical & health information, activities, highlights, significant events, changes, concerns, or anything that may need follow-up or further action.

Recording of information such as progress notes and the data monitoring of progress towards goals and objectives are necessary to verify that services were delivered for individuals and demonstrate the right of providers to receive payment. The documentation should include the signature/initials of the staff member providing the service.

The Overall Goals and Learning/Support Objectives on the Active OSP will pre-populate to the Quality Enhancement Review (QER), so that they can be reviewed and monitored by the DD Program Manager during the QER process.
**This information must be made available to DD Program Managers for review during the Quality Enhancement Review (QER) process.*

<u>Overall Goals</u> are defined as behavior, actions, or states attained by the person that can be observed, measured and can be determined

reliable and valid. Overall Goals in the OSP could be referred to as the person's valued outcomes and are generally longer than a year to achieve. The Overall Goals are derived from desired outcomes/goals identified by the person in their Self- Assessment and from assessments and information provided and discussed during the team meeting.

The individualized **Overall Goals** must be included in the PCSP section of the plan and listed on the left side of the Grid. A statement indicating "See attached" is not acceptable.

Most people will have Overall Goals in the areas of living, working (daytime hours if the person is retired), and leisure/recreation. It might be necessary for the team to prioritize the overall goals that will be worked on during the period the overall service plan is in effect, particularly if there are multiple goals identified.
The goals might also be identified as a strategy to mitigate identified risk(s).

Agencies may continue to utilize the Self-Assessment to collect data for CQL as required for licensure. However, the CQL Personal Outcomes Measures do not represent the Overall Goals for the person in the Outcomes Section of the PCSP- the actual goals and objectives that are developed for the person's plan must be written to be unique and specific to the person and must be measurable (goals should not restate the POM wording). The CQL valued personal outcomes are a good format to help explore and guide discussion in the various areas of a person's life and discovering what is important to them.

It is not expected that the Overall Goals address all CQL personal outcomes or include all of those which are not met. It is more meaningful and effective to prioritize and focus on certain goals versus attempting to address all areas that are indicated as not present or wanting to achieve. It is essential to focus on what the person desires while also assuring support for health and welfare.

**Refer to Appendix "CQL Personal Outcome Measures"*

Learning Objectives are defined as behavior/skill acquisition or change on the part of the person for whom the plan is written. Learning Objectives were previously referred to as "teaching" or "training" objectives that assist the person in achieving their Overall Goal or valued outcome. Learning objectives will have specific measurable criteria, data will be taken, and the objective will be monitored to measure progress made. The learning objectives might be identified as a strategy to mitigate identified risks.

Learning Objectives should directly relate to the Overall Goal(s) and should be labeled as a learning objective. A statement indicating "See attached" is not acceptable.

Support Objectives are defined as supports or actions taken to enhance the person's quality of life or ongoing actions or assistance that will be completed with, provided to or for the person. Support objectives are generally actions on the part of the staff or agency that assist the person in achieving their overall goals/valued outcomes.

Support objectives listed in this area should directly relate to the priority goals identified in the overall goals section. The support objectives should be labeled as a support objective. The support objectives might be identified as a strategy to mitigate identified risks.

The Learning and Support Objectives must be written in the PCSP section of the OSP. A statement indicating "See attached" is not acceptable.

A person may have a number of supports that do not specifically relate to a priority outcome/goal (e.g. not every support is expected to be associated with a goal). The RMAP also identifies risks which are to be mitigated in the plan. However, not all risks may be identified as a priority or warrant mitigation with a goal, learning objective, or support objective. These additional supports can be included throughout in the corresponding assessment sections and describe/summarize the person's support needs. These are supports that may not be a priority or address an area where the person is stable in but still need ongoing assistance.

> *Example: Dressing and care of clothing may not be identified as a priority to be addressed in the goals and objectives section for that person. This may be in the Residential Assessment section by indicating "staff will assist Mary in getting dressed in the morning. She can select her clothes and get dressed except that staff needs to assist her in fastening."*
>
> *Example: A person requires assistance with cleaning glasses. This may be in the Vision section by indicating "staff will assist Mary in cleaning her glasses as needed".*
>
> *Example: A risk of finical management is identified in the RMAP due to previous trends in spending money, etc. The person has a Representative Payee to mitigate this risk. In the Representative Payee section-the person or agency that is responsible to carry out the responsibility for monthly bills, budget spending money, holding spending money, completing benefit applications, etc. is listed and addresses the risks identified in the RMAP.*

It is expected that the team process determines if data should be collected for support objectives. The determination may be based on the priority, if it

is a task/activity that should be followed up on, would it be meaningful, what would be the purpose of the data, what is the purpose of the support objective, is it to ensure staff completion, etc.

> *For example: A person has a goal related to finding employment in an area that interests them. A support objective is that staff will assist the person in exploring 2 volunteering activities each month. Data may be taken on what activities were tried, what the person's response was, etc. In this case, the support objective information might be meaningful and beneficial toward the goal in discovering the person's likes, dislikes, interests, what worked, what did not work, etc.*

Methods are defined as detailed instructional methods, specific techniques, approaches, or procedures. Methods should be specific enough so that anyone can read them and implement the objective as written. The Methods will not be included in the OSP/PCSP component of the plan as methods may frequently change and should not require a revision to the plan. Methods will not be included in the QER.
Although the Methods will not be included in the OSP, methods will be developed and made available to the DD Program Manager, person and legal decision maker upon request.

This may be done by using the Therap ISP Programs, reviewing treatment sheets or other additional supporting documentation.

For additional information on writing measurable goals, learning objectives and support objectives refer to the training information provided from NDCPD and the training Modules. Program Coordinators should consult with their agency trainers for further assistance.

Refer to the State Operations Manual for Active Treatment and Individual Program Plan regulations in ICF/IID settings.

PCSP

PCSP Meeting Date

List the date of the OSP team meeting including the meeting for Annual, Admission, 30 Day Comprehensive, Team Review and ISP Update.
If changes are made to the OSP without a team meeting, list the date changes were made in the PCSP meeting date section.

Assessment Review sections

In each assessment review section:

1. **Summarize the results and information gathered in that particular section.**

- Some information may correspond to several assessment sections. It is not necessary to repeat or include the same information in multiple assessment sections.
- The summary of results and information should be in language that is understandable, meaningful, and person-centered, with no professional jargon and technical language. The OSP should contain information so anyone, even someone unfamiliar with the person, can review the plan and implement it.
- Providers may have their own terminology and varying tools for some assessments in addition to the state required assessments. Capturing the information in the plans is more important than lining up what assessment information goes in what section.

2. Document any team discussion, recommendations and decisions made during the team meeting regarding the particular section.

- *Documenting "see attached" in the section is not acceptable. Each section is limited to a number of characters. If additional documentation is required, a Word document can be attached to the OSP to continue the documentation and discussion.*
- *Some have elected to attach other documents or updates to the plan in an effort to become "paperless". This is not a problem as long as the OSP/PCSP Assessment sections contain the required summarized information AND the attachments that are required. There is a risk of not having enough space to attach everything they wish to.*

3. Describe any additional support objectives that are necessary to mitigate risks identified in the risk assessment (RMAP) if not addressed in the priority outcomes/overall goals and objectives section above.

- The priority outcomes/goals will be reflected in the Outcome/overall goals section of the plan along with the learning objectives and support objectives that relate to the specific priority outcome or goal.
- A person may have a number of support objectives that do not specifically relate to a priority outcome/goal but are critical to the health and safety of the person, are essential in mitigating identified risks from the RMAP and therefore must be delivered out by the provider. These additional support outcomes will be included in the corresponding section of each assessment section.

- If a person requires treatment beyond first aid on a regular basis and care is routine in nature due to a diagnosis, chronic condition or procedure (i.e., a seizure protocol, mickey button replacement, etc.), they must be identified in the RMAP and procedures/protocol placed in the various assessment sections of the plan.

Example: A person has a seizure disorder - this will be reflected in the medical or neurological assessment section depending upon which physician is treating the person for the seizure disorder. If the seizure disorder is a significant concern and is a priority, it can be addressed in an overall goal and an accompanying learning or support objective in that section of the OSP. If it is not addressed in that section, but the person still requires medications, assistance with medications or there is a specific response to seizures (e.g. seizure protocol), this must still be reflected in the OSP. This can be accomplished by a support objective described in the medical or neurological assessment section of the plan.

Example: A person who has hearing aids. The results of the most recent hearing exam will be summarized in the Hearing assessment section and might be identified as a priority by the team in some circumstances and addressed in the in the overall goals/objectives section above. However, if it is not, and the person still needs someone to support them in putting in and caring for their hearing aids, the support objective for this will be included in the Hearing assessment section.

Example: Bathing might be addressed in the overall goals/objectives section particularly if it is a priority for the person to learn to become more independent. However, if staff are to assist the person, a support objective be may be written in the Residential section of the plan to address the need and any identified risks.

**It is important to note-according to DD Policy, anything which requires treatment beyond first aid requires reporting as a serious event unless it is identified in the plan.*

4. In the corresponding assessment sections, reflect how any natural supports and self-directed services assist the person in services, supports, and achievements of identified goals.

- Natural supports are unpaid supports (family, friends, community, etc.) that are provided voluntarily to the person in lieu of services and supports.

Example: A person attends church every Sunday and established relationships with certain parishioners. Every Sunday, a person attends church with their neighbor. That neighbor provides the transportation to and from church in addition to the companionship during mass. This could be highlighted in the Residential Section.

5. In a corresponding assessment section, such as the Self-Assessment Section or the Vocational/Employment/Day

Supports/VR Section, provide a summary where the person lives, works, attends school, and/or attends day supports.

- If there are any barriers affecting the person's preferences to where they live, work, or attend day supports; the person-centered planning process should initiate and address any future steps in meeting their preferences.

Review of plan and progress towards outcomes section

In this section, the status of the previous year's goals and objectives-based data will be reviewed. Outcomes or goals identified by the person that have not been achieved should be discussed to determine if they should become a priority and worked on within the next year. This section should also focus on successes and highlights of the person's life over the past year since the last plan was developed. Significant family, medical, travel and other events that are important to the person should be reflected. This is the time to celebrate the person's accomplishments and highlight any significant changes.

Review of Self-assessment section

The self-assessment is the foundation of the plan. Each person will have a self-assessment completed annually, prior to the annual team planning meeting.

- In this assessment section, the most vital and essential aspects of the person's identity, individual experiences, and what makes them unique; skills, interests, personality and values; what is important to the person, who is important to the person, non-negotiables, how the person communicates, strengths, likes, dislikes etc. should be summarized. This information represents what is important TO a person to feel happy, content, fulfilled, and satisfied. Team members will share positive gifts and capacities of the person and assist them in exploring new experiences or to learn new skills that are personal and unique for that person.
- Information such as educational (school) services, natural supports, self-directed services, and any other generic services or activities the person participates in could be reflected and highlighted.
- Summary of the person's daily schedule or description of the person's typical day and activities based on their preferences. However, days and activities may vary somewhat based on choices etc., but this will provide staff, especially new staff, how a day in the life of the person may typically be.

- What the person wants to do for the next year and future should be reflected

Obviously, all of the information contained in the self-assessment is important; but in this section, the characteristics of most consequence and magnitude should be described so that those reading the plan have a good idea of "who" the person is and can interact with them in meaningful ways that reflect the person's preferences and their health and safety needs. This section should clearly describe what makes this person unique; what makes them happy, what is a good day for the person, what is a bad day, what should be avoided, are there tasks that need to be done in a specific order for the person, etc.

Review of RMAP (Risk Assessment) section

The Program Coordinator will give team members an opportunity to address any questions, concerns, additions, or deletions related to the updated assessment and document the discussion and decisions in this section. If revisions or changes need to be made to the RMAP assessment, the Program Coordinator will update the assessment following the meeting and attach the revised copy of the RMAP to the OSP before it is sent to the DD Program Manager for approval.

In this section a high-level summary of **all** risks identified in the RMAP will be described as well as any team discussion that occurs relative to the identified risks. Only areas of identified risk need to be reviewed at the team meeting and mitigated in the OSP/PCSP. This information represents what is important FOR the person to have good health, be safe, and be a valued member of the community.

The RMAP is divided up into sections e.g., Activities of Daily Living, Behavior and Psychiatric, Medical and Physiological Risk Factors, Environmental Risk Factors, Community Living Activities. It may be helpful to list those sections and then any risk that is indicated "yes" and falls under that section in the RMAP along with any team discussion that occurs regarding each risk.

Remember, the RMAP is the assessment that identifies the risks and indicates specifically which section in the OSP/PCSP the risk is mitigated. The actual mitigation strategies for each identified risk must be developed within the OSP/PCSP.

All safeguards, supports e.g., support objectives, education and teaching e.g., goals and learning objectives that are necessary to mitigate the

identified risks must be addressed within the PCSP sections of the OSP and should not be attached. The mitigation strategies should identify who will be responsible for each of the needed safeguards and actions.

Significant risks or priority risks will most likely warrant the development of a goal and learning or support objective in the Outcome section of the PCSP. Risks that are not of great significance or are determined not to be a priority can be mitigated in the appropriate Assessment section of the PCSP.

> *Example: The RMAP identifies loss of benefits as a risk. The person has a representative payee to assist them. This risk can be mitigated in the Rep Payee section of the PCSP.*
>
> *Example: The RMAP identifies dressing and care of clothing as a risk e.g., the person is unable to do this without assistance. Dressing and care of clothing may not be identified as a priority to be addressed in the goals and objectives section for that person. This can be mitigated in the Residential Assessment section by indicating for example the "staff will assist Mary in getting dressed in the morning. She can select her clothes and get dressed except that staff need to assist her in fastening."*

The Meaning of Risk Mitigation

Risk mitigation is the plan, services, supports, interventions, or strategies to minimize or manage the risk. Mitigation may take various forms, such as a goal; learning objective; support objective; descriptive statement; consumer training; safeguard; etc.

States cannot guarantee that people will never experience risk or a negative outcome. Life happens to all of us. However, people with disabilities may be more vulnerable and have more difficulty in making informed decisions about risky behaviors and their possible consequences. Therefore, it is essential that potential risks are identified, and a plan is developed to minimize or manage the risks through interventions, services and supports.

All people, disabled or not, have potential risks, take risks, and have a right to risks. Dignity of risk reflects a person's right to control their destiny and fully experience life, both the good and bad. Similar to the individual needs and preferences that are addressed in planning, risks are also highly individualized. Risk is a combination of individual circumstances, events and perceptions.

Risks must not only be identified, but also addressed as fully as possible during the development of strategies, supports and services that will mitigate those risks.

Balancing a person's right to make choices, including potentially unhealthy or unsafe ones, with the State's need to assure the health and welfare of a person is an over-riding concern for States. Health and welfare safety are not an absence of risk, instead it is matching the level of risk to the person's wellbeing, which leads to the challenge of managing the risk.

Risk identification is more than a conversation between people, their families, program managers and others. **It also involves a comprehensive documentation of that conversation. Such documentation provides the context and rationale for elements in the service plan and provides evidence that a risk management process is in place.**

> *"Choice is the most powerful word and the most abused word in the current lexicon of the disabilities service system." Michael Smull.*

It includes three related and embedded concepts: preference, opportunities and control. The team needs to start planning with an understanding of what people need for their happiness and then examine the risks entailed, as risk is both relative and contextual. The degree of risk is determined by weighing the dangers in the environment, individual skills, experiences, and supports. No specific guidelines can ensure unquestionable safety for everybody.

CMS has not published thresholds for acceptable levels of risk because risk is highly individualized. Risk identification and mitigation is not to prevent people from living in the community. In addressing trade-offs between choice and safety, States will best be served by documenting:

- the concerns of the person, staff, providers, and any other stakeholders.
- the negotiations process and the analysis and rationale for decisions made and actions take.

When states document these aspects of their monitoring activities, they will have solid evidence to support their policies and individual plans.

Review of Residential Assessment section

This section will summarize the residential assessment that describes the person's strengths and support needs and any team discussion that occurs in relation to the residential assessment. Any needs and/or identified risks will be mitigated in this area through a support objective particularly if it is not addressed or reflected in the Outcome/Goal/Objective section above.

Vocational, Employment, Day Supports/VR

Each service/program will have a written assessment for the annual meeting that provides an overview of the person's strengths, support needs and recommended goals/objectives for the service or program.

A summary of the assessment, team discussion and action plan will be reflected in this section including any needed support objectives that relate to their vocational, employment or day support program if not previously addressed above. Highlight any specific skills, needs, preferences, likes, dislikes, etc. that are important to the person in this area. A summary of the activities, jobs, volunteering, interests, etc. should also be part of the information.
If the team determines that an individual will receive Day Habilitation in a residence; the situation, reason, and individual's need must be justified and documented in this section. Individual needs include medical or behavioral needs which may impede successful programming in the community or facility-based program. The discussion and documentation must include other strategies and options that have been tried and have not been successful. Personal preference must also be considered and documented. Throughout the year, options should be explored and tried. The team must discuss and document these attempts in the individuals' plan at least annually.

Health and Welfare

Health status review section

- ✓ If there is no current or previous information available, indicate "N/A" or "not applicable" in the specific section so it is clear that each section was addressed.

- ✓ In addition, the team should determine whether an updated exam is needed.

Physical Exam (date of last exam):
The date of the last physical exam will be entered. This section should document:

- A summary /impression of the results of the most recent physical exam(s) and name of physician who completed the exam.
- Follow up that is needed, if applicable

Nursing Services
If receiving, list name of agency and type (public health, home health services, agency nurse) and describe the tasks provided by the nurse.

Diagnoses Review
All current diagnoses must be listed in this section of the plan. Includes any ID, mental health, personality disorders, medical diagnoses.

Medication Review
This section should indicate if the person receives medication and if so what conditions, diagnoses or medical conditions the medication is prescribed for.

e.g., medication for high cholesterol; supplements for bone and overall health; water retention; constipation etc.

*Specific medications and dosages do not need to be included in this section as they may change over the life of the OSP. However, this section should indicate where the current MAR is located.

The date of the most recent med review, and the med review schedule should be listed if known.

Specific side effects that need to be monitored should be listed.

Lab work
Describe date of most recent lab work; frequency of lab work and for what conditions/diagnoses the labs are completed.

Allergies
List all allergies and any necessary precautions that are taken including use of Epi-pens etc. and where stored/located.

Immunization
Indicate whether immunizations are up to date; or if immunizations are needed, list the immunization needed and who is responsible to obtain.

Review Checklist for recommended examinations (date of last exam)
Refer to the recommended screenings/exams from the Centers for Disease Control or American Cancer Society
Document whether the recommended screenings, exams and appointments are up to date. If screenings are needed, indicate which screenings are needed and who is responsible to assure the person is scheduled for the screening.

Nutrition/dietary
List the date of the most recent consultation and summarize any nutritional or dietary orders. Summarize any related discussion or concerns regarding nutrition or diet based on the medical information regarding the person's current weight etc.

Vision (date of last exam)
List date of most recent exam; summarize findings from the report including recommendations, recheck appointments; name of doctor and clinic.

Hearing (date of last exam)
List date of most recent exam, name of evaluator and office name. Summarize the results of the exam notes relative to the person's hearing status and recommendations, re check appointments.

Dental Status (date of last exam)
List the date of most recent dental visit and summarize results of the exam notes, cleaning schedules, significant concerns and follow up etc.; and provide name of dentist and dental clinic name.

If the person requires any type of restrictive intervention or restraint for medical or dental procedures this should be listed in this section and also addressed under Safeguard Section.

If the person is receiving Additional Dental Reimbursement through Medicaid due to challenging medical and/or behavioral challenges, this should be noted in the dental section as well and the Dental service

should be listed in the ISP section of the OSP. *Refer to the dental service protocol for the approval process.

Psychological
List the date of the most recent psychological evaluation including the name of the psychologist/location of the psychological evaluation; team discussion of any psychological counseling the person is currently receiving (if they see someone regularly for appointments).

The team will determine and document whether a new psychological is needed to reflect the persons current level of functioning, particularly if the psychological evaluation is old and not reflective of the person's current status.

The diagnosis from the psychological evaluation does not need to be listed since there is a Diagnosis section listed earlier in the OSP.

Psychiatric
List the date of most recent psychiatric evaluation and appointments, the name of the psychiatrist/location of the psychiatric assessment and a summary of the psychiatric results; and team discussion of what the person is currently receiving (if they see someone regularly for appointments).

The team will determine and document whether a new psychiatric assessment is needed to reflect the person's current level of functioning and diagnosis, particularly if the psychiatric assessment was completed a long time ago or is not reflective of the person's current status.

The diagnosis from the evaluation does not need to be listed since there is a Diagnosis section earlier in the OSP.

Neurological
List the date of the most recent neurological appointment and summarize the exam notes and recommendations, re check appointments, name of physician and clinic.

If there are specific precautions that need to be taken for the person due to seizures etc. this must be listed.

Cardiac
List the date of most recent cardiac appointment; summarize the exam notes, recommendations; recheck appointments and name of physician and clinic.
If there are specific precautions that need to be taken for the person this must be listed.

Other List
List the dates of any additional appointments consultations or exams that have not been addressed above such as chiropractic, urology, podiatrist, gastroenterologist. Summarize the exam notes, recommendations, future rechecks and list the name of the physician/examiner and clinic or office.

OT (Occupational Therapy)
List the date of most recent OT appointment/evaluation and summary of exam notes, recommendations; recheck appointments and name of therapist and clinic.

PT (Physical Therapy)
List the date of most recent PT appointment/evaluation. Summarize evaluation and exam notes, recommendations; list any recheck appointments and name of therapist and clinic.

Speech
List the date of the most recent speech evaluation /appointment. Summarize the exam notes, recommendations; list any recheck appointments and name of therapist and clinic.

Adaptive, Orthotic, corrective, communication equipment/supplies, augmentative devices
List the equipment or devices used by the person and the reason for the support. Describe the situations in which it is to be applied or used, a schedule for use and maintenance schedule if any.

Document the condition of the equipment and if any equipment is in need of repair, document the plan for follow up.

The use of devices such as splints, braces, bedrails to prevent injury, wheelchair harnesses and lap belts to support a person's proper body positioning and alignment must be included in this section including medical necessity and procedures for their use. Address under the Safeguard section as appropriate.

If there is adaptive equipment or technology that the person does not have, but the team believes the person can benefit from, this should also be listed in this area.

Level of supervision/assistance for medical
Describe the level of assistance needed by the person, if any, to schedule appointments, attend appointments, and understand and implement any recommendations or instructions made by the medical professional and indicate who provides the assistance.

Behavioral Health
Describe any behavioral or mental health issues that have not been included in other assessment sections including any behavioral support plans or mental health interventions that are being utilized. Include any types of therapy (individual, family, group, play, etc.), addiction services, behavior analyst services that have not been included under the Psychological or Psychiatric assessment sections.

All behavior support plans must include a functional assessment which will identify any environmental influences along with the function and predictability of the behavior. The functional assessment must be completed prior to the writing of the behavior support plan. The plan must first utilize positive behavior strategies and the data must support any recommendations and use of restrictive interventions.

Safeguards

Each of the areas listed below should be reviewed and discussed within the team meeting and documented.
Names and Dates should be documented where applicable.

****The following information must be documented in this section.***

Rights Limitation and Due Process (check all that apply) *

- ✓ *List any rights restrictions. The DD Bill of Rights should also be reviewed annually by the team.*
  **Refer to Appendix DD Bill of Rights.*
- ✓ *List type of restrictive interventions used including any restraints (chemical, mechanical or physical) including those utilized for medical, surgical or dental procedures. These restraints may be used only if absolutely necessary for the person's protection during the time that a*

medical condition exists. The physician or dentist must specify the scheduled use of restraint and it is monitoring, and utilization methods must be documented in this section.

- ✓ *Summarize the team discussion in each area.*
- ✓ *If the item does not pertain, indicate "N/A" or "Not applicable".*
- ✓ *Each box can be checked to indicate that the item was addressed although it is not required. **
- ✓ *Modifications that are made to the following list of conditions must be justified and documented in the plan for ALL residential settings, unless otherwise noted.*
  - *a) For provider-owned residential settings (does not apply to ICF/IID): People have a lease for the unit/dwelling they own, rent, or occupy. The lease, at a minimum, has the same responsibilities and protections from eviction that tenants have under ND landlord/tenant law.*
  - *b) People have privacy in their bedroom and home:*
    - *i. For provider-owned residential settings (does not apply to ICF/IID): Bedrooms have doors lockable by the person, with only appropriate staff having keys to doors under emergency situations or circumstances identified by the team planning process and documented in the plan. If a person does not want a lockable bedroom door even after being informed of their right to, this will be documented in the Residential Assessment section of the plan.*
  - *c) People, who share bedrooms have a choice of roommate(s).*
  - *d) People can furnish and decorate their bedroom or living areas within the lease or other agreement.*
  - *e) People control and have choice in their own schedules and activities and have access to food at any time.*
  - *f) People have visitors of their choosing any time.*

☐ **Individual and/or guardian approval (Release signed specific to plan restrictions)**
List any restrictions and summarize the basis for the restrictions and document that approval from the person and/or guardian has been obtained along with the assurance that the interventions and supports will not cause harm to the person.

- ✓ For modifications made of the conditions listed above (a-f) in addition to any restrictions, the following will be additionally summarized in this section: The specific, individualized assessed need for the modification and a clear description of the diagnosis that is related to the need. This

cannot be solely based on a diagnosis or disability. The diagnosis may accompany the justification, but the situation and reasons are individualized, and according to assessments. The focus will likely be around health and welfare concerns and the consideration of risk mitigation. People are unique, so considerations for the plan will also vary.

Example: A person has a diagnosis of Prader Willi Syndrome. Stating the restriction of having a locked pantry and fridge is due to Prader Willi is not sufficient. The evidence and summary should also entail the description of any related findings from assessments, the difficulty or inability of the person to not portion their food or stop eating when full, current health implications related to their eating difficulties, etc.

- ✓ The positive interventions/supports and less intrusive methods tried in the past that may have not been effective
- ✓ The collection of data reviewed to measure the ongoing effectiveness. The team will consider what is reasonable for the person to evaluate the effectiveness; considering the individual circumstances, weighing any risks, and that amount of time that would be given for a response.
- ✓ Established time limits for periodic reviews to determine if the modification(s) is still necessary or can be terminated. Modifications that affect a person's rights should not be without time limitations or be on a continuous basis.

Example: Restriction-locked food. Jenny is diagnosed with Prader-Willi, obesity, and will daily continuously eat food up to the point of vomiting when she has full access. Nutrition education has been provided, having food unlocked during certain times of the day, and having healthy snacks available have been tried in the past but were not successful-Jenny would continue to eat excessively. The number of times Jenny attempts to obtain access to food or non-edibles is tracked and over the past year averages 20 attempts per day. Data will be checked and reviewed in 6 months.

☐ **Behavior Support Committee Approval**
List dates of approval and review schedule if applicable

☐ **Human Rights Committee Approval**
List dates of approval and review schedule if applicable

☐ **Review of Guardianship status**
This section will describe the type of guardianship and document the team's review of the person's guardianship status including the current level of guardianship to determine if it continues to be appropriate. If it is determined the person needs a legal guardian, or a change in guardian, this should be reflected in this section as well as who will follow up to obtain guardianship.

Teams should also discuss other options that are available as a least restrictive alternative to guardianship such as Supported Decision Making, Power of Attorney, etc.

A review of the guardian responsibilities and participation regarding program planning, decisions, signing consents, Person Centered Service Plan, Individual Service Plan (ISP) and QER visits and contacts will be completed and documented.

Document the date of the most recent guardianship review and the date of the next review, if known.

☐ **Specific guardian requests (specific contacts, notifications, spending limits etc.).**
Describe guardian requests such as notifications and/or preapproval for med changes, medical appointments, immediate notification of injury or other incidents, spending limits, once monthly phone contacts etc. and who is responsible to ensure the requests are carried out.

☐ **Representative Payee: review of responsibilities of payee, spending limits.**
List the person or agency and position within the agency that is responsible to carry out responsibility for any of the following:

- Monthly bills
- Budget spending money, holding spending money
- Completing benefit applications. Notifications, redeterminations to Medicaid, SNAP, housing assistance, etc.

☐ **Durable Power of Attorney**
List the name of the DPA and what powers they have.

☐ **Health Care Directives**
Describe the directives and list the date directives were signed and dated and where the directives are located e.g., agency records, individual file, with legal decision maker, at hospital, physician's office etc. if applicable.

☐ **Living Will**
List status and when documents were signed and dated and where located e.g., agency records, individual file, with legal decision maker, at hospital, physician's office etc. if applicable.

Benefits and Insurance (check all that apply)

- ☐ SSI
- ☐ SSDI
- ☐ Other income/benefit
- ☐ Earnings from employment

*The team may wish to address amount of benefits, need for spend down to remain eligible for Medicaid benefits.

- ☐ **Trust/Estate/Special Needs Trust and Contact**

  List the specifics if a person has a trust. Document that this area was discussed.

  This is an opportunity to inform or remind the person and/or their family/legal decision maker of the fact that a trust, estate or special needs trust can affect a person's continued Medicaid eligibility if the trust or estate is not handled in compliance with Medicaid requirements.
  If any of these exist or are to be established, the family should contact the Legal Advisory Unit in the Department of Health and Human Services for information regarding continued Medicaid eligibility and requirements.

- ☐ **Burial Account – where located**

- ☐ **Medicaid – list county or zone where MA case is managed**

- ☐ **Recipient Liability/Worker's with disabilities premium**

- ☐ **Medicare Type**
  List all types of Medicare the person participates in or receives

- ☐ **Private Insurance - health, renters, vehicle, life etc.**
  List the specific insurances

- ☐ **Room and Board Costs**
  Room and Board is the responsibility of the person for DD **residential waiver** services because Medicaid is not available for room and board as part of a home and community-based service. Room means hotel or shelter type expenses including all property related costs such as **rental** or purchase of real estate and individual furnishings, maintenance, utilities such electricity, water and sewer. heating fuel,

and resident telephone and cable television. Board is the individual's food cost.
It is best practice to acknowledge that for people who reside in any provider-owned residential settings, that the person has a lease which is signed by the person and/or legal decision maker.

People should also be aware that they have landlord tenant rights and that there are resources available if they feel their rights are being violated or are interested in learning about landlord tenant rights.

For people residing in an ICF/IID the room and board costs are included in the ICF/IID rate so room and board costs are not applicable, and N/A should be documented in this section for people residing in ICF/IID,
List the cost for the person's room and board for residential waiver services (individual setting and group home) at the time of the OSP meeting.

A disclaimer or note can be made to indicate that the room and board may fluctuate from month to month. However, it is important for people to know and understand their room and board costs since these are costs that must be incurred from their personal resources.

- ☐ **Housing Assistance**
- ☐ **Food Stamps (SNAP)**
- ☐ **LIHEAP (fuel assistance)**
- ☐ **Phone Assistance**
- ☐ **Other**
    - **Could list vacation services, etc.**

Additional Safeguards

A. Level of supervision for work, home and medical

Describe how much supervision is provided in each of the environments including the community, what type of support is provided, how long the person can be left alone and under what circumstances. List significant risks and strategies used to manage identified risks.

The Statewide definitions may be used, which are found and correspond in the RMAP. The description could reflect the level/definition identified in the RMAP, but additionally expand and include individual specific information.

B. Emergency Back-up Plan (if provider or service could not provide services, what would the person do. Who would they contact? What if the primary caregiver was no longer available?)

This section of the plan is specific to the person. Every agency is required to have an Emergency Plan. However, this Emergency Back- up plan is specific to the person.

The following information must be documented in this section.

<u>The team will discuss and document the following:</u>

1. **For people who have onsite staff presence:**
   Please describe the setting.

   Also, describe the person's ability to evacuate independently in an emergency or natural disaster. If the person cannot evacuate independently, describe the type of assistance needed and who will be responsible to assist the person.

2. **For people supported in their own private residence or other settings where staff or caregivers might not be continuously available, an effective and <u>individualized back up pl</u>an must be incorporated into the PCSP.**
   - ❖ The emergency back- up plan must evaluate what will occur in the event scheduled staff for that person is not available. Back up arrangements may include programmed contact number for designated provider agency staff to furnish staff support on an on-call basis if the person is capable of notifying the agency; notification of family members or neighbors, routine or periodic checks by provider agency to assure direct support staff arrive on shift as assigned (preventative).

   - ❖ The team must evaluate the person's ability to evacuate independently in an emergency, such as a fire or natural disaster (tornado), and if the person is not independent, document how this will be mitigated and who is responsible. For example, if the person is hearing impaired, does the person have a visual fire alarm? Can the person evacuate independently in a fire? If not, what is in place to ensure the person is evacuated and who is responsible.

- Does the person know what to do, where to go and how to stay safe in the event of a tornado, blizzard or flood? What is the specific plan for that person and who is responsible to ensure the person is safe in each of these circumstances?

- People who utilize specialized equipment or supplies, particularly electricity-dependent equipment required for health and safety must have an effective back up plan. May include a plan for power outages and where possible, purchase manually powered items or purchase an emergency generator, solar panels or adaptor for the car. Know the location and availability of several facilities that can provide life-sustaining treatment if needed. Contact the customer service department of the local utility company to learn if they keep a list of power-dependent customers in case of an emergency for priority reconnection service.
  In some situations, extra supply of medications, oxygen, catheter supplies, may also need to be considered.

- When people rely on a specialized equipment such as emergency response, Night Owl monitoring etc., the team must discuss, develop and describe the actions that will be taken and by whom when the systems are activated. E.g. who will respond, how they will respond and timelines for response.

- If a person relies on transportation or special transportation modes to address critical health and safety issues such as dialysis, other medical or psychiatric conditions, an effective back up plan should be identified if their primary system fails.

- For people who reside with a primary caregiver or who depend upon natural/unpaid supports to help assure their health and safety, a plan should be discussed as to provision of person's care in the event the caregiver is unable to provide care due to injury, illness etc. Short term and long-term plans should be discussed. In these situations, this can be discussed during the completion of the Risk Assessment. If the primary caregiver or unpaid supports are unwilling to discuss, document the attempt and response and then re-approach at a later time. This subject needs to be approached with sensitivity but emergency plans are important and efforts to develop them must be documented.

Emergency Contacts

The team will review the emergency contact information to assure information is current relative to emergency contacts and the guardian status is up to date for the Provider ID.

The DDPM will also review the information in the Involved Individual section in the View Details on the State side to ensure that information is up to date as well.

DDPM final review and discussion

The following information must be documented in this section.

DD authorized services received to be placed in the ISP
This section will be entered by the DD Program Manager.

At the OSP meeting, the DDPM will discuss with the team the following and document that these were addressed in this section:

Anticipated change in residence, services, supports, provider
Discuss any anticipated changes in services within the next year.

Document the person's choice in setting for where they live, work, and/or attend day supports. Summarize the options that were available, considered, and visited by the person. The DDPM reviews the options available with the person to ensure community integration and choices are continued to be afforded. Information with any necessary tours and visits are available to assist in informed decision making. This is completed prior to the initial service plan, reviewed annually thereafter prior to the team meeting, when service needs change, or when requested by the person. If there are no anticipated changes, the DDPM can document the discussion with the person and/or legal decision maker regarding ongoing options and their right to make changes any time.

If the place to live, work, and/or receive day supports was not chosen by the person, highlight the reasons, circumstances, or barriers that may have contributed and future steps in place to address the person's preferences. If the person has a legal guardian who makes the decision regarding service settings this should be noted.

Out of home placement of children under the age of 18
If a child is placed out of the home into a DD licensed service (e.g. ICF/IID, FCO, Residential Habilitation), the DDPM will document initially and annually the discussion/review of the need, least restrictive alternatives, and appropriateness of the out of home placement.

Authorizations to disclose information
Review the current Authorization to Disclosure/ Release of Information forms and have them signed and dated.

Signature and Consent Forms
Review the ISP including the Rights statements at the top and obtain signatures from the person and/or legal decision maker and provider representatives.

Self-Directed services through traditional waiver, DDPM will bring up if person qualifies
Review or address any Self-Directed Services, including the purpose and how the person controls the aspects of the service (equipment, supplies, environmental modifications that the person has or is eligible for and may benefit from).

Review of timelines for approvals
List date the written OSP is to be submitted to the DDPM
List date the plan must be approved by the DDPM (Approval Date)
Document if the plan was not submitted within the required timelines, reasons for the delay and/or contacts made.
Comment
Describe any additional follow up required including planned OSP team reviews OSP updates or change of annual OSP schedule etc.

16-21-year-old non-school days:
If the team determines that additional hours are needed for non-school days for a person who is 16-21 years old, the DDPM will document here that these additional hours are needed to account for these non-school days, that the person is in school, and eligible for IDEA.

School aged individuals ages 18-21:
If a person will be graduating early and enters any DD authorized Day or Employment services prior to age 21, the DDPM must verify and document that a person has met their education requirements, no longer qualifies, or are not eligible for VR services.

SIS/ICAP/Outlier:
Document any relevant team discussion regarding SIS/ICAP hours, staffing supports, decision to submit to an outlier, etc.

OSP Participants/Attendees

The people or entity responsible for monitoring the plan must be identified. Verbiage will be added after the title of the Program Coordinator and DDPM. The verbiage provided below is to be consistently used among providers and region HSC.

- Program Coordinator- internal monitor of services & plan
- DDPM- in-depth monitor of services & plan

OSP Attachments Required

- Current RMAP in PDF format
- Behavior Support Plan, if applicable
- Medical protocols that receive specialized training, are very specific/unique to that person, or for procedures that pertain to an outlier. For example, seizure protocols, catheter procedures, trach cares/procedures, nursing care plan. **Protocols that are typical, everyday care (e.g., toothbrushing, toileting, medications, tube feedings) are not required to be attached.**
- OSP Signature page
- Self-assessment in PDF format
- Environmental Scan checklist - completed by DDPM and checklist attached for people in non-facility based Independent Habilitation or Residential Habilitation settings, Homemaker, Parenting Supports, FCO, AFC, and Respite Care with AFC.
- Assessment Results Form if applicable (most current version)
- All ISPs associated with the plan period.
- SFN 1800 Employment Readiness Assessment (only applicable to those receiving Prevocational Services)
- EHHC: Nursing Plan of Care, nursing assessment, physician order for Home Health Care/Skilled Nursing Care
- Virtual Support Checklist SFN 1522, if applicable

Waiver and Level of Care Check

The DDPM will check:

- "Yes" if person is receiving waiver service
- "No" if person is receiving ICF/IID services

Acknowledgements

"By approving this document, I acknowledge that identified risks have been addressed in the plan."

- The DDPM, as a representative of the state Medicaid agency, checks this box to indicate for a waiver assurance that the identified risks in the RMAP are addressed and mitigated throughout the plan.
- By checking this box, the DDPM is acknowledging they have read the RMAP and PCSP, and to the best of their knowledge risks have been addressed, especially the priority risks.

"By approving this plan, I acknowledge that all checklist items have been discussed."

- The DDPM, as a representative of the state Medicaid agency checks this box to indicate for a waiver assurance that all required plan components have been discussed and reflected in the plan.

Annual-no PCSP OSP type

The DDPM is responsible to enter this OSP type for people receiving the following services and must update the ISP section if a person is admitted or discharged. The Annual-no PCSP is completed when the Person Centered Service Plan/care plan portion of the plan is not completed in Therap.

- DDPM only
- DDPM and
  - Adult Foster Care
  - Respite with Adult Foster Care
  - Traditional Self-Directed Supports: Behavior Consultation, Equipment and Supplies, Environmental Modifications
  - Section 11 Residential or Section 11 Vocational – (unless the provider chooses to enter a PCSP in Therap).
  - Homemaker
  - Nursing Facility
  - Personal Care MA State Plan
  - Basic Care
  - Life Skills and Transition Center (ICF/IID)
  - North Dakota State Hospital (NDSH) (service is inpatient psychiatric)

- Any self-pay/private pay services (in this case the service will be identified with a disposition of non-DD licensed service receiving and funding source of private pay.

Goals and Objectives:

Goals are optional for the following services:

- DDPM only
- Section 11 Residential or Section 11 Vocational
- Nursing Facility
- Personal Care MA State Plan
- Basic Care
- Life Skills and Transition Center
- NDSH
- Private pay

The person and/or their legal decision maker may determine it is important or helpful to them to have a goal and for the DDPM to provide information, referral, or follow up on. The DDPM should inquire with the person and/or their legal decision maker if a goal and support objectives are of interest.

Goals are required for the following services, which are home and community-based waiver services and a QER is completed:

- Adult Foster Care
- Respite with Adult Foster Care
- Traditional Self-Directed Supports of Behavior Consultation, Equipment and Supplies, Environmental Modifications
- Homemaker

Goals should be developed and tied to the purpose of the service. Learning Objectives may not be applicable due to the nature of the service; however, Support Objectives may be included to reflect those actions/supports that are being provided.

Attachments:

- All ISP's associated with the plan period
- RMAP
- Providers PCSP
- Behavior Consult Notes (applicable to Behavior Consultation)

- Personal Care: SFN 1265 (Personal Care Service Plan of Care), SFN 1267 (Risk Assessment and Health and Safety Plan), and Eligibility and Needs Assessment*
- Basic Care Personal Care: SFN 662 (Personal Care Service Plan of Care), Eligibility and Needs Assessment*
- AFC and Homemaker: SFN 1810 (Authorization to Provide DD Services), SFN 1811 (Individual Care Plan – DD), Eligibility and Needs Assessment, SFN 1012 (Monthly Rate Worksheet) (SFN 1012 is not for Homemaker) *

  **Note: DD Service Administrator will add all forms after the approval process.*

Self-Assessment is not applicable for these services

Update Annual-no PCSP OSP Type

The DDPM is responsible for entering this OSP type, similar to the Annual-no PCSP.

Reasons for Update Annual-no PCSP OSP:

There is a drop down of "Reasons for Review"

- Add DD Authorized Service
- 30 Day Review of New Service
- Discharge from Service or Provider-Voluntary
- Discharge from Service or Provider-Involuntary
- Change in Medical or Behavior Status
- Change in Outcomes or Supports Provided
- OSP Revisions

Appendixes

Appendix

Transition Between OSP/IFSP

People may transition between the formats in Therap, based on the services and waivers they choose and their age.

The plan formats in Therap:

1. OSP
2. IFSP

It is important for the DDPM to initiate the correct plan format to correspond with the services received and to terminate services and close plans when the person transitions from one format to another. There should only be one active plan in Therap.

The following is an example when transitions occur between plan formats:

1. *Child exits Infant Development (IFSP) at age 3 but continues to be eligible at the eligibility redetermination. The child may receive In Home Supports which will require an OSP type on the provider side of Therap. In either case, the DDPM will need to close the IFSP when either new plan format becomes Active.*

When a person will be moving from one format to the other the DDPM will need to assure that the following is completed:

1. Terminate the services the person is exiting in the ISP section of the current plan.
2. If the person is starting a service in the waiver, a waiver slot will need to be requested and approved before the waiver services can start.
3. The start date of the new plan will be the day after the services on the previous plan are terminated.
4. Once the new plan is in Active status, the DDPM will need to Close the previous plan if the previous plan is in a different format. The new plan format will become the Active plan. It is essential that only one plan is Active in Therap.

Potential scenario:
A child is receiving Infant Development and has an IFSP. The child is turning 3 on 1-30-13 and will exit Infant Development but has been found eligible at re-determination and will continue to receive DD services. The child wants to start In-Home Support in December 2012.
The child will continue to receive In Home Supports under the traditional waiver, so no new waiver slot needs to be requested. The Case Action Form will also remain in effect.
Since the IFSP will be in place until 1-29-13 when In Home Supports starts in December 2012, In Home Supports will need to be authorized in the current active IFSP.
The IFSP team, DDPM, and In-Home Support providers will meet with parents/child to hold an Admission meeting before In-Home Supports actually starts in the home. The IFSP will indicate that an admission meeting for In Home Supports was held and the discussion that occurred e.g., Review

of Risk Assessment, review of current IFSP, decision as to what outcomes/goals/activities will carry over if any, into In Home Supports and plan etc.
The Admission meeting should also be documented in Progress Notes by the DDPM.
The service of Infant Development should be terminated on the IFSP 1-29-13.
The start date of FSS on the IFSP is 12-1-12.
DDPM start date will remain the same on the IFSP.

In this case, the child will still be receiving services through the IFSP when the 30-day Comp meeting is held. Again, the IFSP team should convene along with the In-Home Supports program staff to determine how services are going and whether any revisions need to be made prior to the ending of ID services. The 30-Day Comp meeting should be documented in the IFSP.

The In-Home Supports provider will provide primary program coordination once Infant Development ends.

A. *The In-Home Supports provider will complete the following steps:*
   a. *An OSP (pending) should be started on the provider side of Therap.*
   The OSP type selected should be Annual on the provider side since the Admission and 30-day plan has already been held and documented in the IFSP,

      **Within the Annual OSP, document that the Admission meeting and 30-Day meeting was previously held and can be located within the IFSP.*

   b. *The start date of In-Home Supports and DDPM on the Annual will be 1-30-13*
      - *The IFSP will continue to authorize DDPM and In-Home Supports until the start of services on the annual OSP.*

      - *The In-Home Supports provider must enter a PCSP at least 15 days <u>before the existing services and plan format ends.</u>*
        - *In this example, ID and the IFSP format will terminate on 1-29-13. The new OSP and DDPM and In-Home Supports will be re authorized with a new effective date of 1-30-13 on the new OSP on the provider side. Therefore, the PCSP must be entered and sent to the DDPM at least 5 working days prior to 1-30-13, so the DDPM can approve on or before that date.*
        - *This will establish the Annual OSP date for the next year.*

<u>Closing previous Plan formats</u>

There should only be one active plan in Therap. Until all plan formats are on the Therap provider side we need to assure that there is only one ACTIVE plan in the Therap system.

When a person moves from one plan format to another, the DDPM must close the previous/old plan when the new plan format is Active.

Having only one Active plan in the Therap system will ensure that it is clear which plan is currently in effect and which services the person is receiving. It is also important to have only one Active plan so that the correct outcomes populate to the QER.

Closing the IFSP on the state side:

A CLOSE button located on the IFSP on the State side to allow the DD Program Manager to manually close one plan type when another plan type is created.

To close the previous plan, select the Close button at the bottom. A confirm close window will appear.

Type in the reason for closing the plan. e.g., "New Plan format has been initiated"; Select "Proceed"; Select "Close" button. Confirmation message "are you sure you want to close" will appear. Select "OK".

"Closing" an OSP on the provider side:

If the DDPM is creating a new IFSP on the State side, the DDPM will need to "Discontinue" the OSP on the provider side when the IFSP is activated on the State side.

Appendix

OSP Terms, Concepts, Actions

Editing Alert!

Since the OSP is a shared plan between the licensed provider and the State, both entities have access to the plan and the ability to edit the OSP when the plan is in a pending status. Currently the Therap system does not indicate when there is more than one person working in a plan. If there are two people working in the plan the person who "saves" the document first will retain their information, but the other person will lose the information they entered. When the DDPM has sent the OSP to the provider the DDPM should not edit the plan until the provider submits the OSP to the DDPM. When the provider has submitted the OSP to the DDPM, the provider should not edit the plan until the DDPM sends the OSP back to the provider.

Program Coordinators and DD Program Managers should communicate prior to making any modifications, so the chance of losing information is reduced.

The OSP has an assigned status depending upon where it is in the completion and workflow process.

There are action buttons on the OSP form that when selected perform certain functions.

Active

The start dates for the Approved OSP have been reached and the OSP is operational and implemented. **Active** indicates the OSP is the current plan for that person.

There may be an Approved OSP that is waiting to reach the start date while an Active OSP is still in place. Once the start date is reached on the Approved OSP, the OSP status will switch to Active and the previous Active OSP will go to Discontinued status.

An Active OSP cannot be edited or revised. To make revisions to the OSP "COPY" the OSP forward. Do NOT Discontinue Active OSP's. The slot status will become suspended because there is not an Active plan.

Example: Active OSP is in effect from 7-1-16 to 6-30-17. The annual PCSP meeting is held 6-2-17. The start date for the next plan is 7-1-17 and end date is 6-30-18. The new plan is sent to the DDPM for approval and the DDPM approves the plan on 6-28-17.

The Active OSP will remain in effect until 6-30-17 and the new OSP will remain in Approved status until that date as well. Therap will run a batch job in the early morning hours of 7-1-17 which will change the new OSP status from Approved to Active and will change the status of the current Active OSP 7-1-16 to 6-30-17 to discontinued status.

The new Active Annual OSP is in effect from 7-1-17 to 6-30-18.

If there is not an Active OSP:

- The person's slot status will be in pending or will go to suspended status until the Approved OSP becomes Active.
- Outcomes will not be populated when a QER is created.
- The person is not authorized for services until the Approved OSP becomes Active
- The provider may not be able to access the OSP (Secondary or tertiary providers will also not be able to see the plan in Therap until it is approved and activated)
- The person will not be counted in current service report data as only Active plans are counted.

Approved

The OSP has been reviewed by the DDPM (State Medicaid agency) and meets the requirements as outlined in this policy. The DDPM approves the OSP by selecting "approve".

Clicking on the 'Approve' button will show a warning message on the screen stating that the user will not be able to edit the OSP once it is approved.

The Approved OSP is activated when the start date of the OSP is reached. If the Approve date is within the Start Date and End Date of the OSP, then the OSP will immediately become Active status. Otherwise, the OSP will remain in the Approved status until the Start Date of the OSP is reached. Upon Activation of the approved OSP the system discontinues the existing Active OSP.

**Because only one OSP with the 'Approved' status can exist for a person, if changes are required before the system updates the Approved OSP to activate on the OSP start date, the current Approved OSP must be 'Discontinued' before a new OSP is created by clicking the Copy button.

If you copy an Approved OSP without discontinuing it first, an error message will appear when you try to save or approve the new pending OSP and you will have to back out of or cancel this OSP, therefore losing your work.

Copy and revise an Approved plan

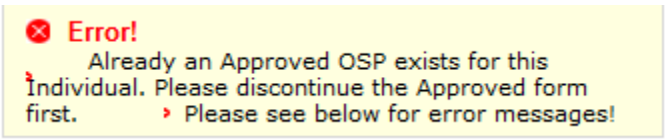
OSPs can be copied so that relevant information does not need to be re-entered by the user.

Although the Therap web-based application has the copy feature for certain documents so that the user does not have to re-enter this information, it is important that the true intent of the individual planning process is not compromised as a result. It is the responsibility of the team to take the time to review, discuss and update the plan as needed so that it continues to be the dynamic, unique and individual process it is intended to be.

Only one Approved OSP may exist for a person. If an Approved OSP needs to be revised, the current Approved OSP must first be Discontinued before a new OSP is created by clicking the COPY button. The Discontinue button is ONLY used when the OSP is in Approved status. Do not "Discontinue" when the OSP is in Active status. There must always be an Active OSP in Therap so if an Active OSP is discontinued the data will be skewed for reporting purposes, the waiver slot will suspend. If the DDPM fails to discontinue the Approved OSP, the DDPM will receive a message when they attempt to approve the new pending OSP stating that two Approved documents cannot exist.

The DDPM will open the Discontinued OSP and "Copy" it to create a new Draft OSP. All information will be copied from the Approved OSP to the Pending OSP and the revisions can then be made. Once the desired modifications are made, the OSP will then require approval by the DDPM.

If the DDPM fails to Discontinue the Approved OSP before selecting COPY and receives the following message



the DDPM will need to back out of the OSP or "Cancel" and start over resulting in lost work.

To COPY and revise an Active OSP, select "COPY" to create a pending OSP. Do not select "Discontinue" when copying an Active OSP.

There must be an ACTIVE OSP in the system at all times. If a new Draft OSP is needed, the DDPM will need to select only "COPY". Once the plan is copied, changes can be made and then approved by the DD Program Manager. The new approved OSP will be activated on the start date of the OSP Program Management and the current active OSP status will be updated to Discontinued by the system.

Delete

Only the state Oversight user- DDPM or RDDPA has the ability to "Delete" a Pending OSP.

Discontinued

When the start date of the Approved OSP is reached and the status goes to Active, the existing Active OSP status will be updated to Discontinued by the system. Discontinued is equal to Closed.

Draft

The OSP (including the ISP and PCSP sections) can be edited by the Primary Program Coordinator and the DDPM as determined by their role access.

Linked Individual – Refers to an individual who is receiving DD Program Management through the Oversight agency (State) and is linked to a DD provider(s) in Therap. The individual is "linked" with a matching Oversight ID so information regarding the linked individual can be shared between the Oversight agency and linked providers.

Pending

Once created, an OSP is in pending status until it is "saved". The user must "save" before exiting or the document and work will be lost. The pending OSP cannot be viewed or edited by anyone other than the user who created the draft, the DDPM and RDDPA.

Pending for Provider Input

The OSP in this status has been sent to the Primary Program Coordinator by the DDPM so the Primary PC can complete the PCSP section of the OSP.

Once the Program Coordinator has completed the written PCSP, the Program Coordinator will submit the Draft OSP to the DDPM for approval.

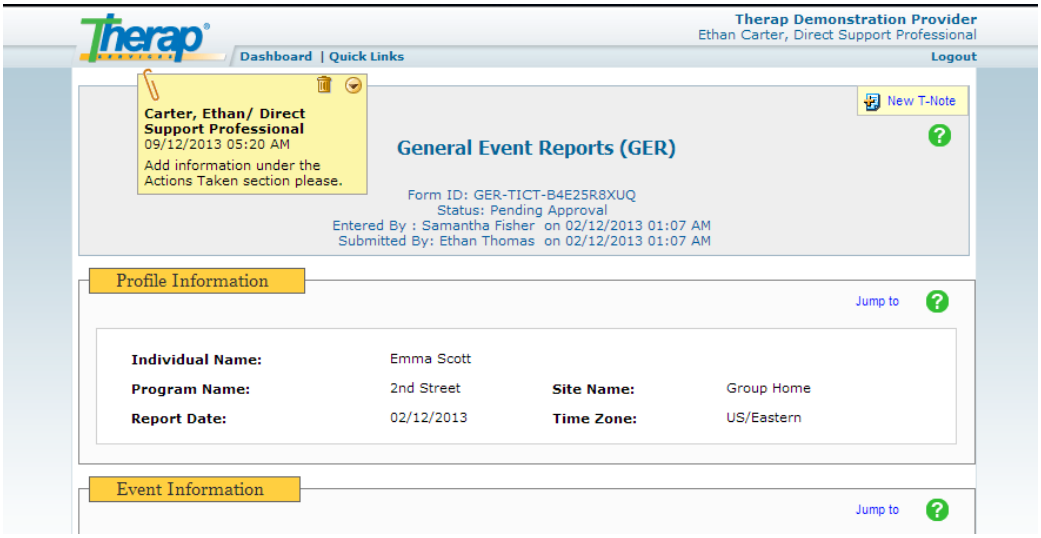
Save

The user must "Save" the draft OSP so that it is in Draft status. Once saved, the DDPM who has access can search to find the Draft OSP.

Once the OSP is "saved" and in Draft status, the OSP Type and Primary Provider fields are no longer editable.

Secondary Service – A DD authorized service/program that does not have primary program coordination responsibility. e.g., Day Habilitation would be considered the secondary service if an individual was receiving a residential DD authorized service as the residential service provider would already have the primary program coordination responsibility.

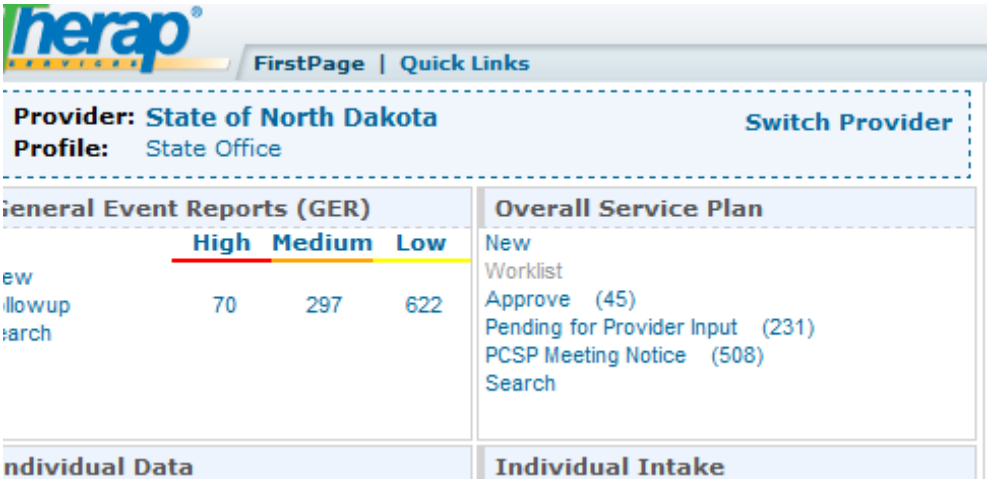
T-notes



The T-Note feature works like an electronic sticky note that can be attached to the OSP to convey small pieces of information or to make notes to oneself and to other users who are working in the draft OSP (not approved yet). T-Notes may be used to share thoughts, point out changes, highlight a certain piece of information, etc. The T-Note can be added and removed by any user at any time. Any T-Note attached will be automatically removed when the OSP is Approved. The colored boxes represent the colors available for a T-Note and you may choose any color to add your comments.

- Click on Add T-Note button at the top of the form.
- A pop-up window will appear where you enter the details then click Save.
- Click on Trash icon to remove the T-Note.

Module Link options for Overall Service Plan



The Overall Service Plan module can be accessed from the dashboard in Therap by the Module link options noted above in the Overall Service Plan section. After clicking on one of the functions, click on the User ID to open the OSP.

New – The user can create a pending OSP.

Worklist function– Once a user has created a New OSP the user must select the "save" button to save the OSP form to the Worklist so it can be worked on at a later time.

Please note: If a Draft OSP has been developed by another user it will not show a count in this area for the other user. The other user will need to "search" to determine if a Draft OSP has already been completed for a person. e.g., if a Program Coordinator has entered a Draft Annual OSP, the draft plan will not be reflected in the Worklist for the DDPM user to indicate that a Draft OSP exists. Before entering a Pending OSP, both parties should utilize the Search function to determine if a pending OSP already exists. It is recommended that either user notify the other if they have plan to create a Draft OSP.

Approve function – Once the Program Coordinator of the primary linked provider has completed the written OSP and submitted it to the DDPM (oversight provider) for approval, the Approve link section will show a

count. The DDPM user will "Approve" the OSP once it is determined all criteria are met.

Once the OSP is APPROVED by the DDPM oversight agency, the Primary provider can review the approved OSP. The secondary provider cannot see the OSP until it becomes Active.

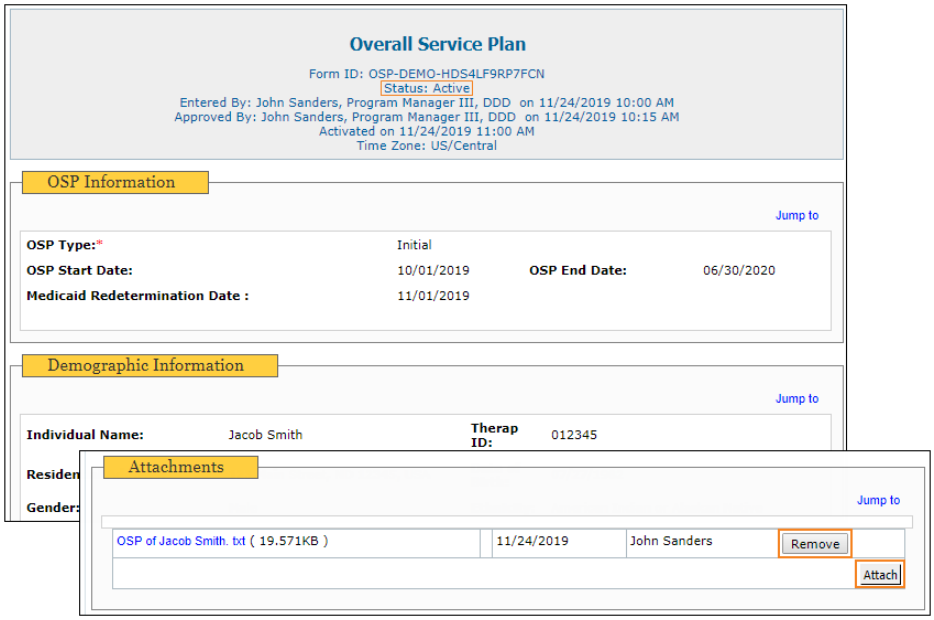
Pending for Provider Input function – Once the DDPM sends the OSP form to the Program Coordinator of the primary linked provider, the" Pending Provider Input" link in the OSP section shows a count. As a rule, the DDPM should not edit the OSP document when the OSP is "Pending for Provider input" as this indicates the Program Coordinator is working on the OSP.
The Program Coordinator will complete the PCSP section of the OSP and as a Primary Provider the PC can submit the OSP to the DDPM for approval by selecting the ISP PLAN SUBMIT button.

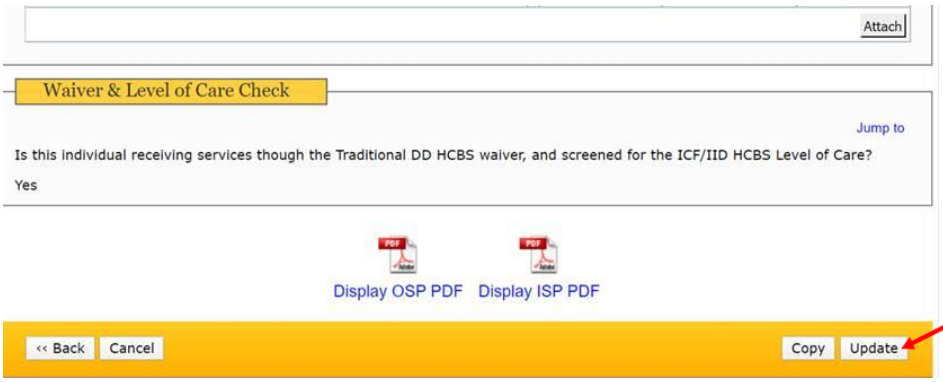
Switch Provider – By clicking on this link the state user (DDPM/RDDPA) will go to the Switch Provider page where they can select and switch to the First Page/Dashboard of a Linked Provider. The user can select a particular provider and access individual records for clients who are on the user's caseload.

DDPMs and RDDPAs can access the Individual Data form to determine the status of the person at the provider agency. For discharged people, the discharge comments will not be displayed at the top of the Individual Data form.

Attachments

Users can attach and remove files from "approved" and "active" OSP forms using the Attach and Remove buttons. This allows attachments to be added to the OSP without needing to copy forward and create an OSP Update, which eliminates the step to have the plan re-approved. An s-comm should be sent to alert the other parties that an attachment was added. By clicking on the "update history" section, users will be able to see what has been done to the document and when.





The "copy" button is to initiate a new OSP. The "update" button is used to add/remove attachments.

APPENDIX

The SIS for Overall Service Planning

The life activities of the SIS address many of the same components important to enhancing an individual's quality of life and mirror topics covered in service planning and CQL's Personal Outcome Measures. The assessment schedule is not aligned with the person's service plan.
It is not a requirement; however, the SIS may be another tool used to identify strengths and support needs for people in the planning process. It is possible to connect some of the SIS related needs with the person's goals.

> *For example, the SIS reflects the person's level of support is low in personal hygiene. If this is important to the person and they need support in the area of personal hygiene, the team can assist in identifying what that support would look like.*

The SIS interviews may provide opportunities for additional discovery for the person. Comprehensive discussions of activities take place which may lead to:

- Opportunities that may never have been considered before
- Development of goals or objectives
- Discovering opportunities in the person's daily routine that could benefit from adaptive equipment or assistive technology
- Discovering what is important to/for the person
- Identify what may or may not be working

Meeting the Client's Overall Support Needs
People will use a variety of supports to foster independence and assistance in achievement of goals. Person-centered planning will identify ALL the strategies and resources in the person's life that contribute to a life a person wants, with services (e.g. paid supports) being only one of the possibilities.
Supports include but are not limited to:

- Natural supports - family, friends, relationships, social roles, neighbor, church members, hobby groups, clubs, etc.
- Personal strengths, skills, and learning opportunities - goals/objectives, behavior support plans, cooking classes, sexuality training/sex education, use of public transportation, groups, anger management, household management, self-regulation, etc.
- Education
- Technology – Night Owl, emergency response, monitors, adaptive equipment, medication dispensers, etc.
- Environmental modification

- Universal designs (pre-chopped foods, detergent pods)
- Community – public transportation, Senior Center, Meals on Wheels, Home Health, support groups, YMCA, mentor programs, probation officer, Public Health Units, etc.
- Paid supports

Supports should have the following characteristics:

- Flexibility
- Portability-should typically be the same from one place to another, however there may be some individual circumstances where changes in supports may be needed (e.g. if a person lives in Bismarck and moves to Fargo, some supports may need to be adjusted due to the new living environment)
- Individualized to the person and not to "fit into programs"
- Provide engagement, empowerment, and participation to the best of the person's ability

The team should discuss how the individual's support needs are being met in terms of type, frequency, and intensity considering the direct and/or indirect hours from the assessment score hours and in addition to what the person is currently receiving or other recommendations. It is the team's role to also discuss alternative strategies for meeting needs, achieving personal goals and fostering independence. The team assists in recognizing and helping the individual to sort through and focus on goals with the highest priority, as there may be times that everything is not practical or achievable at that time. The person's plans should document and reflect these actions and supports.

If the team has considered alternative remediation strategies (including but not limited to the items listed above) and still have concerns about meeting the individual's health and safety needs with in the identified hours, the individual may qualify for an outlier (extraordinary care or exception). Refer to the Outlier Policy.

If unmet needs or concerns continue in the current environment, the team may need to develop a transition plan to consider the person for a more appropriate setting. Individual's and/or legal decision makers have the right to choose providers and services anytime. If the provider determines that their services are no longer appropriate for the individual, the involuntary discharge procedures, including the 30-day discharge notice, will need to be followed.

Team discussions may include the following review and considerations:

- The individual's favorite activities, times of meaningful activities, and importance of work.
- The individual's living and day programming situation (where and whom they live with, interact with).
- Activities that the individual is responsible for or able to complete.
- Times that the individual can be alone or time/activities not requiring support, if applicable.
- Hours of direct support that are needed/provided.
- Type of supports that are available/provided for activities.
- Frequency or how often support is needed (e.g., less than once a month, daily, once an hour, or more, etc.)
- Daily support time for activities (e.g., no support time, 30 minutes to less than 2 hours, etc.)
- The person's typical weekly schedule and who provides the supports (these could be listed in order of least to most amount of support). Teams may also consider building an alternate schedule to address holidays, vacation, events, school/work variations, planned caregiver absences, illness, etc. Develop actions or strategies related to support needs, designation of responsibilities, frequency, dates, review, and methods to review how things are going.
- Current and needed home modifications, mobility, medical needs, medications, treatments, mental health issues, nutrition, communication, behavior concerns, possible risk factors, etc.
- What are the barriers for the individual (e.g., health issues, transportation, behavioral, etc.)?
- What is currently in place to support the individual and what is working or not working.
- Staff sharing/shared supports (pairing people with common interests to attend community events, shared transportation, sharing living expenses, etc.). Sharing supports may be used for people living together and those who do not live together but share common interests.

Appendix:

CQL PERSONAL OUTCOME MEASURES®

5 Factors | 21 Personal Outcome Indicators

My Human Security – Non-negotiable human and civil rights

1. People are safe
2. People are free from abuse and neglect
3. People have the best possible health
4. People experience continuity and security
5. People exercise rights
6. People are treated fairly
7. People are respected

My Community - Access to be in, a part of, and with community

8. People use their environments
9. People live in integrated environments
10. People interact with other members of the community
11. People participate in the life of the community

My Relationships - Social support, intimacy, familiarity, and belonging

12. People are connected to natural support networks
13. People have friends
14. People have intimate relationships
15. People decide when to share personal information
16. People perform different social roles

My Choices - Decisions about ones' life and community

17. People choose where and with whom they live
18. People choose where they work
19. People choose services

My Goals - Dreams and aspirations for the future

20. People choose personal goals
21. People realize personal goals

Appendix

DD Bill of Rights

1. THE RIGHT TO TREATMENT, SERVICES, AND HABILITATION IN THE LEAST RESTRICTIVE APPROPRIATE SETTING.
2. THE RIGHT TO BE PRESUMED COMPETENT UNTIL A COURT OF LAW DETERMINES OTHERWISE.
3. THE RIGHT TO VOTE.
4. THE RIGHT TO FREE EXERCISE OF RELIGION.
5. THE RIGHT TO FREE ASSOCIATION, INCLUDING ASSOCIATION WITH THE OPPOSITE SEX.
6. THE RIGHT TO CONFIDENTIAL HANDLING OF PERSONAL AND MEDICAL RECORDS.
7. THE RIGHT TO RECEIVE, POSSESS, USE, AND HAVE SECURE, LAWFUL PERSONAL PROPERTY.
8. THE RIGHT TO REASONABLE ACCESS TO MAIL, TELEPHONE, AND VISITORS.
9. THE RIGHT TO BE PAID THE VALUE OF WORK PERFORMED, TO FREELY DEPOSIT EARNINGS AND OTHER FUNDS, AND TO RETAIN ALL ACCUMULATED FUNDS, INCLUDING WAGES EARNED FROM THE SERVICE PROVIDER.
10. THE RIGHT TO APPROVE OR DISAPPROVE SERVICE PROVIDERS AS PAYEE OF THE PERSON'S SOCIAL SECURITY, PENSION, ANNUITY TRUST FUND, OR ANY OTHER DIRECT PAYMENT OR ASSISTANCE.
11. THE RIGHT TO RECEIVE APPROPRIATE AND ADEQUATE MEDICAL AND DENTAL CARE IF LIVING IN AN INSTITUTION OR RESIDENTIAL FACILITY.
12. THE RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS AND TO RECEIVE ONLY PROPERLY PRESCRIBED AND PROMPTLY RECORDED DRUGS AND MEDICATIONS.
13. THE RIGHT TO BE FREE FROM CORPORAL PUNISHMENT.
14. THE RIGHT, EXCEPT IN EMERGENCIES, TO BE FREE FROM ISOLATION AND PHYSICAL RESTRAINTS.
15. THE RIGHT, EXCEPT PURSUANT TO COURT ORDER, TO BE FREE FROM PSYCHOSURGERY, STERILIZATION, AND MEDICAL RESEARCH.
16. THE RIGHT, EXCEPT PURSUANT TO INFORMED CONSENT FROM THE INDIVIDUAL OR OTHER RESPONSIBLE PARTY IN THE EVENT OF INCAPACITY, TO BE FREE FROM SHOCK THERAPY.
17. THE RIGHT TO BE CHECKED AT LEAST ONCE EVERY THIRTY MINUTES WHEN PROPERLY PLACED IN RESTRAINTS OR ISOLATED FOR PROGRAM PURPOSES.
18. THE RIGHT TO AN ADEQUATE AND SUFFICIENT DIET PLANNED BY A QUALIFIED DIETICIAN.
19. THE RIGHT, IF BETWEEN AGES 6 THROUGH 21, TO A FREE AND APPROPRIATE EDUCATION IN THE LEAST RESTRICTIVE, APPROPRIATE SETTING.
20. THE RIGHT TO AN INDIVIDUALIZED HABILITATION OR EDUCATION PLAN, WITHIN 30 DAYS AFTER ADMISSION TO A PROGRAM, TO BE RENEWED ANNUALLY.
21. THE RIGHT TO REFUSE TREATMENT UNLESS REQUIRED TO PREVENT SERIOUS HARM TO ONESELF OR OTHERS.
22. THE RIGHT TO ENFORCE THESE RIGHTS IN A COURT OF LAW OR APPROPRIATE ADMINISTRATIVE PROCEEDINGS.

These rights are assured by NDCC 25-01.2 enacted by the 47th North Dakota Legislative Assembly

APPENDIX

How to Complete the OSP for: In Home Supports (IHS provider managed and self-directed), Family Care Option (FCO), Parenting Supports (PS), Extended Home Health Care (EHHC provider managed and non-DD licensed provider), Medically Fragile Waiver (MFW)

All sections of the OSP will be entered according to the OSP instructions along with any specifications listed below.

OSP Sections	Instructions
OSP Information, Demographics, & ISP	– Primary Provider type "Non-DD Licensed Provider" will be selected for services with no DD licensed provider (e.g., IHS self-directed). *DDPM Contact the Service Administrator if this option does not pre-populate.
Overall Goals, Learning (LO) & Support Objectives (SO)	– FCO: goals relate to the child's needs. LO not required unless team determines necessary. SO should include those actions/supports provided. – IHS: goals based on what is being provided (e.g., eating, personal safety). LO not required unless team determines necessary. SO should include those actions/supports provided. – EHHC: goals based on person's health outcomes or nursing care. LO not required unless team determines necessary. SO should include those actions/supports provided (e.g., range of motion, monitor respiratory health). – PS: goals based on how service is supporting the client (the parent). Outcomes and LO will address teaching strategies that will be worked on by the parent to increase the parent's skills in areas such as, but not limited to; nutrition, maintaining clean & safe

	environment, age appropriate discipline, family routines, using community resources, budgeting, etc. LO data should measure progress and be documented. LO may be less prescriptive than habilitation objectives. (Ex: Parent will create a grocery list weekly to follow the family's nutritional meal plan; Parent will document on child's chore chart based on parent's request to complete chores). SO should include those actions/supports provided by staff. – MFW: goals based on the identified need of the service. LO not required unless team determines necessary. SO should include those actions/tasks provided and identify the responsible person (e.g. DDPM, parents, etc.).
Review of Plan & Progress Toward Outcomes	– Complete according to current instructions (review previous year, status of goals, highlights, significant events, successes, etc.)
Review of Self-Assessment	– DD provider agencies will use their current self-assessment form to gather information. – IHS self-directed, EHHC non-DD provider, and MFW: formal self-assessment not required, but information should be gathered through discussions with the family, other means, etc. – Complete according to current instructions (People's preferences, strengths, non-negotiables, hopes & dreams, likes, dislikes, expectations from services, etc.) – PS: information included should be in regard to the parent, who is the recipient of the service. Child information may be included to supplement the parent's plan as the

	goal is to maintain the child in the parental home.
Review of Risk Assessment	– EHHC, IHS, MFW: **Intermittent Risk Assessment SFN 866** sfn00866.pdf (nd.gov). – PS, FCO: **RMAP DHS-ND-2016.10 used**. – RMAP is completed by DDPM if there is no DD licensed provider program coordination. – Complete according to current instructions. – PS: information included should be in regard to the parent, who is the recipient of the service. Child information may be included to supplement the parent's plan as the goal is to maintain the child in the parental home.
Review of Residential Assessment	– FCO, IHS, EHHC, PS, MFW: IPOP's are optional, but information can be gathered through discussions with the family, risk assessment, other means, etc. – Complete according to current instructions (support needs, what does for themselves). – PS: information included should be in regard to the parent, who is the recipient of the service. Child information may be included to supplement the parent's plan as the goal is to maintain the child in the parental home.
Vocational/Employment/Day Supports/VR	– Complete according to current instructions (work, day habilitation, school: locations, schedule, activities, support needs, assessment information). – PS: information included should be in regard to the parent, who is the recipient of the service. Child information may be included to

	supplement the parent's plan as the goal is to maintain the child in the parental home.
Health & Welfare	– Complete according to current instructions (date of exam, status, follow up needed, medications, adaptive equipment, level of supervision/assistance for medical, behavior health, etc.). – All items should be reviewed, but if person/primary caregiver does not want to share certain information, this preference will be documented. – Supervision/assistance for medical: for those living in home of a primary caregiver, documentation can state that the primary caregiver is responsible for the medical appointments. – PS: information included should be in regard to the parent, who is the recipient of the service. Child information may be included to supplement the parent's plan as the goal is to maintain the child in the parental home. – EHHC: all information must be obtained due to the nature of the service. Nursing Plan of Care must be developed by RN, referenced, & attached to OSP.
Rights Limitation & Due Process	– Complete according to current instructions (consent, HRC/BSC approvals, guardianship status, benefits & insurances, etc.) – Restrictions: these services may not have rights restrictions due the service being provided in a caregiver's home. For DD licensed provider if staff implementing restrictions, must be taken through committees and section completed.

	– MFW: rights/restrictions will not be applicable to this service. – PS: provider staff should not implement, but instead teach parenting skills.
Additional Safeguards	– Benefits & insurances: All items should be reviewed, but if person/primary caregiver does not want to share certain information, this preference will be documented. – Complete according to current instructions (level of supervision, emergency back-up plans, contact numbers) – PS: information included should be in regard to the parent, who is the recipient of the service. Child information may be included to supplement the parent's plan as the goal is to maintain the child in the parental home.
DDPM Final Review & Discussion	– Complete according to current instructions (choice in setting/services, authorizations, self-direction, plan timelines) – Documenting choice in setting is not applicable as they are living in the family home. Documenting choice of services and providers will apply and is required. – OSP timelines: For self-directed or non DD provider, the DDPM document any delays due to illness or family reasons.
OSP Participants/Attendees, Absent Team Members	– Complete according to current instructions
Attachments	▪ RMAP, behavior support plan, medical protocols, self-assessment (DD providers only), signature sheet, signed ISP –

	– FCO: Initial Children's Regional Review (Admission OSP type only) – EHHC: Nursing Plan of Care, nursing assessment, physician order for Home Health Care/Skilled Nursing Care

APPENDIX

How to Complete the OSP for Prevocational Services, Small Group Employment Support, and Individual Employment Support

All sections of the OSP will be entered according to the OSP instructions along with the following specifications listed below.

Prevocational Services

- This service has program coordination built into the rate.
- Outcome/goals and objectives should be related to the need of the service to develop general abilities and skills to prepare towards employment. These do not include job specific skills, but may focus more on communication skills, workplace attire, following directions, attending to tasks, problem solving, workplace safety, etc. Data will support the need to continue Prevocational Services if the individual has made progress or not and if the services needs to continue. Support objectives may be included which describe how staff will support the individual. These will transfer to the QER so the DDPM can monitor during the QER process.
- The RMAP Version: DHS-ND-2016.10 is to be utilized.
- IPOPS are optional. Residential Assessment section will be completed according to other applicable services.
- Vocational/Employment/Day Supports/VR section-provider is responsible to complete an assessment, provide a summary, summarize work, hours, etc.

Small Group Employment Support

- This service has program coordination built into the rate.
- Outcome/goals and objectives should be related to the need of the service. They may be related to obtaining, maintaining, or improving employment (hours, pay, job responsibilities, etc.) Support objectives may be included which describe how staff will support the individual. These outcomes/goals will transfer to the QER so the DDPM can monitor during the QER process.
- The RMAP Version: DHS-ND-2016.10 is to be utilized.
- IPOPS are optional. Residential Assessment section will be completed according to other applicable services.

- Vocational/Employment/Day Supports/VR section-provider is responsible to complete an assessment, provide a summary, summarize work, hours, etc.

Individual Employment Support

- This service has program coordination built into the rate.
- Outcome/goals and objectives should be related to the need of the service. They may be related to obtaining, maintaining, or improving employment (hours, pay, job responsibilities, etc.) Support objectives may be included which describe how staff will support the individual. These outcomes/goals will transfer to the QER so the DDPM can monitor during the QER process.
- The RMAP #3 can continue to be utilized, however the Version: DHS-ND-2016.10 may be utilized.
- IPOPS are optional. Residential Assessment section will be completed according to other applicable services.
- Vocational/Employment/Day Supports/VR section-provider is responsible to complete an assessment, provide a summary, summarize work, hours, etc.

Appendix:

OSP Sample Checklist

This sample checklist may be used as an optional tool by the PC and DDPM interchangeably as a quick reference guide on the OSP. This checklist is based on the OSP Instructions and contains information for the use as a quick reference guide. Refer to the appropriate sections for further detail. This NOT for the purpose of the meeting agenda.

Individual: Current OSP End Date:

2 Months Prior to the meeting	Done-Notes/Comments
Contact team to set meeting date • Meeting location & time was chosen by the person and/or legal decision maker. • Person and/or legal decision maker selected meeting participants (includes other than paid professionals).	
Meeting notice sent out 2 months prior to OSP end date.	
Meet with person, legal decision maker, & staff as applicable to review/obtain input on Self-Assessment, IPOPs (optional), & RMAP.	
Obtain other assessments as necessary.	
Provider(s) of secondary services submit applicable assessment information & individual goal/objective data.	
DDPM update the Individual's Home page on the State side. *(needs to be completed before OSP is initiated)*	
2 Weeks Prior to Meeting	Done-Notes/Comments
Self-Assessment completed & sent out. • DDPM reviewed.	
Residential & General IPOPs copy forward, updated, approved, & sent out. (optional) • DDPM reviewed & acknowledged.	
RMAP-copy forward, updated, approved, & sent out. • PC completes GER review of past year. • RMAP identifies the risks present. • RMAP indicates in which section of plan mitigation strategies are located. • DDPM reviewed & acknowledged.	
Meeting Items	Done-Notes/Comments
Planning process reflects the person's cultural considerations, learning style, & is meaningful & understandable to the	

person/legal decision maker. *(e.g. cultural awareness, interpreter available, accessible location, etc.)*	
Person has the opportunity to engage and/or direct their planning process & development to the extent they wish.	
Meeting Agenda, if desired.	
Review DD Bill of Rights	
Review of ISP rights, including right to appeal *(completed with no professional jargon & in manner understandable to the person and/or legal decision maker)*.	
Release of Information/Authorizations.	
Signature Sheet signed.	
Rights Restrictions Informed Consent obtained.	
OSP Sections Completed	Done- Notes/Comments
ISP includes all services the person is receiving *(regardless of funding source, refer to service grid)*. Completed by DDPM.	
Virtual Supports (if person is receiving). Completed by the DDPM. • Tasks, supports, objectives that can be delivered remotely. • Technology platform used. • Estimated number of hours. • Any other team discussions, decisions.	
Outcomes/goals identified based on the self-assessment, person's preferences, & other assessments. • Each DD authorized service has an outcome or goal associated with the service. • IHS, Parenting Supports, FCO, EHHC services- each service has an outcome associated with that outcome.	
Overall goals, learning & support objectives • Goals & learning objectives are measurable. • Each DD authorized service has a learning objective associated with the service. • IHS, FCO, EHHC, Medically Fragile Waiver- learning objectives are not required, unless team determines necessary. Tasks or supports with the service will be included. • Learning Objectives & Support Objectives relate to the person's goals.	
PCSP Meeting Date updated to reflect either date of meeting or when changes were made without a team meeting.	
Review of Previous Plan/Progress- status of goals/objectives, accomplishments, significant events, year in review	
Self-Assessment-summarize self-assessment; individual experiences, reflects "who the person is"; the person's desired	

outcomes, goals, preferences, dreams, interests, values; how they communicate, strengths, choices, non-negotiables, dislikes, likes, what's important to them, what they want to learn, etc.	
RMAP-summary of all risks identified. • Strategies to mitigate the risks reflected throughout the plan. (e.g. outcomes/goals, learning objectives, support objectives, corresponding PCSP sections)	
Residential-person's abilities & supports needs	
Vocational/employment/day supports/VR-person's strengths, support needs, person's day, goals, activities, jobs, volunteering, interests, hours, specific skills, etc. If receiving day programming in the home situation, reason, and individual's need justified and documented.	
Plan reflects what person can do for themselves, support needs, natural supports, who provides support (including family & unpaid supports), preferences in daily routines, ADLS/IADLS, leisure/community activities, summary of where person lives/works/day supports.	
Rights Restrictions (This information, must be documented in this section) • List restrictions & basis • Assessed need/diagnosis related to the restriction • Interventions/supports attempted but not effective • Summary of data to measure to the ongoing effectiveness/need for restrictions • Individual/guardian approval • Dates of HRC/BMC approval • interventions/supports will not cause harm Approval from person/legal decision maker, BMC & HRC prior to implementation of rights restrictions.	
Level of Supervision described in each environment, type of support provided, how long person can be alone	
Emergency Backup Plan (This information, must be documented in this section) • plan for people with continual staff presence and those where staff is not continually present. • Where people will relocate if evacuated. • Ability to evacuate in emergencies. • What occurs if scheduled staff are not available. • Specialized equipment or transportation considerations. • Plan if primary caregiver unable to provider care.	
DDPM Final Review (This information, must be documented in this section) • Person's options, tours, visits, & choice of where they want to live/work/day supports; choice of	

provider/services, who they want to live with, & if they are satisfied documented. • DDPM provides information about services & supports available, providers available, setting options. Includes options not exclusive for people of disabilities. • If no anticipated changes, document the discussion of ongoing options & right to make changes at any time. • ROI & rights reviewed. • Purpose & how person uses Self- directed services reviewed. • List date OSP is to be submitted & approval date. • Reasons & contacts made for delay of plan. • If additional hours are needed for non-school days for a person who is 16-21 years old • Verify & document if transitioning to any DD authorized Day or Employment services prior to age 21. • Review of out of home placement for individuals 18yrs and younger • Document SIS/ICAP/Outlier discussions	
Plan captures team discussions at the meeting & any decisions that were made.	
Plan written so anyone so anyone can review plan & implement at a basic level to assure health & welfare & provide assistance according to the person's preferences. No professional jargon used; the language is meaningful & easy to understand.	
Participant section identifies DDPM & PC responsible for monitoring the plan.	
▪ **Attachments** - RMAP, Self-Assessment, Behavior Support Plan, medical protocols, Environmental Scan, Assessment Results Form, ISP, OSP Signature page, Virtual Support Checklist SFN 1522, etc.	
After the Meeting	Done- Notes/Comments
Plan submitted to DDPM for approval at least 5 working days prior to end date.	
Plan is approved by DDPM within 5 working days of receipt of plan.	
Copy of plan is shared with the person, legal decision maker, & other team members	
HRC and/or BMC reviews scheduled as needed.	
Update necessary forms (e.g. program book, master file, objectives, tracking sheets, etc.)	
Staff trained on plan prior to the person beginning services or prior to the start date of plan.	

Appendix:

Person-Centered Resources

North Dakota Person-Centered Practice Initiative
https://www.hsri.org/ND-PCP

National Center on Advancing Person-Centered Practices & Systems (NCAPPS)
https://ncapps.acl.gov/

Charting the LifeCourse (person-centered framework and tools)
LifeCourse Nexus – Exchange Knowledge | Build Capacity | Engage Collaboratively (lifecoursetools.com)

HRC/BSC Toolkit
https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/hrc-bsc-guidebook.pdf

Dignity of Risk Toolkit
In development, Coming Soon!

Title XIX Regulations (ICF/IID)
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_j_intermcare.pdf

CMS Federal Home & Community Based Setting (HCBS) Rule
https://www.hhs.nd.gov/human-services/hcbs

Plain Language
- https://www.selfadvocacyinfo.org/
- https://autisticadvocacy.org/wp-content/uploads/2021/07/One-Idea-Per-Line.pdf
- www.plainlanguage.gov
- https://www.sabeusa.org/wp-content/uploads/2014/02/GuideToCreatingAccessibleLanguage.pdf
- https://www.plainlanguage.gov/