Licking County Board of Developmental Disabilities

Administrative Policy Manual

Policy: Individual Support Planning	**Board Approved: 5/01** **Revised: 2/06, 8/14, 8/16, 3/17** **Reviewed: 1/11, 9/15, 12/15**
Section: 4.4	

POLICY

I. PRINCIPLES

It is the policy of the Licking County Board of Developmental Disabilities, hereinafter referred to as the Board, that eligible persons have a written support plan based on the interests, preferences, and desired outcomes of the person supported and his/her family. It is the Board's intention to plan with people in a person- centered way. The following principles are used to guide the Board's actions related to support planning:

Quality of Life: is defined by each person with an emphasis on the balance between what is important *to* the person and what is important *for* the person. We will identify the person's interests, preferences and desired life, and assure it is in balance with, but not controlled by, what others believe are necessary for health and safety.
Language: Language conveys respect for the person and is easily understood by everyone. Language used throughout documents, discussions and decisions is consistent with person centered values.
Culture of Strengths and Abilities: The system uses a framework that emphasizes the strengths, capabilities, talents and contributions of each person and his or her family. These are recognized, acknowledged and promoted by all team members. The focus is on what is positive and productive.
Collaborative: Collaboration is a defining characteristic of the system. Contributions from all members are equally valuable and responsibility is shared. Efforts to assure that those involved understand the information and opportunities available is a priority. Creativity and innovation in the management, design and delivery of services and supports is expected.
Results based: Supports are designed to achieve results that are purposeful and meaningful to the person's life. The system shares responsibility for people in need of support. Everyone's focus is on building upon what works, and learning from what does not work, while continuously seeking improved results. Processes, tools, measurements and workforce development align with the intended results.
Practical: A balance is sought between quality of life and the boundaries of public resources, with an understanding that limited fiscal resources must be responsibly administered to support, but not replace, relationships with family and friends. To accomplish this, everyone works to promote natural connections in neighborhoods and communities, and address only those areas where the person supported wants involvement from the system. The system provides support as defined by persons served rather than caretaking as defined by others.

II. GOVERNANCE

An Individual Support Plan is any plan created through an interdisciplinary, multidisciplinary, or trans-disciplinary process and required by Ohio Administrative Code. These include:

- The Individual and Family Service Plan (IFSP) written for families and children ages birth through two. The requirements for Individual and Family Service Plans (IFSP) are found in OAC 3701-8-07.1.
- The Early Childhood Services Plan written for children ages three, four and five, who receive early childhood services as defined by section 5.01 of the Board's administrative policy manual.
- The Individual Support Plan written for persons ages eighteen or older and any person receiving paid supports as required by OAC 5123:2-1-11.
    - An individual plan that includes services paid for in part by federal financial participation through a Medicaid Waiver will also meet the requirements of OAC 5123:2-9-04, paragraph (C)(2).
- The individual support plan for young people between three and eighteen years of age receiving no paid services/supports and persons age three years and older who use only family support services is referred to as the one-page profile. The individual support plan for all other eligible persons is called the Imagine Plan.

The service coordinator assigned to or selected by the person is the primary point of coordination. The service coordinator facilitates collaborative efforts to develop, implement and assess the results of any plan and is responsible for assuring the plan complies with the appropriate requirements of Ohio Administrative Code.

Applicability

This policy applies to Board staff and agencies providing specialized services to persons with developmental disabilities including:

- Providers licensed under Section 5123.19 of the Ohio Revised Code; and
- Providers of supported living certified under Section 5126.431 of the Ohio Revised Code; and
- Providers of services funded in part by Medicaid Home- and Community-based Waivers, including providers of adult day care, vocational habilitation, and supported and community employment and;
- Residential facilities certified under Title XIX of the Social Security Act as intermediate care facilities for the developmentally disabled.

Nursing facilities and schools operating under requirements promulgated by the Ohio Department of Education are not required to comply with OAC 5123:2-2-06. When federal laws exist that govern the content of service plans developed on behalf of persons with developmental disabilities, then it is recognized that those requirements override state rules and local Board policy.

PROCEDURES

I. KEY COMPONENTS OF SUPPORT PLANNING

A. Discovery and Assessment

The provisions of Board Policy 5.01 (Early Childhood Services) guide the evaluation and assessment process for children up to age six years of age. Assessment for children ages six through twenty one years of age is conducted by the school district in conjunction with the individual education plan process.

Discovery as described here is used when eligible young adults begin to actively begin post high school transition planning at age thirteen but no later than fourteen.

The purpose of the Discovery process is to determine a person's current abilities, natural supports and desires in order to help them plan for the future.

Nine Discovery modules are available to guide conversation and learning in these areas of a person's life: communication and learning; community membership; day to day life; career exploration; finance; getting around; health and wellness; home and housing; and relationships.

The service coordinator, person supported, and other team members use person-centered tools to collect Discovery information. The information gathered in Discovery should clearly identify:

- What the person is good at and what they are interested in;
- Those things that are of most importance **to** the person;
- Those things that are important **for** the person to be safe and healthy;
- Any identified **risks** that the team and others in the person's life need to know about;
- The person's place on the path to employment;

- The type and frequency of support already present in the person's life; and
- Any supports requested by the person, guardian (when applicable) and family.

Individual Discovery modules are used to collect information when the person expresses an interest in or need for paid or unpaid supports in an area covered by the module(s).

Key features of Discovery are:

- It is a conversation rather than an assessment; Trigger questions from initial Discovery, which typically occurs when an eligible person is introduced to the Board, direct the user to select which Discovery modules to complete.
- The modules on Relationships; Communication and Learning; Finance; and Career Exploration are always used. Other modules consistent with the person's needs and requests are used as applicable. These additional modules may be identified through the person centered stewardship discussion.
- Not all questions in a module need to be asked.
- The focus is on the person's capabilities and existing supports including the capacity and means of the person, their family (extended family), network and community.
- Current risks are identified along with specific ways they are managed, addressed and minimized.
- Discovery information is updated whenever there are major life changes or events; or the team has other reasons to believe it is necessary and needed. Discovery information is reviewed by the team no less than annually to verify that the information is accurate. Discovery is on-going.
- The completion of specialized/functional assessments may be recommended as a result of Discovery.
- Essential health information is collected and recorded throughout the conversation to ensure proper medical care home for the person.

1. Core Responsibilities for Discovery

   a. Service coordinators are **responsible for**:
      - Establishing a good rapport with the person who is supported, the guardian when applicable, providers and others close to the person which enable conversations that facilitate discovery;

- Using person centered thinking skills and tools to determine when and which modules to use during conversations;
- Sharing discovery results with the person supported and assigned team members to be sure they are accurate; and making adjustments when needed;
- Documenting Discovery results in enough detail that a provider understands how the person gets his or her needs met and what level of support is needed by the provider;
- Using modules that have previously been used or using new modules when a person's situation changes and/or when new areas of interest and/or needs emerge so that discovery results are always current;
- Assuring completion of the ICF-IID Level of Care, annual redeterminations, the Acuity Assessment Instrument, and Ohio Developmental Disabilities Profile for a person being enrolled on a Medicaid waiver to pay for services and supports.

b. Persons supported and their family are **responsible for**:
- Sharing their story and providing information needed to know the person;
- Informing the team what is working in a person's life and what is not working;
- Updating the team when things change so that discovery results are always current.

c. Providers of service are **responsible for**:
- Sharing what they know about the person and how best to support him or her; and
- Informing the team through use of the learning log about what is working and not working in the person's life from the provider's perspective;
- Updating the rest of the team when things change so that discovery results are always current.

Discovery results are summarized in a quick summary, which shows which modules were used; a summary of risks and how they are addressed; and a summary of important to and important for.

B. Planning

One of the Board's primary responsibilities is to help persons we serve and their families plan for a desirable future by balancing what is **important to** the person with what is **important for** him or her. The purpose of the individual support plan is to provide guidance for achieving the person's desired outcomes. Completion of Discovery results in identification of the person's potential desired outcomes.

Planning starts with Discovery results and includes these key features:

- It occurs at a place and time chosen by the person, his or her guardian and/or advocate, and others the person chooses to invite; and
- It is collaborative and involves only people who know the person well and care about him or her; and
- Shows a relationship between what was learned in Discovery through active listening and learning efforts; and
- Addresses the person's needs relative to personal safety, health and ongoing learning; and
- Acknowledges and builds on the person's strengths, abilities and interests; and
- Identifies activities and actions that are the core responsibility of various team members including the person and his/her family; and
- Includes responsibilities that may be discharged using creativity and judgment; and identifies any responsibilities that are typically not those of a paid staff member; and
- Identifies specific outcomes which are central to the plan and can be measured. These outcomes should contribute to the person's quality of life as he/she defines it. The outcomes make it clear the intended results of the services and supports provided to the person; and
- Includes assignment of action plans to team members who have agreed to support achievement of the outcome(s). These action plans are completed collaboratively by the person and his or her provider. The action plans are working plans that are updated and modified as needed by the provider and do not a require the team consent; and
- Includes the identification of current risks and how they are to be addressed; and

- Includes the community resources to be used and the source for paid services; and makes clear the combined cost of services including service titles, date spans, units, and selected providers; and
- Includes detailed information known as support considerations needed to support a person in specific settings within the framework of the outcome(s).

In addition, the individual support plan:

- Identifies the service coordinator by name, and the names of other people important to the person;
- When possible, is recorded in a medium that is understandable to the person or family/advocate of choice (video, audio, paper, etc.);
- May include photos and other visual information the person wants to share as part of a positive introduction; and
- Is reviewed at a minimum once a year, and more frequently if deemed necessary through listening and learning.

Core responsibilities for planning:
Service Coordinators are **responsible for**:

- Learning what a person wants to accomplish by using services and supports;
- Using this information to draft outcomes; sharing draft outcomes with the team and incorporating feedback;
- Learning how a person wants to be supported;
- Balancing what is important to the person with what is important for them;
- Collaborating with the person's team to find creative ways of accomplishing the desired outcomes;
- Assisting the person, family and guardian (when applicable) to choose willing and qualified providers that will support the person to achieve their desired outcomes;
- Respecting the contributions of all team members;
- Securing agreement from assigned team members; and
- Adjusting outcomes, support considerations and the levels/types of service based on listening and learning.

Persons Supported and their family are **responsible for:**

- Helping the service coordinator and provider understand how best to support the person; and

- Communicating (with words and/or actions) what they want and don't want to accomplish by using services.

Providers of service are **responsible for:**

- Sharing what they know about the person and how best to support him or her;
- Contributing to discussions about support considerations and potential outcomes;
- Communicating the amount of service needed and the time it will take to accomplish outcomes; and
- Planning with the person supported what actions they will take to help accomplish the person's desired outcome

Three important pieces of the individual support plan are the outcomes developed by the team, the support considerations that describe a person's support needs, and the action plan for addressing the outcomes.

1. **Outcome Development**
   - Outcomes describe how the person's circumstances will be different from what they are today. They are written in the present tense.
   - Outcomes are based on Discovery learning and what is identified as important to and for the person.
   - The Donut Sort Person Centered Thinking tool is used to determine core responsibilities, suggested utilization of creativity and judgment, and identifies responsibilities of the identified team member. The person being supported should always have a core responsibility to meeting their own outcome.

2. **Action Planning**
   Action planning by identified providers in consultation with the team begins as outcomes are determined. The purpose of an action plan is to describe how an outcome will be accomplished. Providers and other team members as assigned develop a plan of action with the person being supported. The action plan describes the steps the responsible team member will take in order to accomplish their core responsibilities towards achievement of the outcome. Other key features of action planning include:
   - Action plans are assigned to providers chosen by the person who agree to provide paid services and/or supports. The service

coordinator may develop an action plan or assign another team member to develop an action plan when warranted.
- The provider/team member assigned will work collaboratively with the person/family to determine the way they will accomplish the outcome, however, all team members are expected to provide feedback on action plans.
- Action plans should be concrete and describe how the person will be supported to accomplish the outcome.
- Action plan revisions are between the person being supported and the responsible support person. No team signatures are required, although the revisions must be documented and made available to other members of the team.

3. **Support Considerations**

Support considerations are detailed information used to support a person in specific settings to accomplish specific outcomes. Support considerations are drawn from Discovery information that identifies the people, places, and things that are important to a person. They are the result of a thorough understanding of the impact, or influence that the presence or lack of presence of these people, places, and things has on a person's thoughts, feelings, and actions. Support considerations are intended to prevent situations in which a person engages in actions, activities, and responses to other people, places, and events that interfere with the achievement of their goals (personal, educational and vocational), preferred lifestyle, and standards of behavior required of all citizens.

Support considerations that promote quality of life and mitigate risk are by definition preventive. Teams are charged with the responsibility of continually listening to and learning about persons they support so that support considerations are effectively identified and used, generate good results for the person, and adjusted as necessary. Support considerations increase the likelihood a person experiences successes.

Support considerations should:
- Be preventative in design;
- Be culturally and socially sensitive and inclusive;
- Promote self-determination, self-management, and competence;
- Encourage, motivate, and support the person through natural, everyday means;

- Enhance personal reputation;
- Encourage learning;
- Result in improved personal relationships; and
- Reduce the potential for actions that place the person or others at risk of harm (safety) and/or legal sanctions.

Board staff and paid providers are required to use support considerations that are person centered, supported by the discovery process and functional assessment as appropriate, and acknowledge the person's learning style. In addition, Board staff and paid providers will:

- Actively involve the person, his/her guardian, family, friends, and others important to the person in the discovery and individual support planning process;
- Provide support and guidance for family, friends, co-workers, and others who are important to the person;
- Identify support considerations needed for the various places the person spends time in;
- Identify support considerations that are non-intrusive. Support considerations that are intrusive or disruptive to the person's preferred routine are only used when other strategies don't work and with the consent of the person and his/her guardian; and
- Identify support considerations that are consistent with the person's health, any medical contraindications, and medications prescribed by a licensed physician to treat a diagnosed psychiatric condition.

Providers who agree to provide services and assist persons in meeting their support plan outcomes agree to provide the level of support that considers and addresses the person's known needs. This includes support required to address activities of daily living such as personal hygiene, assistance in selection of clothing, meal preparation, household chores, etc. The provider's signature on the individual support plan verifies the provider's commitment to addressing these known needs.

Board staff and paid providers are prohibited from developing and using support considerations and/or action plan strategies that are considered restrictive to control a person's actions or responses to other people, activities, or events for the sake of convenience. Restrictive strategies and procedures are only permissible when they are necessary to keep people safe from direct and serious physical harm and/or legal sanctions.

The following restrictive procedures are strictly prohibited under any conditions:

- Prone restraint where a person's face and/or frontal part of his/her body is placed in a downward position touching any surface for any amount of time;
- Time out which means a person is required to remain in a designated area with no contact with others against his or her will;
- Use of a manual or mechanical restraint that has the potential to inhibit or restrict a person's ability to breathe or that is medially contraindicated;
- Use of a manual or mechanical restraint that causes pain or harm to the person;
- Disabling a person's communication device;
- Denial of breakfast, lunch, dinner, snacks or beverages;
- Placing a person in a room with no light;
- Subjecting a person to damaging or painful sound;
- Application of electric shock to a person's body;
- Subjecting a person to any humiliating or derogatory treatment;
- Squirting a person with any substance as an inducement or consequence for behavior;
- Using any restrictive measure for punishment, retaliation, instruction or teaching, convenience of providers, or as a substitute for specialized services.

Eligible persons are never asked or required to implement restrictive measures for other eligible persons.

Developing Support Considerations Associated with Risk

In response to a trend or pattern of unusual incidents**,** major unusual incidents, or a request from the person, his/her guardian, family, friends, or support staff the person's service coordinator will do the following:

1. Review the current support plan and evaluate the outcomes, both important to and important for;
2. Review the results of the Discovery communication and learning modules. If the information has not been updated within the previous twelve months, the service coordinator will meet with the person and significant others to gather and update the information.

3. Review other available data that reflects the frequency with which the specific actions have occurred, when they occurred, and what activities and/or other people are present when the specific action occurs.
4. Use relevant person centered tools to collect, update, and document important to and important for;
5. Review relevant and current medical, psychological, psychiatric, PT/OT, and speech evaluations;
6. Review the person's medication regime and potential side effects of these medications; and
7. Review historical information on previous support plans, procedures and interventions used, and their success.

Plans Including Restrictive Measures

Supports that involve restrictive measures shall:

- Be supported by documentation that demonstrates positive and non-restrictive measures have been attempted and determined ineffective;
- Be supported by a risk assessment completed within the past twelve months by a professional as indicated in OAC 5123-2-2-06;
- Be designed in a manner that promotes healing, recovery, and emotional wellbeing with consideration of the person’s history of traumatic experiences as a basis for acquiring insight into the origins of the person’s actions;
- Be data-driven with the goal of improving outcomes for the person over time, and describe actions to be increased or decreased;
- Recognize the role environment plays in a person’s actions;
- Capitalize on the person’s strengths to meet challenges and address needs;
- Identify those who are responsible for implementation and how progress will be measured;
- Specify steps to be taken to ensure the safety of the person and others;
- As applicable, outline necessary coordination with other entities (e.g., courts, prisons, hospitals, and law enforcement) charged with the person’s care, confinement, or reentry to the community.

The service coordinator will collaborate with the team to update the individual support plan to include new or additional support considerations and procedures based on listening to the person and learning from the activities delineated above. Additionally, if the supports include restrictive measures:

- The service coordinator will work with the person and his/her guardian where appropriate to acquire informed and written consent for the support plan changes.
- The Human Rights Committee coordinator will schedule the plan to be reviewed by the Human Rights Committee (see section on Human Rights Committee below).
- The person's service coordinator will notify the plan author (if other than the service coordinator) and request his/her attendance at the upcoming Committee review.
- The service coordinator and plan author will review the plan with the Human Rights Committee. If approved, the service coordinator will notify the provider responsible for implementation and monitor the staff education and other preparations for implementing the plan.
- If a plan fails to gain approval by the Human Rights Committee, the Human Rights Committee coordinator will notify the **s**ervice **c**oordinator in writing and the service coordinator will share the comments and recommendations with the person's support team. The Service Coordinator will give the person's guardian information regarding his/her appeal rights. Subsequent revisions to the plan will be forwarded to the Human Rights Committee for review and approval.

A status report that reflects progress and/or lack of progress on the plan outcome(s) will be completed every thirty days by the person designated as responsible for this task by the support team. The report will be provided to:

- The person receiving services and for whom the support is provided;
- The person's service coordinator;
- The court-appointed guardian of a person eighteen years old or older;
- The parent or guardian of a person under eighteen years of age;
- Providers that are contributing members of the support team;
- The Human Rights Committee coordinator; and
- Others chosen by the person.

The status report will include a summary of information on frequency of actions, activities, skills, and/or response to people, activities, and events; and any difficulties/problems in implementing the support considerations and procedures included in the plan. The team will need to review supports at least every ninety days to document the effectiveness and determine whether current supports should be continued, discontinued, or revised. A decision to continue

the current supports shall be based on review of up-to-date information which indicates risk of harm or likelihood of legal sanction is still present.

Any plan, especially those involving a restrictive measure of any kind should be discontinued by the team if they do not effectively address the person's ISP outcomes(s). This means if there is no progress, then the plan should be adjusted to reflect what has been learned.

Review and Approval of Support Considerations Associated with Current Risks

If a person's actions are harmful to self or others, and other requirements contained in this policy and OAC 5123:2-2-06 are met, then a qualified staff person (or contractor), as defined by that rule, with training in the use of person centered discovery tools and support strategies is assigned to develop and monitor support plans that include support considerations and/or action plans that contain restrictive components consistent with the requirements in OAC 5123:2-2-06. Before the plan are used by the Board and provider, the Board's Human Rights Committee, must review and approve the individual support plan.

Human Rights Committee

The Human Rights Committee is intended to fulfill specific functions defined in Ohio Administrative Code 5123-2-2-06. The Board's Human Rights Committee serves any agency or organization providing specialized services to Board eligible persons in Licking County.

The Human Rights Committee will consist of at least four (4) persons that

- Includes at least one individual who receives or is eligible to receive specialized services;
- Includes a qualified person who has either experience or training in contemporary practices for behavioral support; and
- Reflects a balance of representatives from both individuals or family members of people who receive or are eligible to receive specialized services, and county boards or providers.

All efforts will be made to assist Human Rights Committee members with understanding the role of a committee member and with understanding the strategies he/she is asked to approve.

If a committee member is chronically absent from the meeting (two (2) or more times in a year), the Committee Coordinator will notify the Director of Service Coordination who will contact the member to inquire as to his/her interest in

remaining on the committee.

Providers serving on the Human Rights Committee will not be involved in the approval of any plan for a person who has selected the provider agency to provide services. Board staff will not be involved in the approval of any plan they authored.

The author of any individual support plan that contains restrictive measures intended to mitigate/manage risk is expected to be present at the Human Rights Committee meeting for the purpose of explanation and to respond to questions from Human Rights Committee members.

Meetings of the Human Rights Committee occur no less than nine times annually. The purpose of the Human Rights Committee is to comply with the requirements of Ohio Administrative Code 5123:2-2-06.

Specific activities include, but are not limited to:

- Technical assistance to persons' support teams;
- Approval or disapproval (prior to implementation) of support plans that include interventions defined as restrictive;
- Approval or disapproval of support plans that involve potential risks to, or questions about, a person's human and civil rights;
- Review of data and accompanying analysis on the use of restrictive measures conducted every thirty (30) days by the person's service coordinator or other person designated by the support team;
- Periodic review of this policy to determine whether changes are needed to reflect evidence based practices, national standards, and rule(s) promulgated by the Ohio Department of Developmental Disabilities. Written recommendations for revisions are addressed to the Superintendent.

Interim approval of a plan that contains a restriction can be obtained for a period not to exceed 45 days when the plan is approved by at least two members of the Human Rights Committee.

The Board's superintendent will designate a Committee Coordinator to perform the following responsibilities:

- Identify, review, and track support plans containing support considerations/action plans considered restrictive; and
- Schedule Human Rights Committee meetings, develop agendas, and facilitate Human Rights Committee discussion about proposed plan(s); and
- Notify the person's service coordinator of the date, time, and location of

the Human Rights Committee meeting; and

- Share Human Rights Committee actions as needed with service coordinators and providers; and
- Monitor the completion of thirty day data reviews, ninety day team reviews, and other reports of progress; and
- Keep records necessary to document/establish compliance with Ohio Administrative Code 5123:2-2-06 including attendance and training requirements for Human Rights Committee members; and
- Notify the Ohio Department of Developmental Disabilities if any support plan using restrictive measures is approved by the Human Rights Committee prior to implementation. Assure that any requests for information by the Ohio Department of Developmental Disabilities are responded to appropriately and without delay.
- The Committee Coordinator will assemble the agenda, including relevant documentation, and distribute by e-mail to Committee members at least five (5) business days before the meeting. All information and documents provided are considered confidential;
- The Committee Coordinator will facilitate the meeting;
    - A quorum of the Committee, defined as two-thirds (2/3) of the current membership, must be present for the committee to conduct business;
    - A simple majority of those Committee members present is necessary to formalize a decision including annual approval as long as a quorum is present. The Committee Coordinator votes only in the event of a tie;
- The Committee's discussion is considered confidential. The Committee Coordinator will record the Committee review, approval, disapproval, and recommendations to the person's service coordinator using the Board's standard meeting minute form. Copies of the minutes are distributed to the members and others who request them consistent with confidentiality and privacy procedures for release of information;
- Dissenting opinions can be recorded by members of the Committee and attached to the meeting minutes;
- Vacancies on the Committee will be filled within thirty (30) days of notice of the vacancy or as soon as practically possible;
- Any Committee member with a conflict of interest or a possible conflict of interest will disclose it immediately to the Committee Coordinator;
- An eligible person or his/her guardian may appeal a decision of the Committee using the Board's complaint resolution process.

Crisis Situations

A crisis is an emergency that requires an immediate response to protect a person(s) from immediate serious injury to him/herself and/or others. Staff

should intervene in a manner that uses the least amount of restrictive intervention needed to prevent injury or harm to the person and others.
Some crisis situations may meet the definition of a major unusual incident (OAC 5123:2-17-02) and should be reported consistent with those requirements. Any use of restrictive measures not identified in the support plan is reported as a major unusual incident.

Informed Consent
Written and informed consent is obtained before any support considerations and action plans meeting the definition of restrictive are included in a person's support plan. A person has the right to give and withdraw his or her informed consent unless he or she is:

- Under 18 years of age. Written and informed consent must be obtained from the parent or guardian of a minor; or
- Over 18 years of age with a court-appointed guardian.

"Informed" consent means that the individual support plan containing support considerations and action plans defined as restrictive has been presented in a manner that can be understood by the person, guardian, or parent/guardian of a person under the age of 18. It also means that the person or his/her legal guardian has been provided full disclosure of all relevant facts which include at minimum:

- Information about the risks and benefits of the proposed plan;
- Alternatives to the plan as proposed;
- The risk of harm and/or legal sanctions;
- The right to refuse the proposed plan; and
- The right to revoke consent to use the plan at any time.

Informed consent also requires the person and or guardian to agree that the proposed plan be implemented. When an adult person without a guardian needs the assistance of an involved family member, friend, or advocate to decide whether or not he she wants to consent, Board staff will actively engage such person in the process of determining consent.

Informed consent is in writing on a form provided by Board staff. Written informed consent is updated annually and at any time a revision is made to the plan that requires Human Rights Committee review.

The person and/or guardian may revoke consent at any time by verbally expressing so to the person's service coordinator. The person or guardian will be provided with written notification and explanation of the right to seek administrative resolution if dissatisfied with the supports or the process used for its development at least annually.

Staff Education
Board staff and employees of contracting agencies that develop, implement, and supervise individual support plans that contain restrictive procedures will be knowledgeable about the use of person centered discovery and support planning processes; and the requirements of OAC 5123:2-2-06. Staff expected to implement support considerations and action plans are taught the expected procedures before beginning to use them. A record of the training is made and kept by the provider who accepts responsibility for implementing the plan. These records must be available for review by Board staff, the Committee, and the Ohio Department of Developmental Disabilities.

When specific additional training for Board and/or paid provider staff is identified as important to successful implementation of a plan, the additional training and means for acquiring it will be documented by the Human Rights Committee Coordinator.

Annually, Board staff will review the content of this policy. A record of their review will be kept.

II. LISTENING AND LEARNING

The purpose of listening and learning is on-going Discovery. It promotes a continuous and collaborative process of gathering information and using it to support the person more effectively.

Listening and learning contributes to trusting relationships and supports a culture where others' skills and capabilities are recognized. Listening and learning is not an annual event. It is a continuous, anticipatory, and responsive approach to capturing key elements to completion of people's preferred outcomes. It happens at a frequency that makes sense for the person.

Effective planning is largely the result of listening and learning, and may bring the team back to Discovery, Planning, or Resource Management at any given time.

The Learning Log provides the framework for dialog when the person and his or her team is evaluating progress towards the person's desired outcome.

The entire team (e.g. families/guardians, providers and service coordinators) participates in Listening and Learning.

Core Responsibilities in listening and learning:

1. Service coordinators are **responsible for:**

- Learning what it is that people want to accomplish by using services and supports; and
- Looking for concrete and objective evidence of progress towards those accomplishments; and
- Reviewing information collected in various person centered tools such as Learning Logs and Communication Charts; and
- Talking with people supported and important people in their life to learn what's working and what's not working; and
- Capturing what's learned from team members and making connections back to:
  - Discovery – adding new information, having conversations in topic areas not previously discussed
  - Support considerations – refining how to best support
  - Developing new outcomes with people as they grow and change
- Using Person Centered skills to help teams problem solve and determine next steps.

2. Person Supported and their family are **responsible for** sharing successes and concerns with their team of supporters.

3. Providers of service (content experts) are **responsible for:**
   - Reporting progress on action plans in the learning log at the frequency agreed upon by the team; and
   - Reporting new learning in the learning log and revising action plans based on that learning; and
   - Completing and maintaining documentation that is required by rule or activity; and
   - Sharing observations, concerns and successes with the person supported, family, service coordinator and other team members.

III. RESOURCE MANAGEMENT

The purpose of Resource Management is to identify methods and/or provide funding needed to accomplish outcomes desired by people we support, in a way that builds on the capacities of families and their communities.

Key features of Resource Management:

- Builds on the strengths, capabilities and resources of the person, using their natural and community supports and resources before using local or waiver funding;
- Emphasizes the need for stewardship and supports creativity in planning;
- Develops and uses community resources rather than segregated services, regardless of funding source;

- Focuses on “how can we help you today?”; and
- Identifies what people are waiting for if they ask to be placed on a waiting list.

Core Responsibilities of the Team Members:
Service Coordinators are **responsible for:**

- Exploring options that may be available in the community, with family, friends and neighbors to accomplish outcomes; identifying supports that may already exist and may be in place; when possible **these supports should be maintained rather than replaced by paid staff;**
- Documenting any new resources that are discovered; and
- Soliciting from providers what it will take to accomplish outcomes and identifying possible funding sources.

Person Supported and family members are **responsible for:**

- Helping to brainstorm creative solutions for accomplishing outcomes.

Providers of service are **responsible for:**

- Sharing what they believe it will take to accomplish outcomes and helping to identify community resources; and
- Supporting people to make connections in their communities.

IV. PLAN APPROVAL

A. Informed Consent

The ISP is signed by the person, his or her guardian if applicable, and each service provider that participated in the plan development.

The plan is reviewed and approved by the service coordinator and service coordination team leader or director of service coordination. This approval is evidenced by signature.

A copy of the plan is provided to the person and his/her legal guardian, and other members of the person’s support team at least fifteen calendar days before the plan’s implementation date.

A team member that disagrees with any portion of the plan may document their concerns in writing. This document will be attached to any paper copy of the plan for as long as the plan is current, or until the concerns are resolved and withdrawn.

B. Revisions to the Individual Support Plan

The service coordinator will initiate a revision to a plan under any of the following circumstances:

- At the request of the person or a member of the person's team;
- Whenever the person's needs or circumstances change;
- As a result of new Discovery information; listening and learning; and trends/patterns identified through ongoing review of unusual and major unusual incidents;
- One or more outcomes are met and/or a new outcome(s) is established. New or additional outcomes require the approval process detailed above; and
- Whenever a Medicaid service is reduced, denied, or terminated by the department of ODJFS

C. Due Process

- The Service Coordinator provides a person and/ or his/her legal guardian with written notification and explanation of the person's right to a Medicaid fair hearing if the plan results in a recommendation for the approval, reduction, denial, or termination of a service paid for in part by a Medicaid home and community based waiver. Notice shall be provided in accordance with Section 5101.35 of the Revised Code.
- Annually, the service coordinator will provide a person with written explanation of his or her right to use the Licking County Board of Developmental Disabilities Administrative Resolution of Complaint process if the plan results in the reduction, denial, or termination of a service paid for with local Board money. The notice shall be provided in accordance with OAC 5123:2-1-12 and the Board's Administrative Resolution of Complaints policy.