



Department
of Health

NYS Department of Health Nursing Home Transition and Diversion (NHTD) Program

Medicaid Waiver Orientation Training: Unit 5

Person-Centered Plans

Recommended Content

Person-Centered Plans

- It is required that each individual receiving Medicaid home and community-based services (HCBS) have person-centered service plans.
- Demonstrate best practices as defined by the philosophy and requirements of the NYS Nursing Home Transition Diversion waiver program.
- Are essential tools that clearly state the responsibility of each of the services and supports that the waiver Participant needs, based upon a comprehensive, person-centered assessment.

Person-Centered Plans continued

- Include the description of methods for addressing the applicant/participant's goals and objectives and identifies persons and/or services responsible for implementing and monitoring the plan.
 - These methods are discussed and evaluated at each service plan review.
- Include an assessment of the individual to determine the services needed to prevent institutionalization or return to a facility.
 - This assessment should include a description of the individual in person-centered terms, psycho-social history and a description of their strengths and needs.

Person-Centered Plans continued

- Are individualized based upon the applicant/participant's strengths, unique needs, abilities, challenges, choices, wishes and preferences.
- Assist the person in achieving personally defined goals and desired outcomes and that services contribute to their health and welfare.
- Reflect the services and supports that assist the individual to achieve identified goals.

Person-Centered Plans continued

- Include the natural/informal supports available to the individual.
- Require the informed consent of the applicant/participant in writing and signed by all persons/providers responsible for its implementation.
- Are distributed to the applicant/participant and other people involved in the plan.

Person-Centered Plans continued

The written plan must confirm that the applicant/participant has chosen the setting where they reside. The setting must also be integrated and support full access to the greater community including:

- Opportunities to seek employment and work in competitive integrated settings
- Engagement in community
- Control of personal resources
- Receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

Initial and Revised Service Plans

- There are two types of Service Plans used by the NHTD waiver: Initial Service Plan (ISP) and Revised Service Plan (RSP).
- Both documents may be updated or amended by an addendum to the existing service plan. The RSP is revised/rewritten annually.
- The Service Coordinator (SC) is responsible for completing the ISP/RSP.
- Service Plans are expected to evolve as the participant experiences community life, requests revisions, experiences significant life changes, or as new service options become available.

Initial Service Plan (ISP)

The focus of the ISP is on the individual. It includes:

- information regarding significant relationships
 - current informal and community supports, desired living situation
 - recreation or community activities.
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- The ISP must also contain a description of the individual's strengths and limitations, including any cognitive, behavioral or physical concerns, and the services necessary to maintain them safely in the community.

 - Upon approval, the ISP confirms waiver eligibility and establishes service provision for the first year.

Revised Service Plan (RSP)

- The RSP reflects a review and evaluation of the participant's progress during the previous twelve (12) months of waiver services.
- Addresses how waiver services continue to prevent institutionalization and indicates whether these services should continue unchanged, be modified or discontinued.

Addendum or RSP

A Service Plan review is required when:

- The individual's needs change and an adjustment in the frequency and duration of services is indicated
- There is a change in the participant's living situation that warrants a change in services
- The participant seeks a change in services or content of the Service Plan
- Participant relocates outside of their current service area

If indicated, changes can be made via an Addendum or RSP.

Addendum Review and Approval Process

- The RRDS must review the Addendum to determine the need for changes in the service(s).
- There may be a need for an emergency increase of services to a participant to meet their health and welfare in the community. For example, the caregiver has an unplanned hospitalization. In these unexpected events, the Service Coordinator needs to contact the RRDS and obtain verbal approval for the increase in service(s).
 - If the emergency service(s) is intended to be ongoing, then the Service Coordinator must submit an Addendum to the RRDS for approval.

Detailed Goal Plans

- Is developed and implemented by the individual waiver service provider to identify the specific tasks and activities to be provided by the waiver provider in support of the participant's overall goals as identified in the Service Plan.
- Is essential in clearly stating the responsibility for each of the services and supports, the waiver Participant's strengths and needs based upon a comprehensive, person-centered assessment

Protective Plan of Oversight (PPO)

- Indicates all key activities and protective measures that directly impact the health and welfare of the participant and clearly identifies the individual(s) responsible for providing the needed assistance to the participants in the event of an emergency or disaster.
- The PPO explicitly states the individuals who are responsible for assisting the participant with daily activities/emergencies, medication management, financial transactions, fire/safety issues and back-up plans are also included
- The PPO is included with the Service Plan sent to the RRDS for review and signature.
- A copy of the PPO must be provided to the participant by the SC to be maintained in an easily accessible location of the participant's choice within his/her home. A copy is also provided to each waiver service provider listed in the Service Plan.

Team Meeting and Staff Roles

Recommended Content

Team Meetings

- Team Meetings are utilized to review and/or develop the participant's Service Plan.
- The participant must be the driver and key decision maker.
- Team Meetings are essential in ensuring the participant's health and welfare to live independently in the community in meaningful ways.
- Are instrumental in the development and implementation of an individualized and purposeful Service Plan.

Team Meetings continued

Team Meetings are used to:

- Garner information from the Participant and informal supports about needed services, changes in physical or cognitive status, discussion about individual progress and to recommend service changes
- Address barriers to participant accomplishing goals related to daily activities in being able to live fully in their community
- Build on participant's achievements towards goal attainment

Roles and Responsibilities of Staff

- The Service Coordinator works with the Participant to schedule, coordinate and facilitate meetings as desired by the Participant
- All staff are expected to actively participate.
- The Service Coordinator is responsible to ensure that all required waiver service providers are available and actively participate in the Team Meeting.

Team Meeting Summary

The Team Meeting Summary must include:

- Date, time and location of Team meeting
- Participant or designated representative's input and comments
- Issues addressed
- Recommendations for changes in the Service Plan
- Meeting attendees