People First Care Manager & Provider Information Session
Info Session Updates
2nd and 4th Wednesdays of Each Month at 12 Noon

• Session 1– January 23, 2019
  – Care Coordination Organization (CCO) and Provider Collaboration on the Life Plan

• Session 2- February 13, 2019
  – Quality of the Life Plan

• In lieu of Info Sessions on these dates we encourage attendance at:
  – February 27, 2019- Overview of Service for Willowbrook Class Members”
  – March 13, 2019- Quarterly Care Managers Conference

For viewing of or registration for the Care Manager and Provider Info sessions go to the OPWDD website at:

https://opwdd.ny.gov/providers_staff/care_coordination_organizations/msc_webinars
Care Manager and Provider Information Sessions

CCO
Care Manager and Provider Collaboration on the Life Plan (LP)

Kate Bishop
Division of Person Centered Supports
OPWDD
The Life Planning Process requires full team collaboration and Person-Centered Planning (PCP) as the driving force!

Comprehensive Assessment Process (CAS, DDP2, IAM) → Collaborative Life Plan development

Person-Centered and IT-Integrated through Health Information Technology (HITS)

Review, Evaluate and Revise

Staff Action Plan (SAP) → Service Delivery

The Life Plan development is driven by the person with input and participation of all members of the care planning team.

It is crucial that all members of the care planning team are included, engaged and working together towards the ultimate outcome of a comprehensive person-centered service plan that meets the needs, overarching safeguards and life goals of the person.
Life Plan and Staff Action Plan timeframes are extended to support person-centered Life Plan and Staff Action Plan development.

By December 31, 2019 all individuals will have a Life Plan.

By March 1, 2020 all individuals will have a Staff Action Plan.

A Life Plan must be developed for individuals new to services.

Even with the extended timeframes, Life Plans should be done as soon as possible.
Flow Between the Life Plan and the SAP

**Life Plan**
- The person is the driver, not the technology
- The Care Manager is the facilitator/coordinator of the process
- The Life Plan is the overarching and active document defining the person’s goals/value outcomes and needed safeguards
- It’s a team process to arrive at an accurate and comprehensive plan that is the person’s blueprint
- Technology assists the Person-centered Process, it does not replace it

**SAP**
- SAP is derived from the Life Plan
- The broad strokes of what the provider will do to help the person achieve his/her goals has already been determined through the Life Plan meeting(s)/process (provider assigned goals/actions)
- SAP 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; and exploration of new experiences) for what staff must do and how they will do it
Life Plan participation and agreement by the providers responsible for implementing the plan is a key requirement

• A final LP requires the agreement of the person and the major service providers that must implement the LP or it can not be considered final

• This is even more important now than previously because the LP contains specificity about what providers are expected to deliver on with the development of services/supports – i.e., the provider assigned goals (their frequency and timeframe) that are the starting point for development of a Staff Action Plan
Person-Centered Planning Process

As described in 14 NYCRR Part 636-1.2 the person-centered planning process includes “developing strategies that address conflicts or disagreements in the person-centered planning process, including clear conflict of interest guidelines for individuals, and communicating such strategies to the individual who is receiving services as appropriate”
Disagreements in the Person-Centered Planning Process

In order to achieve person-centered resolution in situations where there are conflicts or disagreements with the development and implementation of the Life Plan, the Care Manager (CM) and providers need to collaborate to find solutions with the care planning team and or through the policies for resolution developed by the involved organization.
Collaboration to Reach a Person Centered Resolution

- Care Planning Team Members
- Training, Compliance Agency Counsel staff
- CCO and Provider Leadership
- Supervisors
Life Plan Collaboration Expectations–Some Quality Check Points for the CM

• The person is included in the Life Plan process and is the driver to the extent he/she desires

• All major providers that must implement the Life Plan are included in the Life Plan meeting(s)/process

• The person and all major service providers understand and agree to what is being assigned to them prior to the end of the Life Plan meeting (including frequency-how often the provider assigned goals will be delivered)
Life Plan Collaboration Expectations—
Some Quality Check Points for the CM

• The number of goals and supports in Section II and III makes sense in light of the supports and services that will be delivered--there are not too many or too few goals/supports
  - If too many, there is a prioritization discussion with the person/team and goals/supports are edited based on that discussion
  - If there are too few, there is a discussion about other things the provider is working on with the person or whether the person actually has a need for the services/supports

The LP must comprehensively and accurately address the person’s needs, safeguards, and meaningful goals/outcomes. The Life Plan helps to establish whether there is a need for the authorized services in Section IV
Life Plan Agreement—the Dos and Don’ts for Care Managers

Do!
Problem-solve and resolve the issue(s) when a provider (or another member of the Circle of Support) indicates that the Life Plan isn’t accurate or reflective of the person’s goals/needs

No—Don’t!
Don’t tell a member of the Circle of Support or a provider that the Life Plan can’t be changed once finalized if something inaccurate is brought to the CM’s attention
LP Agreement and IAM Assessment —
the Dos and Don’ts for Care Managers

• **Do!**
Work on the IAM Assessment prior to the LP meeting to try to complete as much information as possible from applicable sources.

• **Do!**
Plan to review and amend the output of the IAM Assessment—the goals/supports in Section II and III— with the person and planning team during the Life Plan meeting. Edit and prioritize as needed.

• **No, Don’t!**
Start filling out the IAM Assessment in its entirety during the Life Plan Meeting.

• **No, Don’t!**
Just accept and finalize a Life Plan without review, amendment and prioritization of goal/support output from the IAM Assessment AND agreement/acknowledgement from the providers responsible for implementing the plan.

The IAM Assessment output is only a starting point.
Life Plan Agreement and IAM Assessment — the Dos for Care Managers

• **Do!**
  Edit the Life Plan to ensure that what populates to the Life Plan from the IAM assessment is accurate and relevant and that the Life Plan is understandable by all that read it

• **Do!**
  Request and invite the care planning team to participate and provide feedback on the development of the Life Plan

• **Do!**
  Ensure the appropriate provider representatives are the ones that agree to and acknowledge the Life Plan for finalization
LP Agreement—Do’s and Don’ts for Providers

• **Do!**
  Bring to the attention of the CM if the Life Plan is not reflective of the person’s needs/safeguards and goals

• **Do!**
  Work through needed changes with the person, CM, and applicable Circle of Support.
  If working through the CM doesn’t help, go up the CCO chain of command to resolve issues

• **Don’t!**
  Refuse to agree/sign the LP due to concerns over whether a Provider Assigned Goal should be listed as a Goal(G) or Support(S).

• **Don’t!**
  Threaten to discontinue services to the person over LP disagreements.

• **Don’t!**
  Go directly to OPWDD with individual Life Plan concerns/issues without trying to work through them with the CM and CCO chain of command.
Life Plan Agreement—the Dos the Don’ts for Providers

• **Do!**
  If necessary, be as specific as possible and follow up in writing about the changes needed to the Life Plan and how they are related to accurately and comprehensively reflecting the person’s needs, goals and safeguards

• **Don’t!**
  Don’t expect or mandate the CM to include in the Life Plan all the same goals/supports that were previously included in the person’s Habilitation Plan just to ensure billing/staff convenience
Life Plan Agreement Expectations – CCOs and Care Managers

- CCOs need to establish and implement processes and training tools for addressing updates and corrections to the Life Plan to ensure the Life Plan comprehensively captures the person’s needs and goals.
- CCOs need to have an internal process through the organization’s chain of command to address Life Plan areas of disagreement if the Care Manager cannot resolve them themselves.
- The Developmental Disabilities Regional Office (DDRO) is the last resort to be consulted when the disagreement cannot be resolved between the provider and the CM chain of command.
Expectations for CCOs and Care Managers

- CCOs need to ensure that CMs understand how to effectively facilitate a Life Plan meeting including developing consensus about provider assigned goals, frequency and timeframes; Review, amend and prioritize IAM output
- CCOs should ensure CMs are receiving proper training on person-centered planning and Life Plan development to develop a meaningful Life Plan for all individuals served
- Standard operating protocols should be developed by CCOs
Expectations for Providers

• Train staff responsible for attending Life Plan meetings and developing Staff Action Plans

• Processes for disagreement—work through CM/chain of command and involve provider chain of command when necessary

• Understand that everyone is experiencing a learning curve with the transition to an electronic person centered service plan and health information technology
Remember!
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

• The planning team needs to establish and develop the 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
Thank you – Questions?
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