On August 30, 2018 and September 17, 2018, OPWDD organized two WebEx training sessions to help Care Coordination Organizations (CCOs) and OPWDD service providers develop a comprehensive understanding of:

- how all the essential components of the Life Planning process work cohesively to drive an individual'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 Administrative Memorandum (ADM)) and;
- how to assess whether the person-centered Life Planning process is achieving what the individual needs and wants from his/her life.

Resources from the “OPWDD Care Management Life Planning and Service Delivery Process: Connecting the Dots” WebEx training sessions can be found at the following links:

- WebEx training session recording: https://youtu.be/d0uzboNE5U4
- WebEx training session Power Point: People First Care Coordination Informational Session 20
- Staff Action Plan Template: https://opwdd.ny.gov/opwdd_regulations_guidance/staff-action-plan-template

The questions addressed below were submitted to OPWDD during the two WebEx training sessions.

**Life Plan**

1. **Are the Life Plan and Staff Action Plan two separate documents?**

   Yes. The Life Plan is the active document defining the person-centered habilitative goals/values outcomes and required individual safeguards/Individual Plan of Protection (IPOP) needs. The Staff Action Plan is then developed by the appropriate habilitation provider and will describe, in detail, what habilitation staff will do to help the individual reach the habilitation goals/values outcomes through the habilitation provider assigned goal(s) identified in the individual’s Life Plan.

2. **What plan formats should be utilized if a Life Plan has not been created for the individual yet?**

   During a one-year transition period, July 1, 2018 through June 30, 2019, both Individualized Service Plans (ISPs) and Life Plans may be in effect throughout the Office for People With Developmental Disabilities (OPWDD) service system. An individual’s ISP will remain in effect until the individual’s Life Plan is developed and implemented. For individuals who have an ISP as their controlling active plan of care,
habilitation providers must continue to follow the guidance regarding *Habilitation Plan Requirements* prescribed in ADM #2012-01, until the individual’s Life Plan becomes the controlling plan of care.

3. If the Information Technology (IT) system the CCO is using is not fully operational for the development of the Life Plan, can other plan formats be used?

   The Life Plan format must be used, even if there are challenges with the IT system that supports it. If there are errors with the way that the information is transitioning through electronic means, then manual input and/or corrections should be made. The habilitative goals should be clearly identified within the Life Plan and any habilitation service that is authorized for the individual should have a Staff Action Plan developed consistent with the Staff Action Plan ADM. Please continue to work with your CCO administration for ongoing guidance.

4. How will the information from the ISP and its required attachments be incorporated into the new Life Plan?

   A person-centered planning (PCP) process is required for developing the Life Plan. The Life Plan meeting will be arranged by the individual’s Care Manager and is required to include the following parties: the individual, family member(s) and/or advocate(s) (if permitted by the individual), and all other major service providers. At the time of transition to the Life Plan, the entire team will be able to discuss all of the relevant information to inform the development of the Life Plan.

5. Are CCOs required to transition ISPs to Life Plans for September and October?

   As referenced in the Care Coordination E-Visory #04-2018, OPWDD issued a memorandum on August 29, 2018 titled *REVISED – Care Coordination (CCO) Individualized Service Plan (ISP) to Life Plan Conversions for July, August, September and October 2018*. The purpose of this memo is to provide clarification and guidance on the timeframe for Care Managers to convert ISPs due in July, August, September and October 2018. It can be read in full at the following link: [https://opwdd.ny.gov/opwdd_services_supports/service_coordination/medicaid_service_coordination/msc_e-visories/04-18](https://opwdd.ny.gov/opwdd_services_supports/service_coordination/medicaid_service_coordination/msc_e-visories/04-18).

   Additionally, in OPWDDs September 26, 2018 policy memorandum titled *Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual Updates*, the following guidance and clarification is provided:
   - Individuals who transitioned from MSC/PCSS on July 1, 2018 and are tier 1-3, it is expected that his/her ISP will be transitioned to a Life Plan at the time of his/her annual review date, but if that is not possible, then they must be transitioned no later than June 30, 2019.
• Individuals who transitioned from MSC/PCSS on July 1, 2018 and are tier 4 non Willowbrook class members, it is expected that his/her ISP will be transitioned to a Life Plan at the time of his/her annual review date, but if that is not possible, then they must be transitioned no later than December 31, 2018.
• All Willowbrook class members will be transitioned to a Life Plan at the time of his/her annual review date, but if that is not possible, then they must be transitioned no later than March 31, 2019.
• Individuals who change to a tier 4 status after July 1, 2018 must transition to a Life Plan if they have a significant change in service need or at the time of his/her annual review, but no later than June 30, 2019.

6. How are services documented in the Life Plan?

Section IV of the Life Plan: Home and Community-Based Services (HCBS) Waiver and Medicaid State Plan Authorized Services is where all HCBS and Medicaid State Plan services are listed. In Section V of the Life Plan: All Supports and Services; Funded and Natural/Community Resources is where any services that are not HCBS or Medicaid State Plan services are listed.

7. Who can be assigned a provider assigned goal?

During the Life Planning process, care managers/care planning team can identify the provider assigned goals for OPWDD service providers.

Staff Action Plan

8. What services require a Staff Action Plan?

Staff Action Plans are required for individuals receiving the following habilitation services:
  • Residential Habilitation in certified sites (Individualized Residential Alternatives (IRA), Community Residences (CR), and Family Care Homes);
  • Day Habilitation;
  • Community Habilitation;
  • Prevocational Services;
  • Pathway to Employment; and
  • Supported Employment (SEMP).

9. What are the Staff Action Plan billing standards?

The billing standards for the Staff Action Plan are found on pages 12-13 of the Staff Action Plan ADM, at the following link: https://opwdd.ny.gov/opwdd_regulations_guidance/staff-action-plan-program-and-
**billing-requirements.** The standards listed here are the same standards that were outlined and required per previous administrative guidance found in ADM 2012-01, except for the following new requirements:

#7 – identification of the provider assigned goals from the individual’s Life Plan;
#8 – the frequency of the services(s) and support(s) is now required in addition to the description of the services(s) and support(s) that the habilitation staff will provide; and
#12 – Evidence demonstrating the Staff Action Plan was distributed no later than 60 days after: the start of the habilitation services; the life plan review date; or the development of a revised/updated Staff Action Plan, whichever comes first (which may include, but is not limited to: a monthly narrative note; a HITS upload; or email).

10. What are the required sections of the Staff Action Plan?

The required sections of the Staff Action Plan are found on pages 9-12 of the Staff Action Plan ADM, at the following link: [https://opwdd.ny.gov/opwdd_regulations_guidance/staff-action-plan-program-and-billing-requirements](https://opwdd.ny.gov/opwdd_regulations_guidance/staff-action-plan-program-and-billing-requirements).

11. When are providers expected to begin using the Staff Action Plan?

At the time of transition to the Life Plan, Habilitation Plans must transition to Staff Action Plans. Habilitation Plans created between July 1, 2018 and the issue date of the ADM (September 4, 2018), must transition to Staff Action Plans no later than 60 days of the issue date of the ADM.

12. How is the Staff Action Plan developed, and who is responsible for the development of the Staff Action Plan?

Habilitation provider assigned goals are established by the individual receiving services and his/her planning team during the person-centered Life Plan development process. Staff Action Plans must be developed based on the habilitation provider assigned goals as outlined in the individual’s Life Plan by the habilitation provider in collaboration with the individual, his/her advocate, Care Manager, and any other parties requested and approved by the individual. Additionally, agencies providing Residential Habilitation must continue to demonstrate the involvement of a Qualified Intellectual Disabilities Professional (QIDP) in the delivery, management or supervision of residential habilitation services. Staff Action Plans detail how staff will provide supports and services to help the individual achieve his/her defined habilitative goals/valued outcomes.

13. Do you need a separate Staff Action Plan for each habilitation service?

Issued November 15, 2018
Staff Action Plans may include multiple habilitation services, if all included services are provided by the same provider/agency. For Staff Action Plans that incorporate multiple habilitation services, the Staff Action Plan must have a separate section that describes the supports and services associated with each service.

14. Is the Staff Action Plan a required attachment of the Life Plan?

The Life Plan will be the active document to define an individual’s person-centered goals/values outcomes and safeguard needs. When an individual’s ISP transitions to a Life Plan, his/her goals/values outcomes and safeguards will be integrated into the Life Plan. Attaching Habilitation Plans to the Life Plan will not be required, as these components will become embedded within the Life Plan itself. Section IV of the Life Plan identifies HCBS and State Plan services that have been authorized for the individual.

15. Will our current Habilitation Plan format work if it includes all of the required elements?

An optional Staff Action Plan Format has been issued with the Staff Action Plan Program and Billing Requirements ADM. Providers may use this format or create their own, so long as the document includes the minimum required elements of a Staff Action Plan.

16. How long does the habilitation provider have to finalize and distribute the Staff Action Plan?

The Staff Action Plan is not an attachment of the Life Plan. As described in the Staff Action Plan Billing Standards section of the ADM, the habilitation provider must forward the Staff Action Plan to the Care Manager via the CCOs portal or another mechanism for prompt communication agreed upon by the Care Manager and habilitation provider no later than 60 days after: the start of the habilitation service; the Life Plan review date; or the development of a revised/updated Staff Action Plan, whichever comes first. The habilitation provider must maintain evidence demonstrating the Staff Action Plan was distributed within the required timeframe (which may include, but is not limited to: a monthly narrative note; a HITS upload; or e-mail).

17. Is the Staff Action Plan required to be sent to the Care Manager electronically?

The Health Information Technology System (HITS) is an electronic information sharing system. HITS ensures consistent, timely, and comprehensive information sharing between providers and Care Managers, and must be used if available and accessible. HITS access is available to the individual, the individual’s family member(s) and/or advocate(s) as permitted by the individual, and any other parties requested and approved by the individual. If the individual or family requests access to the Staff Action Plan...
Plan in a different format, it is the responsibility of the habilitation provider to provide the document as requested. If the CCO HITS is not available or accessible, another mechanism for prompt communication agreed upon by the Care Manager and habilitation provider may be utilized so that the person being contacted can update the HITS. For the Basic HCBS Plan Support service, HITS may be used, but it is not required.

18. Is there a timeline established for when Staff Actions Plans would need to be updated?

The Staff Action Plan must be reviewed at least twice annually, and revised as frequently as necessary based upon the individual’s needs. It is recommended that Staff Action Plan reviews occur at six-month intervals coordinated with the Life Plan review. At least annually, one of the Staff Action Plan reviews must be conducted at the time of the Life Plan meeting.

19. If the Staff Action Plan is reviewed and there are no changes, are habilitation providers still required to send the plan to the Care Manager?

Habilitation providers must keep a record of notification indicating that they notified the individual and Care Manager verbally or in writing that there were no changes to the Staff Action Plan.

20. Do people receiving Respite need a Staff Action Plan?

Respite must be identified as a service in the Life Plan, however, since Respite is not a habilitation service, a Staff Action Plan is not required. The Respite provider must ensure that all staff working with the individual are aware of all of his/her safeguard needs.

21. Are Staff Action Plans required for individuals who are enrolled in Partners Health Plan (PHP)?

Staff Action Plans are required whether the individual receives Care Management from a Managed Care Organization (MCO), or a CCO providing Health Home Care Management/Basic HCBS Plan Support. For those individuals enrolled in PHP on July 1, 2018 through the issue date of the ADM (September 4, 2018), and individuals enrolled in PHP who began a new habilitation service on July 1, 2018 through the issue date of the ADM (September 4, 2018), Staff Action Plans must be created for habilitation services within 60 days of the issue date of the ADM (September 4, 2018).

22. Will there be different billing standards for goals, supports or tasks?
Habilitation provider assigned goals and supports identified in Sections II and III of the Life Plan meet the requirements for habilitative goals described in the habilitative provider’s Staff Action Plan. Tasks are a one-time activity assigned in the Life Plan, and are not habilitative in nature. Therefore, tasks do not meet the billing requirements to be a habilitation goal.

**Individual Safeguards/Individual Plan of Protection (IPOP)**

23. How are health and safety concerns addressed in an individual’s Life Plan?

As part of the person-centered planning process, Care Managers and providers must work together to ensure that all health and safety needs of an individual across service settings are addressed appropriately in Section III of the Life Plan: Individual Safeguards/IPOP. In addition, Section II of the Life Plan: Outcomes and Support Strategies, includes a space for special considerations. This allows for the provision of additional information that may need to be considered in assisting the individual to achieve their valued outcome(s) or ensure their health and safety needs are being met. There may be instances where an individual receiving services chooses not to follow specific medical or treatment advice; information relative to decisions of this nature should be included within this section.

24. How are safeguards addressed in the Staff Action Plan?

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. This guidance on protective oversight measures must align with the overarching Section III Individual Safeguards/IPOP articulated in the Life Plan.

25. Are the IPOP/safeguards added for specific providers?

The individual safeguards/IPOP needs described in Section III of the Life Plan are used as the starting point for the habilitation service provider to develop the Staff Action Plan safeguard detail, and any other internal guidance documents that outline the individual-specific protective oversight measures staff must implement or ensure for the individual. Safeguards are necessary to provide for the individual’s health and safety while participating in the habilitation service.

26. Is a Plan of Protective Oversight still required?

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

For all other habilitation services, 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. This guidance on protective oversight measures must align with the overarching Section III Individual Safeguards/IPOP articulated in the Life Plan.

27. Are Behavior Support Plans still required, and, if so, how are they incorporated into the Life Planning process?

Yes, 14 NYCRR Part 633.16 regulations remain in effect. The overarching protections listed in the individual safeguards/IPOP section identified in the Life Plan may be further detailed in a Staff Action Plan or internal guidance document(s) created by the habilitation provider. The Staff Action Plan and/or internal guidance document(s) further details the individual’s needed safeguards, staff supports, and/or specific/detailed protective oversight measures to ensure the health and safety of the individual receiving the habilitation service(s). The Life Plan and/or the Staff Action Plan must specifically reference where the additional detail is located (e.g., see “Plan of Nursing Services”, see “Behavior Support Plan”, see “Community Supervision Safeguarding Protocol”).

28. How are changes in an individual’s needs and/or safeguards communicated between the provider and the Care Managers?

A mechanism for prompt communication agreed upon by the Care Manager and habilitation provider must be established and utilized to ensure that the individual’s safeguard needs are immediately identified, and appropriate supports and services to address the individual’s safeguard needs are immediately implemented. Safeguards must be updated based on the individual’s identified or changed needs. If the individual’s support needs change, the service provider must communicate this change to the Care Manager. This communication ensures updates and timely communication of changes to other support givers/providers. Additionally, it is critical to ensure timely notice of significant support need changes to ensure health and safety.

Assessments

29. What is the difference between the Certified Assessment System (CAS) Assessments and the I AM Assessment tool?

The CAS is the State-approved functional needs assessment that is holistic across an individual’s life and settings and is used to inform the comprehensive assessment process. It is not program specific, but, rather specifically tailored to capture the unique health and support needs of individuals with intellectual and developmental disabilities.
(I/DD) in New York State. The I AM Assessment is one of the care planning tools that facilitates a conversation with the individual receiving services, their involved family members and/or advocates, and service providers and is used to develop a person-centered Life Plan.

30. What is the I AM Assessment process, and who should be engaged in that process?

As Care Managers begin to transition Individual Service Plans (ISPs) to Life Plans or develop Life Plans for individuals new to the OPWDD service system, they will be conducting meetings with the individual, his/her family/representative, and care planning team. The I AM Assessment is one of several care planning tools used to develop a person-centered comprehensive Life Plan. The I AM Assessment tool is completed by using information gathered from the individual’s record and/or other information sources, including the State sanctioned assessment, in advance of a facilitated conversation with the individual who is receiving services, their family/representative, and care planning team. The Life Plan meeting with the individual’s care planning team, including service providers, is the final step in the process to ensure the completion of a robust person-centered planning process that will aide in identifying the outcomes most important to the individual and the areas where supports are needed to achieve maximum health and safety. At this person-centered planning meeting, the Life Plan can be refined further to reflect what is most important to the individual.

31. What are the notification requirements to the members of the individual’s care planning team including Willowbrook Class Members who have an active Consumer Advisory Board (CAB) representative for the completion of the I AM Assessment? In addition, what members are required to participate?

The use of the I AM Assessment tool is one part of the service planning process for the development of the Life Plan. The CAB representative and remaining members of the care planning team must be given timely and reasonable notice (minimum 10-day notice) of the planned date for the I AM Assessment and must be offered the opportunity to participate. It is the responsibility of the Care Manager to provide this notice as well as provide flexibility on dates with the recognition that there may be conflicts. However, only after reasonable notice and flexible dates have been provided, and the CAB representative or care planning team member(s) are not able to participate, can the I AM Assessment be completed without their participation. The I AM Assessment is one of several assessments that inform an individual’s Life Plan, and is reviewed as part of the Life Plan meeting. The entire care planning team is expected to participate in the development of the Life Plan, so if the CAB representative or care planning team member(s) for some reason are not able to participate in the I AM Assessment meeting, they can provide input at the time of the Life Plan meeting.
32. If specific valued outcomes are automatically generated from the I AM Assessment, can valued outcomes be added manually to the Life Plan?

The I AM assessment is a care planning tool that facilitates a conversation between the individual who is receiving services, their involved family members and/or advocates, and service providers. The I AM Assessment is one of several tools used to develop a person-centered comprehensive Life Plan that identifies the outcomes most important to the individual and the areas where supports are needed to achieve maximum health and safety. The I AM Assessment does inform the Life Plan, however, the Care Manager uses a person-centered planning process with input and participation from the individual’s entire care planning team for the development, completion and review of the Life Plan and can work with the individual and his/her team to make changes as needed to ensure that the Life Plan is representative of what the individual wants and needs.

33. How are the Personal Outcome Measures (POMs) created, and where are they in the Life Plan?

The valued outcomes within the Life Plan must link to one of the twenty-one (21) Council on Quality and Leadership (CQL) POMs. The I AM Assessment planning tool integrates POMs. Goals in the I AM assessment tool link to one of the 21 POMs and are then integrated into Life Plan Section II: Outcomes and Support Strategies.

Person-Centered Planning (PCP)

34. How do individuals and providers resolve conflicts and disagreements in the person-centered planning (PCP) process?

Habilitation providers and Care Management entities must develop strategies to address conflicts and disagreements in the PCP process and communicate them to the individual, and his or her circle of support. Individuals and their circles of supports should be informed of the provider’s policies for resolving disagreements between individuals receiving services and circle of support members during the PCP process.

In the event that a resolution for an identified disagreement/conflict cannot be achieved, the individual receiving services can utilize the objection to services process as described in 14 NYCRR § 633.12.
Habilitation Service Documentation

35. Will a monthly summary still be required with the implementation of the Staff Action Plan?

ADM for each HCBS Waiver service remain in place and outline the service documentation requirements and billing standards that habilitation providers must continue to follow. All OPWDD ADMs are available on the OPWDD website at: https://opwdd.ny.gov/opwdd_regulations_guidance/adm_memoranda.

36. What are the documentation requirements for therapeutic leave days?

The documentation requirements regarding therapeutic leave days have not changed and are described in ADM #2014-01.