



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

Title	Page
9 CSR 45-3.010 Individual Support Plans	3
9 CSR 45-3.020 Individualized Supported Living Services—Definitions (Rescinded June 30, 2016)	4
9 CSR 45-3.030 Individual Rights.....	4
9 CSR 45-3.040 Rights of Designated Representatives, Parents, and Guardians	5
9 CSR 45-3.050 Admission and Treatment of Clients with Aggressive Behaviors (Rescinded September 30, 2002)	5
9 CSR 45-3.060 Services for Individuals with Autism Spectrum Disorder	5
9 CSR 45-3.070 Certification of Medication Aides Serving Persons with Developmental Disabilities.....	7
9 CSR 45-3.080 Self-Directed Supports	10
9 CSR 45-3.090 Behavior Supports.....	12



**Title 9—DEPARTMENT OF
MENTAL HEALTH**

**Division 45—Division of Developmental
Disabilities**

Chapter 3—Services and Supports

9 CSR 45-3.010 Individual Support Plans

PURPOSE: This rule prescribes procedures for development and implementation of individual support plans for all individuals receiving services from the Division of 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. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Definitions.

(A) Assessment—the process of gathering information about an individual for use by the individual support plan team as a basis for the individual support plan. Assessment, as used in this rule, does not include determination of eligibility by the Department of Mental Health (DMH) as set forth in 9 CSR 45-2.010.

(B) Division—the Division of Developmental Disabilities.

(C) Home and Community-based Waivers—also referred to as home and community-based services (HCBS) in this rule; 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.

(D) Individual Support plan (ISP)—a document developed by the individual, with assistance as needed from a representative, in collaboration with the individual support plan team. The ISP identifies strengths, capacities, preferences, needs, and desired outcomes of the individual. The ISP encompasses a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally defined outcomes. Training, supports, therapies, treatments and/or other services to be provided for the individual become part of the ISP. ISP is also referred to as a person-centered service plan.

(E) Individual support plan team—the individual, the individual's guardian or 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, guardian, or designated representative.

(F) MO HealthNet—Missouri's name for the state's Medicaid program, authorized under Title XIX of the Social Security Act.

(G) MO HealthNet participant—an individual enrolled with MO HealthNet.

(H) Natural supports—any unpaid support including, but not limited to, immediate and extended family members, friends, co-workers, neighbors, and community services available to any individual regardless of disability.

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

(J) Waiver participant—individual receiving HCBS services.

(2) Every individual referred to a qualified provider of targeted case management who is a participant of MO HealthNet or who receives any services funded by the division, including services under a home and community-based waiver or services funded only by general revenue, shall have an individual support plan (ISP).

(3) Person-centered planning shall be done in accordance with 42 CFR 441.301(c)(1). The individual shall lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual or guardian, if applicable. In addition to being led by the individual receiving services and supports, the person-centered planning process shall—

(A) Include people chosen by the individual;

(B) Provide necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;

(C) Be scheduled at times and locations of convenience to the individual;

(D) Reflect cultural considerations of the individual and be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient; and

(E) Include strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.

(4) In accordance with 42 CFR 441.301(c)(2), the ISP shall reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual and the scope of services and supports available through the division, the ISP shall—

(A) Reflect the individual's strengths and preferences;

(B) Reflect clinical and support needs as identified through an assessment of functional need;

(C) Include individually identified goals and desired outcomes;

(D) Reflect the services and supports (paid and unpaid) to assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports;

(E) Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;

(F) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the ISP to be understandable, it is written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient;

(G) Identify the individual and/or entity responsible for monitoring the ISP;

(H) Be distributed to the individual and any other individuals or providers who sign the plan, as specified in section (5) of this rule;

(I) Include those services, the purpose or control of which the individual elects to self-direct or designate an authorized representative to direct on his or her behalf;

(J) Prevent the provision of unnecessary or inappropriate services and supports; and

(K) Document that any restrictions of individual rights is supported by a specific assessed need and justified in the ISP in accordance with 42 CFR 441.301(c)(2).

(5) The ISP shall be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation in accordance with 42 CFR 441.301(c)(2)(ix), with the exception of providers of assistive technology, dental, durable medical equipment, environmental accessibility adaptations, specialized medical equipment and supplies, and transportation.

(A) Signatures may be added to the plan electronically using a format accepted by MO



HealthNet.

(B) If it is not possible to obtain a written signature from the individual or guardian, the Division Regional Office Director or his or her designee may approve an exception if the following steps are completed:

1. At least two (2) attempts to obtain the signature are documented. One (1) attempt may be either by phone or E-mail, and the other attempt documented through certified mail with delivery validated by a signed return receipt;

2. A justification is attached to the ISP describing these and any other efforts made to obtain the signature; and

3. The regional director may require additional efforts by the support coordinator to obtain the signature from the individual or guardian.

(C) If the exception to the signature is approved by the regional director or designee, a copy of the approved exception request is sent to everyone to whom a copy of the ISP is distributed.

(6) ISP Review: The ISP shall be reviewed and revised upon reassessment of functional need in accordance with 9 CSR 45-2.010 at least every twelve (12) months, when the individual's circumstances or needs change significantly, or at the request of the individual. The reassessment of functional need shall be completed within ninety (90) days before the ISP review.

(7) ISP updates require prior written approval from the ISP team before implementation of the change and signatures in accordance with section (5) of this rule. ISP updates requiring prior written approval include:

- (A) Addition of a new service;
- (B) Increase or decrease in amount and/or frequency of a service already in place;
- (C) Termination of a service;
- (D) Limitation of rights as set forth in 9 CSR 45-3.030; and
- (E) Change in ISP outcomes.

(8) Changes in legal information including, but not limited to, arrests, incarceration, court orders, and legal actions other than changes in guardianship shall be documented in the ISP but shall not require prior written approval or signatures if the change does not result in a change in services.

(9) Denial, reduction, or termination of a service is subject to appeal as set forth in 9 CSR 45-2.020.

(10) Changes in training plans or methods to ensure progress toward achievement of outcomes already documented in the ISP may be made by the provider of the related service as

needed without approval of the ISP team.

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

(12) The division shall provide guidance and technical assistance to providers of support coordination in the person-centered planning process and the development and oversight of the ISP.

(13) Individuals with developmental disabilities, as defined in 9 CSR 45-2.010, but who are not MO HealthNet participants and who do not receive services from the division funded by general revenue shall be provided with individualized information based on, but not limited to, their age, diagnosis, and geographic residence.

*AUTHORITY: section 630.655, RSMo 2016. * 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. Amended: Filed Jan. 22, 2019, effective Aug. 30, 2019.*

**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 exer-

cise 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 bi-annual 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		
<input type="checkbox"/> Use of generic drugs		
<input type="checkbox"/> How to pour, chart, administer and document		
<input type="checkbox"/> Information and techniques specific to the following: inhalers, eye drops, topical medications and suppositories		
<input type="checkbox"/> Infection Control		
<input type="checkbox"/> Side effects and adverse reactions		
<input type="checkbox"/> Update on new medications or new procedures		
<input type="checkbox"/> 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:		
<p>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.</p>		
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.*

***Pursuant to Executive Order 21-07, 9 CSR 45-3.070, section (4), subparagraph (10)(A)2.B., and subsections (14)(A) and (14)(B) was suspended from April 23, 2020 through August 31, 2021.*

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 employ-

ment 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.*

***Pursuant to Executive Order 21-07, 9 CSR 45-3.080, subsections (4)(H) and (7)(D) was suspended from April 23, 2020 through August 31, 2021.*

9 CSR 45-3.090 Behavior Supports

PURPOSE: This rule sets forth requirements for providers under contract with the Department of Mental Health to support individuals with intellectual and developmental disabilities and assure the rights of individuals to receive best practice behavior strategies that lead to greater independence and enhanced quality of life. This rule describes the division's oversight of behavior supports, establishes and describes the role and function of behavior supports review committees.



(1) Definitions—

(A) Applied behavior analysis—The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior, as established in section 337.300(1), RSMo;

(B) Behavior analysis services—Use of applied behavior analysis principles and technology to assist support systems of individuals with challenging behaviors to prevent those behaviors as well as teach, promote, encourage, and reinforce alternative skills and behaviors;

(C) Behavior support plan (BSP)—A part of the individual support plan that is comprised of behavior analytic procedures developed to systematically address behaviors to be reduced or eliminated and behavior skills to be learned;

(D) Blocking—A staff person using a part of their body to prevent an individual from inflicting or incurring harm when an individual is attempting to hit, kick, or otherwise harm himself or herself, the staff, or another person. Use of pads, cushions, or pillows to soften or prevent impact to the individual or others is also considered blocking. Blocking does not involve grasping or holding any part of the individual's body;

(E) Challenging behaviors—Culturally undesirable behavior(s) likely to both limit access to the community and interfere with independence and autonomy;

(F) Chemical restraint—Medications (prescribed or over-the-counter) administered with the primary intent of restraining an individual who presents a likelihood of serious physical injury to himself or others, not prescribed to treat a person's medical condition (as defined in section 630.005, RSMo);

(G) Due process—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;

(H) Emergency interventions—Reactive strategies that are not part of the individual's plan used to maintain safety of the individual or others in the threat of imminent harm. These are strategies used for one (1) or two (2) incidents until a planned intervention is developed in the safety crisis plan and/or BSP. These emergency interventions may involve physical restraint strategies. These interventions must be least restrictive and

comply with statutes, rules, regulations, and policies of the division;

(I) Emergency intervention system—also called physical crisis management programs—A formal curriculum and training program to teach prevention, de-escalation, and physical restraint, also called manual holds, to maintain safety in emergency situations;

(J) Exclusion time out—The temporary exclusion of an individual from access to reinforcement, as part of a formal BSP, in which, contingent upon the individual's undesirable behavior(s), the individual is excluded from the potentially reinforcing situation but remains in the same area with others present;

(K) Functional Behavior Assessment (FBA)—Information-gathering process used to understand the purpose of challenging behavior. The functional assessment must be designed and monitored by a licensed behavior analyst, or licensed psychologist, counselor, or social worker trained in behavior analysis;

(L) Informed consent—Consent for treatment based on certain basic elements that include: an understandable explanation and purpose of the procedure to be followed, a description of physical, emotional, or mental discomfort or risk to be expected, an offer to answer any inquiries concerning the procedure, and an explanation that at any time consent can be rescinded. Informed consent must be obtained from the individual, or the guardian for individuals who have a guardian. Every effort should be made to obtain informed agreement from individuals with guardians;

(M) 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;

(N) ISP team—The individual, the individual's designated representative(s), and the support coordinator. Providers of waiver-funded services may also participate in the ISP team if the individual or guardian requests such participation;

(O) Least restrictive procedure—A procedure that maximizes an individual's freedom of movement, access to personal property, and/or ability to refuse while maintaining safety. The degree of restrictiveness is based on a comparison of the various possible procedures that would maintain safety for the individual in a given situation;

(P) Licensed behavioral support professional—individual licensed in the state of Missouri under section 337.315 (6) and (7), RSMo.

(Q) Manual hold—also called physical restraint and manual restraint—Any physical hold involving a restriction of an individual's voluntary movement. Physically assisting someone who is unsteady, or blocking to prevent injury, is not considered a manual hold;

(R) Mechanical restraints—Any device, instrument, or physical object used to confine or otherwise limit an individual's freedom of movement that cannot be easily removed. Examples may include locking a wheelchair, taking crutches, taking power mechanism from wheelchairs, special seat belts that cannot be removed by the individual, or other ways of restricting an individual's mobility. Mechanical restraints are prohibited from use in home and community based settings. The following are not considered mechanical restraints:

1. Medical protective equipment prescribed as part of medical treatment for a medical issue;

2. Physical equipment or orthopedic appliances, surgical dressings or bandages, or supportive body bands or other restraints necessary for medical treatment, routine physical examinations, or medical tests;

3. Devices used to support functional body position or proper balance, or to prevent a person from falling out of bed, or falling out of a wheelchair;

4. Typical equipment used for safety during transportation, such as seatbelts or wheelchair tie-downs; or

5. Mechanical supports or supportive devices used in normative situations to achieve proper body position and balance;

(S) Person centered planning process—A process directed by the individual, with the inclusion of a circle of support created by or with the individual, a guardian, the responsible party or other person as 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 become part of the ISP;

(T) Preventative strategies—Clearly defined protocols which describe knowledge and skill sets that providers and/or the individual must implement in order to prevent occurrences of undesirable behaviors or the use of restrictive supports while also creating increased opportunities for success.



Preventative strategies are documented in the support section of the ISP;

(U) PRN—A medical term meaning “when necessary”;

(V) PRN Psychotropic medication for behavioral support—Medication (pharmacologic agent) that affects a person’s mental status and is prescribed to be given according to circumstance rather than at a scheduled time. If utilized, the BSP/ISP must include skill or responses to be developed to reduce the need for the PRN and must specifically describe strategies to address the situation prompting the PRN use. Use of PRN psychotropic medication is considered both a reactive strategy and a restrictive intervention;

(W) Provider—Any entity or person under contract with the Department of Mental Health (DMH) to serve individuals with developmental disabilities funded by general revenue or through home and community-based waivers administered by DMH;

(X) Psychotropic/behavior control medications—Any medication that affects the person’s mental status or behaviors regardless of their diagnoses;

(Y) Qualified personnel—Staff persons who have received training, demonstrated competency, and maintained required certification and understanding of the following:

1. The Physical Crisis Management System utilized at the agency in which they are employed;

2. The implementation of the individual’s safety crisis plan;

3. The implementation of the BSP and ISP;

4. All requirements as a service provider outlined in the most current service definitions for providers;

(Z) Reactive strategies—Actions, responses, and planned and unplanned interventions in response to challenging behavior. Emergency interventions are types of reactive strategies. Reactive strategies have the aim of bringing about immediate change in an individual’s behavior or control over a situation so that risk associated with the behavior is minimized. Reactive strategies may take a number of forms and can include environmental, psychosocial, and restrictive interventions. Such procedures may be utilized as a first time response to an emergency situation. This also includes responses that are more delayed such as restricting access to the community or increased levels of supervision;

(AA) Reactive strategy threshold—The use of five (5) or more reactive strategies within a one (1) month period. This threshold applies to the use of reactive strategies that also meet the definition of restrictive inter-

ventions;

(BB) Regional Behavior Supports Committee (RBSC)—A committee consisting of a chairperson who is a Licensed Behavior Analyst, employed by the division and appointed by the division director or designee, along with qualified members, whose functions include meeting the expectations set forth in this rule;

(CC) Regional Office (RO)—Local offices of the Division of Developmental Disabilities (referred to as “the division” throughout this document) serving a defined geographic region of the state;

(DD) Restrictive interventions—The use of interventions that restrict movement, access to other individuals, locations or activities, restrict rights or employ aversive methods to modify behavior. These may also be called restrictive supports, procedures, or strategies;

(EE) Safety assessment—An assessment by the planning team and a medical professional of an individual’s physical, and/or emotional status. This includes history and current conditions that might affect safe usage of any reactive strategies, and identifies those reactive strategies that should not be used with the individual due to medical or psychological issues of safety. The safety assessment should be completed annually or on the occasion of any significant change;

(FF) Safety crisis plan—An individualized plan outlining the reactive strategies designed to most safely address dangerous behaviors at the time of their occurrence or to prevent their imminent occurrence, included as part of a BSP or ISP;

(GG) Seat belt guard—A safety device to prevent the release of the seat belt while the car is in motion. Seat belt guards are not mechanical restraints;

(HH) Seclusion time-out—The involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving. This is sometimes referred to as a safe room or calm room. Locked rooms (using a key lock or latch system not requiring staff directly holding the mechanism) are prohibited.

(II) Significantly challenging behaviors—Actions of the individual which can be expected to result in issues described in paragraphs 1.—6. below. Services to address these behaviors may necessitate involvement of a licensed behavior analyst or other licensed professional with appropriate training and experience—

1. Have resulted in external or internal injury requiring medical attention or are expected to increase in frequency, duration,

or intensity such that medical attention may be necessary without intervention by a licensed behavior support professional;

2. Have occurred or are expected to occur with sufficient frequency, duration, or intensity that a life-threatening situation might result because of self-injury, aggression, or property destruction. Examples include excessive eating or drinking, vomiting, ruminating, eating non-nutritive substances, refusing to eat, swallowing excessive amounts of air, or running into traffic;

3. Have resulted or are expected to result in major property damage or destruction, value of property more than two hundred dollars (\$200);

4. Have resulted in or are expected to result in arrest and confinement by law enforcement personnel;

5. Have resulted in the need for additional staffing and/or behavioral/medical personal assistant services; or

6. Have resulted in the repeated use of emergency interventions and restrictive supports; and

(JJ) Waiver assurances—As a condition of waiver approval by the Centers for Medicare and Medicaid Services, states collect and report performance data to measure compliance with assurances specified in the *Code of Federal Regulations* at 42 CFR 441.302.

(2) Rights of individuals and assurances.

(A) No individual shall experience restrictive supports without due process. Restrictive supports include, but are not limited to, any limitation of access to:

1. Communication with others;

2. Leisure activities;

3. The individual’s own money or personal property;

4. Goods or services per typical routines;

5. Access to parts of the home or the community; and

6. Privacy or independence via any direct observation and procedures such as continuous one-to-one staffing during times or places which would otherwise be considered private.

(B) In addition to those rights described in and assured by federal and state law and 9 CSR 45-3.030, all individuals served by the division have the right to be treated with dignity and respect, to receive services in the least restrictive environment, and to be assured freedom from coercion and aversive stimuli.

(C) All individuals served by the division have strategies that may prevent problem situations and challenging behaviors included in their ISPs. Preventive strategies shall meet



the following conditions:

1. If there is a BSP, preventive strategies must be included;

2. Preventive strategies may be developed by non-licensed team members if the behavior of concern meets the following conditions:

A. The behavior has not caused significant injury or danger to self, others, or property; and

B. The behavior has not restricted the individual's access to the community, and if the support strategies involved typically may be considered public domain by promoting a more positive environment, enriching the individual's daily routine, and teaching more functional skills, but are not solely the practice of applied behavior analysis.

(D) Individuals who are receiving paid supports who have experienced or are considered by the person centered planning team as likely to experience emergency interventions shall—

1. Have qualified personnel supporting them who have been competency trained in an emergency intervention system, who maintain current certification in the system; and

2. Have a safety assessment and a current safety crisis plan with all support providers.

(3) Service delivery.

(A) Individuals have the right to receive appropriate supports and services in accordance with their ISP and in accordance with 9 CSR 45-2.017.

(B) Individuals are integrated in and have access to the greater community in accordance with 42 CFR 441.301. The division ensures that services provided are of good quality and comparable to those provided to persons in the community without disabilities.

(C) Providers comply with the terms and conditions of the home and community-based waivers approved by the Centers for Medicare and Medicaid Services and operated by the division and the MO HealthNet DD Waiver Provider Manual.

(4) Contracted providers shall monitor and implement positive proactive strategies to reduce the likelihood that an individual will require reactive strategies or restrictive interventions. Providers shall develop processes to review the problem situations when the reactive strategy threshold is reached.

(A) Individuals reaching the reactive strategy threshold trigger the planning team's extensive review and analysis of the problem situations. The planning team should—

1. Convene within five (5) business days to complete the review and any restrictions of the supports, environment, training for staff, medications, or other issues that might affect the individual;

2. Identify triggers, preventative strategies, and barriers to using the least restrictive strategies;

3. Consider the need for a functional behavior assessment, and development of a formal BSP or revision of an existing BSP; and

4. Develop new or revised proactive strategies and strategies to prevent situations that are likely to result in use of reactive strategies.

(B) Any individual meeting the reactive strategy threshold for three (3) consecutive quarters should be referred to the Regional Behavior Support Review Committee for consultation. If an individual meets the reactive strategy threshold of five (5) or more in a one (1) month period, the planning team should request the support coordinator submit a request for behavioral services.

(5) Restrictive Interventions other than approved physical crisis management procedures shall not be used as an emergency or crisis intervention.

(A) Use of restrictive procedures that meet the definition of reportable events must be reported in accordance with 9 CSR 10-5.206.

(B) Restrictive interventions are utilized only as alternatives to more restrictive placements and only as a means to maintain safety and allow the teaching of alternative skills that the individual can utilize to more successfully live in the community.

(C) The ISP must include justification for any restrictions. The following requirements must be documented in the ISP:

1. Identification of a specific and individualized assessed need;

2. Documentation that the positive interventions and supports used prior to any modifications to the ISP;

3. Documentation that less intrusive interventions were tried but were not successful;

4. Regular collection and review of data to measure the ongoing effectiveness of the intervention;

5. Established time limits for periodic reviews to determine if the intervention is still necessary or can be terminated;

6. Informed consent of the individual or their legal guardian; and

7. Assurances that interventions and supports will cause no harm to the individual as described in 42 CFR 441.301(c)(2)(xiii).

(D) Prohibited procedures—The following

interventions are prohibited by the division and are considered at high risk for causing harm:

1. Any technique that interferes with breathing or any strategy in which a pillow, blanket, or other item is used to cover the individual's face;

2. Prone restraints (on stomach); restraints positioning the individual on their back supine; or restraints against a wall or object;

3. Restraints which involve staff lying/sitting on top of an individual;

4. Restraints that use the hyperextension of joints;

5. Any technique or modification of a technique which has not been approved by the division, and/or for which the person implementing the technique has not received division-approved training;

6. Mechanical restraints;

7. Any strategy that may exacerbate a known medical or physical condition, or endanger the individual's life, or is otherwise contraindicated for the individual by medical or professional evaluation;

8. Use of any reactive strategy or restrictive intervention on a "PRN" or "as needed" basis;

9. Standing orders for use of restraint procedures not part of a comprehensive safety crisis plan that delineates prevention, de-escalation, and least restrictive procedures to attempt prior to use of restraint;

10. Any procedure used as punishment, for staff convenience, or as a substitute for engagement, active treatment, or behavior support services;

11. Use of law enforcement or emergency departments cannot be incorporated into ISPs or BSPs as "PRN" procedures or as contingencies to eliminate or reduce problem behaviors;

12. Reactive strategy techniques administered by other individuals who are being supported by the agency;

13. Corporal punishment or use of aversive conditioning—Applying painful stimuli as a penalty for certain behavior, or as a behavior modification technique;

14. Overcorrection strategies—Requiring the performance of repetitive behavior as a consequence of undesirable behavior designed to produce a reduction of the frequency of the behavior;

15. Placing persons in totally enclosed cribs or barred enclosures other than cribs; and

16. Any treatment, procedure, technique, or process prohibited by federal or state statute.

(E) Procedures that may be conditionally



approved in writing by the division—

1. Any modification to a physical crisis management technique or any non-nationally recognized physical crisis management system;

2. Seclusion time-out placement of a person alone in a secured room or area which the person cannot leave at will shall only be utilized as part of an approved BSP. The use of seclusion time-out requires ongoing services from a licensed behavioral service provider and prior review and approval by the RBSC; and

3. Use of physical crisis management procedures when part of a comprehensive safety crisis plan that delineates prevention, de-escalation, and least restrictive procedures to attempt prior to use of restraint.

(6) BSPs are developed by a licensed behavioral service provider in collaboration with the individual's support system. The techniques included in the plan are based on a functional assessment of the target behaviors. The techniques meet the requirements for the practice of applied behavior analysis under sections 337.300 through 337.345, RSMo. The BSP includes the following information:

(A) Alternative behaviors for reduction and replacement of target behaviors, defined in observable and measurable terms. They are specifically related to the individual and relevant environmental variables based on FBA;

(B) Goals and objectives for acquisition of appropriate alternative behaviors;

(C) Interventions aligned with positive functional relationships described in FBA including strategies to address establishing operations, contextual factors, antecedent stimuli, contributing and controlling consequences, and physiological and medical variables;

(D) Data collected must include antecedents/triggers, description of events, duration, consequence/result, and effects of interventions;

(E) If physical restraint or seclusion time-out are used, health status is monitored and data documented for one (1) hour after the event in fifteen (15) minute intervals. Health status data includes monitoring of vital signs including pulse, visual observations of energy/lethargy level, engagement with others, and other observed reactions;

(F) Description of specific data collection methods for target behaviors to assess the effectiveness of the strategies and data collection methods to assess the fidelity of implementation strategies;

(G) Data displayed in graphic format in the monthly progress reports, with indications for the environmental conditions and changes

relevant to target behaviors;

(H) Proactive strategies to prevent challenging behaviors, improve quality of life, promote desirable behaviors, and teach skills, that are specifically described for consistent implementation by family and/or staff;

(I) Specific strategies with detailed instructions for reinforcement of desirable target behaviors;

(J) Specific strategies to generalize and maintain the desired effects of the BSP, including strategies for fading contrived contingencies to natural contingencies to support system changes and maintain these strategies after BSP is faded;

(K) A safety crisis plan if it is necessary to have strategies to intervene with at risk behaviors to maintain safety;

(L) If a plan includes physical restraint or seclusion time-out, specific criteria and procedures are identified;

(M) Target behavior(s) related to the symptoms for which psychotropic medications were prescribed and when they should be administered and the process for communicating data with the prescribing physician;

(N) Description of less restrictive methods attempted in the past, their effectiveness, and rationale that proposed BSP strategies are the least restrictive and most likely to be effective as demonstrated by research or history of individual;

(O) The method of performance based training to competency for caregivers and staff providing oversight;

(P) The qualified behavioral service provider reviews data at least monthly; and

(Q) Description of how the plan will be communicated to all supports and services including the frequency with which the ISP team will receive updates.

(7) A safety crisis plan is developed by the support team after the first use of any reactive strategy or when the personal history of the individual indicates there is a likelihood that reactive strategies may be needed in the future, or where the individual's support team plans to use reactive strategies.

(A) If reactive strategies are considered likely and necessary, the team should be proactive and consider the need for more specialized support strategies in the ISP and services such as Person Centered Strategies Consultant or Behavior Analysis Services (see Medicaid Waiver service definitions).

(B) Procedures identified are least restrictive and within safety parameters of the safety assessment. These are used as a last resort after implementation of proactive, positive approaches.

(C) If a safety crisis plan includes physical

restraint, exclusion time-out, or seclusion time-out, specific criteria and procedures are identified.

(D) The plan includes the informed consent of the person, their parent, or guardian.

(E) The safety crisis plan is a part of the ISP.

(F) Safety crisis plans are part of any BSP.

(8) If a safety crisis plan includes the use of physical restraint, the name of the approved or nationally recognized crisis management program must be included in the individual's safety crisis plan (as per section 630.175.1, RSMo). Restraints are only used in situations of imminent harm to prevent an individual from injuring self or others. Less restrictive crisis management procedures, including de-escalation techniques and environmental management, should be attempted prior to use of any type of restraint. Use of physical restraints are documented in a safety crisis plan.

(A) Physical Restraints. Techniques used to physically restrain individuals are limited to those from nationally recognized physical crisis management programs or internally developed programs approved by the division.

1. Requests for use of physical crisis management systems other than those that are nationally recognized must be made, in writing, to the Chief Behavior Analyst of the division. If internally developed systems are approved and utilized, a quarterly analysis of the use of the restraint procedures and strategies to eliminate the need is completed and submitted to the Chief Behavior Analyst.

2. The physical restraint techniques are used only in the manner designed, are formally trained to competency, and staff maintain certification as specified by the physical crisis management system.

3. Physical restraint techniques are only employed for situations of imminent harm to self or others and not to protect property.

4. Any improper or unauthorized use of a physical restraints or excessive application of force may be considered abuse and may prompt an investigation.

5. Blocking is not considered a physical restraint procedure if used as defined in this rule.

(B) Chemical restraints include prescription and over the counter medications and require the approval of the division director or his/her designee prior to implementation of these restraints. Any use of a chemical restraint must be included in an approved safety crisis plan meeting the following criteria:

1. Identification of chemical restraints to be used;



2. Written physician orders for any chemical restraints are time limited and for no longer than three (3) hours;

3. Written physician orders are placed in the individual's record and contain at least the following information:

A. Brief description of the imminent harm situation including ongoing activities, staff actions, and the individual's actions that relate to the imminent harm;

B. Type of chemical restraint used;

C. The time when the order was written;

D. The time when the chemical restraint was first administered;

4. Ongoing visual observation and safety checks during the time that the chemical restraint is affecting the individual;

5. Standing or PRN orders for chemical restraints shall not be used. Specification in a safety crisis plan or reactive strategies deemed safe for an individual and/or recommended as the most likely to be effective will not be considered as PRN orders;

6. The authorized medical professional designated by the physician writing the order observes the individual and evaluates the situation within thirty (30) minutes from the time chemical restraints were initiated; and

7. In an emergency in which an on-site authorized physician is not available, only a registered nurse or a qualified licensed practical nurse may administer chemical restraints to an individual and only after receiving an oral order from an authorized physician.

A. The documentation of such oral orders include the following:

(I) Name of physician who gave the order;

(II) Name of nurse who received the order;

(III) Name of nurse who actually administered the chemical restraint—identify behaviors requiring the chemical restraint in specific terms that allow measurement;

(IV) Anticipated effects of the medication and time frame related to the effects.

B. The person administering the chemical restraints documents the information required and the physician's oral order in the individual's record or equivalent record.

C. The oral order is signed by a physician as soon as possible after the initial administration of the chemical restraint.

(C) Mechanical restraints are prohibited.

(9) Utilization of a seclusion time-out (or safe-room) procedure requires prior approval from the Chief Behavior Analyst. Request for such approval must include a functional assessment of the target behavior, a BSP, the rationale for the use of the procedure, and

data supporting the need for the procedure and that less restrictive interventions were ineffective. The Chief Behavior Analyst must also approve of the designated time-out area or room.

(A) Seclusion time-out will become a prohibited procedure as of July 1, 2021.

(B) Behavioral services remain active during the time period in which the BSP (seclusion time-out intervention) is in place.

(C) The BSP with a seclusion time-out procedure includes all elements identified in section (6) of this rule as well as the following:

1. Specification that only qualified personnel may use seclusion time-out for an individual under conditions set out in an approved BSP;

2. If the BSP includes time-out, it is reviewed and approved by the following:

A. RBSC;

B. The individual or the family, or legal guardian as appropriate; and

C. The Chief Behavior Analyst or designee;

3. Target behaviors, operationally defined, and consistent with the function identified in the functional assessment for the target behavior;

4. Description of strategies to ensure high rates of positive reinforcement and engaging activities are available for the individual making "time in" an enriched situation;

5. Criteria for release from seclusion time-out and discontinuation of a seclusion time-out episode—

A. Release from seclusion time-out criteria is limited to no more than five (5) minutes of calm behavior;

B. Total duration for the seclusion time-out episode is no more than one (1) hour except in extraordinary instances (during initial stage of program) that are personally approved at the time of occurrence by the behavior analyst and reviewed within one (1) business day by the region's assigned area behavior analyst;

C. Continuous observation of the person in time-out;

D. Seclusion time-out will be discontinued if there are any signs of injury or medical emergency and the person will be assessed by appropriate medical personnel; and

E. The date, time, and duration of each seclusion time-out intervention is documented on a data sheet and on an event management form.

(D) Time-out areas or rooms shall meet the following safety and comfort requirements:

1. Areas and rooms to be utilized for

seclusion time-out and the procedures for the use of seclusion time-out are reviewed and approved by the Chief Behavior Analyst or designee;

2. Continuous observation of the individual in the area is maintained at all times;

3. Adequate lighting and ventilation is used at all times;

4. The area or room is void of objects and fixtures such as light switches, electrical outlets, door handles, wire, glass, and any other objects that could pose a potential danger to the individual in time-out;

5. If there is a door to the room or area, it will open in the direction of egress such that the individual in the room is not able to bar the door to prevent entry;

6. The door is void of any locks or latches that could allow the door to be locked without continuous engagement by a staff person; and

7. The room or area will be at least six (6) feet by six (6) feet in size or large enough for any individual who will utilize the room to lie on the floor without head or feet hitting walls or door.

(10) The division provides oversight for services provided to individuals with significantly challenging behaviors through RBSCs. The division establishes at least two (2) RBSCs. Additional RBSCs may be established depending upon need and staff capacity.

(A) Members of the RBSC are appointed by the division director or designee.

(B) The RBSC consists of three (3) to five (5) members including:

1. A chairperson who is a licensed behavior analysis employed by the division;

2. A member or members of the provider community licensed to practice applied behavior analysis or who provided behavior therapy under contract with DMH prior to January, 2012 or who are working towards Board Certified Behavior Analyst (BCBA) or Board Certified Assistant Behavior Analyst (BCaBA) certification under the supervision of a licensed behavior analysis; and

3. A medical consultant or other professionals as indicated by the information under review or requested by the chairperson.

(C) The RBSC meets at least once every three (3) months, and may meet as often as needed to fulfill responsibilities.

(D) The purpose of RBSCs is to promote the implementation of best practice strategies that lead to greater independence and enhanced quality of life for individuals experiencing challenging behaviors. RBSCs ensure the following:

1. That waiver assurances are met;



2. That best practice behavioral services are followed;

3. That ethical guidelines are followed;

4. That behavioral strategies are least restrictive; and

5. That implementation of strategies documented in the ISPs and BSPs support progress toward greater independence and enhanced quality of life.

(E) The division establishes RBSC review criteria to prioritize the individuals with significantly challenging behaviors and those individuals whose supports include restrictive interventions.

1. Individuals experiencing significantly challenging behaviors reaching threshold criteria for reactive strategies, or who have been prescribed psychotropic/behavior control medications, or who have PRN psychotropic medication for behavioral support.

2. A BSP may be reviewed based on a request by the members of the ISP, including, but not limited to, the parent/guardian, support coordinator, or Regional Director (or designee) to provide technical assistance.

3. The Regional Director and the RBSC prioritize reviews to ensure appropriate representation based upon issues that represent regional challenges to meet identified objectives.

4. The RBSC shall respond to requests for review within thirty (30) calendar days of receipt of the request.

5. The support coordinator and provider of BSPs and ISPs reviewed by the RBSC will receive written summary of the RBSC's recommendations within five (5) working days of the RBSC's review of the BSPs or ISPs.

(11) If use of prohibited or unauthorized procedures is discovered, the following occurs:

(A) Regional Director is notified of the use of prohibited procedures, the agency involved, persons for whom the procedures were utilized, and reasons for use;

(B) Regional Director directs regional staff and Area Behavior Analyst to conduct a focused review of the agency;

(C) If the focused review confirms that prohibited or unauthorized procedures were used, the Regional Director will be informed and notify the provider and support coordinator;

(D) Area Behavior Analyst works with planning teams to determine appropriateness of strategies and need for additional services to assist the provider to address the situations positively, proactively, and preventatively;

(E) Area Behavior Analyst refers supports of individuals, for whom the prohibited practices have been used, to the RBSC; and

(F) Follow up reviews of the provider will

occur to ensure that appropriate procedures and supports are utilized and prohibited practices have been discontinued for a duration determined by the Chief Behavior Analyst.

AUTHORITY: sections 630.050 and 630.175, RSMo Supp 2019. Original rule filed Sept. 20, 2019, effective March 30, 2020.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008 and 630.175, RSMo 1980, amended 1996, 2008, 2014, 2016, 2019.*