The Individualized Plan of Care (IPC) is a document written by the case manager, with input from the participant and plan of care team, which outlines the services the participant needs and the manner in which providers should deliver those services.

It is critical that the IPC be detailed and include all of the information necessary in order for the participant to receive the services that they want and need.

All sections of the IPC are important and should be specifically written in a way that reflects the participant’s wishes, goals, medical condition, health and safety needs, and behavioral concerns.

First and foremost - please refer to The IPC Guide for detailed information related to how teams should complete the IPC.
Individual Preferences

- Identify the accomplishments the participant would like to achieve over the upcoming year.
- Summarize progress made on habilitation objectives in the past year, and include the participant’s new habilitation service objectives. Habilitative service objectives need to be person-centered, and must meet the service definition.
- Include an overview of important events that occurred in the past year, which are relevant to the participant’s goals and planning.
If demographic information such as an address, phone number, etc. changes, update the Demographics screen in EMWS within seven business days of the notification.

Delete old information (addresses, phone numbers, email addresses).
The Center for Medicare and Medicaid Services (CMS) requires specific criteria be met before the rights of a participant receiving home and community based (HCB) waiver services can be restricted. Specific criteria can be found in Chapter 45, Section 4(h) of the Department of Health’s Medicaid Rules.

Case managers must attest that they have reviewed rights and restrictions (if applicable) with the participant and/or the legally authorized representative (LAR) before the IPC can be submitted.
Imposing a Rights Restriction

The following information must be included in the IPC in order for a rights restriction to be imposed:

1. How and why is this right limited?
   - Identify the specific and individualized assessed need.
   - Include a clear description of the restriction and how it is directly proportional to the specific assessed need. This should also include specific instructions for the provider(s).
   - A restriction may be authorized through a protocol in the behavior plan, through a contractual agreement, court order, staff supervision due to health and safety, behavior, etc.
2. What previous methods have been tried unsuccessfully?

- Document the positive interactions and supports used prior to the implementation of this restriction.
- Document less intrusive methods of meeting the need that have been tried but did not work.
3. How will the team monitor this right?

- Include the informed consent of the individual.
- Include an assurance that the restriction will cause no harm. The risk to the participant or others without the right restriction must be greater than the risk associated with the restriction.
4. How will the team work to restore this right?

- Teams must continually review whether restrictions can be lessened or removed over time. The team must identify how they will assist the participant to exercise the right more fully.

- Include regular collection and review of data to measure the ongoing effectiveness of the modification. Data must demonstrate that restraints and restrictions are being used properly and as a last resort.

- Include established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated. Reviews must occur at least every six months, but can be more frequent.
Documentation Required from a Licensed Medical Professional:

The following situations require a signed and dated letter from a licensed medical professional (defined as someone who can prescribe medication). The letter must be uploaded into EMWS.

- **Food or Beverage Restrictions** – Can only be restricted due to a participant’s specific health concern. Letter must explain why the restriction is necessary. **An updated letter is required every year.**

- **Community Access Restrictions** – Letter must include a description of the risk to the community, the specific measurable and observable behavior that must be demonstrated if a restriction is to be imposed, and the criteria for restoring access to the community.

- **Physical Restraint** – If physical restraint is included in the IPC, letters from the licensed medical and behavioral professionals that detail medical and psychological contraindications that may be associated with the restraint are required.
Contacts listed in this section may include family members, relatives, friends, neighbors, representative payee, landlord, school supports, employment supports, natural supports, community members and agencies, doctors, therapists, providers, DFS workers (if participant is a ward of the state), etc.

The case manager and back up case manager, along with contact information for both should be listed.

If the participant has a power of attorney, LAR, or representative payee, upload the legal document (guardianship papers, Representative Payee selection letter from Social Security) and include the person in the Circle of Supports. Use the appropriate File naming convention. The full legal document must be uploaded.

Enter the phone number and address for each contact, and remove duplicate entries. Update contact information if it changes.
The team is responsible for reviewing each applicable support area and documenting behaviors or conditions that pose a health and safety risk to the participant. If this section includes a restriction, the restriction must also be reflected on the Rights section.

- The team will identify the necessary detail needed to provide support to the participant in each area. If the support area is not applicable, such as employment for a 12-year old, enter a brief statement such as, “Susie is going to school and too young for employment.”

- Specific examples are included in the IPC guide for each Needs and Risk category. (Communication, Community, Employment/Employment Training, Family & Friends, Financial & Property, Healthy Lifestyle, Mealtime, Mobility, Physical Conditions, Self Advocacy, Self care/Personal Hygiene/Bathing, Supervision, Transportation, and Vulnerability.)
When a participant has formal guidelines or protocols, such as mealtime guidelines, feeding protocol, special safety precautions, equipment guidelines, etc., include them in the appropriate support area by selecting “Yes” to “This assessment has protocols” and uploading the corresponding document in the box provided. Guidelines and protocols are considered part of the IPC, and must be uploaded in the corresponding document section. Do not simply upload protocols into the document library section.

It is critical that guidelines and protocols are reviewed at the annual and semi-annual meeting to ensure they are still current and relevant for the participant. Guidelines and protocols must be updated or changed as needed to meet the participant’s needs.
Pursuant to Chapter 45, Section 10(f) of the Department of Health’s Medicaid Rules, “The individualized plan of care shall be reviewed at least semi-annually, when the participant’s circumstances or needs change significantly, or at the request of any team member. The plan shall be revised upon reassessment of functional need, as needs arise, and every twelve (12) months for a new plan year.”

No one’s life remains the same throughout the year. The IPC must be updated to reflect changes in the participant’s life, including supports, needs, risks, etc.
Follow the Medical section of IPC Guide (p. 33-34) when developing this section of the IPC.

- Case managers are responsible for educating the participant and team on the importance of receiving regular medical care. Case managers are responsible for documenting when they have requested that a provider or family member schedule a medical appointment and their response.

- Check, verify, and update the Diagnoses section. Add any additional medical diagnoses for which there is supporting documentation to verify the diagnoses. All diagnoses should be current.
  - When a participant receives Community Living Services Level 3 – 6, they should have current medical appointments.
Keep the medication list as current as possible. A Medication Assistance Record (MAR) may be uploaded instead of manually entering each medication and dose. A new medication list or MAR must be submitted with each supplemental request or modification to the IPC.

Specific medical protocols must be uploaded in this section, including protocols for feeding tubes, PRNs, meal time, seizures, positioning, Vagus Nerve Stimulators, and medication assistance (i.e. participant needs to take medications in applesauce; medications need to be locked-up in the home, etc.).
Behavioral Support

- Make sure the targeted behaviors identified as moderate or above are up to date, based on the most recent ICAP. Previous targeted behaviors can be deleted by clicking the red X, but targeted behaviors from the current ICAP should remain.

- There will be a prompt to “Include a Positive Behavior Support Plan (PBSP)
  - In the Positive Behavior Support Plans section, select “Add”, complete the checklist, and upload the functional behavioral analysis (FBA), PBSP, and summary of the behavioral data collected over the past plan year as it relates to the targeted behaviors.
  - If the team no longer considers an ICAP targeted behavior to be moderate or above and the ICAP was completed more than one year ago, select the pencil icon next to the behavior and select “No behavior plan needed”. In the screen that populates, document why the team has determined that a PBSP is no longer needed.
Teams should use the manual Developing and Implementing a Positive Behavior Support Plan to help them develop the FBA and PBSP. This manual is found on the Forms and References Library page of the Division website site, under the References/Tools tab. Rules related to positive behavior supports can be found in Chapter 45, Section 17 of the Department of Health’s Medicaid Rules.

- The functional behavioral analysis (FBA) should be used to help guide the team in developing the PBSP. Refer to the PBSP Form that is available in EMWS. Any PBSP must follow the components of the template.

- Participants with challenging behaviors identified by the plan of care team must have a FBA completed within the past year, which includes baseline data on the frequency, intensity, and duration of targeted behaviors, prior to implementation of the PBSP. Data on frequency, intensity, and duration of target behaviors over the past 6 months since the PBSP began should also be included.

- The PBSP must be developed using a person-centered approach, and the participant must be included in its development.
Positive Behavior Support Plans (Cont.)

- The PBSP must clearly define antecedents and the target behavior(s) that are to be replaced or reduced. Target behaviors need to be stated in observable, measurable terms with a detailed description of what the target behavior looks like.

- The PBSP must clearly identify the replacement behaviors that are desired, the staff support needed to help the participant learn these behaviors, and how to support the participant when they may be in crisis.

- The PBSP must focus on positive interventions that are considered the least restrictive and most effective, for staff to use when the target behaviors occur.

- Remember that all behavior is a form of communication. Try to determine what the participant is trying to communicate through their behavior.
Pursuant to Chapter 45, Section 18(h) of the Department of Health’s Medicaid Rules, participants **must** have a PBSP if restraints are outlined in the IPC. “The case manager shall reconvene the participant’s plan of care team if any restraints are used in the previous calendar quarter. When convened under this section, the team shall review all restraints for the previous quarter and make plans for reducing the number of restraints performed. On a quarterly basis, the case manager shall report data received from the provider concerning the number of restraints performed on the participant.”

If a PRN psychoactive medication is prescribed, this must be addressed in the PRN section of the PBSP. Please reference the [provider bulletin](#) dated August 1, 2019 that addresses PRN psychoactive medications.

The PBSP must be reviewed at least every 6 months by the provider and case manager to assess the effectiveness of the PBSP, or more frequently as needed.
The Participant and Legally Authorized Representative Verification form (often referred to as the Verification form) can be downloaded from the Participant/Guardian Verification tab on the Verification screen.

- The LAR and/or participant will complete and sign the form.
- The case manager must answer the questions on the Verification screen. Answers must coincide with the responses provided by the participant and legally authorized representative on the Verification form.
- Upload the completed form to the Participant/Guardian Verification tab.
The case manager must verify when a participant’s relative (defined as a biological, adoptive, or step parent) is providing services on the IPC.

- Selecting “Yes” in the box provided. Once “Yes” is selected, the Relative Disclosure form can be downloaded.

- The Relative Disclosure form must be signed by the Provider Support Specialist (PVS) prior to uploading it into EMWS. Obtaining this signature may take up to seven business days.

- A new Relative Disclosure form must be completed if the relative provider changes the services being provided, or the waiver type changes. This form must be uploaded annually with the IPC.
After the IPC is fully developed, all team members are required to read, sign, and date the Team Signature and Verification form (often referred to as the Team Sign form). This form is located in EMWS in the Verification link.

- Upload the completed form under the Team Signature and Verification tab.
- If a team member’s signature is unable to be obtained due to an extraordinary situation, the case manager can work with the assigned PSS on a timeline for submitting the signature.
- Providers who fail to sign the Team Signature and Verification form will not be authorized to provide services on the IPC.
- If changes to units, the case manager, or rights restrictions are made in the review process, or if services are added, all team members must be notified and sign a new or revised Team Signature and Verification form.
Case Managers are required to evaluate and monitor the IPC, which includes a review of documentation of service delivery as outlined in the IPC, and monthly tracking of the units used. Case managers should document all monitoring and evaluation activities, follow-up on concerns and actions completed, and make appropriate changes to the IPC with team involvement, as needed.

- Objectives and schedules are developed by the provider, approved by the participant and team, and must be submitted to the case manager prior to the submission of the IPC, or more frequently, as changes are needed.

- The case manager documents the participant’s progress toward achieving objectives on the Monthly Review and Quarterly Review forms, which are submitted in EMWS.

- The case manager must receive monthly documentation from the provider, including progress on the objectives, by the 10th business day of the next calendar month. If the documentation is not received, the case manager must complete a Provider Documentation Noncompliance form, and submit it to the Division. Service providers must maintain schedules that meet the documentation standards identified in Chapter 45, Section 8 of the Department of Health’s Medicaid Rules.
If an IPC includes self-directed services, the case manager must monitor the Financial Management Services utilized by the participant to self-direct in accordance with the approved waiver. This includes reviewing budget usage, units used and ensuring services are provided according to the service index guidelines.

The case manager is the second-line monitor for participants receiving medications. Second-line monitoring is conducted to help ensure a participant’s medical needs are addressed and medication regimens are delivered in a manner that promotes the health, safety, and well-being of the participant. The case manager must provide monitoring of, and review trends regarding, the usage of the participant’s over-the-counter and prescription medications through a monthly review of medication assistance records and PRN medication usage records.

Monthly home visits must be conducted and documented on the Case Manager Monthly Review form. The review form must be submitted prior to billing for the month.
Continuing Education Credits (CEUs)

To earn continuing education credits, please complete the linked survey.