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OPWDD Care Management
Life Planning and Service Delivery Process: Connecting the Dots

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Learning Objectives

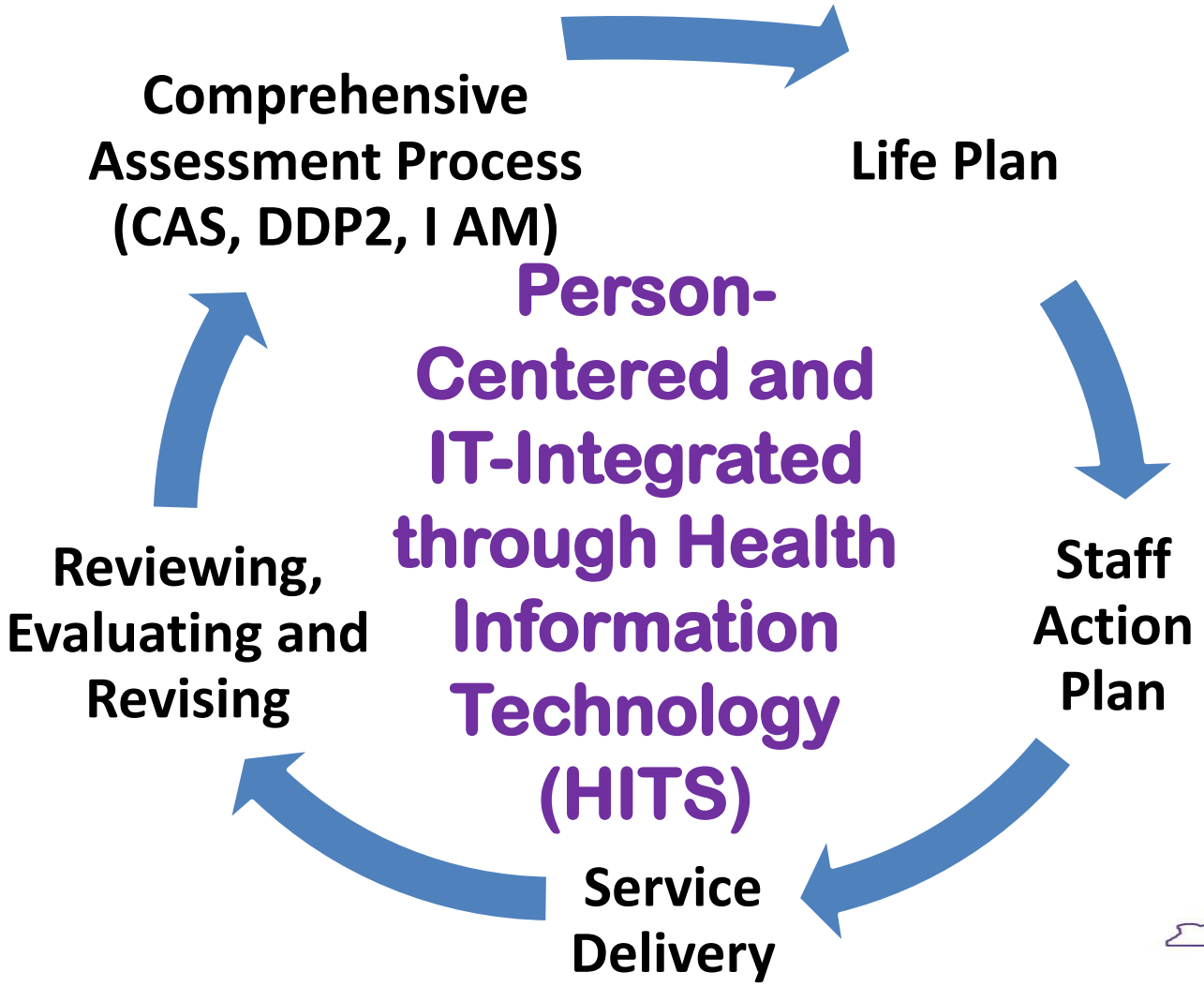
- Participants will develop a comprehensive understanding of

  ✓ How all of the essential components of the Life Planning process work cohesively to drive a person's most meaningful goals and outcomes

  ✓ How habilitation providers translate individual Life Plan goals into Staff Action Plans and service delivery methods (Staff Action Plan ADM)

  ✓ How to assess whether the person-centered Life Planning process is achieving what the person needs and wants from his/her life

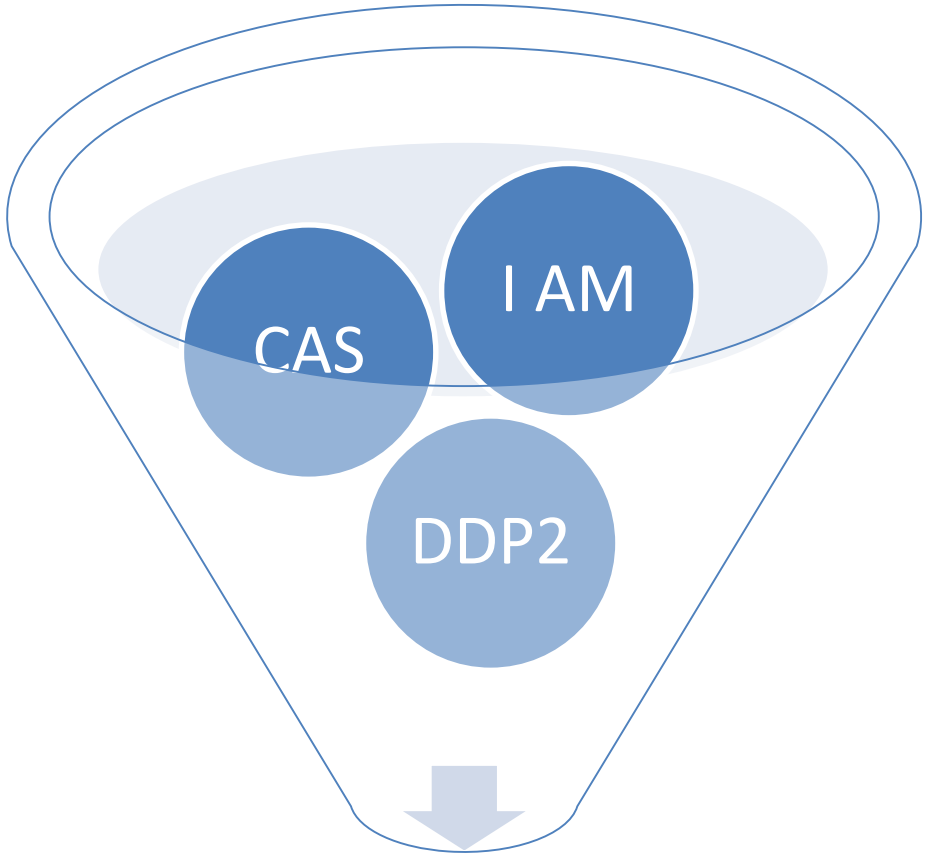
The Life Planning Process Cycle - Essential Components



Comprehensive Assessment Process

- Care Management enrollees must be comprehensively assessed (within 60 days of enrollment and annually thereafter), using one or more tools to identify

  - ✓ Developmental disability
  - ✓ Medical
  - ✓ Mental health
  - ✓ Behavioral health
  - ✓ Chemical dependency
  - ✓ Social and emotional needs



Tools Included in the Comprehensive Assessment Process

Comprehensive Assessment Tools for Functional Assessment

Comprehensive Assessment System (CAS)

New Functional Assessment

- Holistic across all the person's life and settings with input from the person and his/her family/circle of supports
- Comprehensive Behavioral/Medical and all other domains through multiple supplements
- Conflict-free; initial assessment completed by OPWDD or OPWDD designee; Reassessment anticipated to be completed by CCO/Care Manager
- Required qualifications to administer, extensive rigorous training, sharing of summary with person/family/supports, quality review

Developmental Disabilities Profile Form (DDP2 will be phased out when CAS is fully implemented)

Traditional Statewide Assessment

- Setting/program specific; not designed for input from the person
- Behavioral Health/Medical domain areas not comprehensive
- Completed by providers/programs
- No qualifications required, lack of consistent training to administer, lack of sharing of results with person/family/supports, no quality review process

The I AM Tool – Care Planning Assessment

In-depth, practical information about needs and preferences of a person

Recommends specific services and supports to help achieve the person's hopes and dreams

Delivers six in-depth narrative profiles representing the person's own story

Offers a list of preferences and supportive routines for the person who cannot communicate their wishes

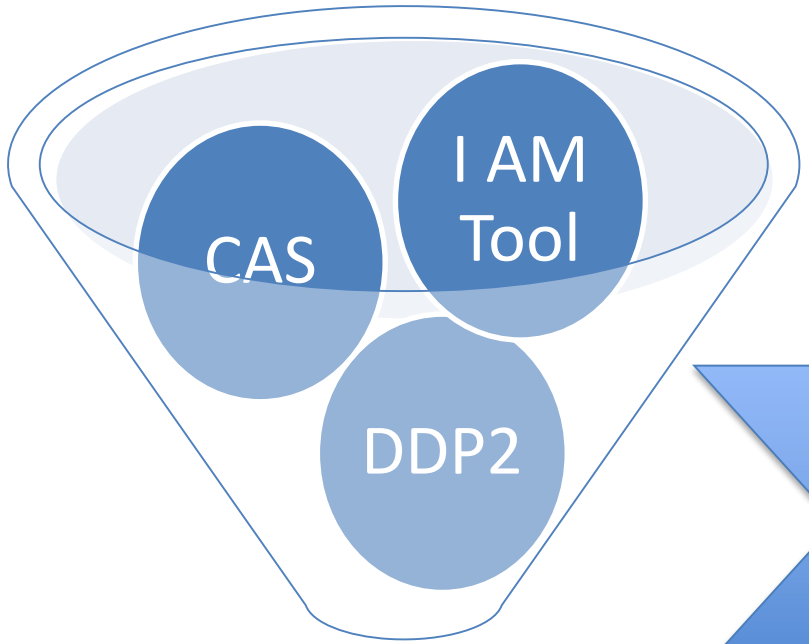
Integrates the Council on Quality and Leadership (CQL) Personal Outcome Measures (POMs)

Aggregates all documented information to be used as part of the Life Plan including: goals and actions and printed summary of content areas

The I AM Tool - Assessment Summaries

Profile Summary	Allergies Summary	Durable Medical Equipment and Supplies	Supportive Routines
POMs Preview	Preference Summary	Goals and Actions Summary	Individual Safeguards and Plan of Protective Oversight (IPOP) Preview

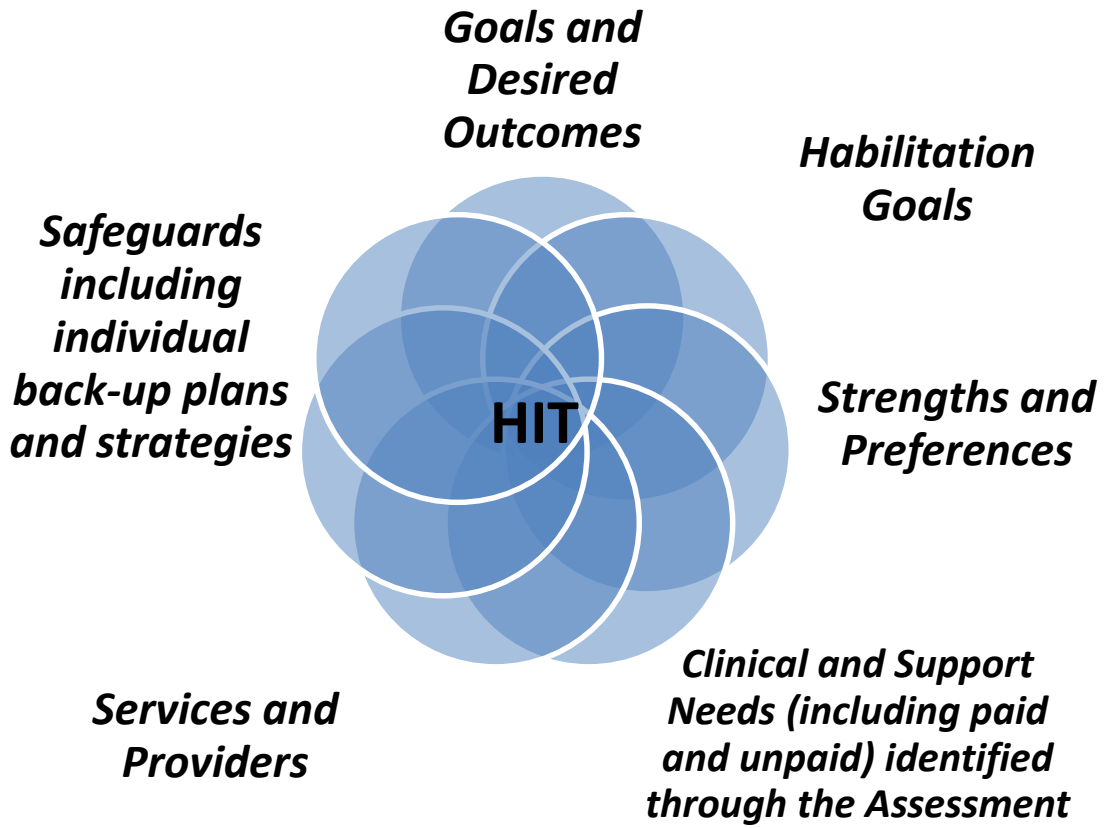
Person-Centered Planning and Health Information Technology (HIT) is Integral



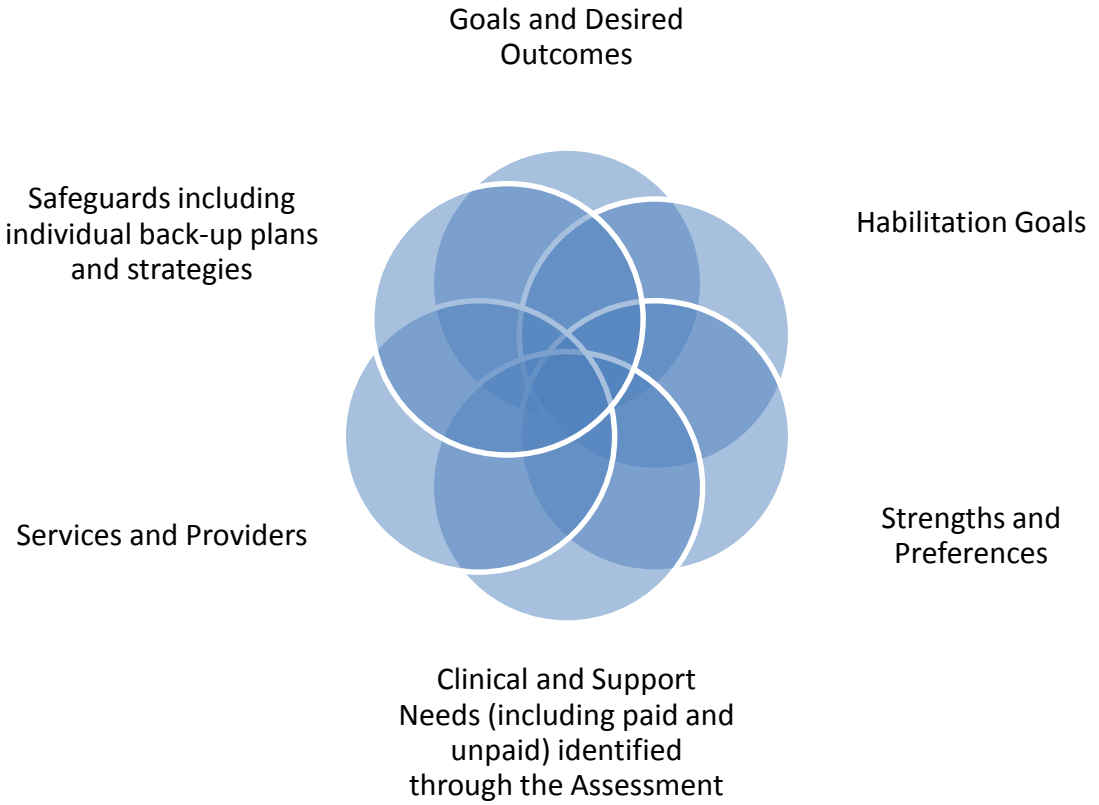
Comprehensive Assessment Process

Assessment Process Populates and Informs the Life Plan

Life Plan



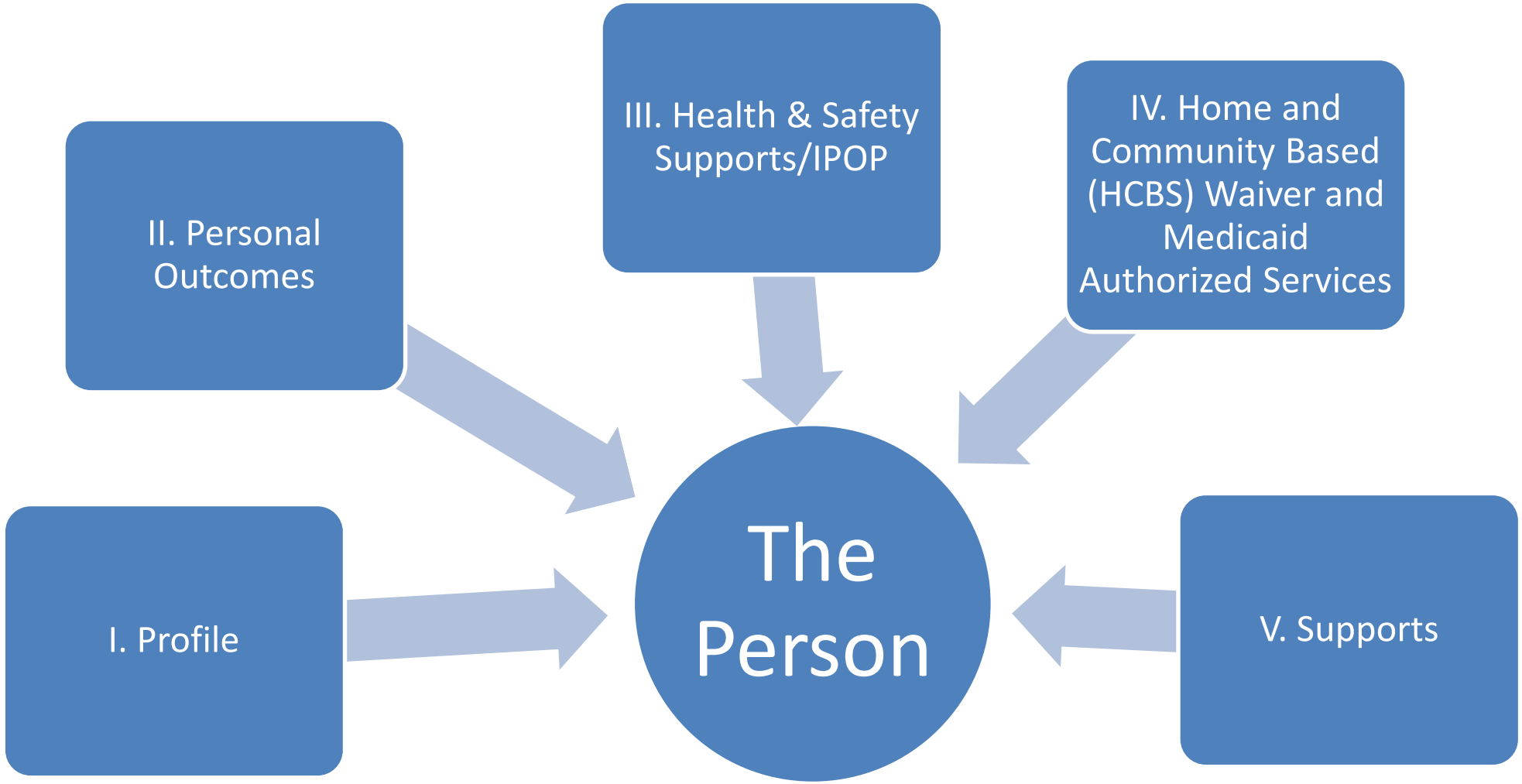
Person-Centered Life Plan Development:



- ✓ Collaborative and recurring process driven by the person
- ✓ Describes who the person is and what he/she wants to accomplish and who/what will help the individual accomplish their goals/valued outcomes
- ✓ Integrates all services and natural supports
- ✓ Understandable to the person
- ✓ Must be finalized and agreed to with the person's informed consent

The Life Plan is person-driven and a living document subject to continuous updating and monitoring by the Care Manager

Life Plan Sections



Individual Safeguards and Plan of Protective Oversight (IPOP)—Across All Settings

Includes the person's desired actions for health and safety and risk prevention

Includes detailed back-up plans for various situations

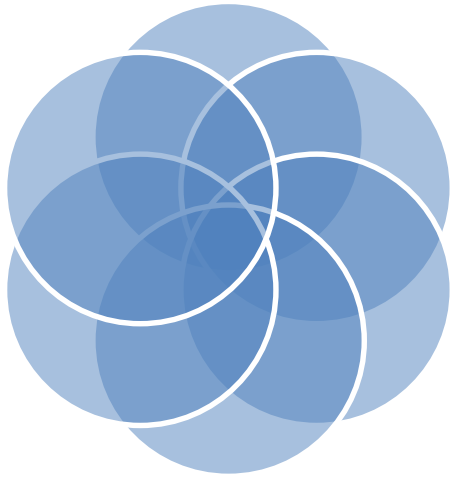
Life Plan Section III – Individual Safeguards

- Compilation of all supports and services needed for the person to remain safe
- Defines the overarching need areas for the person in consistent terminology
- Are person focused, not unique to a program
- Habilitative service providers must ensure that Staff Action Plans and internal guidance such as Behavior Support Plans or Travel Plans are consistent with the Life Plan Safeguards
- Must be updated in real time for use across service providers

Care Managers Assign Life Plan Goals to Providers

Goals and Desired Outcomes/Hab Goals

Safeguards including individual back-up plans and strategies



Services and Providers

Strengths and Preferences

Clinical and Support Needs (including paid and unpaid) identified through the Assessment

II. Goals/ Personal Outcomes

III. Safeguards

Habilitation provider develops Staff Action Plan

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

Providers Develop Staff Action Plans to Implement Habilitation Services

- 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

Providers Develop Staff Action Plans

- The Staff Action Plan details how the individual's needed safeguards (from the Life Plan) will be met; the staff supports; and/or specific details on protective oversight measures to ensure the health and safety of the person

- If additional detail on safeguards is located in another document, the Staff Action Plan must reference the location of the additional detail

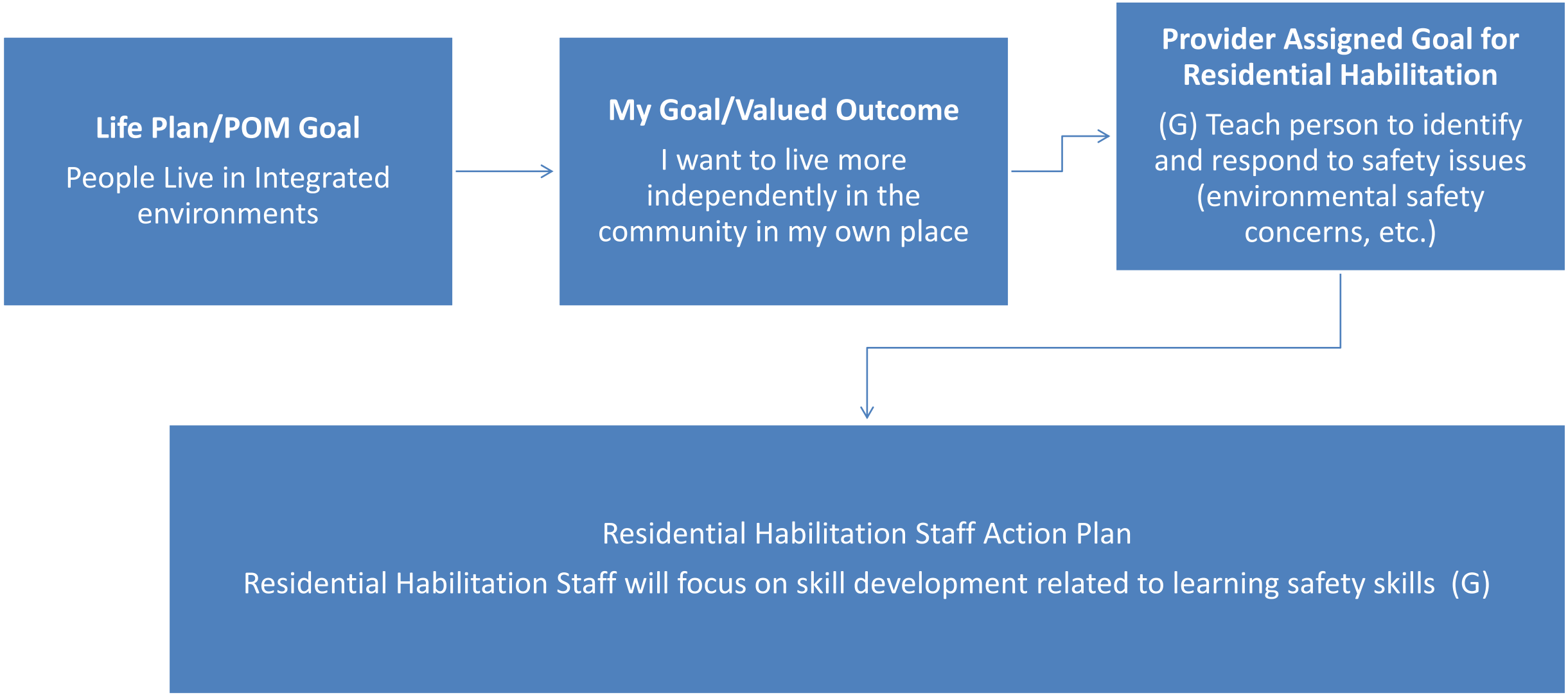
- The Life Plan will assign valued outcomes/goals to the provider with the following labels

  (G) = Goal
  (S) = Support
  (T) = Task

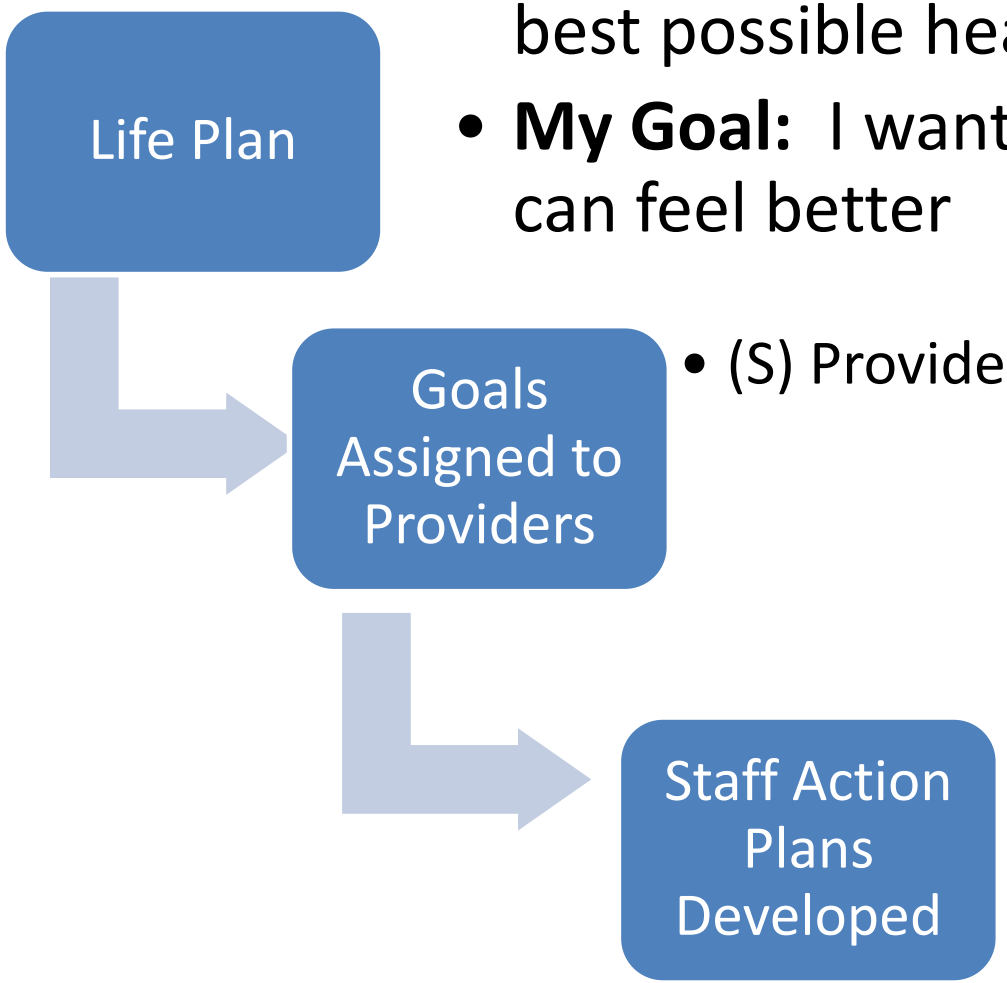
Goals Assigned to Providers are Translated to Staff Action Plans e.g., Valued Outcome - To Live More Independently in the Community

Goal (G)	• "Teach" • e.g., "Teach the person to take public transportation"
Support (S)	• "Provide" • e.g., "Provide diet counseling for healthy food selections"
Task (T)	• A one-time activity (does not meet definition of habilitation and is not billable) • e.g., "Take the person to view different types of apartments"

Assign Life Plan/Performance Outcome Measures Goals to Provider - Example



Assign Life Plan Goals to a Provider – Example



- **Goal/Valued Outcome**: People have the best possible health
- **My Goal:** I want to lose some weight so I can feel better

- (S) Provide exercise Program
  - Community habilitation staff will work with the individual to determine what kind of exercise program the individual is interested in and will help the person engage in this activity three times per week for at least 30 minutes (put in Staff Action Plan)

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

- Staff Action Plan detail
- Individual specific protective oversight measures that staff must implement

Staff Action Plan Program Standards

- Staff Action Plans are developed using person-centered planning processes and are person-centered
- 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
- 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

Staff Action Plan Review and Revisions

- Purpose is to reassess the effectiveness of the Staff Action Plan and services
- It is recommended that the Staff Action Plan review be coordinated with the Life Plan review
- Timely communication between habilitation staff and the Care Manager is necessary
- Consider the person's progress and prevention of regression
- Review must include: discussion about services/supports provided; challenges; new strategies and methodologies that may be needed; and, establish agreement on objectives
- Must include recognition of the accomplishment of the person and what has been achieved since the last review
- Person's satisfaction with the Staff Action Plan

Changes to the Life Plan

- The Life Plan is a person-driven living document and must accurately reflect the meaningful goals, needs, safeguards, and preferences of the person

- The Safeguard Section 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 trigger an update to the Life Plan (e.g., interests and safeguard change)

What are 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 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

Health Information Technology System (HITS) and Impact on the Life Planning Process

- HITS is an electronic information sharing system and must be used if available and accessible
  - -- If the CCO HITS is not available/accessible, another mechanism for prompt communication agreed upon by the Care Manager and providers must be used

- Ensures consistent, timely and comprehensive information sharing between providers and Care Managers

- Provides access to the individual, individual's family member(s) and/or advocates as permitted by the individual and any other parties requested and approved by the individual

Life Planning Cycle-Reviewing and Evaluating Key Question(s) to be Explored with the Person

Is the Life Planning 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-System Measures

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?

Division of Quality Improvement Person-Centered Review Tool

- 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

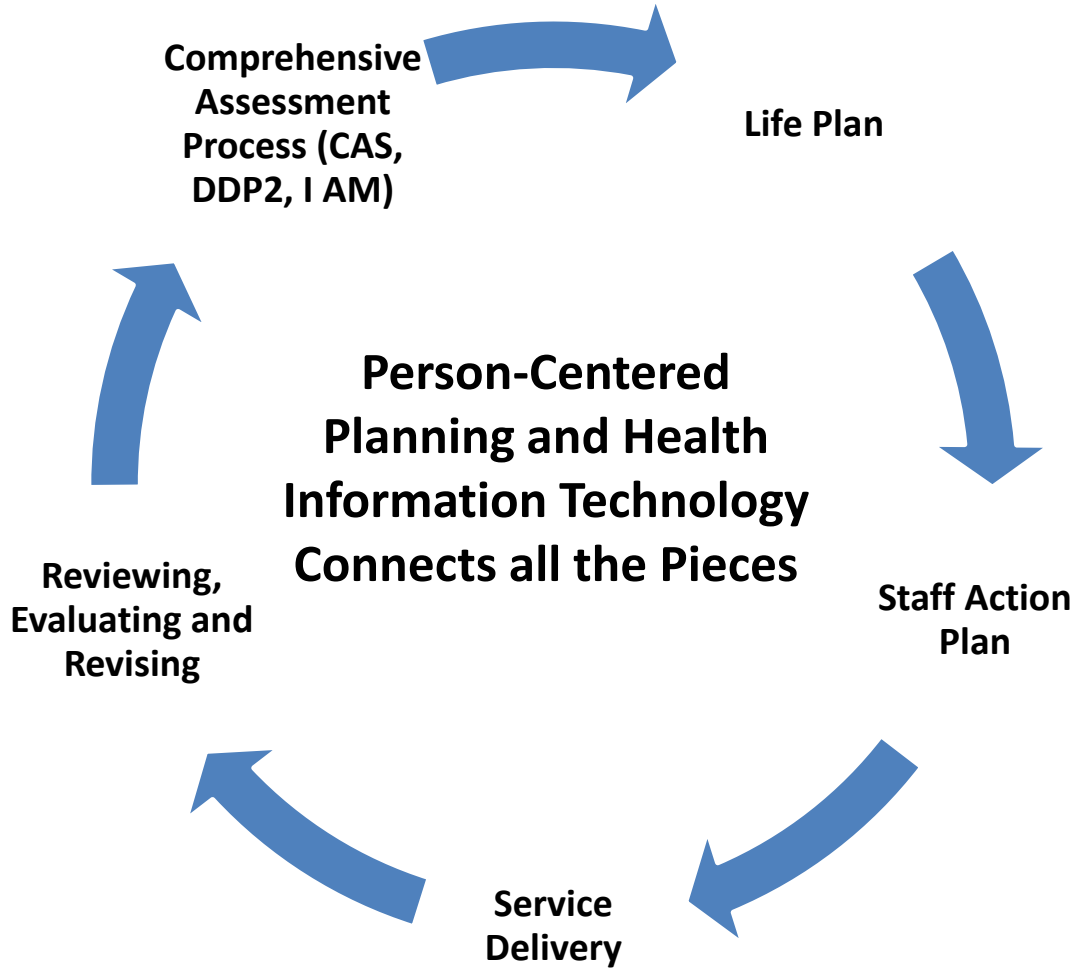
Meaningful Community Participation Experiences; System Outcome = DQI PCP Tool Standards 4-1, 4-3

- ✓ 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

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

Valued outcomes are the person's chosen life goals and the driving force behind the services and supports he/she receives

Putting it all Together--The Life Planning Cycle



Questions and Answers