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Care Coordination

E-VISORY

The Care Coordination E-VISORY is an electronic publication which provides information on policies, guidance, available programs and services and training opportunities related to Care Coordination services. In order to receive an email notification when a new Care Coordination E-Visory is posted, or to view past issues, visit the following link: Care Coordination E-Visory

ISSUE # 11-2018 **December 11, 2018**

Materials for December 12, 2018 Quarterly Care Managers Conference

The Quarterly Care Mangers Conference is being held on December 12, 2018 via videoconference and WebEx from 9:30am-12:30pm. The conference agenda is as follows:

- CCO Implementation and Ongoing Activities to Ensure a Successful Transition
- Process Flow for Service Authorization
- The Staff Action Plan and Delivery of Habilitation Services for Care managers/Care Coordination Organizations
- Surrogate Decision Making Committee (SDMC) and Informed Consent

NOTE: The materials that will be referenced during this conference are attached to this E-Visory. There will not be any materials distributed on the day of the conference.

Registration can be accessed at: http://www.opwdd.ny.gov/opwdd_careers_training/training_opportunities/slms. Existing users can log into SLMS from the page listed above. You can search OPWDD-QCMC in SLMS. If you choose to attend the conference by WebEx the link will be available in SLMS day of or you can register through the following link: https://meetny.webex.com/meetny/onstage/g.php?MTID=ef6bd0b18fbabbb0e96c7c0cdeb0bb268

If you have any issues with registration or logging in on the day of the conference please contact Talent and Development by email at talentdevelopment@opwdd.ny.gov or by phone at 518-473- 1190.

If you need assistance on how to access the OPWDD SLMS or how to create an account information can be found at the following links:

SLMS Account Creation (First time users)
https://opwdd.ny.gov/opwdd_careers_training/training_opportunities/slms-account-creation

SLMS Login (Existing users)
https://nyslearn.ny.gov/

Using SLMS
https://opwdd.ny.gov/opwdd_careers_training/training_opportunities/slms-user-guide

NOTE: Certificates are only provided to video conference attendees who sign in. If you attend this conference by WebEX certificates are not provided.

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Welcome to the Quarterly Care Manager's Conference

December 12, 2018

Welcome

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Information

Materials can be found in the Care Coordination E-Visory at:

https://opwdd.ny.gov/opwdd_services_supports/service_coordination/medicaid_service_coordination/msc_e-visories

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4

Agenda

- Welcome
- Hot Topics
- Care Coordination Organization Implementation and Ongoing Activities to Ensure a Successful Transition
- The Staff Action Plan and Delivery of Habilitation Services For Care Managers/CCOs
- Surrogate Decision Making Committee (SDMC) and Informed Consent
- Closing

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5

Hot Topics

- Medicaid Service Coordinator user role in CHOICES
- Connecting the Dots Question and Answer
- Care Coordination Support Liaison (CCSL)
- CCO/HH Policy updates
- Life Plan Review
- CCO Enrollment, Disenrollment and Transfer overview
- DDP2

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6

Hot Topic

OPWDD Regional Office Care Coordination Support Liaison (CCSL)

- The CCSLs can provide information and assist with understanding CCO Care Management program requirements
- https://opwdd.ny.gov/opwdd_services_supports/service_coordination/medicaid_service_coordination/contacts

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7

Hot Topic

CCO/Health Home Provider Policy Guidance and Manual update

- CCO/Health Home Provider Policy Guidance and Manual is available at:
  https://opwdd.ny.gov/providers_staff/care_coordination_organizations/providers/cco-manual
- As CCO/HH policies are updated or created, guidance documents will be posted to OPWDD's website in the "CCO/Health Home Policy and Updates" at the above link.
- Currently the following updated information is posted
  - CCO Policy Update Memorandum-September 2018
  - CCO/HH Care Manager Checklist-Revised September 2018

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8

Hot Topic

Policy updates- Checklist requirements

- Completion of the CCO/HH Care Manager Checklist
  - CCO/HH Care Manager Checklist must be completed for all individuals
  - The checklist must be completed face-to-face or via telephone within thirty (30) days of CCO/HH enrollment
  - The checklist assists with identifying and understanding the individual/family's current service needs and planning
  - The checklist assists with educating the individual/family on CCO/HH services
  - Immediate needs must be addressed by the planning team through a coordination of efforts with OPWDD DDROs and the individual's service providers
  - If an individual changes CCOs a new checklist will need to be completed within thirty (30) days of enrollment into the new CCO/HH.
- The updated checklist is available at the following link: https://opwdd.ny.gov/providers_staff/care_coordination_organizations/providers/cco-manual

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9

Hot Topic

Policy Updates

	Completion of Checklist	Finalization of the Life Plan
New individual enrolled after the 1st quarter of launch (October 1, 2018 forward)	30 days	90 days from enrollment in CCO/HH or HCBS Waiver whichever comes first
New individual enrolled during the 1st quarter of launch (July 1, 2018 through Sept 31, 2018)	30 days	120 days from enrollment
Individuals who transitioned from MSC/PCSS on July 1, 2018	No later than October 31, 2018	Annual review date (no later than June 30, 2019)

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10

Hot Topic
Policy Updates

	Completion of Checklist	Finalization of the Life Plan
Individuals in Tier 4 who transitioned from MSC/PCSS on July 1, 2018	No later than October 31, 2018	December 31, 2018
Members of the Willowbrook Class	N/A	March 31, 2019
Life Plan Reviews	N/A	45 days from the review meeting the Life Plan will be signed by the Care Manager and is acknowledged and agreed to by the individual and the provider(s) responsible for implementing the Life Plan
Individual transitioning to a different CCO/HH	A new checklist must be completed within 30 days of enrollment into the new CCO/HH	Annual review date

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11

Hot Topic
Life Plan Review

- The Life Plan reviews must take place at least twice annually
  - The annual review must occur within 365 days of the prior annual review or by the end of the calendar month in which the 365th day occurs
- It is recommended that the Life Plan review occur every six months

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12

Hot Topic
Enrollment

- Enrollment into CCO for a person will be the 1st of the month following all eligibility requirements being met and submitted into CHOICES
  - Enrollment is completed through the CCO enrollment form (CCO1) in CHOICES
  - The LCED Transmittal form with LCED date must be completed for an enrollment to process
  - Enrollments will "pend" until all the enrollment documentation requirements are met
  - Ensure when submitting enrollment forms that the correct care management service the person has consented to is chosen

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13

Hot Topic
Medicaid

- If a person has never received any OPWDD services and is new to Medicaid, the CCO will need to provide the newly established Medicaid information to the appropriate OPWDD Regional staff who will then send this information to the Revenue Support Field Office (RSFO) to be verified and added to the individual's TABS ID.

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14

Hot Topic
Non-Medicaid Case Management

- Individuals who are authorized for State Paid Care Management must be enrolled into the appropriate TABS program code
  - submit a DDP1 in CHOICES
- The roster for Non-Medicaid Case Management is available to the CCOs through the Enrollment Inquiry function in CHOICES

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15

Hot Topic
Choosing a CCO service

- All individuals must receive information in order to make an informed choice about which care management service option is right for them
- Individuals have the choice of HCBS Basic Plans Support Care management or Health Home Care Management
- Individuals have the right to change CCO Care Management service

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16

Hot Topic
Changing CCO

- Care Managers must provide education to individuals about their freedom of choice of available CCO/HH options in their region
- A CCO transfer will be effective on the first day of the next month
- The CCO/HHs involved need to discuss and appropriately plan the timing of the transfer
  - Only one (1) CCO/HH may bill for an individual in a given month.
  - The current CCO/HH along with the individual and/or their family/representative must sign a Withdrawal of Consent Form (DOH-5058) if they are enrolled in Health Home Care Management or for HCBS Basic Plan Support the DDRO verifies disenrollment, generates the NOD and uploads it to CHOICES for CCO monitoring and sends it to the individual/parent/legal guardian/representative
  - The new CCO/HH must obtain a Consent to Enroll Form (DOH-5055 or DOH-5200 & DOH-5201) if they are enrolling in Health Home Care Management or for HCBS Basic Plan Support individuals must sign a "Care Coordination Organization (CCO) Consent for Participation in Basic Home and Community Based (HCBS) Plan Support" form

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17

Hot Topic
Withdrawals

- Withdrawals will "pend" to the end of the month in which the CCO2 was submitted except when:
  - Individual is deceased;
  - Individual is no longer enrolled in Medicaid; or
  - Individual is now permanently residing in an ICF/MR or ICF/DD, a nursing facility or another non-qualifying setting
- DDRO approval is required when:
  - Individual does not meet Level of Care; or
  - individual has chosen to no longer receive any care management from any provider

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18

Hot Topic
Withdrawal Date

- The withdrawal date and reason **must** accurately reflect the date and reason for the withdrawal
- The date must be the **actual** date for the following withdrawal reasons:
  - Individual has died; or
  - Individual is no longer enrolled in Medicaid
- When a person enrolls into a non-qualifying setting the date must be the day **prior** to enrollment and the following reason on the CCO2 is:
  - Individual is now permanently residing in an ICF/MR or ICF/DD, a nursing facility or another non-qualifying setting

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19

Hot Topic
Transfers

- A submitted CCO2 form for a transfer will "pend" to the end of the month it is submitted and the person will be automatically enrolled in the new program code for the 1st of the following month. This will happen for the following instances:
  - Individual is transferring to another program code with in the same CCO; or
  - Individual has chosen to change CCO Care Management Services
- Do not complete a CCO1 in these instances
  - this will create a pending CCO Add that will prevent the CCO2 transfer from processing

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20

Hot Topic
CCO CHOICES Forms

- CHOICES user guides are available at the following link: https://opwdd.ny.gov/opwdd_login/choices
- Each CCO has multiple program codes for;
  - Each DDSO;
  - HCBS Basic Plan Support; and
  - Health Home Care Management services
- CCO staff completing CCO CHOICES Forms **must** carefully review the information prior to submission to ensure that the enrollment, transfer and withdrawal information is accurate
- A pending CCO1 enrollment or CCO2 disenrollment/transfer will prevent any other actions

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21

Hot Topic
DDP2

- In addition to the CCO/HH's comprehensive assessment tool(s), Care Managers must assess every individual using the Developmental Disabilities Profile 2 (DDP2) at least annually, or more frequently if the individual experiences a significant change
- As previously required, the DDP-2 needs to be completed by all HCBS Waiver Providers
  - Within thirty days of when an individual moves to a new program/service
  - Whenever a significant change occurs to an individual's characteristics
  - At least every two years to update a person's capabilities.

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CCO Implementation and Ongoing Activities to Ensure a Successful Transition for Individuals

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Presentation Overview

1. CCO implementation
2. Identification of areas for improvement
3. Actions to ensure ongoing success and commitment made to individuals and families achieved

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CCO IMPLEMENTATION

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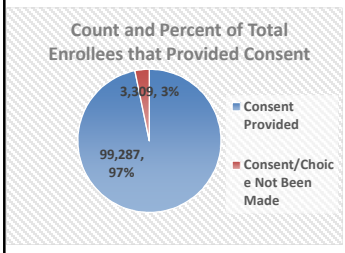
CCO Launch



- 97% of the individuals enrolled in service coordination made a choice to receive Health Home or Basic Plan Support Services on July 1, 2018
- Care managers were unable to reach 3% of the total population leaving those who did not make a selection
- OPWDD pre-assigned these individuals based on affiliate relationship to a CCO to ensure continuity of service
- Since July 1st, this group of individuals have selected a CCO and care management service or confirmed an alternate decision

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Care Manager Outreach and Communication

- Data has been collected and made available to OPWDD Regional Offices to assist individuals and families to identify Care Manager and contact information, where needed
- OPWDD will continue to monitor CCOs to confirm all individuals have a care manager and care manager supervisor

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Face to Face Contact

- In October, letters were sent to each individual without a face to face meeting communicating their care manager name and contact information
- OPWDD is monitoring progress to ensure face to face contacts have occurred for all enrollees

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Care Management Services Delivered

- Care Management Services were provided to over 80% and of individuals enrolled during the month of July
- 90% of individuals received a service in August 2018
- The state continues to monitor data to confirm services are being delivered to individuals

IDENTIFICATION OF AREAS FOR IMPROVEMENT

Stakeholder Partnership Critical

- Input from advocates important and helpful in identifying areas of needed focus
- 37 advocate testimonials received and concerns identified
- The state immediately took action prioritizing;
  - Direct outreach to identifiable advocates / families
  - Expanded data collection and
  - Ongoing monitoring of progress

Summary of Stakeholder Concerns

- Phase 1: Enrollment
  - CCO/ Care Manager Responsiveness
    - Choice of Care Management service
    - Education and outreach
    - Contact
- Phase 2: Implementation
  - Information Technology Challenges
    - Assessment process
    - Life Plan development

State Outreach Activities

- Collected Care Manager notes and supporting documentation confirming Care Management activities
- OPWDD called individuals and families to ensure concerns had been resolved, and where needed, OPWDD assisted in resolution
- OPWDD reached out to CCOs to request immediate action be taken on behalf of families, as appropriate

ACTIONS TO ENSURE ONGOING SUCCESS AND COMMITMENT MADE TO INDIVIDUALS AND FAMILIES ACHIEVED

Statewide Actions Items

1. CCO phone systems in place to ensure individuals and families can reach a live person
2. CCO organizational charts posted with regional Care Managers contacts
3. State/CCO weekly call to monitor ongoing activities
4. Individual and family standardized concern log in place at each OPWDD Regional Office for ongoing further analysis and resolution

CCO Monitoring & Facilitation

- Ongoing CCO reporting
  - Care manager and supervisor assignment
  - Completion of assessment and Life Plan development
  - Case load sizes
  - Service authorizations for new individuals
- Two focuses
  1. Customer service and
  2. Information technology
     - OPWDD has hired technician to facilitate the resolution of information technology issues
     - Progress has been made – care managers are completing assessments and Life Plans have been completed

Discussion & Questions

Developmental Disabilities Regional Office (DDRO)
Service Authorization Process

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TOPICS

Review Service Authorization Process Flow

- New to Waiver services - **Request for Service Authorization**
- Existing Individuals **Service Amendment Request Form**
- Identifying **Services for Transitioned Individuals for Life Plan Review**
- Review of documentation expectations for Service Authorization
- Discussion/Questions

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Individuals New to Waiver Services

- Front Door Process
  - Front Door Process Map
- Front Door staff will be reviewing:
  - DDP2
  - Front Door conversation/information gathering
  - Information from an in-process Life Plan
  - Request for Service Authorization (RSA) form
  - Supporting Documents

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Individuals New to Waiver Service
In Process Life Plan

- Care managers will submit in process Life Plan to the Front Door
  - Sections I is a primary focus
  - Other sections also reviewed and used
- Section I – "Assessment Narrative Summary" of the Life Plan
  - Contains information about the individual's needs and goals
  - CM should provide details that will support the need for services being requested
  - Information about the individual's current situation, goals, assistance needed and in what way

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Individuals New to Waiver Service
Request for Service Authorization

- Care manager submit RSA that identifies specific waiver service(s) and units.
- RSA must include a short explanation of the need for each service requested.
- Refer in this section to specific parts of the Life Plan and/or specific sections of other previously submitted documents (e.g. psycho-social, medical etc.) that will justify the service request

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Individuals New to Waiver Service
Request for Service Authorization

- Documents referenced should have been uploaded into CHOICES
- Care Manager (CM) Sends an alert to the DDRO district-specific "CCO Alert" mailbox informing district there are documents awaiting review

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Individuals New to Waiver Service
Front Door Actions

- Review of RSA, DDP2, Life Plan and any other documentation submitted for service authorization
- Authorize services and/or request additional information
- Ensure completed waiver documents have been submitted
- Distribute Service Authorization Letter (SAL), Waiver Notice Of Decision (NOD) and next step guidance document to individual and CM
- Upload SAL and Waiver NOD into CHOICES

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Review of Front Door (FD) Service Authorization Process For Existing Individuals

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Service Authorization Existing Individuals

- Individuals changing or adding services use the Service Amendment process and Service Amendment Request Form (SARF)
- CMs should provide updated Life Plan identifying need for new service, SARF is filled out by the care manager in consultation with the individual and family, and sent to the Regional Office
- DDRO is alerted through CCO Alert email box
- For new services, CM advises providers to submit a DDP1 and a DDP1 Supplement into CHOICES
- For changes in existing services, CM advises providers to submit a DDP1 Supplement only

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Service Authorization Existing Individuals

- DDRO staff review SARF, amended Life Plan and any other documentation submitted for service amendment request
- Authorize services and/or request additional information
- Upload SARF into CHOICES

SERVICES TO BE LISTED IN LIFE PLAN FOR TRANSITIONED INDIVIDUALS Individualized Service Plans (ISPs) are being converted to Life Plans

Converting ISPs to Life Plans

- CM can confirm existing authorized services of individual by:
  - Review of existing ISP provided by MSC at the time of transition; OR
  - Look in individual's Supporting Documents in CHOICES for ISP; OR
  - contact the original MSC agency that produced the ISP; OR
  - ask individual/family for their copy of ISP; OR
  - look at the Service Authorization Letters (SAL) in individual's Supporting Documents in CHOICES (the SAL may not reflect amended services

Converting ISPs to Life Plans

If needed, CM can confirm enrolled and active services of individual by doing a CR4 TABS inquiry in CHOICES:

- in Choices select "individual" tab at the top of the screen
- hover cursor on the dropdown arrow next to the individual's name and a new task bar shows up below
- Select "TABS inquiry
- On the next screen for "Choose an Inquiry" select "individual"

Converting ISPs to Life Plans

- press the "open PDF" button
- "Do you want to open or save this inquiry" – choose open
- CR4 form lists active Waiver and non-Waiver services
- Also provides "Other Historical Info" (service changes)

Converting ISPs to Life Plans

- CM Creates or updates Life Plan to accurately reflect services being received

Discussion & Questions

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The Staff Action Plan and Delivery of Habilitation Services for Care Managers/Care Coordination Organizations

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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 of the Life Planning Process.

View the Webinar: https://youtu.be/d0uzboNE5U4

PowerPoint: People First Care Coordination Informational Session 20

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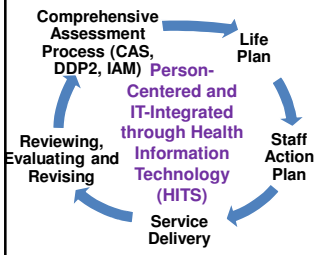
Review of the Life Planning Process Cycle

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.

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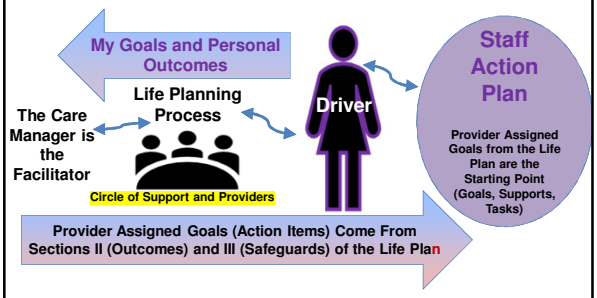
It's A Collaborative Team Process Driven by the Person



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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 as soon as possible to facilitate accurate and timely development of the Staff Action Plan.

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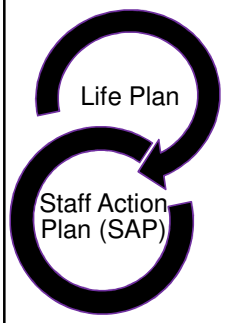
Flow Between the Life Plan and Staff Action Plan (SAP)



- 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/Supports)
- The Staff Action plan fills in further details on how the Provider Assigned Goals/Staff Actions/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.

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Habilitation Services and Staff Action Plans

What are Habilitation Services?

A Staff Action Plan is required for each habilitation service received by the person.

- 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.
- Habilitation Services are:
  - ✓**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).**

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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
- . If additional detail on safeguards is located in another document, the Staff Action Plan must reference the location of the additional detail, for example: Plan of Nursing Care, Behavior Support Plans etc.

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.

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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.

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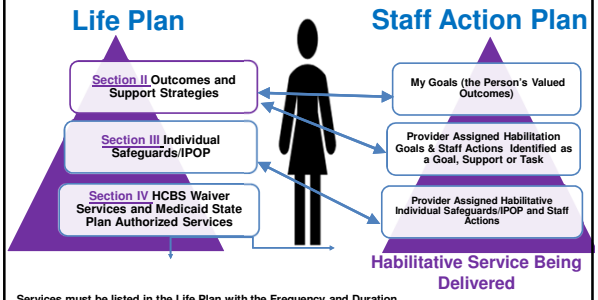
Connecting Points



Services must be listed in the Life Plan with the Frequency and Duration as stated in each Service Related ADM.

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

Life Plan

Goals Assigned to Providers

Staff Action Plans Developed

- **POM Goal Area (1 of the 21 POMs)**: People have the best possible health
- **Person's Goal/Valued Outcome:** I want to lose weight so I can feel better
- **Provider Assigned Goal: Provide Exercise Program (Starting point for the Staff Action Plan)**

Life Plan

- (S) **Provide Exercise Program (Provider Assigned Goal)**
- Staff Action: 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.

Staff Action Plan

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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.
- Not habilitative in nature so will not be billable (e.g., Cut crusts off the bread when you make my sandwich. Make sure to schedule the trip I want to go on).

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Habilitation Services and Provider Assigned Goals/Action Steps

- Every **Habilitation Service** must have at least one valued outcome from the Life Plan.
- Every Person's **Life Plan** must have at least **two POMs** that will be worked on and at least **three valued outcomes that will be worked on (with corresponding Provider Assigned Goals)**.
  - These Provider Assigned Goals/Actions can be Goals (G) or Supports (S) if related to the Person's Valued Outcomes.
- A Provider Assigned Goal/Action Step in Section II and III **can be assigned to multiple Providers** to reinforce the goal/support across all of the person's services and settings.
- **Safeguard areas** should typically **be assigned to multiple Providers** to ensure a holistic approach across settings.

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

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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	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 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 the best possible health	**I want to lose weight so I can feel better**	(S) Provide Exercise Program	**Day Habilitation**	Weekly	3	Ongoing

EXAMPLE FROM LP TEMPLATE: SECTION III
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 Definition	The Person's individually defined goal/valued outcome that relates to a POM area.	**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 would like to communicate better	(S) Provide Speech Therapy	Provider Agency	Day Habilitation	Weekly	3	Ongoing
Ex. 2	I want to improve or maintain my work skills	(G) Teach work skills	Provider Agency	Day Habilitation	Weekly	2	Ongoing

LP Section IV HCBS Waiver and Medicaid State Plan Services

Authorized Service	Provider/Facility	Effective Dates	Qty	Unit	Per	Total Units *
The HCBS Waiver Category of Service	The Provider Agency	The Duration of the Life Plan	**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**	**365**	**Day**	**Year**	**365**
Day Habilitation	**Onward Bound Inc.**	**7/1/2018-6/30/2019**	**220**	**Day**	**Year**	**220**

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 may enter a requested number of total units and later 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 will not expire**. The LP and services will remain in effect until a new LP is written or until the person leaves services or services are modified.
- Only **Habilitation Services require a Goal/Valued** Outcome/Provider Assigned Goals for Section II and Section III of the LP. (Remember that all Life Plans require at least 2 POMs and 3 Valued Outcomes).

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" will be included for the name of the Provider.
- It is important to ensure that the Life Plan is updated with the correct Provider once an Agency is identified to deliver the service.

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" (in "Duration" field or in the Comments if the Duration field was not 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 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 approach as all other HCBS Services in the Life Plan

Staff Action Plan Safeguards/POP

- 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 is 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** provides the **detail** on how the Safeguards will be implemented.
- Section III Individual Safeguards/IPOP includes a space for special considerations that allows for additional information.

Strategies for Service Delivery Documented in the Staff Action Plan

- 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.

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Strategies for Service Delivery: The Staff Action Plan 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
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.

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Staff Action Plan– Example 1

Life Plan/Person's Goal/Valued Outcome

- **My Goal/Valued Outcome from the Life Plan:** "I want to lose some weight so I can feel better"

Provider Assigned Goal

- (S) Provide Exercise Program

Staff Action Plans Developed

- **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.

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The Staff Action Plan Must Include:

- **My Goal/Valued Outcome from Section II of the Life Plan =** "I want to lose weight so I can feel better"
- **Provider Assigned Goal/Support from Section II 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.

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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"

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Staff Action Plan- Example 2

In Life Plan--
My Goal/Valued Outcome
I want to live more independently in the community in my own place

→

Provider Assigned Goal for Residential Habilitation in the Life Plan
(G) Teach person to navigate public transportation

Staff Actions for the Staff Action Plan
My Residential Habilitation Staff will teach me to navigate public transportation (G)

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Staff Action Plan for Provider Assigned Goal "Teach the Person to Navigate Public Transportation"

The Staff Action Plan Includes:

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

"I want to live more independently in the community in my own place"

2. Provider Assigned Hab Goal and Staff Action

Hab Goal—"Teach Person to navigate 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)

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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.

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Staff Action Plan Safeguard - Example 3

In Life Plan--
My Goal/Valued Outcome
I want to live more independently in the community in my own place

Provider Assigned Goal for Residential Habilitation in the Life Plan
(S) Provide supervision in unfamiliar places—Remember my communication system

Residential Habilitation Staff Action Plan
My Staff will provide supervision by keeping me in their visual field when I am in unfamiliar places and will prompt me to remember my communication system.

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Staff Action Plan Detail on Safeguard: "Provide supervision in unfamiliar places"

- My Staff will provide supervision to me when we are in unfamiliar places by keeping me in their visual field and prompting me to use my communication device. My staff will stay behind me so I can take the lead and will only intervene when I need it so that I can learn to be more independent in unfamiliar places.

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.

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 improvement in behavior or physical functioning

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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

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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.**

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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;
- 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

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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

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Questions and Answers

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Contact Information for Additional Questions

Peoplefirstwaiver@opwdd.ny.gov

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Appendix—Supplemental Services Chart

Resource for Listing Services in Section IV of the Life Plan

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How Services Should be Listed in the Life Plan Section IV

Service	Frequency	Duration	Source
Site Based Prevocational	Day	"Ongoing as Authorized"	ADM 2017-03
Community Based Prevocational Services	Hour or Hourly	"Ongoing as authorized"	ADM 2017-03
Supported Employment (SEMP)	Hour or Hourly	"Ongoing as authorized"	ADM 2016-01
Pathway to Employment	Hour or Hourly	Time limited	ADM 2015-07
Community Habilitation	Hour	"ongoing"	ADM 2015-01
Residential Habilitation – Supervised *(only for Res Hab delivered in Supervised IRAs and CRs).*	Day or Daily	Ongoing	ADM 2014-01

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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	Not specified in ADM but suggest using "ongoing"	ADM 2002-01
Residential Habilitation-Family Care	Day or Daily	Ongoing	ADM 2006-04
Day Habilitation	"A Day"	Ongoing	ADM 2006-01
Respite	Hour or Hourly	Ongoing	ADM 2017-01
Support Brokerage or Support Broker	Hourly	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

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Life Plan Template Instructions—Supplemental Services Chart V2.

Service	Frequency	Duration	Notes
Intensive Behavioral Services or IB Services	"Plan/Hourly" (*ADM states since there are two components of the service it is important to list accurately"*)	Time Limited	
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	

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How Should Fiscal Intermediary Services and Support Brokerage be listed in the Life Plan?

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LP Section IV Self-Directed Services Listing Examples

Authorized Service	Provider/ Facility	Effective Dates	Qty	Unit = "Frequency" from ADM	Per	Duration	Total Units *	Comments
Fiscal Intermediary (FI)	ABC Inc.	Same as LP unless new service	12	Month	Year	Ongoing	0	"Per approved Self-Direction Budget"
Support Brokerage	ABC Inc.	""	As Needed	Hourly	Authorization	Ongoing	0	"Per approved Self-Direction Budget"
Community Transition Services	ABC Inc.	""	1	One-time expenditure	Authorization	One-time expenditure	0	
Individual Directed Goods and Services	ABC Inc.	""	As needed	Day	Authorization	Ongoing	0	"Per approved Self-Direction Budget"

NOTES: Valued Outcomes/Provider Assigned Goals are not required to be associated with these services as they are not Habilitative services. Self-Direction Services that are not Agency Supported or Direct Provider Purchased would list the FI as the Provider. For services in a SD Budget, the CM must include "Per approved SD Budget" in the Comments field.

Self-Directed Listing Examples for Section IV of the Life Plan

If there are any issues in getting the correct information into the correct fields, the CM can include that information in the Comments section.

For example, the ADM Frequency for FI may not yet be available in the drop down menu under the "Unit" field. The CM would then insert the following into the Comments field, " The Frequency for FI services is Monthly"

Surrogate Decision Making Committee (SDMC) and Informed Consent Overview

Topics

- What is the SDMC program?
- The Declaration to The Hearing
- SDMC Hearing Overview

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What is the SDMC Program?

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SDMC Overview

- Alternative to the court system
- Provides informed consent for service recipients who lack the capacity to make medical decisions
- No legally authorized decision-maker or family member to make the decision for them

Mental Hygiene Law Article 80

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SDMC Overview *cont'd*

- Receive and process cases from declarants and work to ensure paperwork is complete
- 6 contract agencies across the state
- 4 trained volunteers attend the hearing and make the determination
- Due process rights are recognized with appropriate notifications

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Advantages of SDMC

- Cost free alternative to the court system
- Timely access to health care
- Inclusion of the individual and family
- Due process rights are recognized with appropriate notifications

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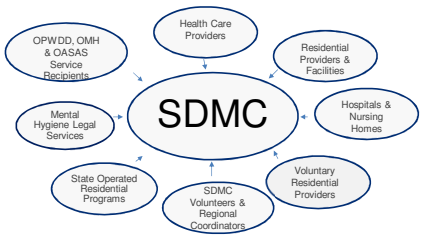
Stakeholders



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Major Medical Treatments

- Treatments with a significant risk
- Use of anesthesia; i.e. IV, monitored or general
- Significant invasion of bodily integrity requiring an incision or producing pain
- Treatment/procedure for which informed consent is required
- Chemotherapy
- Hospice

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End of Life Care Decisions

Only for Persons with an Intellectual (ID) or Developmental Disability (DD)

- SDMC is authorized to make the decision to withdraw or withhold life sustaining treatment
- Includes Do Not Resuscitate(DNR)/Do Not Intubate(DNI)

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SDMC Decision Process Excludes

- Routine treatment or diagnostic tests
- Emergency treatment
- Dental care performed under a local anesthetic
- Electroconvulsive Therapy (ECT)
- Sterilization or termination of pregnancy

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The Declaration to the Hearing

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SDMC Process

A person with an intellectual or developmental disability is in need of a medical procedure or treatment and lacks capacity to provide his own consent

→ Is there a legally authorized person to provide consent on this person's behalf?

→ If no decision-maker, SDMC is an option

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SDMC Process *cont'd*

1. The Declarant coordinates the completion of the forms
2. Declaration is sent to SDMC
3. SDMC processes the case
4. Case is sent to regional coordinator for the hearing
5. Hearing is held
6. Decision is issued

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Declaration Forms for Medical Procedures

Declaration for Surrogate Decision-Making (SDMC Form 200)
Completed by the Declarant*

Certification on Capacity (SDMC Form 210)
Completed by the Licensed Psychologist or Psychiatrist

Certification of Medical Need (SDMC Form 220-A)
Completed by the Physician

Related Medical Information (SDMC Form 220-A)

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SDMC Hearing Overview

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SDMC Hearing

- The individual always attends the hearing
- Hearing is held where it is convenient for the patient and staff to attend
- Testimony by residential staff
- Mental Hygiene Legal Services (MHLS) represents the patient
- Regional SDMC Coordinator
- 4 SDMC Volunteer Panel Members will make the decision

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Three Decisions

1. Capacity
- Does this person have the capacity to understand the risks, benefits, and alternatives to this medical procedure?

2. Legally Authorized Surrogate
- Is there a legally authorized, willing, and available surrogate who can make this decision?

3. Best Interests
- Is this procedure in the best interests of this individual?

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SDMC Resources

- SDMC Mock Hearing Video
https://www.youtube.com/watch?v=v4tyXAnPFKk&feature=youtu.be
- Online training modules
- Guidance Documents
- Webinar training
- Sample forms

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Contact Information

SDMC Phone: 518-549-0328
SDMC Fax: 518-549-0460

sdmc@justicecenter.ny.gov

http://www.justicecenter.ny.gov/services-supports/sdmc

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Discussion & Questions

Next Years Conference

- Will be held via WebEx only
- A survey will be conducted after conferences, OPWDD would like feedback regarding what you want to hear at future conferences

Thank you

for attending, the next Conference will be scheduled for
March 2019

Registration for these conferences can be done through SLMS, please check the SLMS website to register.
https://opwdd.ny.gov/opwdd_careers_training/training_opportunities/slms

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Guidance for Usage of the OPWDD DDRO Specific CCO Alerts Email Boxes

To promote easy communication between CCOs and OPWDD Regional Offices Front Door, electronic Alert mailboxes have been created for use by the CCOs. The email boxes are to be used to alert DDRO districts of document(s) uploaded into CHOICES waiting for review, and to submit specific forms for processing. The email box addresses have a standard format, with the district name being the only distinguishing difference.

The forms* CCOs should submit to the CCO Alert email boxes for processing are:

- Request for TABS ID and Transmittal Form for Determination of Developmental Disability; and
- Service Amendment Request Form (SARF).

The SARF is fillable and can be electronically signed.

* **Only these two forms are to be submitted to the CCO Alert email. Supporting documents are uploaded into CHOICES.**

CCO Alert emails are required to:

- Alert the specific DDRO of the supporting document(s) that have been uploaded into CHOICES awaiting DDRO action, and/or
- Submit any of the two forms mentioned above for DDRO processing *via CCO Alert email*.

Email Alert Types:

- *Eligibility*- Supporting Documents for OPWDD Eligibility Determination
- *Level of Care Determination (LCED)*- Documents and forms
- *Waiver Forms* – Application for Participation and Documentation of Choice
- *Request for Service Authorization- RSA and supporting documents* -Life Plan or Alternative Documents
- *Notice of Decision* – CCO enrollment
- *Notice of Decision* – CCO disenrollment/transfer

Email Form Types:

- *Request for TABS ID Form*
- *Service Amendment Request Form (SARF)***

Email Requirements for CCO submission to CCO alert mailboxes:

- Identify the correct district to send alert/form via the district specific email box
- In the subject line of email, use the required format
  - Required information:
    - Individual's First Name, First Initial of Last Name, TABS ID, Type of Form
      - Ex., Ronald J. TABS ID 123045 Eligibility Determination
      - Ex., Ronald J. TABS ID 123045 LCED
      - Ex., Ronald J. TABS ID Request
      - Ex., Ronald J. TABS ID 123045 RSA
      - Ex., Ronald J. TABS ID 123045 SARF
      - Ex., Ronald J. TABS ID 123045 Waiver Forms
- **In case there are questions regarding the documents relating to the alert or form submission, please include the name of the person to contact in the body of the email.**
  - **Ex., Contact Information: Jane Doe, Intake Worker, ACA CCO 518.369.3693 Jdoe@ACA.com**

The OPWDD Regional Office DDRO Actions:

- Reviews the CCO Alerts email box at least daily, and notifies the appropriate recipient.
- Staff processes the electronically submitted form, and
- Uploads completed electronically signed form to individual's record in CHOICES.

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REGION	DISTRICT	EMAIL ADDRESS
1	Finger Lakes	opwdd.sm.ccoalertFingerLakes@opwdd.ny.gov
1	Western	opwdd.sm.ccoalertWesternNY@opwdd.ny.gov
2	Broome	opwdd.sm.ccoalertBroome@opwdd.ny.gov
2	Central NY	opwdd.sm.ccoalertCentralNewYork@opwdd.ny.gov
2	Sunmount	opwdd.sm.ccoalertSunmount@opwdd.ny.gov
3	Capital	opwdd.sm.ccoalertCapitalDistrict@opwdd.ny.gov
3	Hudson Valley	opwdd.sm.ccoalertHudsonValley@opwdd.ny.gov
3	Taconic	opwdd.sm.ccoalertTaconic@opwdd.ny.gov
4	Bernard Fineson-Queens	opwdd.sm.ccoalertBernardFineson@opwdd.ny.gov
4	Brooklyn	opwdd.sm.ccoalertBrooklyn@opwdd.ny.gov
4	Metro-Manhattan	opwdd.sm.ccoalertMetroManhattan@opwdd.ny.gov
4	Metro-Bronx	opwdd.sm.ccoalertMetroBronx@opwdd.ny.gov
4	Staten Island	opwdd.sm.ccoalertStatenIsland@opwdd.ny.gov
5	Long Island	opwdd.sm.ccoalertLongIsland@opwdd.ny.gov

****Instructions to electronically sign and send the Service Amendment Request Form (SARF) for processing.**

CCO Actions

- CCO Care Manager electronically signs SARF on page 8. [Electronic signature must be created and authenticated before first time use].
- When the electronic signature is requested you must "save as" before your signature will appear on the SARF. This process keeps the form "live" allowing the DDRO to sign electronically.
- Care Manager emails electronically signed SARF as an **attachment** to the DDRO CCO email Alerts mailbox for review and processing by the DDRO.

DO NOT print and scan the electronically signed form to send it. Only hand signed forms are to be printed, scanned and sent via email Alerts mailbox.

DDRO Actions

- DDRO receives the electronically signed SARF. The request is reviewed, processed and the form is electronically signed by the DDRO on page 9.
- DDRO saves the two party (CM and DDRO) signed form as a PDF making it non-editable- "dead document" by:
  - Go to File- Select Print
  - Go to the Printer Drop Down box and select = Adobe PDF or Cute PDF Writer
  - Select Print to Adobe PDF or Cute PDF Writer
  - Rename document using CHOICES Naming Convention
- Upload SARF to individual's supporting documents in CHOICES.
- Notify Care Manager via email that document has been processed.

The hand signed SARF should be scanned and submitted to the Email Alert mailbox for processing. DDRO will process, sign and upload form to individual's supporting documents.

The CCO Alert email boxes should only be used for the above topics. If you have any questions, please contact your DDRO.