Ohio Administrative Code

Rule 5123-3-03 Licensed residential facilities - person-centered planning.

Effective: October 1, 2021

(A) Purpose

This rule ensures that services for individuals living in residential facilities licensed in accordance with section 5123.19 of the Revised Code are delivered pursuant to an individual service plan that is developed through person-centered planning.

(B) Definitions

For the purposes of this rule, the following definitions apply:

(1) "County board" means a county board of developmental disabilities.

(2) "Department" means the Ohio department of developmental disabilities.

(3) "Home and community-based services" has the same meaning as in section 5123.01 of the Revised Code.

(4) "Individual" means a person with a developmental disability.

(5) "Individual service plan" means the written description of services, supports, and activities to be provided to an individual and includes an "individual program plan" as that term is used in 42 C.F.R. 483.440 as in effect on the effective date of this rule.

(6) "Informed consent" means a documented written agreement to allow a proposed action, treatment, or service after full disclosure provided in a manner the individual or his or her guardian understands, of the relevant facts necessary to make the decision. Relevant facts include the risks and benefits of the action, treatment, or service; the risks and benefits of the alternatives to the action, treatment, or service; and the right to refuse the action, treatment, or service. The individual or his or

her guardian, as applicable, may withdraw informed consent at any time.

(7) "Intermediate care facility for individuals with intellectual disabilities" has the same meaning as in section 5124.01 of the Revised Code.

(8) "Ohio individual service plan" means the web-based information technology platform created and maintained by the department used to carry out the person-centered process for assessing and planning with Ohioans with developmental disabilities and includes an information technology platform maintained by a county board or an intermediate care facility for individuals with intellectual disabilities to manage, store, and electronically exchange information with the department's web-based information technology platform.

(9) "Person-centered planning" means an ongoing process directed by an individual and others chosen by the individual to identify the individual's unique strengths, interests, abilities, preferences, resources, and desired outcomes as they relate to the individual's support needs.

(10) "Qualified intellectual disability professional" has the same meaning as in 42 C.F.R. 483.430 as in effect on the effective date of this rule.

(11) "Residential facility" has the same meaning as in section 5123.19 of the Revised Code.

(12) "Service and support administrator" means a person, regardless of title, employed by or under contract with a county board to perform the functions of service and support administration and who holds the appropriate certification in accordance with rule 5123:2-5-02 of the Administrative Code.

(13) "Team," as applicable, has the same meaning as in rule 5123-4-02 of the Administrative Code or means an interdisciplinary team as that term is used in 42 C.F.R. 483.440 as in effect on the effective date of this rule.

(C) Decision-making responsibility

(1) Each individual, including an individual who has been adjudicated incompetent pursuant to Chapter 2111. of the Revised Code, has the right to participate in decisions that affect the

individual's life and to have what is important to the individual and what is important for the individual supported.

(2) An individual for whom a guardian has not been appointed shall make decisions regarding receipt of a service or support or participation in a program provided for or funded under Chapter 5123., 5124., or 5126. of the Revised Code. The individual may obtain support and guidance from another person; doing so does not affect the right of the individual to make decisions.

(3) An individual for whom a guardian has not been appointed may, in accordance with section 5126.043 of the Revised Code, authorize an adult (which may be referred to as a "chosen representative") to make a decision described in paragraph (C)(2) of this rule on behalf of the individual as long as the adult does not have a financial interest in the decision. The authorization shall be made in writing.

(4) When a guardian has been appointed for an individual, the guardian shall make a decision described in paragraph (C)(2) of this rule on behalf of the individual within the scope of the guardian's authority. This paragraph shall not be construed to require appointment of a guardian.

(5) An adult or guardian who makes a decision pursuant to paragraph (C)(3) or (C)(4) of this rule shall make a decision that is in the best interest of the individual on whose behalf the decision is made and that is consistent with what is important to the individual, what is important for the individual, and the individual's desired outcomes.

(D) Development of individual service plans

(1) Person-centered planning shall be the foundation for development of individual service plans.

(2) Individual service plans for individuals who reside in residential facilities other than intermediate care facilities for individuals with intellectual disabilities shall be developed with the individual by a service and support administrator in accordance with rule 5123-4-02 of the Administrative Code.

(3) Individual service plans for individuals who reside in intermediate care facilities for individuals with intellectual disabilities shall be developed in accordance with paragraph (E) of this rule.

(E) Requirements for development of individual service plans for individuals who reside in intermediate care facilities for individuals with intellectual disabilities

(1) What is important to the individual and what is important for the individual as expressed directly by the individual, and as applicable, by an adult authorized by the individual or the individual's guardian shall drive development of the individual service plan.

(2) The services, supports, and activities described in the individual service plan shall reflect what is important to the individual and what is important for the individual to achieve a more independent, secure, and enjoyable life.

(3) The qualified intellectual disability professional shall:

(a) Coordinate development of the individual service plan with the individual and the team within thirty calendar days after the individual's admission and at least annually thereafter.

(b) Describe, annually and upon request, the supports and services available to an individual residing in an intermediate care facility for individuals with intellectual disabilities and the supports and services available to an individual enrolled in a home and community-based services waiver.

(c) Ensure that development of the initial individual service plan and each subsequent individual service plan reflects meaningful planning for:

(i) The individual's discharge from the intermediate care facility for individuals with intellectual disabilities that:

(a) Identifies supports and services necessary for the individual's successful transition to an integrated community setting and specifies who is responsible for ensuring necessary supports and services are provided; and

(b) Includes strategies or methods for meeting the challenges for a successful transition to an integrated community setting.

(ii) The individual's unique strengths, interests, abilities, preferences, resources, and desired outcomes as they relate to community employment in accordance with rule 5123:2-2-05 of the Administrative Code.

(d) Complete an assessment of the individual that:

(i) Takes into consideration:

(a) What is important to the individual to promote satisfaction and achievement of desired outcomes;

(b) What is important for the individual to maintain health and welfare;

(c) Known and likely risks;

(d) The individual's place on the path to community employment; and

(e) The individual's skills and abilities.

(ii) Identifies supports that promote the individual's:

(a) Communication (expressing oneself and understanding others);

(b) Advocacy and engagement (valued roles and making choices; responsibility and leadership);

(c) Safety and security (safety and emergency skills; behavioral well-being; emotional well-being; supervision considerations);

(d) Social and spirituality (personal networks, activities, and faith; friends and relationships);

(e) Daily life and employment (school and education; employment; finance);

(f) Community living (life at home; getting around); and

(g) Healthy living (medical and dental care; nutrition; wellness).

(e) Create an individual service plan that:

(i) Identifies a continuous active treatment program;

(ii) Identifies opportunities for independence, choice, and self-management;

(iii) Identifies needed developmental, behavioral, and health interventions and supports;

(iv) Identifies and promotes opportunities for community participation; and

(v) Identifies and supports preservation and development of interpersonal relationships (e.g., social contacts, relationships, and emotional supports).

(f) Review and revise the individual service plan as needed or upon request.

(g) Review implementation of the individual service plan at least quarterly and revise as needed.

(h) Coordinate the services, supports, and activities being provided to the individual with service providers, as identified in the individual service plan.

(i) Contact the county board when an individual residing in the intermediate care facility for individuals with intellectual disabilities requests, or a person on the individual's behalf requests pursuant to paragraph (C) of this rule, assistance to move from the intermediate care facility for individuals with intellectual disabilities to a community setting.

(4) The qualified intellectual disability professional shall document performance of the tasks described in paragraph (E)(3) of this rule and secure informed consent for the individual service plan from the individual, adult authorized by the individual, or the individual's guardian, as applicable.

(5) The qualified intellectual disability professional shall attempt to address concerns when informed

consent is refused or withdrawn by presenting alternative services or activities to the individual.

(6) The individual service plan shall be provided to the individual, adult authorized by the individual, or individual's guardian, as applicable; to all parties responsible for implementation of the individual service plan; and to authorized regulatory agents. The individual service plan shall not be released to other persons without the informed consent of the individual, adult authorized by the individual, or individual's guardian, as applicable.

(F) Transition to Ohio individual service plan

(1) Prior to September 1, 2022, an intermediate care facility for individuals with intellectual disabilities may conduct assessments and develop and review individual service plans of its residents in accordance with the provisions set forth in paragraph (E) of this rule or in accordance with the provisions set forth in paragraph (E) of rule 5123:2-3-03 of the Administrative Code as it existed on the day immediately prior to the effective date of this rule.

(2) Beginning no later than September 1, 2022, an intermediate care facility for individuals with intellectual disabilities shall use Ohio individual service plan to conduct assessments and develop and review individual service plans of its residents in accordance with the provisions set forth in paragraph (E) of this rule.

(3) No later than September 1, 2023, an intermediate care facility for individuals with intellectual disabilities shall ensure that all assessments and individual service plans of its residents are captured in Ohio individual service plan.