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Office for People With Developmental Disabilities

People First Care Coordination
MSC Information Session

Info Sessions Update

Sessions 1-3

-- Posted on the OPWDD website

Session 5 – February 14

Helping Individuals Transition to CCO/HH

- An overview of what MSCs need to know and do to help individuals and families transition to CO/HH.

Session 6 – February 28

From MSC to Care Manager-

- A summary of the expanded role that MSCs will have as care managers in CCO/HHs.

For viewing or registration go to OPWDD website

https://opwdd.ny.gov/opwdd_services_supports/care_coordination_organizations

Info sessions count towards current required annual MSC professional development hours

Future Session Topics

CCO/HH Transition Plan - Page 46

- https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/draft_idd_1115_waiver.htm

Your Questions

– Many addressed in Transition Plan or FAQ

https://opwdd.ny.gov/opwdd_services_supports/care_coordination_organizations/faq

– Salary, benefits – Provided by CCOs

MSC Information Session 4

What is a Life Plan and How Does is Compare to an ISP?

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Director of Program Development
Division of Person-Centered Supports

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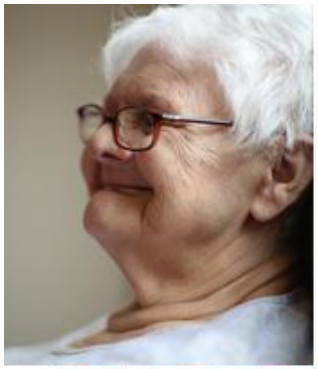
Statewide START and MSC Coordinator

Today's Session

- Provide an overview and introduction to the elements of the Life Plan





Overview

In delivering the six core Health Home services, at a minimum, CCO/HH must have an integrated, electronic and person-centered Life Plan including all services and providers.

The current regulatory requirements of OPWDD governing person-centered planning are consistent with and reflected in the person-centered care planning requirements of the CCO/HH model.

More information about person-centered planning is available at https://opwdd.ny.gov/opwdd_services_supports/person_centered_planning.

The Life Plan

The Life Plan ***replaces*** the ISP document and meets all of the regulatory requirements for a person-centered plan. The Life Plan was designed to integrate preventive and wellness services, medical and behavior healthcare, personal safe guards and habilitation to support each participant's desired personal outcomes in a state-of-the-art document.

The difference between the ISP and Life Plan is that the ISP document ***only*** integrates DD services, whereas the Life Plan integrates ***all*** services and Natural Supports. **This is a Health Home requirement**. The Life Plan must include the OPWDD defined data elements outlined in the CCO/HH application.

Section1: Demographic and Profile

SECTION I
Demographics and Profile

This section of the **Life Plan captures information about the person receiving Health Home services**, including full name of the individual, Medicaid number or CIN number, address, the CCO/HH in which the individual is enrolled, name of lead CCO/HH Care Manager and care management agency,
initial Life Plan date, and Life Plan review dates.

It also describes a person's home, work/employment, relationships, and health and educational profile in person-first language. Each of these sections includes question and answer fields as well as free text to provide a person-centered narrative that captures personal history and appropriate contextual information, as well as a description of skills, abilities, aspirations, needs, interests, things that make the person happy, challenges, pre-school and school age services etc., learned during the person-centered planning process, a record review, and any assessments completed.

Section II: Personal Outcomes

Section II

Outcomes and Support Strategies

This section includes measurable/observable personal outcomes that are developed by the person and his/her IDT using person-centered planning. It describes provider goals/supports and corresponding staff activities identified to meet the persons goal/valued outcome. It captures the following information: goal description, valued outcomes, action steps, responsible party, service type, timeframe for action steps and Personal Outcome Measures. Evidence of achievement must be reflected in monthly notes from assigned providers.

CQL POMS Goal/Valued Outcome	CCO Goal/Valued Outcome	Provider Assigned Goal	Provider/ Location	Service Type	Frequency	Quantity	Time Frame	Special Considerations

Section II is the personal outcome section. This section was designed to represent personal goals that people receiving services would like to work toward achieving. The valued outcomes/goals are related to defined CQL Personal Outcome Measures. These goals are identified during the initial interview and assessment process, as well as through a face-to-face meeting with each person's Interdisciplinary Team (IDT), which includes the person and his or her selected representatives, care manager and primary provider(s) of DD services, as well as other people of his or her choosing (e.g., residential supervisors, friends, and others involved in the participant's supports). There should be a minimum of three goals which attach to at least two different personal outcome measures.

Section III: Health & Safety Supports Individual Protective Oversight Plan (IPOP)

Section III

Individual Safeguards/Individual Plan of Protection (IPOP)

Compilation of all supports and services needed for a person to remain safe, healthy and comfortable across all settings (including Part 686 requirements for IPOP). This section details the provider goals and corresponding staff activities required to maintain desired personal safety.

Goal/Valued Outcome	Provider Assigned Goal	Provider/ Location	Service Type	Frequency	Quantity	Time Frame	Special Considerations

Section III is the personal safeguard section. Included here are actions needed to keep people safe and healthy, including health care, nutrition, fire safety, and personal supports, among others. A person may also choose a needed safeguard as a personal goal to increase independence, such as self-administration of medication or learning to travel safely within the community (e.g., ride the bus or subway).

Safeguard descriptions and supports needed to reduce the likelihood of harm including a detailed back up plan for situations in which regularly scheduled paid or unpaid supports are unavailable or do not arrive and evacuation in an emergency. **All required Safeguard domains identified in the Care Coordination Data Descriptions need to be actively assessed and addressed in the Life Plan, if needed.**

Section IV:
HCBS Waiver and Medicaid State Plan Authorized Services

Section IV HCBS Waiver and Medicaid State Plan Authorized Services **This section of the Life Plan includes a listing of all HCBS Waiver and State Plan services that have been authorized for the individual.**				
Authorized Service	Provider/Facility	Effective Dates	Unit	Comments

CCO/HHs will be required to ensure that these services have been authorized by the appropriate entity (i.e., DDRO or LDSS). For each HCBS service, the waiver service provider, the service type, frequency of support of service, duration of the support or service, and the effective dates must be identified.

The **Health Home Model integrates and lists authorized services** whereas **Managed Care integrates and authorizes services**

Section V: Supports

Section V All Supports and Services; Funded and Natural/Community Resources **This section identifies the services and support givers in a person's life along with the needed contact information**. Additionally, all Natural Supports and Community Resources that help the person be a valued individual of his or her community and live successfully on a day- to-day basis at home, at work, at school, or in other community locations should be listed with contact information as appropriate.			
Name	Role	Address	Phone

For the Medicaid funded services identified in Section IV, **this section will list specific contact information for the appropriate representative for those services**. Other service providers outside of Waiver and State Plan services should be listed in this section along with type of service and current contact information. This section includes a list of all paid and unpaid Supports, such as the person's doctors, dentist, family members, waiver service provider staff, and therapists.

Discussion of Critical Changes

- Requirement that the Life Plan be **integrated** in IT system
- **Integrated** document that identifies Habilitative goals of the person
- **Integrated** document where the safeguards are comprehensive and person focused, meeting IPOP requirements
- Expectation that Special Considerations are described

Useful Documents

- Care Coordination Organization/Health Home (CCO/HH) Application to Serve Individuals with Intellectual and/or Developmental Disabilities

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/hhidd_application_part_1.pdf

- CCO/HH Frequently Asked Questions FAQ

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/cco-hh_faqs.htm

- Individuals with Intellectual and/or Developmental Disabilities (I/DD) 1115 Waiver Transition Plan

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/1115_draft_transition_plan_12_5_2017.pdf

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Thank you – Questions?

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