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

• Sessions 1
  – Posted on the OPWDD Website.
• Session 2- February 20, 2019
  – Life Plan Quality: The “Big Picture” Perspective
• 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
    • Self-Direction, START, LCED Recertification and more.

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

Life Plan Quality: The “Big Picture” Perspective
“Here’s a list of 100,000 warehouses full of data. I’d like you to condense them down to one meaningful warehouse.”
Top Big Picture Quality Checks for Care Managers (CM)

What is ”The Big Picture”?

The “Big Picture” means:

- “Overall view, master plan, essence”.
- The broad overall view or perspective.

The Life Plan is:

- The person’s blue print/master plan for who they are, what they need, and what they want to achieve.
- How services/supports will be deployed to help them.
True Person-Centered Planning (PCP) is the Key to the Life Plan

One of the functions of the PCP process is to work together with the person and support team to develop innovative and non-traditional ways to meet the person’s needs, hopes, dreams and goals.

Uses a combination of paid and unpaid supports and strategies and community/other resources.

Person’s goals should not be restricted to easily identified services/supports.

Source: Administration for Community Living (ACL Guidance on PCP in Home and Community Based Programs, June 2014)
The Big Picture Quality Checks for Care Managers (CM) and Supervisors

1. The person drives the life planning process;
2. The life planning process is collaborative;
3. The Life Plan (LP) comprehensively and accurately reflects who the person is;
4. The LP documents the person’s overarching health and safety needs/supports; concerns and risks; and mitigating strategies;
5. The LP is understandable to all parties and is actionable so progress and goal achievement can be monitored;
6. The LP is informed by/based on required assessments and other needed information or documentation about the person; and,
7. The LP includes all supports/services both paid and unpaid.
Quality Check # 1

The Person Drives the Life Planning Process to the Extent he/she Desires

Care Manager (CM) responsibilities for this include but are not limited to:

- Facilitating support for the person
- Providing/facilitating informed choice
- Ensuring the people who are important to the person and major service providers are included
Division of Quality Improvement (DQI) Person-Centered Review (PCR) Tool Questions

- 1-4: “The person’s planning meetings are scheduled at times/locations convenient for the person”;
- 1-5: “The individual is supported to direct the planning process to the maximum extent possible and desired”;
- 1-2: “The individual’s planning process/planning meetings include people chosen by and important to the individual”;
- 1-7: “The individual is provided information and education to make informed choices related to services and supports; the settings for those services, and service providers”;
- 1-28: LP written in plain language/accessible to person and parties responsible for implementation;
- 1-29: LP signed by person indicating their approval/informed consent;
- 1-34: Person is informed that they can request a change to the Plan and understands how to do so.
Quality Check # 2 Collaboration

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
# 2 Continued:
Collaboration Evidenced by;

- All major providers that must implement the Life Plan are included;
- 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);

- 1-3: Participation and input from required parties;
- 1-6: “Conflicts, disagreements, and conflict-of-interest are appropriately addressed during the individual’s planning process”; and,
- 1-30: “The individual’s person centered service plan is agreed to by service providers and/or members of the team as required”.

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Quality Check # 3
The LP Comprehensively & Accurately Represents Who the Person is and his/her Informed Choices

- The LP narrative describes who the person is;
- The reader can tell what the person’s hopes and dreams are;
- LP conveys goals that are meaningful to the person;
- Person’s strengths and preferences are clearly documented;
- Person’s need for supports/services comes across through the LP;
- Key outcome areas are discussed/addressed: residential, work, community activities; relationships; etc.
# 3 Continued: The Plan Documents;

- 1-13: Clinical and/or functional supports;
- 1-12: Strengths and preferences;
- 1-15: Priorities/interests for meaningful community activities including desired frequency and supports needed to participate;
- 1-17: Goals/priorities/interests for meaningful work, volunteer, and recreational activities;
- 1-11: Goals and desired outcomes;
- 1-14: Cultural/religious and other personalized associational interests/preferences;
- 1-16: Goals/priorities for meaningful relationships;
- 1-9: Person’s informed choice of residential setting and consideration of alternatives; and,
- 1-26: Person’s informed choice on whether or not to self-direct services.
Quality Check # 4: The LP Documents the Person’s Overarching Health and Safety Needs/Supports

- As part of the LP process, Care Managers and Providers work together to ensure that all health and safety needs across service settings are considered and addressed in the LP;

- The collaborative LP process identifies risks while considering the person’s right to assume a degree of personal risk.
  - The LP includes strategies to reduce risks and/or identify alternate ways for the person to achieve meaningful goals.
#4 Continued:
The LP Documents Overarching Health and Safety

- 1-18: Person’s goals/priorities related to health concerns and medical needs;
- 1-19: Food, medication, and/or environmental allergies and corresponding precautions;
- 1-20: Individualized considerations regarding fire safety;
- 1-22: Risks and strategies to minimize including back-up plans

- 1-21: Person-centered planning and the LP allow for acceptance of risk in support of the person’s desired outcomes when balanced with conscientious discussion and proportionate safeguards and risk mitigation strategies
Remember that rights restrictions must be justified by a specific individualized assessed need and documented in the PCP process/plan.
Quality Check # 5
Plan is Understandable to All Parties and Can be Acted On and Monitored

- CMs roles/responsibilities include implementing and monitoring the LP;
- This includes monitoring progress to achieve identified goals so that action is taken when necessary to adjust the LP;
- For example, PCP Review #2a-20 “The CM monitors that the individual is linked to and receiving the services/supports he/she wants and that the services are helping the individual to attain his/her valued outcomes and life goals”.

NEW YORK Office for People With Developmental Disabilities
A reasonable number of meaningful goals that can be acted on by the person and his/her paid and unpaid service/support providers during the LP period:

-- Section II, Outcomes and Support Strategies requires 2 CQL POM areas and 3 of the person’s my goals/valued outcomes

-- Goals should be prioritized if there are too many and the prioritization discussed/documented in the LP
# 5 Continued:

1-36 of PCP Review

- Review of the LP includes the individual’s status/progress towards the achievement of his/her goals, priorities and outcomes.

1-37 of PCP Review

- The individual’s LP is revised whenever changes are necessary and warranted and/or directed/preferred by the person.

2-6 of PCP Review

- The LP (and services provided) clearly evidence the intent to facilitate advancement of the individual towards outcome achievement.
# 5 Continued:

- 2-12 of PCP Review
  - The individual’s LP (and service(s)) is reviewed to determine whether the services/supports are effective in achievement or advancement of his/her goals, priorities, needed safeguards and outcomes.

- 2-10 of PCP Review
  - Services/supports are delivered in a manner that optimizes and fosters the individual’s initiative, autonomy, independence, and dignity.

- 2-13 of PCP Review
  - There is a review summary note reporting on service delivery, actions taken, evaluation of effectiveness and recommendations.
Quality Check # 6
The LP is Informed by and Based on Required Assessments and Documentation

- Level of Care Determination/Redeterminations (initially and annual redeterminations)
- Developmental Disabilities Profile-2 (DDP-2)
- Coordinated Assessment System (CAS)
- 1-10: “Assessments needed by the individual or required by program regulation were completed to inform the individual’s plan development”
Quality Check # 7
The LP Includes all Supports and Services (Paid and Unpaid)

- Section IV includes OPWDD authorized HCBS waiver and State Plan services

- Section V includes other services including funded and natural/community resources
  - Services, supports and caregivers and contact information
  - Primary care physician, dentist, psychologist, podiatrist, NYSTART, Access-VR, ISS
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 newly added services
  - 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.
# 7 Continued:

<table>
<thead>
<tr>
<th>1-8 of PCP Review</th>
<th>• The individual’s LP includes consideration of natural supports as well as paid supports.</th>
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<tr>
<td>1-23 of PCP Review</td>
<td>• The individual’s LP documents each specific service and support to address his/her needs and achieve desired outcomes.</td>
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<tr>
<td>1-24 of PCP Review</td>
<td>• The individual’s LP identifies the amount, frequency and duration of each HCBS waiver service.</td>
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Division of Quality Improvement (DQI) Person-Centered Review (PCR) Tool

• Elements of this tool have been included in this training for your reference
  – More information can be found at the following link;
    https://opwdd.ny.gov/opwdd_regulations_guidance/division_of_quality_improvement_protocols
Resources

- Division of Quality Improvement (DQI) Person-Centered Review (PCR) Tool:
  https://opwdd.ny.gov/opwdd_regulations_guidance/division_of_quality_improvement_protocols

- Care Coordination Organization/Health Home Policy Guidance and Manual (and updates):
  https://opwdd.ny.gov/providers_staff/care_coordination_organizations/providers/cco-manual

- Federal guidance/standards for implementing Person-Centered Planning:

- OPWDD Person-centered planning resources:
  https://opwdd.ny.gov/opwdd_services_supports/person_centered_planning
Resources

“OPWDD Care Management, Life Planning and Service Delivery Process: Connecting the Dots” (the August 30, 2018 webinar)

View the Webinar: [https://youtu.be/d0uzboNE5U4](https://youtu.be/d0uzboNE5U4)
PowerPoint: [People First Care Coordination Informational Session 20](https://opwdd.ny.gov/providers_staff/care_coordination_organizations/providers/staff_action_plan_info)

The Staff Action Plan and Service Delivery:

[https://opwdd.ny.gov/providers_staff/care_coordination_organizations/providers/staff_action_plan_info](https://opwdd.ny.gov/providers_staff/care_coordination_organizations/providers/staff_action_plan_info)
Thank you - Questions?
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