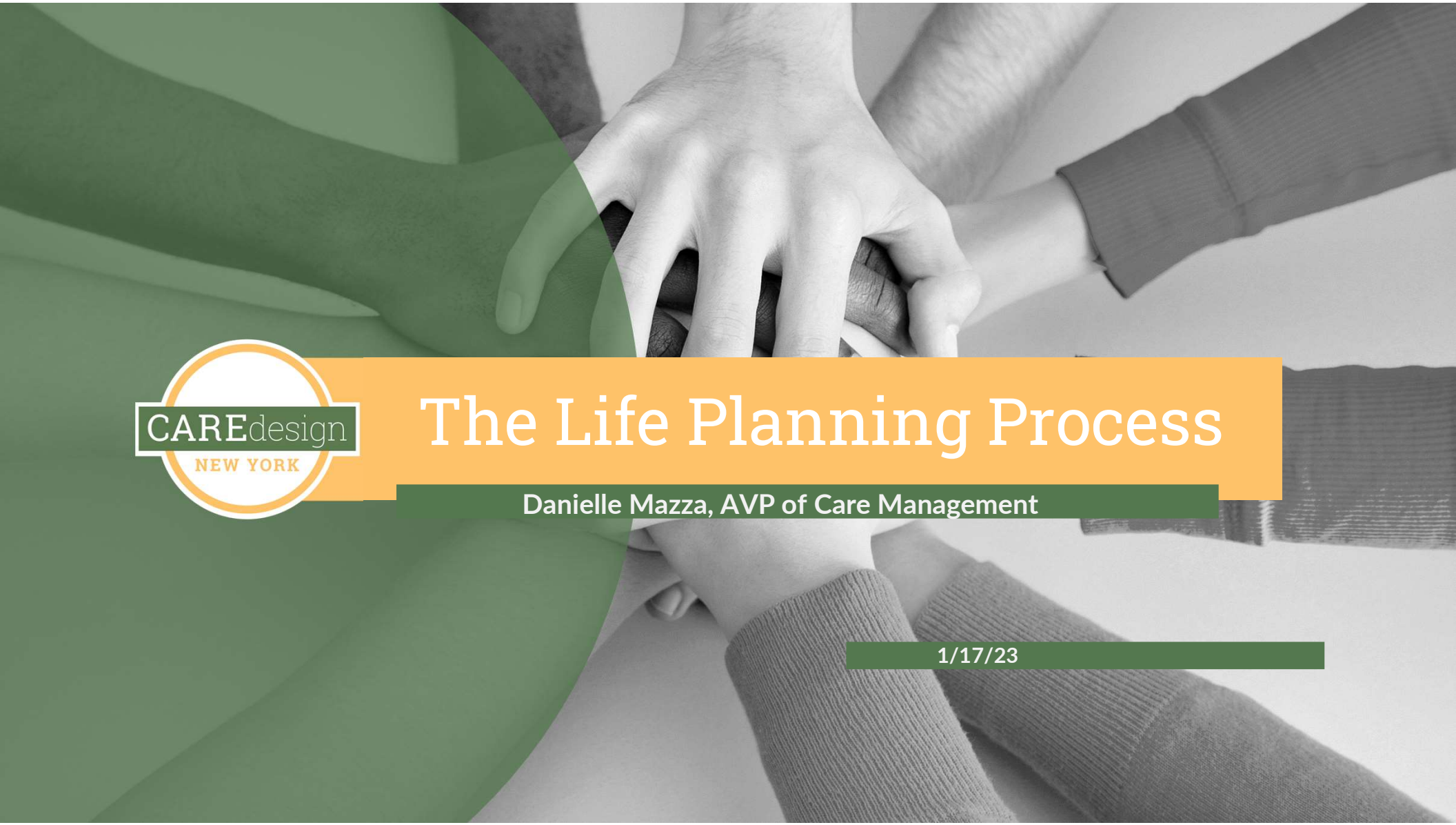

CAREdesign NEW YORK

The Life Planning Process

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1/17/23

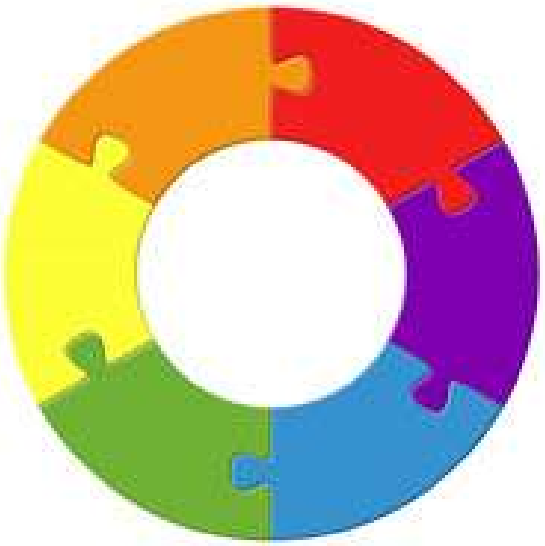
What is a Life Plan?

The Life Plan is created using a person-centered planning process.

The Life Plan serves a number of functions:

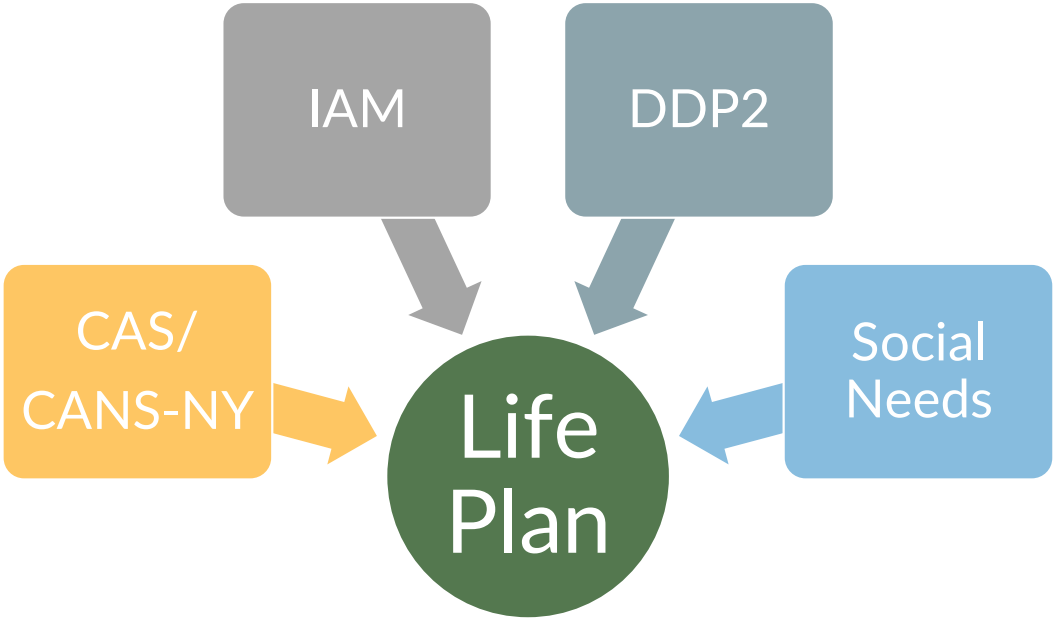
- Narrative sections that describe who the person is and what is important to them
- Goals which address the areas the person wishes to focus on
- Safeguards that are important for others to know in order for the person to be safe and healthy
- The services a person is authorized for – acting as the “prescription" and justification for OPWDD Waiver services
- Important health and medical information – including providers
- Other community supports or organizations that may be providing supports

What Advises the Life Plan



- ✓Most importantly – the person whose plan it is! The person's voice should be strongest
- ✓The person's family, friends and/or natural supports
- ✓Providers of service – particularly those providing goal-based supports
- ✓Personal Outcome Measures
- ✓Assessments

Assessment Sources



Care Design NY uses the I AM Assessment, but there are currently 2 CCO assessments in use – as several other CCOs use an assessment called PATHS. The Social Needs Assessment is 10 questions that are required by CMS.

CCO Assessment vs. State Sanctioned Assessment

CCO Assessment

- Either I AM or PATHS
- Completed by the CCO Care Manager
- Required by OPWDD regulation – each CCO must have an assessment tool "to identify developmental disability, medical, mental health, behavioral health, chemical dependency, social and emotional needs".
- Includes initial assessment and annual reassessment
- Advises Life Plan development but does not dictate it
- Data source for population health information

State Sanctioned Assessment

- Currently 2 tools in use – DDP2 and CAS/CANS
- CAS is for adults 18+
- CANS is for children under 18
- CAS/CANS assessments are completed by OPWDD or MAXIMUS (though contract with OPWDD)
- State Assessments play a role in acuity – meaning they factor into service authorization and funding
- Advises Life Plan development but does not dictate it.

Sections of the Life Plan

Narrative Sections

- Introducing Me
- My Home
- Let Me Tell You About My Day
- My Health and My Medications
- My Relationships
- My Happiness
- My School

Outcome and Support Strategies

- This section includes measurable/observable personal outcomes that are developed by the person and his/her circle of support using person centered planning.
- Provider goals and corresponding staff activities have been developed to meet each Goal/Valued Outcome.

Sections of the Life Plan

Safeguards/Plan of Protective Oversight

- Compilation of all supports and services needed for 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.

Waiver Services and 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.
- It is important that other sections of the plan provide justification for the supports listed in this section.

Sections of the Life Plan

All Supports and Services: Funded and Natural/Community Resources

- This section identified the services and support givers in a person's life along with the needed contact information.
- 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.
- Includes Healthcare Providers

Section VI

- This section includes a summary of the meeting.
- Provides an opportunity for the member to have “the last word”.
- Captures attendance at the LP meeting.
- Lists member diagnoses and may include medications the member takes at the time of the LP publication (should not be considered the source of truth for medications).

Finalizing a Life Plan

From the Life Plan meeting – the Care Manager will develop the written plan based on assessment, discussion, and requested supports and services.

The Life Plan must be approved by you/your representative and this approval must be in a written format. HCBS providers must also sign off.

Must be finalized within 45 days (90 days if new enrollee) per regulation.

Accessing Services and Ongoing Support

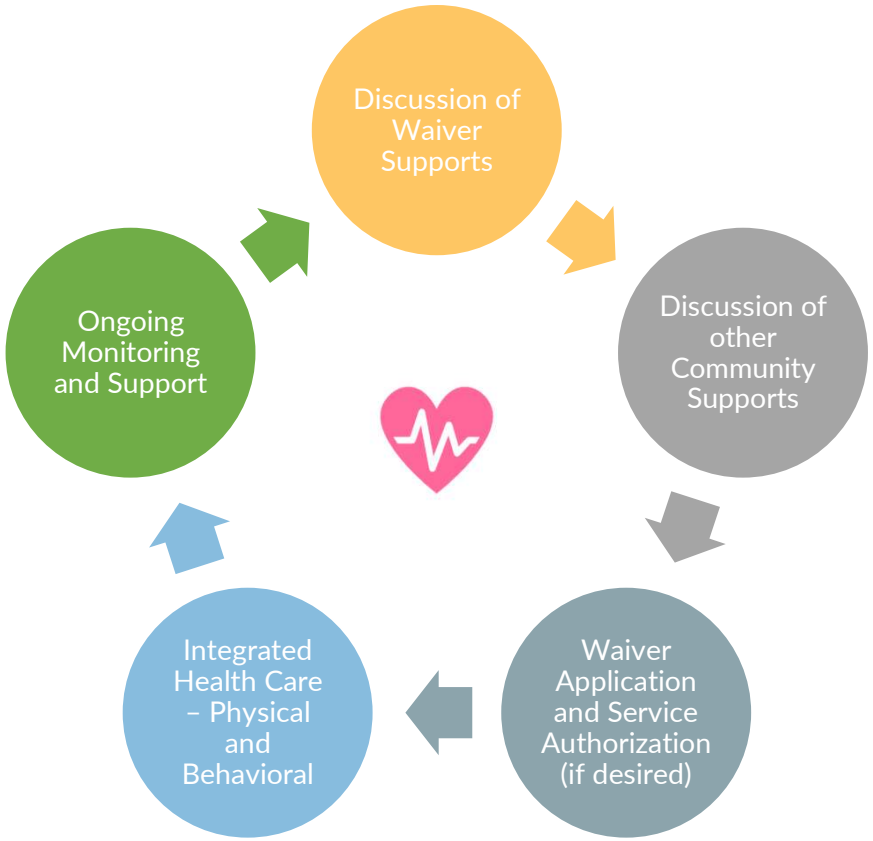
Care Managers will play an ongoing role in supporting you to get the services you need to **live the life you want!**

We will assist with **Waiver application and enrollment and needed/requested**. This includes the application of specific services.

OPWDD is the entity that determines Waiver service authorizations.

We also support you to be healthy and well and manage any chronic conditions you may have, so you can have the **best possible health**.

We will also support you in accessing other supports and services that may be available through other systems or **in your general community.**



Accessing Services and Ongoing Support

It is important to acknowledge that the federal Public Health Emergency has significantly impacted the OPWDD service delivery system.

- The Care Manager's role is to work with members to develop an integrated Life Plan and obtain authorizations for needed services – and then link with providers of those services.
- Care Design NY does not provide OPWDD Waiver services directly – we work with the provider community to access those services.
- However, many providers of service are experiencing crisis level staffing challenges – which have caused service disruptions or an overall lack of services due to the lack of staff.
- Providers are working with OPWDD, as is Care Design NY leadership, on solutions to these challenges.

Health Home - Your Health Included!

What is the role of a Care Design NY Care Manager in my healthcare?

Your Care Manager has the responsibility to **make sure you are supported** in all the ways that lead to the **healthiest outcomes for you** and they **take a whole-person approach** to understanding your unique needs and how to achieve your desired goals.

What can I expect from my Care Manager?

Your Care Manager will ask about your health related goals! In order for your Care Manager to help you navigate your healthcare needs, they will need to know about any chronic conditions you may have, new medical or behavioral health concerns, and any goals you may have to achieve your best health.

Your Care Manager will ask you about:

- ✓ Doctors and providers you see
- ✓ Your annual physical
- ✓ Your annual dental exam
- ✓ Immunizations
- ✓ Chronic conditions
- ✓ Medications
- ✓ Healthcare Screenings

Questions?