Tiered Waiver and Universal Plan of Care

Kim Kennedy, Program Manager
Purpose of Presentation

- Understand why the shift to tiered waiver
- Understand the tiered waiver process
- Planning to Support the person
- CPOC changes (Universal Plan of Care)
- Standardized Provider Documents
Why move to a tiered waiver?

- System “as is” not fiscally sustainable
- Only 50% acceptance rate for NOW with first come, first served
- More than 16,000 people on Registry and NOW average cost of $52,000
- System not able to be responsive to the needs of people who are at high risk of institutionalization
What Does “Tiered Waiver” Mean?

- Offers made based on highest “Screening for Urgency of Need” (SUN) score and earliest registry date
- Adults most appropriate waiver based on a needs based assessment and person-centered planning.
  - All adults will initially receive a DD waiver offer, not for a specific waiver
    - Consideration given first to SW, then ROW, then NOW (Tiered Process)
  - Children under 21 will be offered Children’s Choice waiver
    - Children 18 and out of school can choose Children’s Choice or Supports Waiver
    - At 21, they will “age out” to the Most Appropriate Waiver
Merging Into Single DD RFSR

- Supports Waiver RFSR, NOW RFSR, and OAAS RFSR (with an SOA) were consolidated into a single RFSR, the OCDD Request for Services Registry.
  - Individuals will keep their earliest registry date when combined
  - All individuals impacted received a letter / invitation to meeting

- No longer have “inactive” status. Individuals on current inactive list will retain their RFSR date; if they wish to receive services in the future will contact LGE for screening

- Re-frame how we define / describe the registry
  - Only individuals who are in urgency category 3 or 4 will be considered as “waiting” for services
  - Individuals in urgency categories 2, 1, 0 will be considered as having needs met and “requesting” services but not “waiting”
What is the IDT?
Interdisciplinary Team (IDT)

A coordinated group of experts from several different fields who

work together

towards a common goal.
Members of the IDT

► Persons important to the Individual (family members, close friends, etc.)
► Legal Guardians
► Support Coordination Agency
► Waiver Provider Agency
  ▪ PCA Provider Agency
  ▪ Day Habilitation / Employment Provider Agency
► Behavioral Health Provider Agency
► Other professionals who provide care to the individual being supported (i.e. employers)
Actions of the IDT

Support Coordination coordinates the person centered planning meeting after discovery meeting.

All IDT members are invited.

Support Coordination Agencies and Provider Agencies are required to attend the same meeting.

Information provided during discovery is discussed with the individual and IDT members.

Discussion is led by Support Coordination agency, but provider agency and other IDT members should ask questions and get clarification as needed.

This is a TEAM Effort!
Discovery/Planning Process

Planning to support the person
Values

- Each person defines his/her own outcomes;
- The planning process begins with discovery of who the person is;
- The planning process builds on important, meaningful life experiences of the person rather than with the limitation of services actually available;
- The partnership is with the person and all the important people in his or her life; and
- Individualized supports and services are provided to assist a person to achieve his or her vision and goals
Building the Best Life: A Work in Progress
Learning About Each Person’s Story

- Vision
- Goals
- Preferences
- Non-negotiables

- Opportunities
- Connections
- Environmental Positives

- Behavioral/MH
- Trauma
- Medical
- Legal
- Skills Challenges
- Environmental Negatives
Supporting the Person to ‘Get A Life!’: Outcomes

- Belong to his/her community
- Variety of personal relationships
- Opportunity to advocate for self/others/causes
- Valued roles in family & community
- Support to make major lifestyle changes
- Express one’s personal identity
- Support to manage aspects of life
- Plan reflects a life & supports designed by you & used to create positive image
- Maintain connections
- Be understood & get a response
- Feel safe/emotional well-being
- Opportunity for physical wellness
- Live & die with dignity
Beginning the Conversation: Getting to Know the Person

- Sometimes it’s good to just talk; Should be conversation with the person
- Share the Important Things That Have Happened to the Person (good & bad)
- Remember to Talk About Family Traditions, Important Activities/Dates/Etc.
- Think about your Strengths and Characteristics People Admire Most About YOU
- Think about How YOU Wants to Spend YOUR Day (work, school, fun, etc.) & How does that Compare to How YOU Spend YOUR Time now
Balancing Important to and Important for

Important FOR (what others know about the person’s health/safety needs)
- Diet
- Medication
- Supervision

Important TO (things that the person wants)
- Independence
- Friends
- Eating out
Assessment: What Does it Mean & How Does it Fit (or not Fit)?
Assessments

► Why do we assess?

► Types of assessments

► Informal vs Formal assessments

► Louisiana’s Approach to assessment
Planning

Building the plan of support
Planning

What are the unmet needs?

- Facilitate discussion to identify additional support needs
- Following basis questions may be used:
  - After consideration of information and formal/informal supports are there unmet needs in any areas?
  - What are the unmet needs?
  - Could the unmet needs be met with available/accessible supports? (Waiver Tier currently assigned)
  - Do any of the unmet needs warrant referral to other programs (i.e., could not be met with waiver services)?
  - Are there any remaining unmet needs that could be met with waiver? If so, what are they?
How Does the Provider Fit In?

Role of the Waiver Provider
Active Participation in Discussion

- Support Coordinator completes initial discovery, assessment process, and identification of unmet needs.
  - Information learned is shared at planning meeting with provider

- Provider – Must ask questions in planning meeting and quarterly meeting
  - How to deliver unmet needs
  - Where, when, how identified in provider documents
  - Ability to negotiate how services will be delivered
When is it appropriate to request to move to another waiver tier?

Waiver Exception Request Process
To Move or not to Move

If unmet needs with current waiver assignment, the Support Coordinator will:

- Build the schedule of supports
- Assist the family with locating service provider
- Referrals to other programs if needed
- Assist with locating resources for areas that support may be needed that waiver cannot address
- Complete planning process

If unmet needs can not be met with current waiver assignment and all other options have been considered AND unmet needs could be met by accessing another waiver option, then the SC can request an exception.
Universal Plan of Care Document
Universal Plan of Care (NOW, ROW, SW)

Major Changes

- Modified Cover Page
- Re-Ordered the document
- Health Profile modified
- Standardized documents to be used by service providers
  - Medication Page moved to be provider attachment
Standardized Provider Documents

- Replaces existing ISP formats completed by service provider.
- Intended to provide a snapshot of the actual supports being implemented by the service provider.
  - Extension of the identified goals/strategies – single plan of care document.
- Not every person will require every attachment.
- Attachments to be updated at regular intervals (minimally quarterly) and submitted to the Support Coordination.
Standardized Provider Documents

- Attachment B: Relationship & Community Contacts and Sustained Supports Information
- Attachment C: Daily Living & Home Life Sustained Supports
- Attachment D: Health & Wellness Supports
- Attachment E: Medication/Treatment
- Attachment F: Emotional Wellness and Crisis Prevention Plan
- Attachment G: Behavioral Health Supports
- Attachment H: Emergency Plan
- Attachment I: Back up Staffing Plan
Attachment B: Relationship and Community Contacts and Sustained Supports

- Important Contacts
  - List of family, friends, pastor, church, boyfriend/girlfriend, etc. important to the individual.
  - List phone numbers. List address if out of town.

- Lifestyle/environmental preferences
  - How individual communicates (phone, email, in person visits). Identify barriers to health and safety (inviting strangers to home, internet safety, etc.). Activities that individual wants to pursue (learning to quilt, joining a gym, getting a GED).
Attachment B: Relationship and Community Contacts and Sustained Supports (continued)

- Assistance required to support goal
  - Support needed to visit family/friends, go to church, visit boyfriend, get GED, join a gym.

- Independence/Shared Support
  - Goals for independence (money management, new living arrangement, unsupported time).
## Attachment B: Relationship & Community-Contacts and Sustained Supports Information

<table>
<thead>
<tr>
<th>Name: Leah Clevelanda</th>
<th>ISP/CPOC Date: 9/1/17 thru 8/31/18</th>
<th>Revised:</th>
</tr>
</thead>
</table>

### Important Contacts *(Family/Friend/Community Organization & Contact Numbers)*

- **Lynette (Aunt)** New Orleans, LA – 70126-304-378-9079
- **Bertha (Grandmother)** New Orleans, LA – 504-933-0239
- **Anna (Friend)** Memphis, Tennessee – 901-122-4567

Leah has a network of friends on social media and on the internet. She has remained involved with the deaf community through technology and this is the primary way she interacts/communicates with them.

### Lifestyle/environmental preferences:
It is very important for Leah to have access to the technology as it is her primary mode of communication. She has a video phone, her cell phone, and a laptop. She prefers to have some time to herself to chat with her friends. She does need some prompting and reminders regarding giving out personal information so that she is not taken advantage of and staff should continue to work with her in regards to internet safety.

### Any Assistance Needed in Keeping or Building Connections

<table>
<thead>
<tr>
<th>Assistance Needed in Keeping or Building Connections</th>
<th>Independence/Shared Support Considerations</th>
</tr>
</thead>
</table>

- **Leah needs assistance to schedule visits and transportation.** The staff will assist Leah with scheduling visits and transportation in the following areas:
  - Visiting with family in New Orleans, especially during holidays.
  - Meeting people and becoming involved in groups as much as possible.
  - Leah would also like to join a gym, so staff needs to assist her with visiting local gyms so she can find one that is reasonably close.
  - Leah would like a gym staff needs to assist her with visiting local gyms so she can find one that is reasonably close.
  - Leah needs assistance with scheduling visits with friends locally.
  - Initially and then branch out to other areas. Staff should assist her with planning these types of visits, prompting related to types of information to share with friends, and overall encouraging healthier relationships with friends and companions.

Leah will need assistance from the provider to contact LRS for employment resources so she can seek competitive employment. She will need transportation assistance and assistance communicating.

### Need Transportation Assistance

Leah will begin having some unsupervised time during the POC year. Her team will meet quarterly to discuss progress in terms of alone time and increase periods of alone time over the course of the year.

- Staff should continue to discuss internet safety and what healthy relationships look like (i.e., people not asking for money or personal information, people wanting to get to know her and hang out not just come over to her house or movie, etc.).
- Staff should also prompt Leah related to money management issues. Not spending all of her money so she has spending money when needed. Making sure her bills are paid prior to spending money. Creating an overall monthly budget.
- Leah would like to get her driver’s license. She has looked into driving school. Staff should assist where needed with scheduling to attend driving school and assist with identifying or requesting necessary accommodations.
- Staff should check with her regarding the need for assistance preparing for the written driver’s license test as requested by Leah.
Attachment C: Daily Living and Home Life Sustained Supports

- Describe the level of support required for activities in each section.
- If completely independent, then indicate “no supports needed”.
- This should agree with Section II B in the Plan of Care document.
<table>
<thead>
<tr>
<th>Name: Leah Clevelando</th>
<th>ISP/CPOC Date: 9/1/17 thru 8/31/18</th>
<th>Revised:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mealtime Supports:</strong></td>
<td><strong>Personal Hygiene Supports:</strong></td>
<td></td>
</tr>
<tr>
<td>No supports needed.</td>
<td>No supports needed.</td>
<td></td>
</tr>
<tr>
<td><strong>Physical/Mobility Supports:</strong></td>
<td><strong>Housekeeping/Yard Maintenance Supports:</strong></td>
<td></td>
</tr>
<tr>
<td>No supports needed.</td>
<td>No supports needed.</td>
<td></td>
</tr>
<tr>
<td><strong>Mealtime Prep/Cooking Supports &amp; Preferences:</strong></td>
<td><strong>Other Important Supports/Needs at Home:</strong></td>
<td></td>
</tr>
<tr>
<td>Leah needs minimal supports related to preparing meals. She needs assistance with transportation to get to the grocery store to make a list of needed items, budget money for purchases, and to purchase needed items for her meals. Primary area that she may need support would be with preparing meals that she has never cooked before.</td>
<td>Some monitoring needed while accessing and utilizing social media and/or internet safety. Reminders not to give out her personal information. Needs prompting related to money management. Leah and Kevin will work on her budget and Leah will be responsible for reminding staff when her bills are due to be paid.</td>
<td></td>
</tr>
</tbody>
</table>
Attachment D: Health and Wellness Supports

- Focuses on instructions that specifically address health and wellness needs (medical supports).
- Signs and symptoms to monitor should be listed and how to report if signs / symptoms occur.
  - Reporting method may change based on sign/symptom.
- Identify actions to be taken.
- Align with Section IV A. Health Profile
**Attachment D: Health & Wellness Supports**

<table>
<thead>
<tr>
<th>Exercise and Healthy Eating Preferences</th>
<th>ISP Date: 9/1/17 thru 6/31/18</th>
<th>Revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leah does not currently have any major medical issues or dietary concerns. She would like to join a gym and start exercising on a consistent basis. Staff should assist with locating a gym, budgeting money for this activity, and transportation to the gym.</td>
<td>☐ Dietary considerations MUST be implemented as described by Medical Professional.</td>
<td>☐ Healthy Eating can be supported via guidance and education with some flexibility in dietary choices.</td>
</tr>
<tr>
<td>There are currently no recommendations related to healthy eating beyond typical sorts of making healthy decisions. Staff should support Leah with this area as she requests.</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signs/Symptoms Per Medical Professional to Monitor</th>
<th>Instructions Per Medical Professional for Supports or Assistance with Medical Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Documentation Form/Sheet other than Daily Note</td>
<td>☐ Documentation of Instructions provided by Medical Professional.</td>
</tr>
<tr>
<td>☐ Report to Agency Nurse</td>
<td>☐ Verbal Recommendation during last visit</td>
</tr>
<tr>
<td>☐ Call Medical Professional</td>
<td>☐ Leah sees a PCP for Eczema and regular checkups. Her last exam was in July 2017. She goes to the Hammond Vision Center for eye exams. Her last eye exam was in May 2017.</td>
</tr>
<tr>
<td>Leah has Eczema which flares up periodically. She has ointment to apply when this happens.</td>
<td>☐</td>
</tr>
</tbody>
</table>

☑ Need Transportation: Assistance ☐ Need Assistance Communicating with Professional ☐ Need Assistance Scheduling/Making Appointments ☐
Attachment E: Medication / Treatments

► Providers have the most current medication / treatments for individuals.

► Must list **all** medications, not just medications administered by provider staff.

► Include PRN medications.

► Eliminates discrepancy between Support Coordination list and Provider list.

► Update as changes occur.

► **Not** required to list OTC meds unless taken regularly

► **Not** required to include standing orders for OTC meds
### Section A: List of Medications

<table>
<thead>
<tr>
<th>Medication and Dosage</th>
<th>What is it for?</th>
<th>Frequency</th>
<th>How is it taken?</th>
<th>Prescribing Physician</th>
<th>To be given by:</th>
<th>Delegation needed:</th>
<th>Check appropriate box</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seroquel – 200 mg</td>
<td>Depression</td>
<td>Two tabs at night</td>
<td>By Mouth</td>
<td>Keith Westerfield, MD, (Psychiatrist) Cope/Behavior</td>
<td>Self</td>
<td>□</td>
<td>X□</td>
</tr>
<tr>
<td>Fluoxetine – 40 mg</td>
<td>Improved Mood</td>
<td>1 capsule daily in AM</td>
<td>By mouth</td>
<td>John Tredina, PhD (psychologist)</td>
<td>Self</td>
<td>□</td>
<td>X□</td>
</tr>
</tbody>
</table>

### Section B: List of Treatments

<table>
<thead>
<tr>
<th>Treatment and Dosage</th>
<th>What is it for?</th>
<th>Frequency</th>
<th>How is it taken?</th>
<th>Prescribing Physician</th>
<th>To be given by:</th>
<th>Delegation needed:</th>
<th>Check appropriate box</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
Attachment F – Emotional Wellness and Crisis Prevention Plan

- Not required for all individuals but can be completed with anyone
- Support Coordinator and Provider representative assist individual to complete, or
- Appropriate professional staff assists individual with completion.
- Excellent tool for providers to train staff on how to best support individual and avoid/manage crises.
- Provides additional information for Attachment G: Behavioral Support/Instructions.
Attachment G: Behavioral Health Supports

- Complete if behavioral support is identified in Section IV, Part A.
- Use Emotional Wellness and Crisis Prevention Plan if completed.
- Will not replace a formal Behavioral Support Plan prepared by a physician.
**Behavioral Health Supports (Summary of Supports)**

The information in this section does not replace a formal Behavior Plan if needed. (A formal plan MUST be supplied by the professional and signed by him/her if it is indicated.) This is a set of instructions for staff to support current Mental Health Treatment Therapy based upon recommendations from the treating professional.

<table>
<thead>
<tr>
<th>Name: Leah Cleveland</th>
<th>ISP/CPOP Date: 9/1/17 thru 8/31/18</th>
<th>Revised:</th>
</tr>
</thead>
</table>

**Behavioral Health Symptoms/Behavioral Challenges**

- Documentation Form/Survey other than Daily Note
- Report to Agency Nurse/Supervisor
- Call Professional

Leah needs assistance with scheduling appointments and transportation. Staff does not normally go in with her to the psychiatrist’s office. Last appointment with Dr. Fidenza was 8/1/17.

Leah does not like side effects of some of the medications. If this becomes a problem, staff should encourage her to talk to her doctor about the side effects.

**Coping Skills & Supports Needed to Use**

- [ ]

**Staff Response/supports if symptoms/behavior(s) occur**

- [ ]

**Instructions to Avoid Triggers/Problems**

- [ ] Consult Emotional Wellness & Crisis Prevention Plan first

- [ ]

**Trauma or Behavioral Triggers**

- [ ]

**Staff Response**

- [ ]

**Need Transportation Assistance**

- [ ]

**Need Assistance Communicating with Professional**

- [ ]

**Need Assistance Scheduling/Making Appointments**

- [ ]
Attachment H: Emergency Plan

- Required for all individuals
- Provides standardized form to ensure consistency across the state
- Same standardized form for all OCDD Waivers
- Section V. identifies the Support Coordination Agency responsibilities.
- Requires signatures, including Support Coordination agency.
Attachment I: Back-up Staffing Plan

- Required for all individuals.
- Provides standardized form to ensure consistency across state.
- Same standardized form for all OCDD Waivers.
- Names should be a person’s name, not an agency name.
- Signatures are required.
Attachment E - Back-Up Staffing Plan

Participant's name: Leah Cleveland
Date of Birth: 8/1/1990

Direct Service Provider: All About U
Phone: (985) 345-1400

Waiver Type: ☐ Children's Choice ☑ Support Waiver ☑ Residential Options Waiver ☐ New Opportunities Waiver

Anytime a Direct Service Worker (DSW) is unable to provide service according to the plan of care (POC), the DSW is required to contact both the participant/family and the Direct Service Provider as soon as possible. When this happens, the plan below will be followed:

Primary responsibility for immediate coverage of a DSW's unplanned absence:
☐ Direct Support Provider is responsible for providing a back-up DSW. Call Direct Support Provider staff to contact the on-call point person at (985) 345-1400. Karen Lee will contact back-up staff. Staff on duty will remain with Leah until back-up staff is located. All staff working with Leah will be trained to provide supports as noted in her individual plan of care.
☐ Family/natural support chooses to provide support and does not wish to have a back-up staff. Call the primary contact listed below:
☐ Person(s) responsible for back-up coverage (list all family/natural supports who have agreed with this Back-Up Staffing Plan and their contact numbers):

Signature/Verbal agreement indicate they have agreed to provide support.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Main Contact</th>
<th>Other Contact</th>
<th>Signature</th>
<th>Verbal Agreement (indicate name and date of person who obtained verbal agreement in name and date of person who obtained verbal agreement)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑ Obtained Verbal Agreement</td>
<td>12/23/2022</td>
</tr>
<tr>
<td></td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
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<td>12/23/2022</td>
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<td></td>
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<td>☑</td>
<td>☑</td>
<td>☑ Obtained Verbal Agreement</td>
<td>12/23/2022</td>
</tr>
</tbody>
</table>

Direct Service Provider Representative Signature: __________________________ Date: 12/23/2022

I understand that if I am not happy with the plan, I can choose another Direct Service Provider. I agree with this Back-up Staffing Plan.

Participant/Responsible Representative: __________________________ Date: 12/23/2022
What’s Missing????

Supported Employment, Prevocational Services, and Day Hab Attachment

Attachment is currently in development.

Providers may use their existing ISP format for these services.

If no “in-home” provider:

- Support Coordinator completes Attachment E
- Provider may need Attachment D and/or G if monitoring for signs and symptoms
Timelines
Timelines – SC Agency

- Support Coordination Agency
  - Notify Provider Agency 30 days in advance of an annual planning meeting, in writing and confirm meeting two weeks in advance.
  - Send finalized support plan to Provider Agency within 7 calendar days of the planning meeting.
Timelines – Provider Agency

- Provider Agency
  - Provider Agency will review plan, sign budget sheets, and return plan and budget sheets along with provider documents within 5 calendar days of receipt of support plan and budget sheets.
  - Provider Agency should be preparing provider documents immediately following the planning meeting to meet the timelines.
New POC Implementation Timelines - SCA

- All initial POCs will be documented on the new Universal Plan of Care effective immediately.
  - Medication list (Attachment E) must be completed by SC if not completed by the provider agency.

- All annual POCs will be documented on the new Universal Plan of Care if the POC meeting is held July 1, 2018 or later. However, SCA can use the new Universal POC for annual renewals effective immediately.
New POC Implementation Timelines - Providers

► Provider documents for all POC meetings (initial and annual) held prior to July 1, 2018 can be submitted in the current format used by the provider agency. It is preferred that the new format be used, but it is not required.

► Provider documents for all POC meetings (initial and annual) held July 1, 2018 or later must be submitted on the Universal Plan of Care documents (Attachments B – I).
New POC Final Deadline

As of October 1, 2018, it is expected that any Plan of Care submitted for approval (SC Supervisor approval or LGE approval) will be completed on the new Universal Plan of Care document, including Attachments B through I. If not, the provider agency will have to resubmit their documents on the new Universal Plan of Care (Attachments B – I) for the plan to be approved.
New POC Documents and Instructions are available at:

http://ldh.la.gov/index.cfm/newsroom/detail/1564
Questions and Answers

Kim Kennedy
OCDD Program Manager
Kim.Kennedy@LA.GOV
225-342-4464
www.ldh.louisiana.gov/ocdd