*** Note:** Persons committed to a residential facility or day program operated, funded or licensed by the Department pursuant to Section 552.040, RSMo shall not be entitled to the rights marked with an asterisk * unless the head of the residential facility or day program determines that these rights are necessary for the person's therapeutic care, treatment, habilitation or rehabilitation.

You may also direct your grievance or complaint to the Director of the Division of Behavioral Health, the Director of the Division of Developmental Disabilities, or the Office of Constituent Services at:

Department of Mental Health
P.O. Box 687, Jefferson City, MO 65102
800-364-9687 or 573-751-4122

Division of Behavioral Health:
800-575-7480
573-751-4942

Division of Developmental Disabilities:
573-751-4054

Deaf or Hard of Hearing individuals may call the above numbers or the Office of Deaf Services:
573-751-7033

If you believe any of your rights have been violated, you may file a grievance with the person in charge of the agency, facility, or unit from which you receive services. An impartial review of your grievance will be conducted.

All reports are confidential. Individuals are encouraged to report concerns regarding care and treatment.

The Department of Mental Health complies with applicable State and Federal civil rights laws, and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Free language assistance is available.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-364-9687.

注意：如果您使用繁體中文，
您可以免費獲得語言援助服務。
請致電 1-800-364-9687。

MISSOURI DEPARTMENT OF MENTAL HEALTH

Rights of Department of Mental Health Consumers

The Department of Mental Health is an Equal Opportunity Employer, services provided on a nondiscriminatory basis.

Missouri law gives individuals who receive mental health services the following rights without limitation:

(1) To humane care and treatment;

(2) To the extent that the facilities, equipment and personnel are available, to medical care and treatment in accordance with the highest standards accepted in medical practice;

(3) To safe and sanitary housing;

(4) To not participate in non-therapeutic labor;

(5) To attend or not attend religious services;

(6) To receive prompt evaluation and care, treatment, habilitation or rehabilitation about which the individual is informed insofar that person is capable of understanding;

(7) To be treated with dignity as a human being;

(8) To not be the subject of experimental research without prior written and informed consent or that of a parent, if the person is a minor, or guardian; except that no involuntary committed person shall be subject to experimental research, except as provided by statute;

(9) To decide not to participate or to withdraw from any research at any time for any reason;

(10) To have access to consultation with a private physician at the individual's expense;

(11) To be evaluated, treated or habilitated in the least restrictive environment;

(12) To not be subjected to any hazardous treatment or surgical procedure unless the individual's parent, if the person is a minor, or guardian consents; or unless such treatment or surgical procedure is ordered by a court of competent jurisdiction;

(13) In the case of hazardous treatment or irreversible surgical procedures, to have, upon request, an impartial review prior to implementation, except in case of emergency procedures required for the preservation of life;

(14) To a nourishing, well-balanced and varied diet;

(15) To be free from verbal and physical abuse.

Missouri law gives individuals who receive mental health services the following rights that may be limited for safety or therapeutic reasons:

* (1) To wear one's own clothes and to keep and use one's personal possessions;

(2) To keep and be allowed to spend a reasonable sum of one's own money for canteen expenses and small purchases;

* (3) To communicate by sealed mail or otherwise with persons including agencies inside or outside the facility;

(4) To receive visitors of one's own choosing at reasonable times;

* (5) To have reasonable access to a telephone both to make and receive confidential calls;

(6) To have access to one's own mental and medical records;

(7) To have opportunities for physical exercise and outdoor recreation;

(8) To have reasonable, prompt access to current newspapers, magazines and radio and television programming.

Revised 10/16

Missouri Proclamation of Equal Rights for People with Disabilities as Members of Society*

Introduction

The establishment of the "Missouri Proclamation of Equal Rights for People with Disabilities as Members of Society" began after the *UMKC Institute for Human Development* Consumer Advisory Leadership Team (CALT) identified the need for an overall disability rights statement to guide state practice, policy, and legislative discussions. CALT reviewed existing statements from around the nation to build from, and invited multiple stakeholder organizations from across Missouri to participate in the writing and editing process. The statewide group met three times over the course of a year and reviewed existing statements, identified a model document*, and developed the Proclamation. Below is the resulting recommended language. For a way to share your comments on the document and to see a list of participating organizations, please see page 4.

PREAMBLE

We believe all persons, **including people with disabilities**, are whole human beings, regardless of ability, mobility, expression, communication, intelligence, accommodations, strengths, independence, or support needs. All human beings should be able to grow and develop to their full potential. The human and civil rights of all people must be honored, protected, communicated, and enforced. We believe and affirm that all people should have freedom and power to direct their own lives with determination, dignity, and meaningful choice.

Section I: WE BELIEVE and AFFIRM that all human beings, including people with disabilities, have the basic right to live free from abuse, neglect, and exploitation in their homes, jobs and communities. As such:

1. People should not have to tolerate physical, mental, financial, emotional or sexual exploitation, bullying or abuse. People deserve freedom from situations or systems where these issues have become commonplace or are ignored.
2. People's money and resources must be safe, secure, and under their control and/or direction.
3. People must be free from discrimination, whether based on hate, fear, pity or good intentions. Discrimination is determined by the effect an action has on a person's life, whether the intent of the action was to discriminate or not.
4. People must be free from attitudes, beliefs, and perceptions communicated by others, which diminish their self-worth and standing in society.

* Originally based on the *Washington Proclamation for the Dignity and Rights of All Human Beings*

Section II: WE BELIEVE and AFFIRM that all people, including those with disabilities, have the right to live free from the oppression of:

1. Systems that isolate people from the community, whether in rural or urban settings.
2. Supports that control them and their environment, or fail to recognize that they are in charge of their own lives.
3. The fear that they will be denied treatment or services, abandoned, or left to die, because the circumstances of their existence are deemed too costly, too difficult, or simply not important.
4. End of life decisions and advance directives made without their consent.
5. Placement in situations and institutions, regardless of location, that isolate, control, and segregate them, including housing, employment, and education that does not support autonomy and community life.
6. Labels that separate, devalue, or dehumanize people.
7. Systems that impose or deny services without meaningful participation by those affected by the services.
8. Parents, guardians, professionals, or others who make decisions that ignore or disregard the decisions of people with disabilities, compromising their wishes, perspectives, and input in the process, thereby altering their self-determined course as human beings.
9. Medical discrimination that devalues them through:
   a. Laws, policies, and practices that assume certain people do not deserve medical treatment to improve or sustain their lives.
   b. Medical decisions that deny or force medical treatment without the affected person's involvement and consent, because it is presumed they do not understand or know what is best for themselves.
   c. Treatment that alters or controls people for the convenience of others, society, or any system, without their explicit consent.

Section III: WE BELIEVE and AFFIRM that all people, including those with disabilities, have the freedom to lead a meaningful life, in which:

1. Each person has his or her own name and identity and is acknowledged as a unique individual.
2. People are presumed to be competent.
3. People have the right to grow intellectually, sexually, physically, spiritually, and socially to their full potential, without pressure to alter how they speak, feel, think, or move.
4. People exercise the right to choose their relationships: the people with whom they spend their time, share personal details, or are intimate.

5. People are the primary drivers of their own life choices and decisions, and their right to make decisions for themselves, with or without assistance, is respected, encouraged, and supported.
6. People have the right to fail. Risk is acceptable, even when it results in a person not being successful. The outcomes of people's choices should not affect their value as human beings.
7. People have the right to learn, grow, and have equal access to inclusive education that prepares them to enter the working world and participate fully in their communities. We reject the notion that people are on predetermined paths because they have a disability.
8. People have the right to learn and grow through the pursuit of life-long learning opportunities.
9. People are inspired by others' high expectations for them, helping them strive to become all they can be. Limited, or no expectations, restricts people's growth, advances stereotypes, and leads to labeled incompetence and poverty, instead of self-determined lives.
10. People pursue careers that provide economic stability and freedom, where they can be promoted, form positive work relationships, and receive employment supports that protect and promote their autonomy.
11. People direct and/or control their own finances, consistent with their personal ambitions and responsibilities.
12. People have access to technology, which includes assistive technology that increases their ability to access information, and gives them the ability to interact as equal participants in their communities.

Section IV: WHEREAS all of the above rights are recognized, honored and practiced, we endeavor to create and uphold opportunities that:

1. Promote the health and well-being of all people.
2. Support people to fully, meaningfully, and productively participate in civic, cultural, political, economic, and social life, regardless of communication style, mobility, race, nation of origin, religion, age, gender, sexual orientation, intelligence, accommodations, strengths, independence, support needs, and ability.
3. Presume competence and uphold high expectations.
4. Support and never abandon those who struggle and seek assistance, no matter how difficult.
5. Promote respect for each other, even in conflict.

Comment on the Proclamation

To share your comments on the wording of the Proclamation, please use the link below:

https://www.surveymonkey.com/r/MO-DisabilityRights

Participating Organizations

Representatives of the following organizations participated in all or part of the development of the rights statement. Group and individual feedback was solicited through the entirety of the process, including multiple versions of the statement. Their participation does not imply they agree with everything in the Proclamation at this time.

ARC of Missouri

Governor's Council on Disability

Heartland Self-advocacy Resource Network (HSRN)

Missouri Association of County Developmental Disabilities Services (MACDDS)

Missouri Association of People Supporting Employment Now (MO-APSE)

Missouri Association of Rehabilitation Facilities (MARF)

Missouri Department of Mental Health – Division of Developmental Disabilities (DMH)

Missouri Developmental Disabilities Council (MODDC)

Missouri Protection and Advocacy (MO P&A)

Missouri Self-Determination Association (MoSDA)

Missouri TASH

People First of Missouri (PFMO)

Self-Advocates Becoming Empowered (SABE)

Services for Independent Living (SIL)

University of Missouri-Kansas City (UMKC) Institute for Human Development (IHD)

UMKC IHD Consumer Advisory Leadership Team (CALT)

Rules of
Department of Mental Health
Division 45—Division of Developmental Disabilities
Chapter 3—Services and Supports

Title		Page
9 CSR 45-3.010	Individualized Habilitation Plan Procedures	3
9 CSR 45-3.020	Individualized Supported Living Services—Definitions (Rescinded June 30, 2016)	3
9 CSR 45-3.030	Individual Rights	3
9 CSR 45-3.040	Rights of Designated Representatives, Parents, and Guardians	4
9 CSR 45-3.050	Admission and Treatment of Clients with Aggressive Behaviors (Rescinded September 30, 2002)	4
9 CSR 45-3.060	Services for Individuals with Autism Spectrum Disorder	4
9 CSR 45-3.070	Certification of Medication Aides Serving Persons with Developmental Disabilities	6
9 CSR 45-3.080	Self-Directed Supports	10

Title 9—DEPARTMENT OF MENTAL HEALTH
Division 45—Division of Developmental Disabilities
Chapter 3—Services and Supports

9 CSR 45-3.010 Individualized Habilitation Plan Procedures

PURPOSE: This rule prescribes procedures for development and implementation of individualized habilitation plans for all individuals receiving services from the Division of Mental Retardation and Developmental Disabilities.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

(1) Terms defined in sections 630.005 and 633.005, RSMo are incorporated by reference for use in this rule. Unless the context clearly indicates otherwise, the following terms mean:

(A) Assessment—the process of gathering information about a client for use by the interdisciplinary team as a basis for the client's individualized habilitation plan (IHP);

(B) IHP amendment—documentation of an interdisciplinary team's change in an IHP at a time other than the time of annual review;

(C) Interdisciplinary team—the client, the client's designated representative(s), the case manager or qualified mental retardation professional, and representatives of services required or desired by the client;

(D) Qualified mental retardation professional (QMRP)—a person with qualifications, training and experience as defined in 42 CFR 483.430; and

(E) Reassessment—data obtained from training programs, results of screenings and formal or informal assessments completed since the previous interdisciplinary team meeting.

(2) Every individual receiving services from the division shall have an IHP.

(A) The interdisciplinary team shall develop an IHP within thirty (30) days after the individual has been found eligible for services.

(B) The IHP shall be based upon a comprehensive, functional evaluation of individual needs. It shall define the individual's current level of independence, identify the projected level of independence that the individual is expected to achieve and describe objectives to reach that level.

(C) The interdisciplinary team shall ensure completion of the following steps to efficiently plan, implement and monitor the IHP: assessment, team synthesis of assessment results, development of the IHP, development of training programs, implementation of the IHP, reassessments and annual review of the IHP by the entire team.

(D) The IHP shall contain at least the minimum information required to comply with the division's approved IHP format.

(3) The interdisciplinary team shall review every IHP at least annually. IHP reassessments shall be completed within ninety (90) days before annual IHP reviews.

(4) The case manager or QMRP shall regularly monitor implementation of the IHP.

(A) The case manager or QMRP shall periodically observe each individual during implementation of the IHP.

(B) Each month the case manager or QMRP shall monitor every IHP which prescribes residential services or contains habilitative objectives to determine if services are being delivered as planned and, to assure that progress is being made.

(C) At least annually, the case manager or QMRP shall review each IHP which prescribes nonhabilitative services only.

(5) The case manager or QMRP may make changes in IHP objectives only with prior approval of the interdisciplinary team. Addition of training objectives and deletion of training and service objectives also require prior team approval. Addition of service objectives requires notification of the team. The case manager or QMRP may make changes in training plans or methods to insure progress toward achievement of objectives. Any amendment to the IHP shall be documented in the individual's record.

(6) Division facilities shall prescribe services in an eligible individual's IHP or IHP amendment before the services are authorized, delivered or purchased.

(7) The division facility may authorize emergency residential services, respite care or crisis intervention for up to thirty (30) days without prior approval of the interdisciplinary team.

(8) Each division facility shall develop a policy for implementing the IHP process.

AUTHORITY: section 630.655, RSMo 1994. The rule was previously filed as 9 CSR 10-5.150. Original rule filed Nov. 30, 1990, effective April 29, 1991. Amended: Filed May 25, 1995, effective Dec. 30, 1995.*

**Original authority: 630.655, RSMo 1980.*

9 CSR 45-3.020 Individualized Supported Living Services—Definitions
(Rescinded June 30, 2016)

AUTHORITY: section 630.050, RSMo 1994. This rule was previously filed as 9 CSR 30-5.010. Emergency rule filed Aug. 4, 1992, effective Sept. 1, 1992, expired Dec. 29, 1992. Original rule filed Aug. 4, 1992, effective Feb. 26, 1993. Amended: Filed May 25, 1995, effective Dec. 30, 1995. Rescinded: Filed Dec. 8, 2015, effective June 30, 2016.

9 CSR 45-3.030 Individual Rights

PURPOSE: This rule defines the rights of persons eligible for services from the Division of Developmental Disabilities (Division of DD).

(1) All individuals served by the Division of DD shall be entitled to the following rights and privileges without limitation, unless otherwise provided by law:

(A) To be treated with respect and dignity as a human being;

(B) To have the same legal rights and responsibilities as any other citizen;

(C) To receive services regardless of race, creed, marital status, national origin, disability, religion, sexual orientation, gender, or age;

(D) To be free from physical, emotional, sexual, and verbal abuse, and financial exploitation;

(E) To receive services and supports to achieve the maximum level of independence;

(F) To have access to all rules, policies, and procedures governing the operations of the Division of DD in an accessible format, and to have those rules, policies, and procedures explained in a manner that is easily understood;

(G) Within one's financial means, to have a choice where to live and whether or not to

share a home with other people;

(H) To direct one's own person-centered planning process and to choose others to be included in that process;

(I) To participate fully in the community;

(J) To communicate in any form and to have privacy of communications;

(K) To accept or decline supports and services;

(L) To have freedom of choice among Division of DD approved providers;

(M) To seek employment and work in competitive integrated settings;

(N) To participate or decline participation in any study or experiment;

(O) To choose where to go to church or place of worship, or to refuse to go to a church or place of worship;

(P) To have rights, services, supports, and clinical records regarding services explained in a manner that is easily understood and in an accessible format;

(Q) To have all of an individual's records maintained in a confidential manner;

(R) To report any violation of one's rights free from retaliation and without fear of retaliation; and

(S) To be informed on how to make an inquiry, file a complaint or report a violation of one's rights, and to be assisted in these processes, if requested.

(2) Adults who do not have a legal guardian have the right to designate a representative to act on one's behalf for purposes of receiving services from the Division of DD.

(3) An individual's rights as outlined in section one (1) may not be restricted, including, but not limited to, by a provider of targeted case management or home and community based services, without due process. Due process under this provision includes the right to be notified and heard on the limitation or restriction, the right to be assisted through external advocacy if an individual disagrees with the limitation or restriction, and the right to be informed of available options to restore the individual's rights.

AUTHORITY: section 630.050, RSMo 2016. This rule was previously filed as 9 CSR 30-5.040. Emergency rule filed Aug. 4, 1992, effective Sept. 1, 1992, expired Dec. 29, 1992. Original rule filed Aug. 4, 1992, effective Feb. 26, 1993. Amended: Filed May 25, 1995, effective Dec. 30, 1995. Amended: Filed July 25, 2016, effective Feb. 28, 2017.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008.*

9 CSR 45-3.040 Rights of Designated Representatives, Parents, and Guardians

PURPOSE: This rule prescribes policies for designation of representatives and recognition of certain rights of designated representatives, parents, and guardians of individuals receiving services from the Division of Developmental Disabilities (Division of DD).

(1) Definitions.

(A) Designated representative—a parent, relative, or other person designated by an adult who does not have a guardian. The designated representative may participate in the person-centered planning process and development of the individual support plan, at the request of, and as directed by, the individual.

(B) Circle of support—team supporting the individual and participating in the person-centered planning process.

(C) Person-centered planning process—a process directed by the individual, with the inclusion of a circle of support created by or with the individual, which may include a guardian, public administrator, the individual, and/or persons freely chosen by the individual who are able to serve as important contributors to the process. The person-centered planning process enables and assists the individual to access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally defined outcomes. These trainings, supports, therapies, treatments, and/or other services will become part of the individualized support plan.

(D) Individual Support Plan (ISP)—A document that results from the person centered planning process, which identifies the strengths, capacities, preferences, needs, and personal outcomes of the individual. The ISP includes a personalized mix of paid and non-paid services and supports that will assist the person to achieve personally defined outcomes.

(2) The Division of DD shall recognize that the ISP process is directed by the individual and their circle of support. Parents and legal guardians, who are willing and able to exercise their rights, may participate in person-centered planning, development, and implementation of the ISP, and/or referral as set out in this rule.

(3) As set out in section 633.110, RSMo, parents of minor children and youth and legal guardians have the right to approve or refuse supports or placement of their children or wards.

(4) Adults who have not been declared legally incapacitated may give their written consent for parents, relatives, or other persons to serve as their designated representative to advocate for and advise, guide, and encourage the individual and members of the individual support plan team in developing and implementing individual support plans. Written consent for designated representatives shall include written authorization to disclose protected health information.

(A) In accordance with the federal Health Insurance Portability and Accountability Act of 1996, as amended, and departmental policy, the consent shall authorize the designated representatives' access to those individual records specified by the individual and for periods of time specified by the individual.

(B) Designated representatives shall not have the right to approve or refuse referral, support, or placement of individuals and should act as the individual's advocate against or in support of recommended changes.

(C) Individuals may revoke their consent in writing at any time and the Division of DD and all parties responsible for the implementation of the ISP shall recognize the revocations immediately.

(D) Written consents and revocations shall be maintained in the individual's ISP and copies shall be given to designated representatives.

AUTHORITY: section 630.050, RSMo 2016. This rule was previously filed as 9 CSR 50-1.055. Original rule filed March 4, 1992, effective Aug. 6, 1992. Amended: Filed May 25, 1995, effective Dec. 30, 1995. Amended: Filed July 25, 2016, effective Feb. 28, 2017.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008.*

9 CSR 45-3.050 Admission and Treatment of Clients with Aggressive Behaviors
(Rescinded September 30, 2002)

AUTHORITY: section 630.050, RSMo 1994. This rule was previously filed as 9 CSR 50-1.060. Original rule filed Sept. 1, 1993, effective Jan. 31, 1994. Amended: Filed May 25, 1995, effective Dec. 30, 1995. Rescinded: Filed March 11, 2002, effective Sept. 30, 2002.

9 CSR 45-3.060 Services for Individuals with Autism Spectrum Disorder

PURPOSE: This rule establishes programs and services for persons with autism and their families.

(1) Terms defined in sections 630.005, 633.005, and 633.220, RSMo are incorporated by reference for use in this rule. Also, the following terms mean:

(A) Autism spectrum disorder (ASD)—a group of neurodevelopmental disorders characterized by persistent deficits in social communication and social interaction across multiple contexts as well as by restricted, repetitive patterns of behaviors, interests, or activities. Symptoms of ASD must be present in the early developmental period and cause significant impairment in social, occupational, or other important areas of functioning;

(B) Family support—services and helping relationships for the purpose of maintaining and enhancing family caregiving. Family support may be any combination of services that enable individuals with autism to reside within their family homes and remain integrated within their communities. Family support services are—

1. Based on individual and family needs;

2. Easily accessible for the family;

3. Family-centered and culturally sensitive;

4. Flexible and varied to meet the changing needs of the family members;

5. Identified by the family; and

6. Provided in a timely manner contingent upon availability of resources; and

(C) Service provider—a person or an entity which provides and receives reimbursement for autism programs and services as specified in section (3) of this rule.

(2) The Division of Developmental Disabilities (Division of DD) shall establish programs and services for persons with autism. The Division of DD shall establish such programs and services in conjunction with persons with ASD and their families. The programs and services shall be designed to enhance the abilities of persons with ASD and their families' abilities to meet needs they identify. The programs and services shall—

(A) Develop skills for persons with autism through supports, services, and teaching;

(B) Teach families to provide behavioral supports to members with autism; and

(C) Provide needed family support.

(3) The Division of DD Director, with input from the Missouri Parent Advisory Committee on Autism, shall divide the state into at least five (5) regions and establish autism programs and services which are responsive to the needs of persons with autism and families consistent with contemporary and emerging best practices. The boundaries of such regions, to the extent practicable, shall be contiguous with relevant boundaries of political subdivisions and health service areas. Such regions shall be referred to as regional autism projects in this rule.

(4) Regional Autism Projects may provide or purchase, but shall not be limited to, the following services:

(A) Assessment;

(B) Advocacy training;

(C) Behavior management training and supports;

(D) Communication and language therapy;

(E) Consultation on individualized education and habilitation plans;

(F) Crisis intervention;

(G) Information and referral assistance;

(H) Life skills;

(I) Music therapy;

(J) Occupational therapy, sensory integration therapy, and consultation;

(K) Parent or caregiver training;

(L) Public education and information dissemination;

(M) Respite care;

(N) Staff training;

(O) Social skills training; and

(P) Other contemporary and emerging evidence-based practices.

(5) Regional Autism Projects shall each have regional parent advisory councils composed of from seven to nine (7–9) persons that have family members with autism, including family members that are young children, school-age children, and adults. The members shall be Missouri residents and their family members with autism shall have met the Division of DD's eligibility requirements specified under 630.005, RSMo.

(A) One-third (1/3) of the members serving on July 1, 1995, shall continue to serve until July 1, 1996. One-third (1/3) shall serve until July 1, 1997, and the remaining one-third (1/3) shall serve until July 1, 1998. Length of those terms shall be determined by drawing lots.

(B) Upon expiration of members' terms, new members shall be nominated by the councils for three- (3-) year terms or until their successors have been elected. New members of each of the five (5) regional parent advisory councils shall be appointed by the Division of DD Director or designee from nominations submitted by the regional parent advisory councils. No member shall serve more than two (2) consecutive three- (3-) year terms. No council member shall be a service provider, a member of a service provider's board of directors, or an employee of a service provider or the Division of DD. Regional parent advisory councils shall be encouraged to maintain membership from each region within their project boundaries. The councils shall make every effort to elect members to represent the cultural diversity of the project areas and to represent persons with autism of all ages and capabilities.

(C) Each council shall elect a chairperson, vice-chairperson, and secretary. Annual elections shall occur in July. The councils shall meet bimonthly or more often at the call of the chairpersons. A simple majority of the membership shall constitute a quorum.

(D) Each council shall establish bylaws specific to the council's project area and consistent with parameters established by the Missouri Parent Advisory Council on Autism set out in section (6).

(E) The councils' responsibilities shall include, but not be limited to, the following:

1. Advocacy;

2. Contract monitoring;

3. Review of annual Department of Mental Health audits of projects;

4. Recommendation of services to be provided based on input from families;

5. Recommendation of policy, budget, and service priorities;

6. Monthly review of service delivery;

7. Planning;

8. Public education and awareness;

9. Recommendation of service providers to the Division of DD for administration of the projects; and

10. Recommendation of contract cancellation.

(F) In the event a parent advisory council disagrees with a decision of the Division of DD Regional Director's designee related to operation of the autism project, the issue may be referred to the Missouri Parent Advisory Committee on Autism for its recommendation to the Division of DD Director.

(6) The Division of DD shall establish the Missouri Parent Advisory Committee on Autism. It shall be composed of two (2) representatives and one (1) alternate from each of the five (5) regional parent advisory councils set out in this rule. It shall also include one (1) person with autism and one (1) alternate, a person with autism, who are not members of a regional parent advisory council. The committee shall be appointed by the Division of DD Director.

(A) The Division of DD Director shall make every effort to appoint members nominated by the regional parent advisory councils. The membership should represent the cultural diversity of the state and represent persons with autism of all ages and capabilities;

(B) One-third (1/3) of the members serving on January 1, 1995, serve until January 1,

1996. One-third (1/3) shall serve until January 1, 1997, and the remaining one-third shall serve until January 1, 1998. Length of those terms shall be determined by drawing lots.

(C) Upon expiration of the terms, members shall be appointed by the Division of DD Director for three- (3-) year terms or until their successors have been appointed. No member shall serve more than two (2) consecutive three- (3-) year terms.

(D) At its annual meeting in July, the Missouri Parent Advisory Committee on Autism shall elect a chairperson, a vice-chairperson, and a secretary. The committee shall meet quarterly or more often at the call of the chairperson. A simple majority of the membership shall constitute a quorum.

(E) The committee's responsibilities shall include, but not be limited to, the following:

1. Communication with the projects set out in section (3) to provide up-to-date information to them and the families they serve;

2. Determining project outcomes for autism services;

3. Determining roles and responsibilities of the regional parent advisory councils set out in section (5);

4. Development of positive relationships with the Department of Elementary and Secondary Education and local school districts;

5. Establishing policy for the Missouri Parent Advisory Committee on Autism;

6. Fostering unity with and among the projects set out in section (3) to ensure joint support for legislative, budget, and other issues;

7. Planning and sponsorship of statewide activities;

8. Provision of program recommendations to the Division of DD;

9. Recommendation of service providers to the Division of DD Director in the event a regional parent advisory council and Division of DD Director's designee cannot reach consensus;

10. Recommendation of issue resolutions to the Division of DD Director; and

11. Submission of an annual report to the Missouri Commission on Autism Spectrum Disorders, the governor, the director of the Department of Mental Health, and the director of the Division of DD.

AUTHORITY: sections 630.050 and 633.220, RSMo 2016. Original rule filed Feb. 6, 1995, effective Sept. 30, 1995. Amended: Filed July 31, 1998, effective Jan. 30, 1999. Amended: Filed July 25, 2016, effective Feb. 28, 2017.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008 and 633.220, RSMo 2009.*

9 CSR 45-3.070 Certification of Medication Aides Serving Persons with Developmental Disabilities

PURPOSE: Individuals who administer medications or supervise self-administration of medications in any residential setting or day program funded, licensed or certified by the Department of Mental Health to provide services to persons who are mentally retarded or developmentally disabled, are required to be either a physician, a licensed nurse, a certified medication technician, a certified medication employee, a level I medication aide or Department of Mental Health medication aide. The provisions of the rule do not apply to family-living arrangements unless they are receiving reimbursement through the Medicaid Home and Community-Based Waiver for persons with developmental disabilities. This rule sets forth the requirements for approval of a Medication Aide Training Program designating the required course curriculum content, outlining the qualifications required of students and instructors, designating approved training facilities and outlining the testing and certification requirements.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

(1) The purpose of the Medication Aide Training Program shall be to prepare individuals for employment as medication aides in any residential setting or day program funded, licensed or certified by the Department of Mental Health to provide services to persons with mental retardation or developmental disabilities. The training program does not prepare individuals for the parenteral administration of medications such as insulin or the administration of medications or other fluids via enteral feeding tubes.

(2) All aspects of the Medication Aide Training Program included in this rule shall be met in order for a program to be considered approved.

(3) The objectives of the Medication Aide Training Program shall be to ensure that the medication aide will be able to—

(A) Define the role of a medication aide;

(B) Prepare, administer and chart medications by nonparenteral routes;

(C) Observe, report and record unusual responses to medications;

(D) Identify responsibilities associated with control and storage of medications; and

(E) Utilize appropriate drug reference materials.

(4) The course shall be a minimum of sixteen (16) hours of integrated formal instruction and practice sessions supervised by an approved instructor.

(5) The curriculum content shall include procedures and instructions in the following areas: basic human needs and relationships; drug classifications and their implications; assessing drug reactions; techniques of drug administration; documentation; medication storage and control; drug reference resources; and infection control.

(6) The approved course curriculum shall be the manual entitled *Level I Medication Aide* (IE 64-1), developed by the Department of Elementary and Secondary Education, Department of Mental Health and the Division of Aging and produced by the Instructional Materials Laboratory, University of Missouri-Columbia. This manual is incorporated by reference in this rule. Students and instructors each shall have a copy of this manual.

(7) A student shall not administer medications without the instructor present until s/he successfully completes the course and obtains a certificate.

(8) Student Qualifications.

(A) Any individual employable in a residential setting or day program funded, licensed or certified by the Department of Mental Health to provide services to persons who are mentally retarded or developmentally disabled, and who meet the requirements of 9 CSR 10-5.190, shall be eligible to enroll as a student in this course or to challenge the final examination.

(B) An individual may qualify as a medication aide by successfully challenging the final examination if that individual has successfully completed a medication administration course and is currently employed to perform medication administration tasks in a residential setting or day program operated, funded, licensed or certified by the Department of Mental Health to provide services to persons who are mentally retarded or

developmentally disabled.

(C) Certain persons may be deemed certified under paragraph (13)(B)4. of this rule.

(9) Those persons wanting to challenge the final examination shall submit a request in writing to the Missouri Division of Mental Retardation and Developmental Disabilities enclosing applicable documentation. If approved to challenge the examination, the Division of Mental Retardation and Developmental Disabilities will send the applicant a letter to present to an approved instructor so arrangements can be made for testing.

(10) Instructor Qualifications.

(A) An instructor shall be currently licensed to practice as either a registered nurse or practical nurse in Missouri or shall hold a current temporary permit from the Missouri State Board of Nursing. The licensee shall not be subject to current disciplinary action such as censure probation, suspension or revocation. If the individual is a licensed practical nurse, the following additional requirements shall be met:

1. Shall not be waived: the instructor has a valid Missouri license or a temporary permit from the Missouri State Board of Nursing; and

2. Shall be a graduate of an accredited program, which has pharmacology in the curriculum.

(B) In order to be qualified as an instructor, the individual shall—

1. Have attended a "Train the Trainer" workshop to implement the Level I Medication Aide Training Program conducted by a Missouri registered nurse presenter approved by the Missouri Division of Aging.

2. Meet at least one (1) of the following criteria:

A. Have had one (1) year's experience working in a long-term care (LTC) facility licensed by the Division of Aging or in a residential facility or day program operated, funded, licensed or certified by the Department of Mental Health within the past five (5) years; or

B. Be currently employed in a LTC facility licensed by the Department of Mental Health and shall have been employed by that facility for at least six (6) months; or

C. Shall be an instructor in a Health Occupations Education Program.

(11) Sponsoring Agencies.

(A) The Medication Aide Training Program may be sponsored by providers of residential or day programs operated, funded, licensed or certified by the Department of Mental Health, Division of Mental Retardation and Developmental Disabilities.

(B) The sponsoring agency is responsible for obtaining an approved instructor, determining the number of manuals needed for a given program, ordering the manuals for the students and presenting a class schedule for approval by the local regional center. The sponsoring agency shall maintain the following documentation: the name of the approved instructor; the instructor's Social Security number, current address and telephone number; the number of students enrolled; the name, address, telephone number, Social Security number and age of each student; the name and address of the facility that employs the student, if applicable; the date and location of each class to be held; and the date and location of the final examination. If there is a change in the date and location of the training, the sponsoring agency shall notify the local regional center.

(C) Classrooms used for training shall contain sufficient space, equipment and teaching aids to meet the course objectives as determined by the Division of Mental Retardation and Developmental Disabilities.

(D) If the instructor is not directly employed by the agency, there shall be a signed written agreement between the sponsoring agency and the instructor which shall specify the role, responsibilities and liabilities of each party.

(12) Testing.

(A) The final examination shall consist of a written and a practicum examination administered by the instructor.

1. The written examination shall include questions based on the course objectives developed by the Division of Mental Retardation and Developmental Disabilities.

2. The practicum examination shall be conducted in a residential setting or day program operated, funded, licensed or certified by the Department of Mental Health, Division of Mental Retardation and Developmental Disabilities or an LTC facility which shall include the preparation and administration by nonparenteral routes and recording of medications administered to consumers under the direct supervision of the instructor and the person responsible for medication administration in the facility. When it is not feasible and/or possible to conduct the practicum examination in an approved residential or day program, the instructor may request a waiver from the local regional center to conduct the practicum examination in an approved simulated classroom situation.

(B) A score of eighty percent (80%) is required for passing the final written examination and one hundred percent (100%) accuracy in the performance of the steps of procedure in the practicum examination.

(C) The final examination, if not successfully passed, may be retaken within ninety (90) days one (1) time without repeating the course, however, those challenging the final examination must complete the course if the examination is not passed in the challenge process.

(D) The instructor shall complete final records and shall submit these and all test booklets to the sponsoring agency.

(13) Records and Certification.

(A) Records.

1. The sponsoring agency shall maintain records of all individuals who have been enrolled in the Medication Aide Training Program and shall submit to the local regional center all test booklets, a copy of the score sheets and a complete class roster.

2. A copy of the final record shall be provided to any individual enrolled in the course.

3. A final record may be released only with written permission from the student in accordance with the provisions of the Privacy Act—PL 900-247.

(B) Certification.

1. The regional center shall issue a Department of Mental Health, Division of Mental Retardation and Developmental Disabilities, Medication Aide Certificate to employable individuals successfully completing the course upon receiving the required final records and test booklets from the sponsoring agency.

2. The regional center shall enter the names of all individuals receiving a Medication Aide Certificate in the Division of Mental Retardation and Developmental Disabilities Medication Aide Registry.

3. Medication aides who do not currently meet certification requirements must successfully pass the Level I Medication Aide course or challenge the final examination, if eligible, and obtain a Division of Mental Retardation and Developmental Disabilities Medication Aide Certificate within eighteen (18) months from the effective date of this regulation. Individuals who fail to comply shall not be allowed to administer medications.

4. Individuals who hold a Medication Aide Certificate issued by a regional center or a Division of Aging Level I Medication Aide Certificate, and have completed biannual training as required in section (14), will meet the requirements of this rule.

(14) Bi-Annual Training Program.

(A) Level I medication aides shall participate in a minimum of four (4) hours of medication administration training every two (2) years in order to administer medications in a residential setting or day program funded, certified or licensed by the Department of Mental Health to provide services to persons who are mentally retarded or developmentally disabled. The training shall be taken in two (2) two (2)-hour blocks or a four (4)-hour block and must be completed by the anniversary date of the medication aide's initial level I medication aide certificate. The training shall be—

1. Offered by a qualified instructor as outlined in section (10) of this rule; and

2. Documented on the Level I Medication Aide Bi-Annual Training form MO 650-8730 and kept in the employee's personnel file. This form is incorporated by reference in this rule.

(B) The training shall address at the least the following:

1. Medication ordering and storage;

2. Medication administration;

A. Use of generic drugs;

B. How to pour, chart, administer and document;

C. Information and techniques specific to the following: inhalers, eye drops, topical medications and suppositories;

D. Infection control;

E. Side effects and adverse reactions;

F. New medications and/or new procedures;

G. Medication errors;

3. Individual rights, and refusal of medications and treatments;

4. Issues specific to the facility/program as indicated by the needs of the consumers, and the medications and treatments currently being administered; and

5. Corrective actions based on problems identified by the staff, the trainees or issues identified by regulatory and accrediting bodies, professional consultants or by any other authoritative source.

(C) The Department of Mental Health regional centers will routinely monitor the quality of medication administration. When quality assurance monitoring documents that a medication aide is not administering medications within training guidelines, the regional center may require the aide to take additional training in order to continue passing medications in the residential setting or day program.

(15) Revocation of Certification.

(A) If the Department of Mental Health upon completion of an investigation, finds that a medication aide has stolen or diverted drugs from a consumer or facility or has had his/her name added to the Department of Mental Health Employee Disqualification Registry or Division of Aging Employee Disqualification Registry, the Department of Mental Health shall render the medication aide's certificate invalid.

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
MENTAL RETARDATION DEVELOPMENTAL DISABILITIES

MEDICATION AIDE BI-ANNUAL TRAINING

EMPLOYEE NAME	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER – –
EMPLOYEE ADDRESS	MEDICATION AIDE CERTIFICATE (INITIAL) DATE ISSUED ____ / ____ / ____ CERTIFICATE #	
SPONSORING FACILITY NAME		
SPONSORING FACILITY ADDRESS		

A. Training shall address at least the following	DATE OF TRAINING ____ / ____ / ____ HOURS COMPLETED ____	DATE OF TRAINING ____ / ____ / ____ HOURS COMPLETED ____
1. Medication ordering and storage		
2. Medication administration		
☐ Use of generic drugs		
☐ How to pour, chart, administer and document		
☐ Information and techniques specific to the following: inhalers, eye drops, topical medications and suppositories		
☐ Infection Control		
☐ Side effects and adverse reactions		
☐ Update on new medications or new procedures		
☐ Medication errors		
3. Individual rights, and refusal of medications and treatments;		
4. Issues specific to the facility/program as indicated by the needs of the residents/clients, and the medications and treatments currently being administered		
5. Corrective actions based on problems identified by the staff, the trainees or issues identified by regulatory and accrediting bodies, professional consultants or by any other authoritative source; and		
Other specify:		

The training shall be taken in two (2) two (2) hour blocks or a four (4) hour block and must be completed by the anniversary date of the medication aide's initial certificate. Medication aides who do not participate in at least 4 hours of medication administration training every two years will not be allowed to administer medication in accordance with 9CSR 45-3.060. A signed copy of this form denotes compliance with the training requirement and must be included in the employee's personnel file. It is the responsibility of the agency to offer and the employee to participate in the required training.

RN/LPN SIGNATURE (INSTRUCTOR)	LICENSE NUMBER	DATE
EMPLOYEE SIGNATURE		DATE
SPONSORING FACILITY(AUTHORIZED SIGNATURE)		DATE

MO 650-8730 (12-00)

AUTHORITY: sections 630.050 and 633.190, RSMo 2000. Original rule filed Jan. 10, 2001, effective Aug. 30, 2001.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995; 633.190, RSMo 1993, amended 1995.*

9 CSR 45-3.080 Self-Directed Supports

PURPOSE: This rule establishes the scope of and requirements for the use of Self-Directed Supports, a service delivery option available under Home and Community Based waivers as created by section 1915(c) of the Social Security Act.

(1) Definitions.

(A) Agency-based supports—supports provided by a public or private agency, including independent contractors, under contract with the Department of Mental Health and enrolled with the MO HealthNet Division to serve participants of any home and community-based waivers operated by the department.

(B) Back-up plan—an emergency plan developed to address situations when the employee providing essential supports is unavailable. The individual support plan for all individuals receiving self- and family-directed supports must provide information about the back-up plan.

(C) Budget authority—the right and responsibility of the employer to exercise control and management of a yearly budget allocation.

(D) Designated representative (DR)—a parent, relative, or other person designated by an adult individual or a guardian, who shall act in the best interest of the individual and serves at the discretion of the individual.

(E) Employer—individual receiving services through self-directed supports and/or person with the power to act on such individual's behalf, such as: a designated representative; guardian; or parent, if the individual is a minor. The employer maintains the Federal Employer Identification Number and employs persons to provide services to the individual.

(F) Employment authority—the right and responsibility of the employer to recruit, hire, train, manage, supervise, fire, and establish the wages for employees within the limits described in section (16) of this rule.

(G) Family member—a parent, stepparent, sibling, child, grandchild, or grandparent related by blood, adoption, or marriage, or a spouse.

(H) Fiscal management service (FMS)—a service to assist the employer with payroll-related functions. The FMS ensures the self-directed supports program meets federal, state, and local employment tax, labor and workers' compensation insurance rules, and other requirements that apply when the individual or his/her designee functions as the employer of workers. The FMS makes financial transactions on behalf of the individual.

(I) Home and community-based waivers (HCB waivers)—a set of long term community-based supports and services authorized by the Centers for Medicare and Medicaid Services which are provided as an alternative to care in institutions such as nursing facilities and intermediate care facilities for individuals with intellectual disabilities. The specific services provided under a home and community-based waiver is referred to as home and community-based services.

(J) Improvement plan—a corrective action plan to address issues of non-compliance with program requirements. The goal of the improvement plan is to focus on needed supports to ensure the employer succeeds when using self-directed supports.

(K) Individual—person receiving supports through a home and community-based waiver.

(L) Individual Support Plan (ISP)—a document that results from the person-centered planning process, which identifies the strengths, capacities, preferences, needs, and personal outcomes of the individual. The ISP includes a personalized mix of paid and non-paid services and supports that will assist the person to achieve personally defined outcomes.

(M) Individual Support Plan team (ISP team)—the individual, the individual's designated representative(s), and the support coordinator. Providers of waiver-funded services may also participate in the support plan team if such participation is requested by the individual or guardian.

(N) Natural supports—unpaid support provided through relationships that occur in everyday life. Natural supports typically involve family members, friends, co-workers, neighbors, acquaintances, and community resources.

(O) Self-directed supports (SDS)—a service delivery option available under the home and community-based waivers for persons with intellectual and developmental disabilities and who wish to exercise more choice, control, and authority over their supports.

(2) Eligibility Criteria. Every individual who is receiving services through an HCB waiver shall have the opportunity to utilize SDS as his/her own employer as long as—

(A) The individual; designated representative; guardian; or a parent, if the individual is a minor, is willing and able to act as the employer, assuming both budget and employment responsibilities while receiving HCB waiver services from the Division of Developmental Disabilities (DD); and

(B) The Division of DD does not find good cause to deny the use of this service model under the criteria stated in section (11) of this rule.

(3) Designated Representative. An individual who is eighteen (18) years or older, a guardian, or a parent (if the individual is a minor), may identify a designated representative for purposes of utilizing SDS. Designated representatives must demonstrate a history of knowledge of the individual's preferences, values, needs, and other relevant information. The individual, his or her planning team, and regional office are responsible to ensure that this representative is able to perform all the employer-related responsibilities and complies with requirements associated with representing the individual in directing services and supports.

(A) The following individuals may be designated as a representative:

1. Spouse, unless a formal legal action for divorce is pending;
2. An adult child of the individual;
3. A parent;
4. An adult brother or sister;
5. Another adult relative of the individual;
6. A legal guardian; and
7. Any other adult chosen by the individual with approval of the ISP team consistent with the requirements of this section.

(4) Employer Rights and Responsibilities.

(A) The employer must manage the employees' day-to-day activities ensuring supports are provided as written in the ISP.

(B) The employer may choose to hire eligible persons in accordance with the HCB waiver services requirements and with the following exceptions:

1. A spouse;
2. A parent or stepparent of an individual under age eighteen (18);
3. A legal guardian;
4. A designated representative; or
5. A person who is disqualified from employment under section 630.170, RSMo.

(C) The employer shall complete all forms required by the state's FMS contractor, including Internal Revenue Service (IRS) and Missouri state tax forms.

(D) The employer shall obtain a Federal Employer Identification Number (FEIN) in the name of the individual (or parent/guardian if the individual is under the age of eighteen (18)), with the assistance of the FMS.

(E) The employer shall follow all federal

and state employment laws and regulations including, but not limited to:

1. Recruiting, interviewing, checking references, hiring, training, scheduling work, managing and terminating employee(s). This includes directing the day-to-day care of the individual and addressing conflicts between employees;

2. Submitting all new employee paperwork to the FMS prior to the initiation of service. All required documents must be completed, submitted, and approved as a complete packet in order for them to be processed in a timely manner. Incomplete documents may delay an employee's start date;

3. Providing equal employment opportunities to all employees and interested employees without discrimination as to race, creed, color, national origin, gender, age, disability, marital status, sexual orientation, or any other legally protected status in all employment decisions, including recruitment, hiring, changing schedules and number of hours worked, layoffs, and terminations, and all other terms and conditions of employment. The employer accepts full and specific responsibility for following Equal Opportunity laws and requirements regarding employees. Each employee is to be treated fairly and consistently. For example, if the employer decides to check references on one (1) employee, it must be done for all employees;

4. An employee may not provide services while the individual is hospitalized or receiving any other direct care service reimbursed through the MO HealthNet Division (MHD);

5. Reviewing and approving time worked, which authorizes billing;

6. Submitting documentation of time worked in a timely manner in accordance with the FMS payroll schedule. The employer and employee signatures on/approval of the time sheet validates that the information submitted is accurate and true. If the employer signs/approves and the hours have not been worked, the employer will be held financially liable for payment for the time reported but not worked;

7. The employer is responsible for monitoring the monthly spending summary report provided by the FMS and for keeping all expenditures within the individual budget allocation as specified in the ISP. The employer agrees to reimburse the FMS for any payment of wages and expenses in excess of the amount in the individual budget allocation. Payment to the employee is limited to services actually delivered by the employee;

8. If the employer authorizes use of all funds/hours before the end of the period, the employer is responsible for other service arrangements; for example, use of non-paid natural supports. The employer is responsible for the payment of any wages and expenses in excess of the individual budget allocation. Employees must be paid for all hours worked;

9. Informing the FMS within one working day of any changes in the individual's status, including name, address, telephone number, hospitalization, and termination of program eligibility; and

10. Informing the FMS of the employee pay rate (wages), including timely notification of changes to the pay rate. Changes in pay rates must occur at the beginning of a pay period.

(F) The following must be reported immediately:

1. Any possible fraud, including MHD fraud to the FMS;

2. Abuse, neglect, misuse of property or funds, health risk, or other reportable event to the appropriate authorities. Reports of abuse, neglect, or exploitation of adults shall be made to the Department of Health and Senior Services, to the Division of DD, or to the individual's support coordinator; and

3. Employee changes, including name, address, contact number, and/or employment status.

(G) Appointment of a temporary representative if the employer is not capable or available to manage employees and contact made to the support coordinator to evaluate if a new representative must be appointed.

(H) Establishing a work schedule for employees. Time worked by employees in excess of forty (40) hours per week cannot be billed to MHD. Hours worked over forty (40) hours per week are the responsibility of the employer and must be paid through the FMS to ensure employee taxes are withheld.

(I) The employer shall not supplement wages to the employee outside of the fiscal management agreement.

(J) In accordance with the approved HCB waivers, payment for personal assistance services is not allowed for employee sleep time. If an employer schedules an employee to work a period of twenty-four (24) consecutive hours or more, the employer and employee may agree to exclude from hours worked up to eight (8) hours of sleep time when both of the following conditions are met:

1. The employer furnishes sleeping facilities; and

2. The employee can usually sleep uninterrupted.

(5) Combination of Supports. An individual receiving service through an HCB waiver may receive a combination of supports through SDS and agency-based supports so long as services from one (1) program do not duplicate services from the other.

(6) Exemption from Personal Assistance Services Training. The employer may exempt training for personal assistant services under the following circumstances documented in the ISP:

(A) Duties of the personal assistant will not require skills to be attained from the training requirement; or

(B) The personal assistant has adequate knowledge or experience as determined by the employer.

(7) Family Members Providing Services. The only service family members may provide is personal assistance services and only if he/she is not disqualified under section (4). When a family member provides personal assistance support, the ISP must reflect—

(A) The individual is not opposed to a family member providing the service;

(B) The services to be provided are solely to support the individual and not household tasks expected to be shared with people living in the family unit;

(C) The ISP team determines the paid family member will best meet the needs of the individual; and

(D) The family member cannot be paid for over forty (40) hours per week. Support in excess of forty (40) hours per week provided by a family member is considered a natural (unpaid) support.

(8) Parameter of Services. Services that may be self-directed are specified in each HCB waiver for people with developmental disabilities operated by the Division of DD and approved by the Centers for Medicare and Medicaid Services. Services included in the individual's ISP that may not be self-directed will be delivered through agency-based supports by a provider chosen by the individual.

(9) Consumer-Directed Personal Assistance Program through the Department of Health and Senior Services. Individuals who receive services under the consumer-directed personal assistance program authorized in 19 CSR 15 Chapter 8 and administered by the Department of Health and Senior Services (DHSS) may not simultaneously use SDS under any HCB waiver operated by the Division of DD. Individuals eligible to self-direct supports under both the DHSS consumer-directed personal assistance program and under an HCB waiver operated by the Division of DD must choose which program to direct supports under and choose a qualified provider of

agency-based supports for the other.

(10) Voluntary Termination. If an individual voluntarily requests to terminate SDS in order to receive services through an agency, the support coordinator will work with the individual, guardian, or designated representative to select a provider agency and transition services to agency-based supports by changing prior authorizations based on the individual's needs. When the self-directed services are voluntarily terminated, the same level of service is offered to the individual through agency-based supports.

(11) Denial and Mandatory Termination of SDS. The option of self-direction may be denied or terminated under any of the following conditions:

(A) The ISP team determines the health and safety of the individual is at risk;

(B) The employer is unable or unwilling to ensure employee records are accurately kept;

(C) The employer is unable or unwilling to supervise employees to receive services according to the plan;

(D) The employer is unable or unwilling to use adequate supports or unable or unwilling to stay within the budget allocation; or

(E) The employer has been the subject of a Medicaid audit resulting in sanctions for false or fraudulent claims under 13 CSR 70-3.030 Conditions of Provider Participation, Reimbursement, and Procedures of General Applicability, Sanctions for False or Fraudulent Claims for MHD.

(12) Improvement Plans.

(A) When an employer is found to be out of compliance with program requirements, an improvement plan shall be established. The improvement plan shall be jointly developed by the employer, individual, support broker, support coordinator, and other regional office staff, as needed.

(B) The plan shall include the specific issues of concern and shall include specific strategies and time frames for improvement.

(C) Failure to successfully meet the terms of the improvement plan within the established time frames shall result in termination of the option to use SDS.

(13) Termination of SDS for Non-Compliance. Except under circumstances described in section (11) of this rule, before terminating SDS, the support coordinator or appropriate staff of the regional office will first counsel the employer to assist in understanding the issues, inform the employer what corrective action is needed, and offer assistance in making changes. Counseling shall include the establishment of an improvement plan. If the employer refuses to cooperate, including failure to successfully carry out the terms of the improvement plan, the option of SDS shall be terminated.

(A) A letter shall be sent notifying the employer that the option of SDS will be terminated and a choice of agency-based providers offered.

(B) A choice of agency-based provider(s) must be made within fifteen (15) days.

(C) The employer may request a meeting with the regional director to discuss the unsuccessful completion of the improvement plan. The request for a meeting must be made within five (5) business days of the written notification that the option of SDS will be terminated.

(D) The regional director must schedule the meeting within ten (10) business days of the request.

(E) The regional director shall make a final decision within three (3) business days of the meeting. The decision of the regional director shall be final.

(14) Immediate Termination for Non-Compliance. When there is evidence of fraud or repeated patterns or trends of non-compliance with program requirements, counseling has been provided to the employer, an improvement plan has been established but has not been successfully completed within the agreed upon time frames, the regional director shall immediately terminate SDS and shall authorize agency-based services from a provider agency chosen by the individual.

(A) The regional office shall request repayment from the employer for any recoupments by the Department of Social Services Missouri Medicaid Audit and Compliance office from the DMH Division of DD.

(15) Service Level Requirements after SDS Termination. When the option for SDS is terminated, the same level of services must be made available to the individual through a qualified waiver provider. The individual shall have a choice of provider.

(16) Individual Budget Allocation, Employee Wages, and Reimbursement.

(A) The SDS individual budget allocation shall be based on the total number of hours needed for the span dates of the ISP multiplied by the statewide base rate for comparable agency-based supports.

(B) The SDS individual budget allocation shall be equal to but shall not exceed the level of support the individual would receive from a provider agency.

(C) Supports included in the SDS individual budget allocation to be paid through the HCB waiver shall not supplant or duplicate natural supports available to the individual.

(D) The Department of Social Services, MHD shall establish maximum allowable rates as recommended by DMH for all HCB supports.

(E) Once the individual receives their SDS individual budget allocation, the employer is responsible to set the wages of his/her employees. Wages shall not be less than minimum wage and not in excess of the MHD maximum allowable rate. The wage includes the net pay to the employee plus all related taxes, worker's compensation, and unemployment insurance.

(17) Fiscal management services (FMS).

(A) DMH shall select a FMS contractor through a competitive bid process.

(B) The FMS shall perform the following functions:

1. Managing and directing the distribution of funds contained in the individual budget allocation;

2. Facilitating the employment of staff by the employer by performing employer responsibilities such as processing payroll, withholding and filing federal state, and local taxes, and making tax payments to appropriate tax authorities;

3. Performing fiscal accounting and making expenditure reports to the employer and state authorities;

4. Collecting provider qualifications and training information;

5. Conducting background screens of potential employee candidates;

6. Collecting documentation of services provided; and

7. Collecting and processing employees' time sheets.

AUTHORITY: sections 630.050 and 630.655, RSMo 2016. Original rule filed Dec. 19, 2016, effective July 30, 2017.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008 and 630.655, RSMo 1980.*

Missouri Quality Outcomes

(HCBS--Home Community Based Services)

Purpose of Exercise

- **Clients have the right to privacy**
- **Often, staff focus on "taking care" of the client instead of seeing them as people**
- **Our clients have the right to humane care and treatment and to be treated with dignity as a human being.** 9CSR 45 3.030-1-A

People First Language

- **This is essential**
- **Many refer to our clients by their disabilities which makes them objects and not people.**
- **Our clients will be free from the attitudes, beliefs and perceptions communicated by others which diminish their self-worth and standing in society.**
  - **We will advocate for our clients so they are free from labels that separate, devalue or dehumanize them.**

PURPOSE

- To introduce staff to the philosophy and practice of the Missouri Quality Outcomes
- To ensure continued efforts in supporting persons with disabilities to have improved quality of life.
- To utilize the Missouri Quality Outcomes in person centered planning to enhance the quality of life for person supported.

- The Missouri Quality Outcomes were developed as a result of listening to people with disabilities, their families, and advocates.

- The outcomes were designed to encourage personal quality of life outcomes with individual focus on leading a self-determined life; including personal values, choice, health, safety, inclusion and self-advocacy.

- The Missouri Quality Outcomes are intended to be a guide to assist the user with facilitating discussion around key areas of importance to the individual and supporting their personal goals, dreams and other areas of interest to the individual that defines quality of life.
- Improving quality requires continuous efforts on getting to know the person in the settings and situation where they are supported, as well as, consistent interaction and involvement with the individual and their support systems for on-going assessment of their quality of life.

- **The Missouri Quality Outcomes will be measured through annual data collected by the Division of Developmental Disabilities.**

- **Based on the data, the Division of Developmental Disabilities will address areas of enhancements to services and supports through policies and practices, with the goal of provided continuous improvement for people with developmental disabilities.**

Assumptions

- **People with disabilities are the customers**
- **Quality improvement is based on getting to know the person in the environments and situations where they are supported**
- **Quality improvement efforts are based on the Division's Quality Outcomes**
- **Quality improvement is the responsibility of everyone.**

- Information obtained through quality improvement efforts needs to be shared and used to produce needed change
- Providers and DMRDD are business partners
- Typical life in the community is the benchmark for quality of life
- Improving quality is dependent upon regular interaction with and involvement of people with disabilities throughout the process

Outcome 1

People belong to their community.

Level of Participation

- **Passive Participation—spectator**
- **Minimal Participation—customer**
- **Full Participation—contributor, organization/committee member, decision making, knowing people involved**
- **Right to Refuse**

Question

- **How are you involved in your community compared to your clients?**
- **What is your level of participation compared to your clients?**
- **Is going to a nursey to look at the plants because the person you support likes flowers a meaningful outing?**

Outcome 2

People have a variety of personal relationships

Relationship Map

Missouri Proclamation
(freedom to live a meaningful life*)

- **People exercise the right to choose their relationships: the people with who they spend their time, share personal details or are intimate.**

- **People are inspired by other's high expectations for them, helping them strive to become all they can be. Limited, or no expectations, restricts people's growth, advances stereotypes, and leads to labeled incompetence and poverty, instead of self-determined lives.**

Outcome 3

People have valued roles in their family and in their community

Positive Roles—Valued

vs.

Negative Roles—Not Valued

Supporting Positive Roles

This requires careful planning to enhance the person's skills so that he/she can learn the role and eventually meet the expectations of the role with or without support.

How do we accomplish this with the people we serve?

Outcome 4

People's communication is understood and receives a response

Do people only communicate using words?

Who determines how someone communicates?

Do we have the right to change how someone communicates?

Communication

- **Staff uses the person's language or understand their means of communication**
- **The person has an effective means of communication**
- **The person has an effective means of indicating choice**
- **Communication charts (personal dictionaries) that include what staff should do in response to the person's communication**
- **Others translate respectfully, when needed**

- Communicate for themselves
- Communicates freely with others
- Encouraged to communicate
- Continuous opportunities to communicate
- Environment promotes communication
- Feel listened to
- Communication is respected
- Communication is reciprocal, ongoing and interactive
- Verbal and non-verbal communication is responded to

- Intent of communication is understood
- Communication needs addressed with a sense of urgency
- Adaptive equipment is with the person at all times
- Person and staff know how to use the equipment
- Repair/replacement of adaptive equipment occurs quickly respecting the person's sense of urgency
- Functional alternatives used consistently when primary means are not available

Do You Really Listen?

Five ways to be a better listener

- **Stop talking**
- **Avoid distractions**
- **Concentrated on what the other person is saying**
- **Look for a "REAL" meaning**
- **Provide feedback to the sender**

Outcome 5

People are provided behavioral supports in positive ways

- Behavior is a form of communication

- A person's plan (individualized centered plan/ISP) will address how to support the person with behavioral challenges in positive ways.

What should we be careful of when addressing behavioral challenges?

Outcome 6

People are provided support in a manner that creates a positive image

Positive Image

- **Portrayed in the best light to others in the community**
- **Avoiding stereotypical dress, hairstyle, places and activities**
- **Positive personal appearance**
- **Project a positive impression**
- **Image of personal worth and competence**

Positive Image

- **Pride in accomplishments**
- **Core belief that the person is valued and capable**
- **Engaged in valued, positive activities**
- **Being alone or in small groups when in the community**
- **Spends the majority of time in integrated settings**

Outcome 7

People express their own personal identity

What is your personal identity?

- **Activity: List 3 things that identify your personal style.**
  - **Those things that make you different from others, i.e. way you dress, how you decorate your home, music you listen to, etc.**
  - **Now list 3 things that identify one of your client's personal style.**

Outcome 8

People have control of their daily lives

Who has control in your life?

- **Activity:**

1) **What are three rules in your home?**
2) **Who determined these rules?**
3) **What happens if someone breaks the rules?**

Who makes the rules in the homes of the clients we serve? Who shouldn't make the rules?

Informed Choice

- **Our goal should be providing informed choice.**
- **We should provide our clients with the information they need in order to make an informed decision.**
- **Our clients have the right to fail. Risk is acceptable, even when it results in a person not being successful. The outcomes of their choices should not affect their value as human beings.**
- **Our clients have the right to learn and grow.**
- **Everyone on the planning team needs to understand our clients are the primary drivers of their own life choices and decisions, and their right to make decisions for themselves, with or without assistance, is respected, encouraged, and supported.**

Outcome 9

People have the opportunity to advocate for themselves, for others and for causes they believe in

Advocate

What does it mean to advocate or be a self-advocate?

According to People First of Missouri:

- **Learn how to speak up for ourselves.**
- **Making our own decisions about what we want to do with our lives.**

- **How do we assist our clients in doing this**

How do we advocate?

- **Learning how to get all the information that is needed to understand a topic**
- **Assisting our clients in finding out what and who will support them in meeting their goals**
- **Knowing/teaching rights and responsibilities to our clients**
- **Feeling good about learning from their mistakes**
- **Problem solving when things go wrong**

How do we advocate?

- **Listening to and helping each other**
- **Reaching out to people who are not members**
- **Learning about self-determination**

Outcome 10

People's plans reflect how they want to live their lives, the supports they want, and how they want them provided

Person Centered Plan (PCP)

- **Everyone has a PCP**
- **Our clients have the right to direct their own person-centered planning process and to choose others to be included or excluded from the process.**
- **You are a part of the person's planning team**
- **The PCP contains information about needed supports i.e. health, behavioral, supervision, safety, etc.**
- **They have the right to decline supports and services**

Outcome 11

People live and die with dignity

Living with Dignity

- **Behavior Intervention Services is determined to support our clients throughout their entire life.**
- **Our clients shouldn't be isolated from the people in their community.**
- **Our clients should understand their right to privacy.**
- **Our clients should always be treated with dignity and respect.**
- **Examples of what not to do.**

- **Dying with Dignity**
  - **Our clients have the right to make end of life decisions and advance directives. They shouldn't be made without their consent.**
  - **They shouldn't fear that the circumstance of their existence is deemed to costly or too difficult.**

Outcome 12

People feel safe and experience emotional well being

Activity

- **What are some things that make you feel safe?**
- **What are some things that make you feel unsafe?**
- **How do we control our fears so we don't project them onto our clients/**

Outcome 13

People are supported to attain physical wellness

- What are some things that make you feel healthy?
- What are some things that make you feel unhealthy?
- How do we motivate our clients to become healthier without the use of restrictions?

Outcome 14

People are actively supported throughout the process of making major life style changes

Major Life Style Changes

- **What are some changes you have had in your life?**
- **How did you make the decision to change?**
- **Did anyone help you make this decision?**
- **What things did you take into consideration before making this decision?**
- **How do we assist our clients through difficult times?**

Outcome 15

People are supported in managing their home

Ways we manage our homes:

- **Preparing meals**
- **Cleaning**
- **Laundry**
- **Home repairs**
- **Decorating**
- **Sewing, mending**
- **Caring for the lawn and garden**

Ways we manage our homes:

- **Banking, paying bills**
- **Shopping**
- **Budgeting**
- **Prioritizing**
- **Problem solving**
- **Locating/purchasing needed community services**
- **Handling phone solicitation, obscene callers**

Ways we manage our homes:

- **Doing household tasks with enough frequency to learn them**
- **Grocery shopping: making the list, going to the store, paying for the groceries, putting the groceries away**
- **Staying safe (changing smoke detector batteries, strangers at the door, etc)**

Outcome 16

Action at all levels of Behavior Intervention Services is consistent with a shared mission which is developed in response to the goals and aspirations of the people supported

Mission Statement

- **Our mission is to help each individual we serve reach their highest potential in life, by overcoming barriers and promoting independence, achievement, and inclusion. We utilize proven and positive behavior change strategies to reach their goal, while including all team members, friend, and family in the process.**

- **DEFY LIMITS……EXCEED EXPECTATIONS!!!**

Core Vaules

- **(Com)Passion**
- **Honesty**
- **Commitment**
- **High Standards**
- **ALWAYS!!**

Outcome 17

Behavior Intervention Services initiates and maintains positive working relationships with other organizations within and outside the service delivery system.

Relationships

- **What other organizations both within and outside of the delivery system are you involved with?**

- **How does your relationship with those agencies benefit the consumer, staff, BIS and the service delivery system in general?**

Outcome 18

Behavior Intervention Services empowers staff to meet people's needs.

Empowerment

- **How much input do you allow staff have in their day to day job?**
- **What ways do you empower your staff to meet consumers needs?**
- **How would your staff answer these questions?**

Outcome 19

Behavior Intervention Services regularly evaluates its success in meeting people's needs

Evaluation

- **Monthly QA—completed by the QAM**
- **Director QA**
- **Licensure & Certification Audits**
- **Annual Staff/Guardian survey**
- **Grievance Procedure for both staff and client**

Questions???