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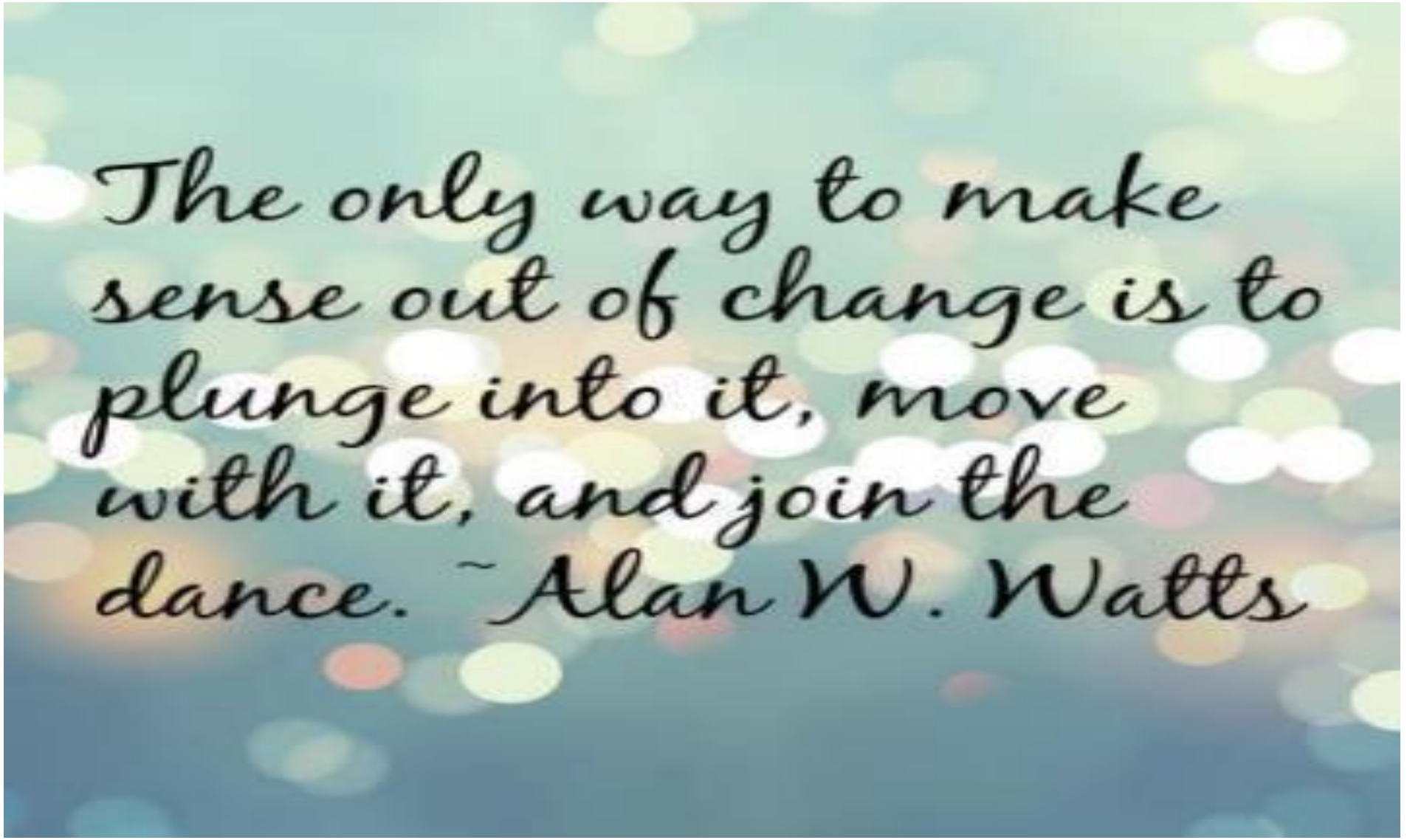
The Staff Action Plan and Delivery of Habilitation Services

Training Webinar 1/15/2019


The only way to make sense out of change is to plunge into it, move with it, and join the dance. ~Alan W. Watts

Learning Objectives and Training Outline

Participants will develop a better understanding of:

- The shift from Habilitation Plans to Staff Action Plans;
- Where and how the Staff Action Plan fits into the Life Planning Process and how Habilitation Providers translate Life Plan goals into Staff Action Plans;
- Requirements and expectations for Staff Action Plan development and Service Delivery (Administrative Memorandum # 2018-09);
- Expectations for ongoing collaboration and coordination between the person served, service provider and Care Manager; and,
- Examples of quality outcome indicators for service delivery based on Staff Action Plans.

Topics Outline

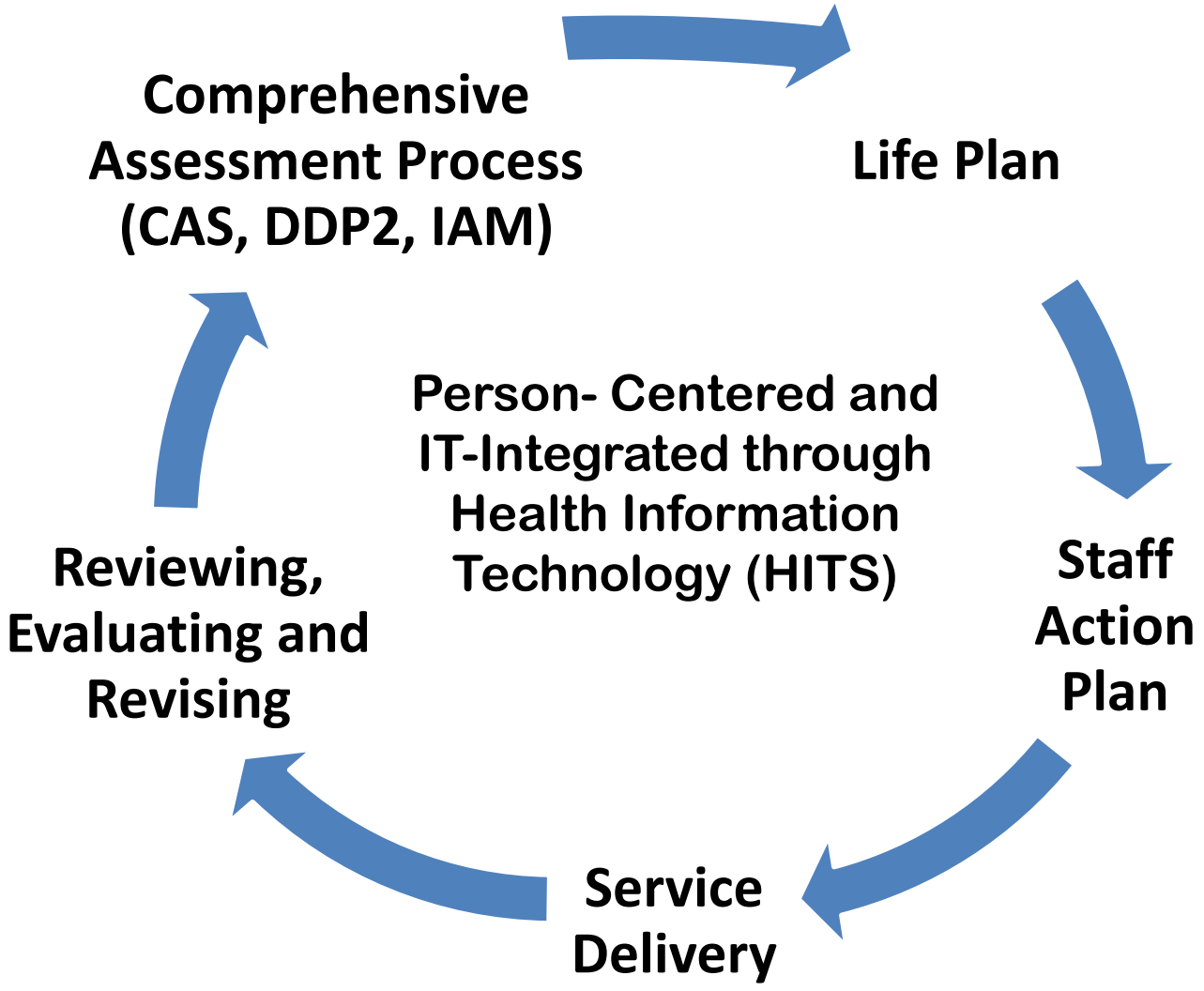
- Conceptual Overview of the Life Plan and Staff Action Plan Connections
- Staff Action Plan Program Standards
- Staff Action Plan Billing Standards
- Quality Considerations
- Question and Answer Time

The Life Plan and Staff Action Plan Connections – Conceptual Overview

It is recommended that participants view "OPWDD Care Management, Life Planning and Service Delivery Process: Connecting the Dots" (the August 30, 2018 webinar) prior to viewing this training for a more in depth overview.

View the Webinar: https://youtu.be/d0uzboNE5U4
PowerPoint: People First Care Coordination Informational Session 20

Review of the Life Planning Process Cycle
The Person and Person-Centered Planning is Always the Driving Force



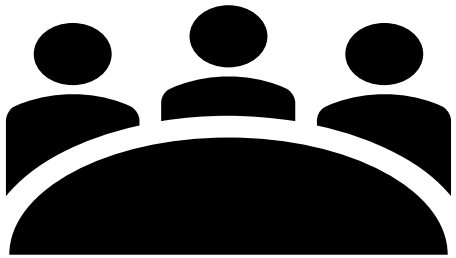
The Life Plan defines the Person's goals/valued outcomes and individual safeguards and how these relate to what is most meaningful to the person.

The new Life Planning process is designed to create consistency at the point of service delivery by organizing goals within the 21 Personal Outcome Areas. This is one of the major reasons for the use of new technology.

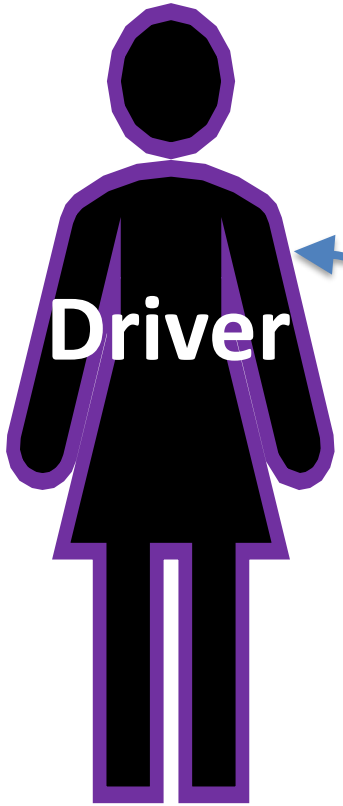
It's A Collaborative Team Process Driven by the Person

The Care Manager is the Facilitator of the Life Planning Process

Life Planning Process



Circle of Support and Providers



The Provider facilitates development of the Staff Action Plan—

Provider Assigned Goals from the Life Plan are the starting point

Personal Outcome Measures (POMs) and the Life Plan? How do POMs relate to the Staff Action Plan?

- Goal related responses from the Person's **IAM Assessment Tool** link to the **The Council on Quality and Leadership (CQL) 21 POMs Indicators.**

- The POMs are then populated within **Section II of the Life Plan, "Outcomes and Support Strategies**" and the planning team uses this information as a starting point to help the Person define and refine his/her Valued Outcomes (what the Person wants to do in Life).
  - This structure helps to organize and categorize the person's Valued Outcomes for comprehensive quality improvement

- **The planning team then identifies the Providers (or unpaid natural supports, etc.) that will assist the person with goal achievement activities to help them meet their individually defined Valued Outcomes.**

Habilitation Services and Staff Action Plans

What are Habilitation Services?

- Habilitation Services are designed to assist in acquiring, retaining, and improving self-help socialization and adaptive skills necessary to reside successfully in home and community-based settings
- Habilitation services involve staff teaching skills, providing supports, and exploring new experiences.

Staff Action Plans Define how Habilitation Services will be implemented to address the person's needs and their defined goals.

- A Staff Action Plan is required for each Habilitation service received by the person.
- The Staff Action Plan describes how Habilitation staff will assist the person to achieve his/her defined habilitation goals/valued outcomes from the Life Plan.

Staff Action Plans: What and Why?

What Are Staff Action Plans?

- Describes in detail what Habilitation staff will do (the specific supports and services that will be provided) to help the individual to achieve his/her defined habilitation goals/valued outcomes.
- Describes how Individual safeguards/IPOP needs identified in the Life Plan will be met.

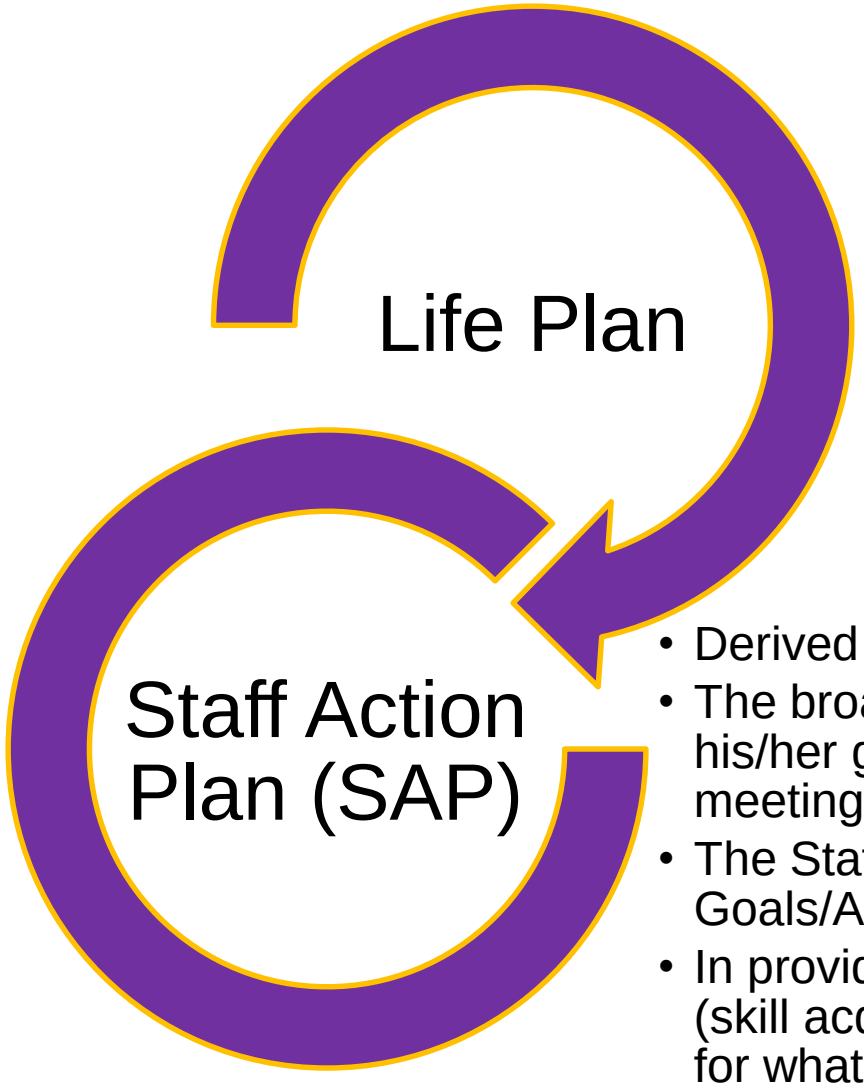
Why Staff Action Plans?

- New structure based on the Habilitation Plan framework that more closely connects to and integrates with the Life Plan through an integrated IT system.
- Strengthens person-centeredness and quality outcomes by focusing staff actions on the person's goals and what is most meaningful to him/her.

What are the Major Differences between the Habilitation Plan and the Staff Action Plan?

- The Life Planning process facilitates a greater connection to Habilitative service delivery through identification of the **"Provider Assigned Goal"** (and related information) in the Life Plan as the **starting point for the Staff Action Plan**;
- The Person's Valued Outcomes that correlate with CQL POMs Indicators, as identified in the Staff Action Plan, allow for **greater consistency** in the identification and analysis of quality outcome areas for a more comprehensive and integrated quality management approach.
- There are a few **new documentation/ billing standards** in the Staff Action Plan ADM that were not part of the Habilitation Plan documentation standards.

Flow Between the Life Plan and Staff Action Plan (SAP)



- The Person is the Driver, Not the Technology
- The Care Manager is the Facilitator/Coordinator of the Process that also includes Providers and other members of the Circle of Support
- The Life Plan is the overarching and active document defining the person's goals/Valued Outcomes and Needed Safeguards
- It's a Team process to arrive at an accurate and comprehensive Plan that is the Person's blue print.
- Technology assists the Person-centered Process, it does not replace it.

- Derived from the Life Plan
- The broad strokes of what the Provider will do to help the Person achieve his/her goals and has already been determined through the Life Plan meeting(s)/process (Provider Assigned Goals/Actions)
- The Staff Action plan fills in further details on how the Provider Assigned Goals/Action Items will be carried out
- In providing this further detail, the SAP outlines service delivery strategies (skill acquisition/retention; staff supports; exploration of new experiences) for what Staff must do and how they will do it.

Connecting Points

Life Plan

Section II Outcomes and Support Strategies

Section III Supports/Individual Safeguards/IPOP

Staff Action Plan

Individual's My Goal/Valued Outcome(s)

Provider Assigned Goal(s)

Staff Actions

What is the Difference Between the My Goal/Valued Outcome vs. the Provider Assigned Goal?

My Goal/Valued Outcome

The Individual's identified goals—What does the Person want out of Life? What does the Person want to do or achieve and/or an area where they need Provider Supports.

Ex 1 "I want to live more independently in the Community"

Ex 2: "I need help taking my medications"

Provider Assigned Goal

Can be a Goal, Support or Task Assigned by the Person/CM and the Life Planning Team and **specifies what the Provider (or natural support etc.) is expected to do as it relates to the Person's Goal/Valued Outcome.**

(G) "Teach me to Take Public Transportation"

(S) Provide Total Assistance

How Many Valued Outcomes are Required?

Per Life Plan for Section II:

There must be at least **2** different **CQL POMs** identified and at least **3 different "My Goals/Valued Outcomes".**

This applies even if the Life Plan does not have Habilitation Services. The My Goals/Valued Outcomes may be supported by Paid Services or Unpaid Natural Supports or identified by the Person as their own personal goal.

Section III does **NOT** count for this Requirement.

Valued Outcomes and Habilitation Services

The Life Plan, through identification of the person's goals and support needs, will demonstrate whether or not a person needs a particular Habilitation service.

The person and the person-centered planning process is how valued outcomes and provider assigned goals are derived (not the billing standards for a particular service).

Per Habilitation Service:

- Every Habilitation Service Authorized must have at least 1 "My Goal/Valued Outcome" (this is not a new Policy).
  - This can be in Section II or Section III of the Life Plan.
- The Provider Assigned Goal/Actions can take the form of teaching Goals or Provider Supports but not Tasks.
  - There can be more than 1 Provider Assigned Goal associated with an individual's My Goal/Valued Outcome.

How is it Determined whether a Provider Assigned Goal (i.e. Action Step) is a Goal (G), Support (S) or Task (T)?

Goals (G):

- Definition: “the object of a person's ambition or effort; an aim or desired result”.
- The person’s goal/valued outcome is to learn or achieve an objective.
- Improve a skill or quality in the person’s life.
- The Provider Assigned Goal will include teaching/instructing/assisting/educating the person to do something where there will be an end outcome resulting for the person. E.g., My staff will teach me to take public transportation.

Support (S):

- Definition: “To give assistance to the person; to hold up; to maintain at a desired level; to keep something going.”
- The person needs a certain level of assistance with daily living skills—the person’s goal/valued outcome will speak to a level of support needed.
- The Provider Assigned Goal/Action Steps will be to “provide” some type of assistance that will typically be referenced as ongoing.
- E.g., Provide diet counseling for healthy food selection.

Task (T):

- Something to be done that is a one time thing.
- Not habilitative in nature so will not be billable (e.g., Make sure to schedule the trip I want to go on).

Example —Translate a LP Provider Assigned Goal/Action Item to a Staff Action

Life Plan

My Goal/Valued Outcome: Improve the quality of my current relationships

Goals Assigned to Providers

(G) Teach Social Sills (Provider Assigned Goal)

Life Plan

Staff Action Plans Developed

- **Staff Action**: Twice weekly, my Community Habilitation staff will work with me to teach appropriate social greetings when I meet with my friends and others in the community.

Staff Action Plan

How and where will the Provider Assigned Goal information appear in the Life Plan Template?

Example from LP Template: Section II Outcomes and Support Strategies

The Frequency and Quantity fields work together to define how often staff actions will be delivered to help the person achieve the specific goal

	CQL POMS GOAL	My GOAL/Valued Outcome for Person	Provider Assigned Goal	Service type	Frequency *This is NOT the unit of service or the billing unit.*	Quantity	Timeframe
Field Definitions	1 of the 21 CQL POMs There must be at least 2 different POMs for each Life Plan	The Person's Individually defined goal that relates to the POM indicator	The starting point for Staff Action Plan development. Identified as a Goal, a Support or a Task.	The Category of HCBS Waiver Service	This is the frequency that the provider will deliver services that help the person achieve the specific goal/support. (*Drop down list includes once, daily, weekly, monthly, quarterly, As needed, ongoing, NA.*)	Relates to the Number of times for the given frequency that the provider will deliver services targeted to helping the person achieve their goal. *Drop Down list includes (1-10, As needed, ongoing, NA)*	When the person's goal is expected to be achieved.
Example	People have intimate relationships	**I want to improve the quality of my current relationships**	(G) Teach Social Skills	**Community Habilitation**	Weekly	2	Ongoing

EXAMPLE FROM LP TEMPLATE: SECTION III

Supports, INDIVIDUAL SAFEGUARDS/INDIVIDUAL PLAN OF PROTECTIVE OVERSIGHT (IPOP)

The Frequency and Quantity fields work together to define how often staff actions will be delivered to help the person achieve the specific goal

	Goal/Valued Outcome	Provider Assigned Goal	Provider / Location	Service Type	Frequency	Quantity	Time Frame
Field Definitions	The Person's individually defined goal/valued outcome	**The starting point for Staff Action Plan development.** **Identified as a Goal, a Support or a Task.**	The Provider Agency	The Service Type	**This is NOT the unit of service or the billing unit.** This is the frequency that the provider will deliver services that help the person achieve the specific goal/support. *(Drop down list includes once, daily, weekly, monthly, quarterly, As needed, ongoing, NA.)*	Relates to the Number of times for the given frequency that the provider will deliver services targeted to helping the person achieve their goal. *Drop Down list includes (1-10, As needed, ongoing, NA)*	When the goal is expected to be achieved.
Ex. 1	I need help to take my medications	(S) Provide Total Assistance	Provider Agency	Residential Habilitation	As needed	As needed	Ongoing
Ex. 2	I want to feel differently	(S) Provide exercise program	Provider Agency	Community Habilitation	Weekly	3	Ongoing

LP Section IV HCBS Waiver and Medicaid State Plan Services

Authorized Service	Provider/Facility	Effective Dates/ Duration	Qty	Unit	Per	Total Units *
The HCBS Waiver Category of Service	The Provider Agency	The Duration of the Life Plan Also "duration" from Service ADM	The Qty and Per Fields Work Together to Calculate the Total Units	The "Frequency" from each OPWDD Service ADM that says how to list in the ISP	Drop Down List options: Day, Week, Month, Year, Authorization	Calculates automatically If unknown, the CM will enter "99999"
Residential Habilitation	**ABC Inc.**	**7/1/2018-6/30/2019 Duration; "ongoing"**	**365**	**Day**	**Year**	**365**
Day Habilitation	**Onward Bound Inc.**	**7/1/2018-6/30/2019 Duration: "ongoing"**	**220**	**Day**	**Year**	**220**

es

Important Things to Note about the Life Plan Template–"Total Units" Field

- The **"Total Units"** Field **does not create an audit risk** as its purpose is for discussion and planning.
- When the Service Authorization Letter is available from the DDRO, the Total Units will match the Units authorized in the DDRO's letter.
- For a person new to services, the CM will **enter a requested number of Total units** and later must update this field to reflect the actual Units authorized by the DDRO in the Service Authorization Letter.
- If there is no Service Authorization Letter or documentation available for Total Units, **"99999"** will be entered with a note in the Comments Section that Total Units is TBD.

Important Things to Note about the Life Plan

- In Fee-for-Service, although the LP and services within it have a “to-from date range”, the LP and **services within it <u>will not expire</u>**. The LP and services will remain in effect until a new LP is written or until the person discontinues services or services are modified.

Important Things to Note about the Life Plan

- There may be situations where a Provider is not yet identified when the Care Manager is developing a Life Plan.
- In these cases, “pending” should be selected from the drop down list for the name of the Provider and Location.
- It is important to ensure that once your Agency is identified as a Provider that the Life Plan is updated accordingly.

The Life Plan Section IV Provides Documentation the Provider Needs to Substantiate Provider Billing

Section IV of the Life Plan should be **consistent with each service specific Administrative Memorandum** and includes:

- The “Category of Service” in the “Authorized Service” field;
- The “Frequency” (in the “Unit” Field);
- The “Duration” (is in the effective date field and noted as “duration is ongoing” or in the Comments if the Duration language was not yet available);
- An effective date that is on or before the first date of service for which the agency bills (for a newly added service).

Note: **Effective dates for Services that are already authorized/listed in an ISP will be the same effective date as the initial Life Plan effective dates.**

Important Things to Note About the Life Plan—Self-Directed Services

- All Self-Direction Services that are not Agency Supported or Direct Provider Purchased must list the Fiscal Intermediary (FI) as the Provider.
- For Services included in a Self-Direction Budget, the CM must add, “Per approved Self-Direction Budget” in the comments column of Section IV.
- For Self-Directed Services that do not have a Provider Assigned Goal, there must be information in the LP narrative section that supports the service provision.
- Direct Purchased Services follow the same requirements as all other HCBS Services in the Life Plan

Staff Action Plan Safeguards/ IPOP

As part of the Life Planning process, **Care Managers and Providers must work together to ensure that all health and safety needs** across service settings are addressed appropriately and accurately in Section III of the Life Plan/Individual Safeguards/IPOP.

The **Life Plan** includes the **broad overarching** need for Safeguards.

The **Staff Action Plan or other internal guidance documents (if needed)** provides the **detail** on how the Safeguards will be implemented/met.

- The SAP can refer to the Life Plan for information on Safeguards if more information/detail than what is in the Life Plan is not needed.

Section III Individual Safeguards/IPOP includes a space for **special considerations** that allows for additional information that may need to be considered in assisting the individual to achieve his/her valued outcome. There may be instances when a person chooses not to follow specific medical treatment advice. Information relative to decisions of this nature should be included here.

Partnership, Communication and Collaboration between the Person, the Care Manager and Providers Throughout the Process is Critically Important

- Successful development and implementation of the Life Plan and Staff Action Plan is dependent upon the strength of the partnerships and communication among all involved.

- Coming to agreement on the Provider Assigned Goals/Action Steps is important during the Life Planning meeting so that all parties leave the meeting with the same understanding.

- A draft of the Life Plan Sections that relate to the Staff Action Plan (Sections II and III at least) should be shared with Habilitation Providers and/or the planning team should develop other means of communication to ensure accurate and timely communication of the Provider Assigned Goals and related information necessary for the development of the Staff Action Plan.

The Staff Action Plan and Service Delivery Program Standards

Source: Administrative Memorandum # 2018-09

Habilitation Services

A Staff Action Plan must be developed for each Habilitation Service received by the Person including:

- Residential Habilitation in Certified Sites (IRA's, CR's, Family Care Homes);
- Day Habilitation;
- Community Habilitation;
- Prevocational Services (Site-Based and Community-Based);
- Pathway to Employment; and,
- Supported Employment (SEMP).

If the person's Habilitation services are provided by the same agency, they can be included in 1 Staff Action Plan with separate sections describing the supports and services (and staff actions) associated with each Habilitation Service.)

The Staff Action Plan Development and Person-Centered Planning Practices

- When developing the Staff Action Plan, Habilitation Staff must follow the PCP guidance described in 14 NYCRR Part 636-1.
- This includes the person driving the process.
- Collaboration and coordination between the person, his/her advocate, CM, providers, and any other parties requested and approved by the person.
- Agencies providing Residential Habilitation must continue to demonstrate the involvement of a Qualified Intellectual Disabilities Professional (QIDP) in the delivery, management or supervision of Residential Habilitation.

The Staff Action Plan—Detail Needed

- The Staff Action Plan detail must include:

  Strategies for Service Delivery that are developed in consultation with the individual, advocates, CM, and the rest of the team.

- Keep in mind that the Staff Action Plan **must include enough detail for any new Habilitation Staff to know:**
  - -- What they must do;
  - -- How to assist the individual to achieve his/her Habilitation goals/valued outcomes; and/or
  - -- How to address the individual's safeguards/IPOP needs.

The SAP Must Address One or More of These Strategies

Skill Acquisition/Retention

- Methods staff will use to help individual become more independent in some aspect of life.
- Access current skills, identify method to teach, measure progress
- Retention considered when skill advancement not reasonably expected—then stemming regression is appropriate

Staff Supports

- Used when individual is not expected to independently perform task without supervision; or when support is essential to preserve the individual's health or welfare, or to reach goal/outcome.
- Staff oversight –typically relates to the provision of defined safeguards
- Exploration of new experiences

Exploration of New Experiences

- Learning about the community and forming relationships often requires an individual to try new experiences to determine life directions and to support greater independence.
- This trial and error process allows the Person to make informed choices and identify new goals/valued outcomes that become part of the Life Plan and Staff Action Plan.

Staff Action Plan– Example 1

(Note: this Goal would populate in Section III of the Life Plan)

- **My Goal/Valued Outcome from the Life Plan:** "I want to feel differently"

- (S) Provide Exercise Program

- **Staff Action for the Staff Action Plan**: My Community habilitation staff will work with me to help me choose what kind of exercise program I'm interested in and will help me engage in this exercise three times per week for at least 30 minutes.

Example 1: The Staff Action Plan Must Include:

- **My Goal/Valued Outcome from Section III of the Life Plan =** "I want to feel differently"

- **Provider Assigned Goal/Support from Section III of the Life Plan** = (S) "Provide Exercise Program"

- **Staff Action(s):** My community habilitation staff will work with me to help me choose what kind of exercise program I am interested in and will help me engage in this exercise three times per week for at least 30 minutes.

Ex.1 Staff Action Plan Includes (continued):

- **Detailed Steps for How this will be Achieved (example):**

Staff will help me explore what I like to do or might like to do for exercise by: taking me to different exercise classes at the Y including exercise bike, yoga class, aerobics class, etc. Staff will also help me to view exercise programs on video/tv to see if I like this method or prefer a class with a group of people or using equipment/machines. Staff will help me engage in a full exploratory process and then through person centered planning will help me narrow down what I most like to do for exercise three days per week for at least 30 minutes—combinations of different things will also be explored.

- **Service Delivery Strategies:**
  - Exploration of new experiences
  - Staff Supports—Staff "provide"

Staff Action Plan- Example 2

POM: People live in Integrated Environments (Section II of LP)

In Life Plan--

My Goal/Valued Outcome

I want to live more independently in the community

Provider Assigned Goal for Residential Habilitation in the Life Plan

(G) Teach person to take public transportation

Staff Actions for the Staff Action Plan

My Residential Habilitation Staff will teach me to take public transportation (G)

Ex 2: Staff Action Plan for Provider Assigned Goal: POM= People Live in Integrated Environments

1. My Goal/Valued Outcome from Section II of the Life Plan" –

"I want to live more independently in the community"

2. Provider Assigned Goal and Staff Action

Hab Goal—"Teach me to take public transportation"

Staff Actions "Staff will teach me how to plan a trip, access transportation routes, and the means of paying for each leg of the trip. Staff will help me learn these skills at least 3 times per week" (Provider outlines the detailed steps for how this is achieved)

Ex. 2: Detailed Steps for How this is Achieved? "Staff will Teach Me How to Plan a Trip, access transportation routes, and the means of paying for each leg of the trip at least 3 times per week"

Staff will teach me how to plan a trip (example detailed steps):

1. My staff will talk to me about the different places I like to go. We will choose 1 place to start working on planning a trip to (My Mom's House).
2. My staff will show me on my iPad how I can use Google Maps and the Bus Schedule to find out how I can go from my residence to Mom's House. We will print out the bus schedule and instructions.

Staff Action Plan and Safeguards

- **All individual safeguards/IPOP needs from the Life Plan** must be identified and addressed in the Staff Action Plan or reference other internal guidance document(s) that outline the detailed implementation of protective oversight measures within the services and settings where services are being delivered.

- Section III of the Life Plan is used as the starting point for the Habilitation service provider to develop Staff Action Plan detail on how the safeguards will be implemented within the services and settings.

Is a Plan of Protective Oversight Still Required?

- **For Residential Habilitation Providers**, the Staff Action Plan or other internal guidance documents that outline the implementation of individual-specific protective oversight measures must meet the requirements of the **Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16** and align with Section III of the Life Plan.

- For all other Habilitation services, the individual safeguards/IPOP needs from the Life plan must be identified and addressed in the Staff Action Plan, or reference other internal guidance document(s) that outline the detailed implementation of protective oversight measures.

- Behavior Support Plans and the **other requirements outlined in 14 NYCRR Part 633.16 Regulations remain in effect.** Additional detail on a safeguard listed in the Staff Action Plan may be referenced as being located in a Behavior Support Plan or other detailed Plan.

How are Changes in an Individual's Needs and/or Safeguards Communicated Between the Provider and Care Manager?

- An Individual's safeguard needs (and any changes) must be **immediately** communicated and implemented.

- **A mechanism for prompt communication** agreed upon between the CM and Habilitation Provider must be established and utilized to ensure this happens.

Changes that Must be Immediately Communicated--Sentinel Events

- Accidents or events resulting in serious personal injury
- A major medical event
- Major psychiatric event or decompensation resulting in extended inpatient psychiatric hospitalization
- Significant changes or improvement in behavior or physical functioning

What about Acute Short-term Support Needs?

- Acute events like monitoring after sedation, flu or short-term illness, do not require a Life Plan change because of the limited temporary nature

- Acute events require staff education for monitoring of health and safety through day-to-day documentation

Safeguards Sections Must Be Accurate!

- The Safeguard Section of the Life Plan and Staff Action Plan must **ALWAYS** be accurate based on any changes such as health condition/event, sentinel event, diet change, etc.

- Any change in the person's life that affects information in the Life Plan must be communicated to the Care Manager

Staff Action Plan Timeframes

- Between July 1, 2018- *December 31, 2019 (extended from June 30, 2019*), both ISPs and Life Plans may be in effect. The ISP remains in effect until a Life Plan is developed.
  - For individuals with an ISP, Habilitation Providers continue to follow Habilitation Plan Requirements in ADM 2012-01 until the Life Plan and Staff Action Plan are developed/implemented.
  - At the time of transition to a Life Plan, a Staff Action Plan must be developed.
  - Habilitation Plans created between July 1, 2018 and September 4, 2018 (issue date of the Staff Action Plan ADM 2018-09) must transition to a Staff Action Plan by November 3, 2018.

No later than *March 1, 2020 (extended timeframe)*, individuals receiving or seeking Habilitation Services are to have a Staff Action Plan.

Staff Action Plan Timeframes

- Staff Action Plans are in place **within 60 days of the start of the Habilitation service or the Life Plan review date**, whichever comes first.

- Staff Action Plans are provided to the Care Manager **no more than 60 days** after the Life Plan review date, the start of the habilitation service OR the development of a revised or updated Staff Action Plan.

- Staff Action Plans **must be reviewed at least twice annually** and revised as necessary. Recommended occurrence **is every six months and coordinated with the Life Plan review.**

- **At least annually**, one of these Staff Action Plan reviews must be conducted at the time of the **Life planning meeting.**

NOTE: OPWDD is working on a communication that would suspend the 60 day requirement from the billing standards through a transition period

When reviewing the Staff Action Plan, the Provider must consider and document:

- The Individual's **progress** including **accomplishments and prevention of regression** since the last review;
- The review must include discussion about:
  - The services and supports that have been provided since the last review;
  - What **challenges** have been experienced;
  - What new **strategies or methodologies** may need to be implemented; and,
  - The **individual's satisfaction** with the Staff Action Plan.
- With the person and his/her circle of support, establish and agree on objectives to be met before the next review

What is Meant By "Establishing and Agreeing Upon Objectives to be Met Before the Next Review" (From the ADM)?

- This is a best practice to help monitor the person's progress towards meeting goals and to help to ensure that service delivery strategies and or the detailed action steps are adjusted based on whether or not the person is meeting these interim objectives.
- Another way to think about objectives is by considering milestones towards meeting an overall goal—what are the interim success indicators that can help the Person and the Team to know if the Person is on track in working towards achievement of their Goal.
  - -- Breaking it down into smaller achievable steps for the person.
  - -- Recognizing these interim successes

Staff Action Plan Required Sections

1. Identifying Information

- Name
- Medicaid ID
- Habilitation Provider
- CCO
- Habilitation Service
- Date of Life Plan and/or Staff Action Plan review meeting

2. Individual Habilitation Goals/Valued Outcomes and Provider Assigned Goals

- Skill Acquisition/Retention
- Staff Supports
- Exploration of New Experiences

3. Individual Safeguards

- Section III of the Life Plan is the starting point
- Staff Action Plan detail
- Individual specific protective oversight measures that staff must implement immediately
- Also includes internal guidance documents

Insert Agency Name

Insert service(s) name(s) Staff Action Plan

Name of Individual: _____ **Medicaid Number (CIN#):** _____
Staff Action Plan Review Date: _____
Name of Care Coordination Organization: _____

Individual Habilitative Goals/Valued Outcomes (My Goal – Section II of Life Plan)

This section contains the individual's habilitative goals/valued outcomes derived from the individual's Life Plan. The habilitation service must relate to the individual's habilitative goals/valued outcomes. To support person-centered practices, each of the goals/valued outcomes identified must relate to a Council on Quality and Leadership (CQL) Personal Outcome Measure (POM) category.

Example: I want to live more independently in the community.

Provider Assigned Habilitative Goals (Section II of Life Plan)

This section contains the habilitation provider assigned (habilitative) goals derived from the individual's Life Plan which will be assigned as Goals (G), Supports (S), or Tasks (T). Tasks assigned in the Life Plan are not habilitative in nature and therefore do NOT meet the billing requirements to be a habilitation goal. Using the habilitative goals/valued outcomes identified above as the starting point, the details in this section describe the habilitation staff actions that will enable the individual to reach his/her goals/valued outcomes.

Example:

***Provider Assigned (Habilitative) Goal**: (G) Teach person to identify and respond to safety issues (environmental safety concerns, etc.)*

***Staff Action:** Staff will teach me how to plan a trip, access transportation routes, and the means of paying for each leg of the trip. Staff will help me learn these skills at least 3x a week. (Provider must outline the detailed steps as to how this is achieved.)*

Individual Safeguards/Individual Plan of Protection (IPOP) (Section III of Life Plan)

This section contains the habilitation provider assigned (safeguard) goals derived from the individual's Life Plan which will be assigned as Goals (G), Supports (S), or Tasks (T). Tasks assigned in the Life Plan are not habilitative in nature and therefore do NOT meet the billing requirements to be a habilitation goal. Using the individual safeguards/IPOP from Section III of the Life Plan as the starting point, this section must include detail and any internal guidance documents that outline the individual-specific protective oversight measures staff need to implement or ensure for the individual. For individuals receiving Individualized Residential Alternative (IRA) Residential Habilitation, the Residential Habilitation Staff Action Plan must meet the requirements of the Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16.

Example:

Provider Assigned (Safeguard) Goal: *(S) Provide the following supervision: Provide supervision in unfamiliar places I need the following accommodation to feel comfortable and safe: remember my communication system*

Staff Action: *Staff will provide supervision by maintaining [person] in visual field while teaching travel skills. Staff will ensure that [person's] communication system is available during activities while outside of home and will prompt [person] to use communication system during travel training activities.* ***Detailed expectations can be described within the staff action plan or internal guidance documents such as a Travel Plan or Communication Plan***

Signatures:

Staff Action Plan Author's Name: _____ Title: _____

Staff Action Plan Author's Signature: _____ Date: _____

Individual (optional): _____ Date: _____

Advocate (optional): _____ Date: _____

Supervisor/Reviewer (optional): _____ Date: _____

Staff Action Plan Billing Standards

Service Documentation for Billing Medicaid for Habilitation Services Remains Consistent with the OPWDD Administrative Memorandum for each Habilitation Service

The Staff Action Plan Billing Standards

- The billing standards for the Staff Action Plan are the same standards that were outlined and required in the OPWDD ADM 2012-01 “Habilitation Plan Requirements” **with the exception of the following new requirements:**

  - Identification of the **provider assigned goals** from the Individuals Life Plan
  - The **frequency of the services and supports (e.g., 3 times per week)** must be noted in addition to the description of the services and supports
  - Evidence of **distribution of the Staff Action Plan no later than 60 days** after the start of the service, the Life Plan review date, or the development/revision of the Staff Action Plan…whichever comes first!

Staff Action Plan Billing Standards—For every Habilitation Service, the SAP must contain:

- Individual's name;
- Individual's Medicaid Client Identification Number (CIN) (if the individual is enrolled in the OPWDD HCBS Waiver);
- Habilitation service provider's agency name;
- Name of habilitation service(s) provided (e.g., Residential Habilitation or Day Habilitation);
- Date (day, month, and year) of the Life Plan meeting, or Staff Action Plan review, from which the Staff Action Plan was developed/revised;
- Identification of the goals/valued outcomes (My Goal) from the individual's Life Plan

Staff Action Plan Billing Standards

- Identification of the Provider Assigned (habilitative/safeguard) Goal(s) from the individual's Life Plan;
- Description and frequency of the service(s) and support(s) (e.g., teaching laundry skills weekly) the habilitation staff will provide to the individual;
  - The frequency of the services and supports (e.g., 3 times per week) must be noted in addition to the description of the services and supports. (This is the frequency of provider assigned goals from Section II and III of the Life Plan.
- Safeguards (i.e., compilation of all supports and services needed for an individual to remain safe, healthy and comfortable across all settings) that will be provided by the habilitation service provider, which may be a reference to internal guidance documents that further define the safeguards;

Staff Action Plan Billing Standards

- Printed name(s), signature(s) and title(s) of the staff who wrote the Staff Action Plan;
- Date (day, month, and year) that staff signed the Staff Action Plan; and
- Evidence demonstrating the Staff Action Plan was distributed no later than 60 days after: the start of the habilitation services; the life plan review date; or the development of a revised/updated Staff Action Plan, whichever comes first (which may include, but is not limited to: a monthly narrative note; a HITS upload; or email)

NOTE: OPWDD is working on a communication that would suspend the 60 day requirement from the billing standards through a transition period

Staff Action Plan Billing Standards

- Evidence that the Staff Action Plan was reviewed at least twice annually. Evidence of review may include but is not limited to a:
  - Review sign-in sheet;
  - Services note indicating a review took place;
  - Revised/updated Staff action Plan

Evidence of Reviews must include: Person's name, habilitation service under review, habilitation service staff signature, date of staff signature and date of Review.

The ISP/Life Plan That Includes/Authorizes the Specific Habilitation Service Must Also Be Retained/Retrievable.

Make sure that Section IV of the Life Plan is **consistent with each service specific Administrative Memorandum** and includes:

- The “Category of Service” in the “Authorized Service” field;
- The “Frequency” (in the “Unit” Field;
- The “Duration” (noted with effective dates—e.g., “duration: ongoing” or in the Comments if that information is not available in another field);
- An effective date that is on or before the first date of service for which the agency bills (for a newly added service).

Note: **Effective dates for Services that are already authorized/listed in an ISP will be the same effective date as the Life Plan effective dates.**

Staff Action Plan Format and Optional Template

Providers may use the OPWDD optional SAP Template or develop their own as long as the SAP includes the minimum information required per the SAP ADM # 2018-09.

Plans must be not only be compliant with the ADM but must be communicated to Habilitation Staff with demonstration of the steps to take to address each Person's needs.

To see the Staff Action Plan template available on the OPWDD website: https://opwdd.ny.gov/opwdd_regulations_guidance/staff-action-plan-template

Quality Considerations

Developing, Reviewing and Evaluating Key Question(s) to be Explored with the Person

Is the Staff Action Plan and Service Delivery Process Helping to Achieve a Person's Meaningful Life Goals?

- Is the person involved in life experiences that he/she values through his/her supports?

- Is there improvement in the person's life according to him/her (health, social, etc.) as a result of the services/supports provided?

OPWDD Outcome Areas For Exploration and Discussion in Life Planning and Staff Action Planning

Does the person live and receive services in the most integrated setting?

Does the person have community participation experiences that are meaningful to him/her?

Does the person have meaningful relationships with friends, family and others that are important to him/her?

Does the person experience personal health, safety and growth opportunities?

Does the person exercise choice and decision making in his/her life and with his/her daily schedule to the extent possible?

Staff Action Plan (SAP) Quality Considerations

- Is the SAP reviewed for challenges that have been experienced and modified accordingly; taking into account the progress or lack of progress of the person; and the service strategies and methods used to deliver the services?
- Are adjustments made to the SAP based on what the Person wants and his/her satisfaction?
- Do SAP reviews establish objectives that are reviewed and updated based on progress or lack of and/or prevention of regression?

Division of Quality Improvement
Person-Centered Review Tool

Staff Action Plans will be incorporated into the DQIPM review for the survey cycle beginning October 1, 2019

- https://opwdd.ny.gov/sites/default/files/documents/PCR_Manual_3-12-18.pdf

- **Quality of Life Summary-- Example Standards (Page 45):**
  - ✓ The person is maintaining their desired role in the community
  - ✓ The person lives safely in their community per their informed choices
  - ✓ The person is satisfied with the supports they receive to help them achieve their desired outcomes
  - ✓ The person's service(s) in total, contribute to advancing toward or achieving their specified goals and personal outcomes

Meaningful Relationships; System Outcome = DQI Person Centered Review Tool Standard 5-1

- ✓ The individual is encouraged and supported to foster and/or maintain relationships that are important and meaningful to him/her

Meaningful Community Participation Experiences; System Outcome = DQI PCP Tool Standards 4-1, 4-3

- ✓ The individual is encouraged and supported to have full access to the community based on their interests/preferences/priorities for meaningful activities
- ✓ The individual regularly participates in unscheduled/scheduled community activities
- ✓ The individual is satisfied with their level of access to the broader community and the support provided to pursue activities that are meaningful to them for the period of time desired

Questions and Answers

Contact Information for Additional Questions

Peoplefirstwaiver@opwdd.ny.gov

Appendix—Supplemental Services Chart

Resource for Listing Services in Section IV of the Life Plan

How Services Should be Listed in the Life Plan Section IV

Service	Frequency	Duration	Source
Site Based Prevocational	Day	Ongoing	ADM 2017-03
Community Based Prevocational Services	Hour	Ongoing	ADM 2017-03
Supported Employment (SEMP)	Hour	Ongoing	ADM 2016-01
Pathway to Employment	Hour	Time limited	ADM 2015-07
Community Habilitation - Regular	Hour	Ongoing	ADM 2015-01
Community Habilitation – Certified Facility Residents	Hour	Ongoing	ADM 2015-01
Residential Habilitation – Supervised ***(only for Res Hab delivered in Supervised IRAs and CRs).***	Day	Ongoing	ADM 2014-01

How Services Should be Listed in the Life Plan Section IV

Service	Frequency	Duration	Source
Residential Habilitation – Supportive ***(Supportive, delivered in IRAs and CRs)***	Month	Ongoing	ADM 2002-01
Residential Habilitation-Family Care	Day	Ongoing	ADM 2006-04
Day Habilitation	Day	Ongoing	ADM 2006-01
Respite	Hour	Ongoing	ADM 2017-01
Support Brokerage or Support Broker	Hour	Ongoing	ADM 2015-06
Individual Directed Goods and Services (IDGS)	Day	Ongoing	ADM 2015-05
Fiscal Intermediary	Monthly	Ongoing	ADM 2015-04
Community Transition Services (CTS)	One-time expenditure	One-time expenditure	ADM 2015-02

How Services should be Listed in the Life Plan Section IV

Service	Frequency	Duration	Source
Intensive Behavioral Services-Implement Services	Hour	Time Limited	ADM 2013-03
Intensive Behavioral Services-Assessment and Plan Development	Plan	Time Limited	ADM 2013-03
Live-in Caregiver (LIC)	Monthly	Ongoing	ADM 2016-03
Family Education and Training (FET)	Annual	Ongoing	Children only
Assistive Technology	One-time Expenditure	One-time Expenditure	
Vehicle Modification	One-time Expenditure	One-time Expenditure	
Environmental Modification	One-time Expenditure	One-time Expenditure	