

Provider Training Series

Chapter 45, Section 10

Individualized Plan of Care (Module #8)

Wyoming Department of Health
Division of Healthcare Financing
DD Waiver Provider Training Series



Welcome to Module #8 of the Wyoming Department of Health, Division of Healthcare Financing (Division), Provider Training Series for Chapter 45 of the Department of Health's Medicaid Rules (Rules). These rules govern the home and community based Comprehensive and Supports Waivers, hereinafter referred to as the DD Waivers.

Chapter 45, Section 15(d) states that all persons qualified to provide waiver services shall complete training in specific areas prior to delivering services. Although some provider organizations may choose to develop their own training modules, individuals who complete all of the Series training modules and associated training summaries will be in compliance with this specific requirement. Please note that there are provider training requirements established throughout Chapter 45, and it is the responsibility of providers to ensure they meet **all** training requirements prior to delivering waiver services.

This module covers Section 10, which addresses the individualized plan of care (IPC).

Purpose of This Training



The purpose of this training is to familiarize case managers and providers of other DD Waiver services with the components and requirements of a participant's individualized plan of care (IPC).

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Training Agenda

- ▶ Purpose of the IPC
- ▶ Plan of care team
- ▶ Plan of care team meeting requirements
- ▶ Components of the IPC
- ▶ Requirements for IPC review

At the end of the module addressing the IPC, the following topics will have been introduced and explained.

- The purpose of an individualized plan of care;
- Who comprises the plan of care team;
- Requirements and timelines for the plan of care team meeting;
- The components that make up a participant's IPC; and
- The requirements for ongoing review and modification of a participant's IPC.

Choice



The IPC is the key to ensuring that providers understand and respect participant choices.

Home and community-based waiver services are based on the tenet that people have the freedom to make choices that impact their lives. The IPC is critical to ensuring that the people who support participants of DD Waiver services understand and respect each participant's choice. The case manager is responsible for ensuring that the IPC clearly and specifically outlines what the participant wants and does not want in their life. It is then up to providers to ensure that the services they deliver are in accordance with the IPC and the participant's choices.

What is an IPC?



A carefully developed plan that explains a participant's wants and needs, and what the people supporting the participant need to do to help the participant get the outcomes they desire.

Before we dive into the requirements and components of an IPC, it is important to understand what the IPC is, and what it means for participants of DD Waiver services.

An individualized plan of care is carefully developed by the plan of care team in accordance with Medicaid Rules. It explains a participant's wants and needs, and what the people supporting the participant need to do to help the participant get the outcomes they desire.

The IPC Explained

- ▶ Roadmap for providers and provider staff members.
- ▶ Contract with the State of Wyoming that identifies what and how services are provided.
- ▶ Living document that must be updated to reflect participant wants, needs, and supports.

A well written, comprehensive IPC is more likely to result in stronger relationships and meaningful services.

The IPC is the roadmap, or guide, for providers and direct support professionals to understand what participants want and need in their lives, what is important to them, the support they need to be as safe and healthy as possible, and what ultimately makes them happy. This document is also critical to recognizing and respecting a participant's individuality and personal choices. The services that a participant receives hinges on the IPC, and the development of the IPC is the responsibility of the case manager.

The IPC is also the contract that each provider has with the State of Wyoming. Providers are required to deliver services as they are outlined in the IPC, including the provision of necessary supports to address potential risks, medical concerns, and choice. The IPC must be written in a way that clearly explains what a participant wants and needs so that the service provider can offer the supports that the participant wants and needs.

Case managers should talk to the participant, legally authorized representative, plan of care team members, and direct support professionals who work most closely with the participant to compile information that is necessary to support the participant. It is a living document that must be reviewed and updated as necessary to ensure that it reflects the participant's current situation and needs. Needs change, and the IPC should change accordingly.

The IPC should include the most comprehensive information available in order to facilitate meaningful services and stronger relationships between the participant, case manager, and

providers.

Developing the IPC

- ▶ The IPC must be developed in accordance with state and federal rules.
- ▶ The IPC must not exceed twelve months.
- ▶ A complete IPC must be submitted to the Division at least 30 days prior to the IPC start date.
 - ▶ Corrections must be submitted within seven business days of being issued.
- ▶ The IPC must be written in plain language.

Federal regulations related to home and community-based services dictate how an IPC must be developed. The Division has incorporated these regulations into Chapter 45.

Section 10(d) specifically outlines that the IPC shall be developed in accordance with state and federal rules. This means that a complete IPC must be submitted to the Division at least thirty (30) calendar days prior to the plan start date. Corrections to the IPC that are required by the Division shall be submitted within seven (7) business days of being issued. Case managers are responsible for IPC submissions.

IPCs cannot be more than 12 months old. Case managers are responsible for ensuring that all deadlines related to submitting an annual IPC are met so that the participant's services are not interrupted.

Section 10(h) establishes that the IPC must be written in plain language. The IPC must be written in a way that the participant, legally authorized representative, and people who serve the participant understand and can implement. The IPC should also be written in a way that demonstrates respect of the participant. Participant needs, including behavioral challenges, should be expressed with consideration for the participant's feelings and self-esteem.

Remember, the IPC is a legal document, and should be written in a professional manner. Case managers must ensure that wording and phrasing in the document are consistent, and that it is

free from grammatical or spelling errors.

IPC Review and Revision

- ▶ At least semi-annually, with a new plan every 12 months;
- ▶ When the participant's circumstances, wants, or needs change significantly;
- ▶ At the request of any team member; and
- ▶ Upon reassessment of functional need, or as needs arise.

As mentioned earlier, the IPC is a living document. As a participant's wants or needs change, the IPC should be modified to capture those needs as well as the support that the participant requires. These changes could include, but are certainly not limited to, the participant deciding they want to work, new medical concerns, or moving to a new apartment.

Section 10(g) states that the IPC shall be reviewed at least semi-annually, when a participant's circumstances or needs change significantly, or at the request of any team member. IPCs should be revised when there is a reassessment of functional need or as the need arises. Again, a new IPC must be developed every year.

Plan of Care Team



The plan of care team is a group of people who are knowledgeable about the participant and are qualified, collectively, to assist in developing an individual plan of care for that person.

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Plan of Care Team Members

- ▶ Participant
- ▶ Legally authorized representative
- ▶ Case manager
- ▶ Providers
- ▶ Advocates chosen by the participant (i.e., employer or counselor)
- ▶ Friends and family members chosen by the participant

Section 10(a) lists people who should be included in the plan of care team. The participant is the team leader, and can choose anyone they'd like to be involved in the person-centered planning process. This includes, but is not limited to, employers, counselors, neighbors, friends, and family members. With the exception of very rare circumstances, the plan of care team meeting should not occur unless the participant is present. Legally authorized representatives are also part of the team, and should attend meetings. The case manager serves as the meeting facilitator, and leads the team through the process, handles any conflicts that arise, and assures equal opportunity for all to participate.

Every provider listed on the IPC should be represented and participate during plan of care meetings. This includes staff members the participant would like to attend. Please remember, Division personnel are not part of the plan of care team. They do not need to be invited to meetings, and will not attend meetings if they are invited.

Plan of Care Team Responsibilities



- ▶ Attend and participate in the participant's plan of care team meeting.
- ▶ Develop an IPC that helps the participant get what they want and need, focusing on their strengths.
- ▶ Participate in regular IPC reviews to ensure the IPC meets the participant's needs.

Although the case manager is responsible for developing and submitting the IPC, it is the responsibility of every plan of care team member to attend and participate in the plan of care team meeting.

The plan of care team is responsible for ensuring that the information that is discussed and included in the IPC fairly and accurately represents what the participant wants in their life, includes choices and decisions the participant has made about their services, and explains the support the participant needs and how the provider should deliver the support. If a plan of care team member has questions, if the plan is unclear, or if specific components of the plan are inaccurate or can't be implemented, they are responsible for addressing it during the meeting and finding a solution before the plan is reviewed.

The team is also responsible for participating in meetings as they arise, and for reviewing the plan as it changes to ensure it continues to meet the participant's needs.

Plan of Care Team Meeting Process

- ▶ Meeting must be timely and occur at times and locations that are convenient for the participant.
- ▶ Case manager must provide written notice to team members at least 20 calendar days prior to the meeting.



Plan of care team meetings must occur early enough to allow time for the IPC to be developed and submitted within the timeframe established by Chapter 45. Remember, the participant is the team leader, so the time and location of the meeting must be convenient for the participant. If a participant works from 11am - 4pm, or has a TV show that they watch every day at 2pm, then the meeting should be scheduled for other times of the day so the participant is still able to do the things that are important to them.

Once the meeting is scheduled, case managers are required to provide written notice to all team members at least 20 calendar days prior to the meeting. Written notice could include a letter or email.

Components of the IPC



Chapter 45, Section 10(e) establishes the components that each IPC must contain.

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Components of the IPC (Continued)

(e)(i) - Necessary information and support to the participant to ensure that the participant directs the process to the maximum extent possible.



Subsection(e)(i) establishes that necessary information and support to the participant must be given to ensure that the participant directs the process to the maximum extent possible.

As discussed in previous trainings, person-centered planning must be used when developing a participant's IPC. In order for person-centered planning to be effective, the case manager and plan of care team need to focus on helping the participant communicate what they want and need in their life. Ask open ended questions and be curious about the person's life and interests. Suggestions include:

What are you interested in?

What do you think you are good at?

What do you want to do in the future?

What do you need help doing?

What do you like to do when you are in town? Are there things that you'd like to do?

Follow up on questions to get as much information as you can. The case manager, team members, and the legally authorized representative can answer questions as well...this is a team process. However, the participant should, to the extent possible, direct the process. This may look a little different depending on if the participant is an adult or a child. It is extremely important that adults who have legally authorized representatives are still able to lead the process, have questions directed to them, and have the opportunity to answer questions based

on their preferences. Remember, the IPC that is being developed is a reflection of the participant's life, so it is critical that the participant is involved in its development. Even if participants have a disability that limits their ability to answer questions, the team needs to find ways for them to be involved.

Components of the IPC (Continued)

(e)(ii) - Services in a setting chosen by the participant from all service options available, including non-disability specific settings and alternate settings that were considered.



Subsection (e)(ii) establishes that the services a participant receives must occur in settings chosen by the participant from all service options available, including non-disability specific settings and alternate settings.

In order for a participant to make a choice on where to receive services, they must first have choices offered. The case manager and plan of care team is responsible for identifying the options that are available so the participant can make an informed choice on where to receive services. As an example, if a provider has an available room in a group home, this is certainly an option if a participant wants the provider to deliver community living services. However, is that room in a group home the only option? What about other group homes? What if the participant would like to live in an apartment, either alone or with a friend?

There may be barriers to a participant getting exactly what they want; however, the case manager and plan of care team should assist the participant in identifying resources that may help the participant overcome the barriers. This may include financial aid, such as low income housing or rental vouchers. The plan to address these barriers should be included in the IPC.

Components of the IPC (Continued)



(e)(iii) - Opportunities for the participant to seek employment and work in competitive integrated settings.

Subsection (e)(iii) states that opportunities for the participant to seek employment and work in competitive integrated settings must be included in the IPC.

People often define themselves based on what they do for a living. Employment contributes to a person's sense of belonging, helps to build confidence and self-esteem, and provides financial rewards. The discussion of employment should be a part of every plan of care team meeting, and should be addressed on every IPC. If a person is too young to work, that should be noted in the IPC, but the conversation of what the participant may want to do when they get older, and what supports would need to be put into place to make that happen should be discussed early and often. If a participant is retired, that should be noted in the IPC, but offering the choice to reenter the workforce, either as a paid or volunteer venture, should be discussed at every IPC meeting.

If a participant has chosen not to seek employment, that should be noted in the IPC, but the team may want to ask some questions to understand why the person doesn't want to work. If it is a barrier that can be addressed, the team should identify ways this may be done. The results of these conversations should be included in the IPC. If a participant expresses a desire to work, the team should do everything they can to help the participant explore employment opportunities.

As a side note, if a provider is working with a participant who has a job, but isn't providing

employment services, it is still important for the provider to support the participant in being successful on this job. This may be as simple as helping the participant with transportation so they can be on time, or supporting them in having the appropriate dress and hygiene for work. The provider may want to ask questions about how work went that day, and provide positive reinforcement on a job well done. If a provider identifies concerns, this information should be shared with the case manager so steps can be taken to address concerns with the team.

Components of the IPC (Continued)

(e)(iv) - Opportunities for the participant to engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services.

Subsection (e)(iv) establishes that opportunities for the participant to engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services must be addressed in the IPC.

As mentioned in a previous slide, the team should ask questions and be curious about what each participant wants and needs in their life. The IPC should reflect not just support needs, which are extremely important, but ways that service providers and team members can help the participant do the things they want, and achieve the goals they have for themselves.

Participants of waiver services must have the same community access that other citizens have. Team members must keep this in mind, and identify creative ways that participants can be involved in community activities and events.

Components of the IPC (Continued)

(e)(v) - Cultural and religious considerations.



Subsection (e)(v) states that cultural and religious considerations must be included in the IPC.

When addressing religious considerations, it is important to remember that participants must have choices in if and where they go to church, even if their choice is different than what a legally authorized representative or provider wants. The IPC should address not only if and where a participant chooses to worship, but who will provide transportation and support during services. Plan of care teams should also consider natural supports that are available, help the participant cultivate those supports, and include that information in the IPC.

As part of the person-centered planning process, participants should be asked about events that are important to them. Many participants may not know or understand their cultural background, so plan of care teams should offer education if this is something in which participants are interested. Events, celebrations, and language preferences that are important to the participant should be included in the IPC so providers can ensure that the participant has the opportunity to observe special occasions.

Components of the IPC (Continued)

(e)(vi) - Services based on the choices made by the participant regarding supports the participant receives and from whom.



Subsection (e)(vi) establishes that the services listed in the IPC must be based on the participant's choices regarding the supports they receive and from whom.

Case managers are required to offer the participant choice in services and providers, and develop an IPC that clearly and specifically outlines what the participant wants and does not want in their life. A link to a searchable provider list can be found on the [DD Participant Services and Eligibility](#) page of the Division website. Case managers can use this tool to educate participants on the providers that are available for specific services. Participants should be able to choose to have one provider deliver employment services, while other providers deliver community living and adult day services.

The services that the participant receives should align with their wants and needs. As an example, Linus wants to be able to go to the movie theater without having a provider tag along. Currently, Linus needs to develop his community safety skills in order to navigate the movie theater without assistance. If Linus' current provider only offers adult day services that won't help Linus meet his goal, Linus' case manager should work with Linus to find a provider that delivers a service that will help Linus develop the skills he needs to go to the movie theater alone.

The services that the participant selects must fit into their assigned individual budget amount (IBA). Teams should help the participant use their IBA in a way that gives them the most bang

for their buck. It may take some creativity, such as using a less expensive service tier to open up more flexibility within the IBA.

Components of the IPC (Continued)



(e)(vii) - What is important to the participant and for the participant.

The plan of care team must use person-centered planning to develop the IPC; therefore, what is important to and for the participant should be included in the IPC. However, subsection (e)(vii) makes this requirement clear.

Case managers need to remember that cutting and pasting information from one participant's plan to another participant's plan is not a person-centered practice. Each participant's support needs and desired outcomes need to be represented in a unique and relevant manner.

As an example, the Individual Preferences section of the IPC must be updated each year. The case manager should clearly describe the participant's desired accomplishments and personal preferences, as well as things that the participant wants people to know about them. The information in these categories changes from year to year, so the case manager must ensure that the information is up-to-date.

Components of the IPC (Continued)

(e)(viii) - Services provided in a manner reflecting personal preferences and ensuring health and welfare.

(e)(ix) - Services based on the participant's strengths and preferences.

Subsections (e)(viii) and (ix) address participant preferences.

Subsection (e)(viii) establishes that services addressed in the IPC should be provided in a manner that reflects personal preferences and ensures health and welfare. Sometimes this can be difficult, especially if the personal preference could present a risk for the participant. Plan of care teams should work together to identify risks and strategies to mitigate the risks, while respecting the participant's preferences. Although not specifically stated in this section of rule, it is also important that all services are delivered in accordance with the Comprehensive and Supports Waiver Service Index.

Personal preferences should be considered in all areas of service provision. As an example, Lucy needs support with hygiene tasks, including help in the shower. Lucy's right to privacy has been restricted in order to allow her provider to help her with this task. Although Lucy's right to privacy has been restricted, there are still many ways that Lucy can make decisions related to her shower. Things such as:

- What time she takes her shower.
- What brand of shampoo and soap she uses.
- If she washes her hair or her body first.
- If she uses a washcloth or a sponge.
- If she listens to music during her shower.

These preferences should be included in the IPC so the provider can ensure that Lucy's preferences are respected.

Subsection (e)(ix) states that services in the IPC should be based on the participant's strengths and preferences. Again, the participant's preferences should be top priority as part of the person-centered planning process. Although it is necessary to address challenges and deficits as part of the planning process, it is also important to acknowledge and celebrate a participant's strengths, and incorporate ways the participant can use those strengths in their daily life.

Components of the IPC (Continued)

(e)(x) - Any rights restrictions, including why the restriction is imposed, how the restriction is imposed, and the plan to restore the right to the fullest extent possible.



Provider Training Module #2 addressed the rights of participants receiving waiver services, including the process for restricting a participant's rights. As established in subsection (e)(x), any rights restriction, including why the restriction is imposed, how the restriction is imposed, and the plan to restore the right to the fullest extent possible, must be written into the IPC, and must meet the criteria outlined in Chapter 45, Section 4(h). Restrictions that don't meet the established criteria and are not specifically listed in the IPC are prohibited.

Components of the IPC (Continued)



(e)(xi) - Clinical and support needs.

Subsection (e)(xi) establishes that clinical and support needs must be included in the IPC.

The support that a participant needs while eating, bathing, or shopping are supports that are regularly discussed and always included in the IPC, which is extremely important. However, there are other times that a participant may need a level of support that can often be forgotten when developing an IPC.

What if the participant visits a counselor, or receives occupational or speech therapy? Does the participant need support during the appointment? If so, the IPC should specify why the support is needed and what it looks like. If an occupational therapist prescribes exercises, will the participant need support with those? How does the information get from the OT to the provider so they can offer the needed assistance? This information, including how the participant wants to be supported in these situations, should be discussed and included in the IPC.

What if the legally authorized representative accompanies the participant on medical appointments, but the community living services provider is responsible for assisting with medications? How does the communication between the legally authorized representative and provider happen? This needs to be specified in the IPC.

If there are historical concerns noted in this section, it is necessary to make sure that they still

have relevance in the participant's life. It is certainly important that past concerns be considered, but no one wants to have their past follow them forever.

Components of the IPC (Continued)

(e)(xii) - Participant's desired outcomes.



The IPC must be written in a way that reflects the participant's desired outcomes, or goals. The participant's objectives should support the overall goals they have for themselves, and their services should be delivered in a way that supports their choices and interests.

Components of the IPC (Continued)

(e)(xiii) - Risk factors and plans to minimize them.



When developing the IPC, the plan of care team will need to review specific areas of the participant's life in order to identify potential risks, and how the provider will work with the participant to mitigate these risks. The IPC should include details on how the provider will support the participant in each area.

Remember, a core value driving the DD Waivers is participant choice. Often, a legally authorized representative, provider, or case manager may believe they know what is best for a participant, or that the participant will make a bad choice if given the freedoms required by the home and community based settings rule. Providers are tasked with supporting individuals in making choices in their lives.

Team members must remember that all individuals, including people who receive waiver services, have the right to make choices, even if those choices may result in poor outcomes. People learn by making mistakes. Providers and other members of the plan of care team must maximize a person's ability to make choices while minimizing the risk of endangering the person or others. Although we want to promote safety for participants, we want to be sure to value safety while supporting the participant's right to dignity of risk.

Components of the IPC (Continued)



(e)(xiv) - Individualized backup plans and strategies, when needed.

Occasionally, the strategies that a team develops don't work as planned. The plan of care team needs to identify challenges that could occur, such as a participant refusing services or leaving without telling anyone if they get angry. As established in subsection (e)(xiv), backup plans that address how the provider will support participants in these instances should be included in the IPC.

If strategies that have been used when assisting the participant are no longer working, the team should revisit the strategy to determine if it needs to be changed or removed from the IPC altogether. Including strategies that are not effective can set the participant and the provider up for failure.

Components of the IPC (Continued)

(e)(xv) - Individuals important in supporting the participant, such as friends, family, professionals, specific staff members or providers.



Subsection (e)(xv) states that people who are important to the participant should be included in the IPC. This could include friends, family, treating professionals such as a counselor or other specialist, employers, and specific staff members or providers. This information should be up-to-date and include the person's relationship with the participant.

While listing these folks in the IPC is important, what is more important is what the provider actually does with the information. If a specific friend or family member is listed as being important to the participant, then the provider should help the person have regular contact with that friend or family member.

As an example, Patty has identified that Marcie is a good friend. Patty's provider should help her invite Marcie to dinner or an event that Patty wants to attend. This help should extend to helping Patty make a menu, shop, and cook a meal, or helping with transportation to the event that Patty and Marcie will be attending. The provider's job is to help people live the life they want to live. This includes spending time with people who are important.

As a reminder, the list may change from IPC year to IPC year. As an example, the participant may choose to work somewhere else, or may have a family member pass away. Perhaps Marcie moves away. If these changes occur, the list of people who are important may need to be updated. Although these people may still be included in the IPC, the case manager and team need to be sure that the list accurately reflects who is important to the participant at that time.

As an example, rather than Patty having dinner with Marcie every week, Patty may need help with sending an email every week.

Components of the IPC (Continued)

(e)(xvi) - Learning objectives for habilitation services that address the training activities, training methods, and the measurement used to gauge learning.



As mentioned in Slide 24, the IPC should include the participant's desired outcomes, or goals. These are the things that the participant is striving to achieve in their life.

Participant's who receive habilitation services are required to have training objectives as part of the service. These objectives should address the participant's overall goal. Subsection (e)(xvi) establishes that learning objectives should address the training activities, the training methods, and the measurement used to gauge learning.

It is best practice to use SMART objectives. When developing a SMART objective, it is important to remember the following:

Objectives should be **Specific** - discuss what will be accomplished and what actions the participant will be demonstrating

Objectives should be **Measurable** - discuss what data will be measured, and what success will look like

Objectives should be **Achievable** - discuss if the objective is doable. Identify the support and resources the participant will need in order to see progress

Objectives should be **Realistic** and relative - discuss how the goal aligns with the participant's broader goals, and discuss why the result is important

Objectives should be **Timely** - discuss the time frame for accomplishing the goal, and how often progress will be measured

More information on SMART objectives and goals can be found on the Division website. A SMART Goals and Objectives training is available on the [Training](#) page, and a SMART Goals worksheet is available on the [HCBS Document Library](#) page, under the *DD References/Tools* tab.

Components of the IPC (Continued)



(e)(xvii) - Relevant protocols that have been updated within the past year.

Protocols are developed when a participant has a behavioral or medical concern that requires a very specific, step-by-step response. The purpose of any protocol is to provide detailed instructions on what should be done, as well as how, when, and why. Subsection (e)(xvii) establishes that updated protocols must be included as part of the IPC. Protocols should be reviewed by the team at least annually, and the date the protocol was developed or reviewed should be included to demonstrate that the protocol is current.

Protocols are part of the IPC and should be included in EMWS as part of the overall IPC. Even if the protocol is presented as a supplementary document and not generated by EMWS, it is still considered part of the IPC. Case managers must remember to upload the protocols into EMWS and include them as supplemental documents when providing the IPC to team members. If a protocol is no longer relevant, the case manager should remove it from the IPC.

Protocols are an extremely important part of the IPC, and directly and significantly impact a participant's life. If providers don't receive protocols from the case manager, they must specifically request these documents.

Components of the IPC (Continued)

(e)(xviii) - Informed consent of the participant or legally authorized representative in writing.



Subsection (e)(xviii) states that the written informed consent of the participant or legally authorized representative must be included as part of the IPC.

Informed consent is the process in which the case manager and plan of care team educates the participant and legally authorized representative about components of the IPC and how the waiver services will impact the participant's life. The participant or legally authorized representative must have the capability to make a voluntary decision about whether or not to agree to the supports and strategies outlined in the IPC. It is the obligation of the case manager and plan of care team to include the participant and legally authorized representative in the decision-making process and avoid making them feel forced or coerced into agreeing with the team.

Written informed consent is obtained on the Participant and Legally Authorized Representative Verification Form, which is downloaded from EMWS. The participant and legally authorized representative are required to answer questions about their involvement in the IPC planning process, their understanding of and agreement to any rights restrictions, and their choice in services and providers.

Components of the IPC (Continued)

(e)(xix) - Signatures of all providers listed in the individualized plan of care after the draft plan, as written, is completed by the team including participant's signature for informed consent.

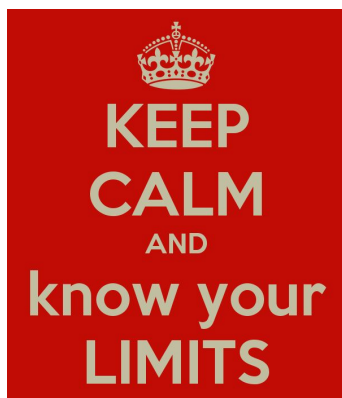
A stylized, cursive handwritten signature that reads "John Hancock". The signature is written in black ink and features a large, sweeping loop at the end.

Subsection (e)(xix) establishes that signatures of all providers listed in the IPC, after the draft plan, as written, is completed by the team, including the participant's signature for informed consent.

All providers are required to sign the Team Signature and Verification form, indicating that they agree to the IPC that was developed. Best practice suggests that this form not be signed until the IPC has been completely developed and reviewed by team members, which would occur prior to it being submitted to the Division. If case managers collect signatures before the IPC is developed, they must ensure that they do not make changes to the IPC since the whole team did not agree to the changes.

Remember that significant changes to the IPC, such as changes to the participant's rights, services, units, or providers, will result in the need for a new signature page.

Components of the IPC (Continued)



(f) - Information addressing a provider's inability to provide any of the supports outlined in subsection (e).

Providers must be transparent about identifying what they can and cannot do in the course of providing services.

Charlie wants to live in an apartment without a roommate, but his funding level doesn't cover that cost. The provider needs to be up front with the challenge that this creates and be honest about their inability to provide the service that Charlie wants. Charlie can then make a choice to stay with the provider and receive the services that the provider can deliver, or look for a provider who can better meet his needs.

Schroeder needs help with his medications every day, but the provider he has selected does not have medication assistance training, and cannot help Schroeder with this task. The provider needs to be honest about this limitation. If Schroeder chooses to stay with the provider, then the IPC must outline how and by whom Schroeder will receive medication assistance.

It is extremely important for providers to understand participant preferences and behavioral and medical support needs. It is not uncommon for providers to accept a participant with challenging behaviors and a high IBA into services only to find that they don't have the capacity or skills to support a participant's challenging behavioral needs. The provider gives the participant a 30-day notice that they are terminating services almost as soon as the services begin. This quick transition can be very confusing for the participant and frustrating for the participant's plan of care team. Providers must be forthright about their competence to handle

situations, and make decisions to accept or not accept a participant into services based on what is best for the participant, not based on potential income.

Training



As mentioned at the beginning of this training, the IPC is a roadmap for providers and direct support professionals to understand what participants want and need in their lives, what is important to them, the support they need to be as safe and healthy as possible, and what ultimately makes them happy. This document is critical to recognizing and respecting a participant's individuality and personal choices.

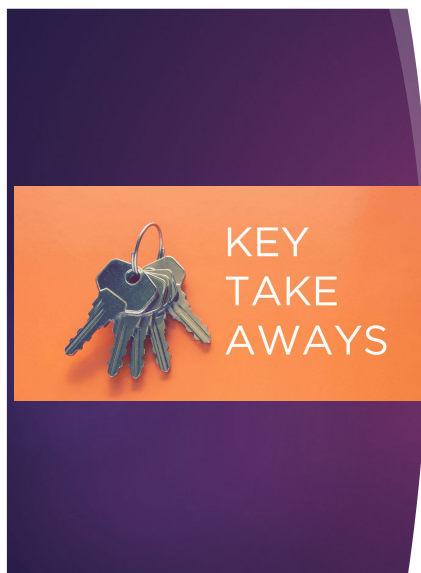
The document can contain every ounce of information required, be written in a way that makes the information easy to understand and follow, and provide detailed steps on how to work successfully with a participant. However, the document is useless if providers and provider staff members don't know what is in the document.

Participant specific training, including comprehensive training on participant IPCs and protocols, is a critical part of providing services. Providers and provider staff members must be knowledgeable of the information contained within the IPC and provide the services as outlined in the document. Case managers are responsible for training a provider representative on the IPC. If the provider employs staff members, the provider is responsible for ensuring that the staff members who will be working with the participant receive comprehensive participant-specific training.

If a provider believes that a change needs to be made to the IPC, they should contact the case manager to schedule a team meeting. Remember, a participant's IPC may change throughout

the plan year, depending on changes in the participants preferences, needs, and circumstances. When an IPC is modified, the provider or staff members who are affected must receive training on the changes before they are implemented so they understand the changes, the provider role in those changes, and how the changes will affect the participant.

Case managers and providers are expected to be able to demonstrate that participant specific training occurred, and must provide this documentation to the Division upon request.



1. The IPC must include the components required in Chapter 45, Section 10 in order to comprehensively outline the services and supports the participant wants and needs.
2. The plan of care team must use person-centered planning to develop the IPC.
3. Providers and staff members must be knowledgeable of the information in the participant's IPC in order to deliver the services as required and desired.

Before you complete this training, we'd like to review some of the key takeaways:

1. The IPC should include the components listed in Chapter 45, Section 10. If all of the components in this comprehensive list are included, the IPC will paint a clear picture of what the participant wants and needs, and give the provider the information they need to provide the service.
2. The plan of care team must use person-centered planning to develop the IPC. This will ensure the IPC reflects what each participant wants in their life. Language must be easily understood and be written in a way that demonstrates respect of the participant and promotes self-esteem and motivation. Remember, cutting and pasting information from one participant's plan to another participant's plan is not a person-centered practice. Each participant's support needs and desired outcomes need to be represented in a unique and relevant manner.
3. Providers and staff members must be knowledgeable of the information in the participant's IPC in order to deliver the services that the participant requires and desires. The IPC can be the most comprehensive document ever written, and still be useless if providers and provider staff members don't know the information and don't implement the strategies and supports that are established.

Questions???

Contact your Provider Support or Benefits and Eligibility Specialist

<https://health.wyo.gov/healthcarefin/hcbs/contacts-and-important-links/>

Thank you for taking time to participate in the training on the individual plan of care that has been conducted by the Division of Healthcare Financing, Developmental Disabilities Section. If you have questions related to the information in this training, please contact your Provider Support or Benefits and Eligibility Specialist. Contact information can be found by clicking on the link provided in the slide.

Don't read during the live presentation

Please be sure to complete a summary of this training so that you can demonstrate that you received training on the individual plan of care.