OLTL Service Coordination Developing Service Plans Module

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# Service Coordination Training

Welcome. The Office of Long-Term Living developed this training to support Service Coordinators and their supervisors in developing the skills and knowledge required to provide service coordination services effectively and in compliance with state and federal standards.

This training applies to people performing service coordination in the OBRA Waiver and Act 150.

## Modules Overview

Service Coordination in these programs is a service that assists a participant in gaining access to needed waiver and program services, medical assistance state plan services, and other medical, social, and educational services regardless of funding source. This includes developing plans that include multiple funding sources and varying levels of formal and informal support.

Four online training modules were developed to cover the requirements and best practices required to perform service coordination. These modules are:

* Roles and Responsibilities,
* Funding and Service Delivery Models,
* Developing Service Plans, and
* Monitoring and Updating Service Plans.

Before we move on, let’s take a moment to review some terminology.

## Terminology Updates

A person’s physical and cognitive ability are assessed to determine if they are eligible for the program. This may be referred to as functional or clinical eligibility.

In the enrollment phase, an individual’s clinical eligibility is assessed using two different tools, based on the program.

Let’s start with the Act 150 program. The Functional Eligibility Determination (FED) tool is used to determine clinical eligibility. Along with the Physician’s Certification, the FED determines whether the individual is Nursing Facility Clinically Eligible (NFCE) or Nursing Facility Ineligible (NFI). The FED is updated during the annual reevaluation.

Now, let’s look at OBRA. The FED tool is also used with the Physician’s Certification to determine clinical eligibility. The level of care for OBRA is called Intermediate Care Facility/Other Related Conditions (ICF/ORC).

In addition to determining an individual’s physical and cognitive capabilities, the enrollment process also assess their long-term services and supports needs. The needs assessment tool for both Act 150 and OBRA is the Care Management Instrument (CMI).

A participant’s plan in both Act 150 and OBRA is called the Individual Service Plan (ISP). Service plans document a participant’s goals, services, risks, and mitigation strategies.

# Developing Service Plans

Welcome to Developing Service Plans. In this module, we’ll explore the regulations, requirements, and best practices related to developing service plans for waiver and program participants.

## Objectives

After completing this module, you will be able to:

* Conduct a service planning meeting.
* Accurately complete the ISP.
* Develop goal statements reflecting preferences, needs, and strengths.
* Identify and document needs, barriers, and risks.
* Document participant choice.

During emergency situations when the Governor issues a disaster emergency declaration, OLTL may need to make temporary changes to the OBRA waiver through an Appendix K amendment, to allow flexibilities in responding to the emergency.

OLTL may also decide to allow similar flexibilities in the Act 150 Program. If OLTL elects to allow temporary flexibilities to a waiver or Act 150, OLTL will inform providers of the approved changes through a ListServ email.

# Service Plans & Planning Meetings

In the first lesson, we’ll review the planning process and preparing for and conducting person-centered planning meetings with participants.

## What Is a Service Plan?

Let’s start with a definition of a service plan. A service plan is a comprehensive, written summary of an individual participant’s services and supports. The service plan reflects the participant’s goals, preferences, strengths, and health status.

The standardized process for service plan development and review provides continuity of care and consistent expectations for participants, Service Coordinators, direct service providers, and OLTL.

## Service Coordination Regulations

Service Coordinators must comply with all applicable state regulations contained in the Pennsylvania Code. Service Coordination Entities (SCEs) are monitored for compliance with these regulations.

The Service Coordination Resources Document has links to the Pa. Code sections that apply to service coordination.

## Service Plan Regulations

The requirements for service plans are listed in 55 Pa. Code, Section 52.26. Let’s take a look at these requirements.

A Service Plan Must Include:

* The participant's needs, as identified and documented on the Department-provided needs assessment tool.
* The participant's goals, preferences, and intended outcomes.
* Services, Third Party Resources (TPRs), or informal community supports that meet the participant's needs, goals, preferences, or outcomes.
* Each participant’s needs must be addressed by a service, TPR, or informal community support, unless the participant chooses for a need not to be addressed.
* If a participant refuses to have a need addressed, the SC shall document when the participant refused to have the need addressed and why the participant chose for the need to remain un-addressed.
* The type, scope, amount, duration, and frequency of services needed by the participant and the provider of each service.
* Risk mitigation strategies for each goal, need, or service and the Individual Back-up Plan for each. Also included is the Emergency Back-Up Plan.

In Addition:

* The participant’s service plan must be completed in a format prescribed by the Department and information must be entered into the designated information system.
* SCs must review the participant’s needs, goals, preferences, and outcomes, documented in the service plan, at least annually with the participant.
* SCs must review and modify, if necessary, participant's needs, goals, preferences, and outcomes each time a participant has a significant change in a medical or social condition.
* SCs are encouraged to review the full set of regulations regarding service planning.

A link to view 55 Pa. Code, Section 52.26 in its entirety can be found in the Resources Document.

## Service Planning Process

Now that we’re clear on the requirements, let’s look at the process as a whole. In addition to having specific steps and milestones, there are required timeframe goals for meeting the milestones in planning.

### Schedule & Prepare

The first step is to schedule and prepare for a person-centered service planning meeting. A Service Coordinator must schedule a face-to-face meeting with the participant within two (2) business days of receiving the participant’s completed information packet from the Independent Enrollment Broker. Please note that the meeting must be scheduled within two business days. The meeting does not need to occur within two business days. If a participant is unavailable or unresponsive, SCs must document their attempts to schedule the meeting and note the times and dates of their attempts. This satisfies the Centers for Medicare & Medicaid Services (CMS) requirements for prompt attention in planning.

### Conduct

The next step is conducting the planning meeting in a person-centered manner. The outcome of the meeting is an initial service plan based on discussions with the participant and whomever else they choose to include in planning.

### Finalize & Supervisor Review

After conducting the meeting, the SC finalizes the service plan for supervisor review. Supervisors approve all plans before submitting them to the Bureau of Fee for Service (FFS) Programs for final review and approval.

This part of the service coordination process (preparing for and conducting the planning meeting, finalizing the initial development of the plan, and submittal to the Bureau of Fee for Service Programs) must be completed within 15 business days. If the timeframes cannot be met, SCs should document the reasons and note times and dates of steps taken and barriers encountered.

### OLTL Review

In the final step, the Bureau of Fee for Service Programs reviews the service plan and determines if planning requirements are met.

### Person-Centered Process

As we’ve learned, SCs must emphasize with participants that the development of a service plan is a person-centered process. Participants have the right to include a representative in the process. This could be a family member, service provider, counselor, advocate, or any other person that the individual wants to include. Others are only included in the meeting at the participant’s request.

## Preparing for a Planning Meeting

Let's take a look at the first step, the planning meeting. To prepare for the person-centered service planning meeting, SCs thoroughly review the Functional Eligibility Determination (FED) and complete the Care Management Instrument (CMI). The FED describes a participant's clinical eligibility. The CMI will document the participant's needs, environment, and current levels of support.

SCs must review these documents to ensure that the planning process and service plan include and address all items identified. We do this for several reasons. A thorough review process provides the basis for in-depth conversation. It also means that the individual does not have to “tell their story” multiple times to multiple people.

The three documents (FED, CMI and ISP) must be aligned and consistent in terms of a participant’s needs, strengths, goals, and supports in order for the Bureau of FFS Programs to approve the plan.

In addition to reviewing the assessments, SCs review the available services under the HCBS waiver or program in which the participant has been enrolled. SCs pay special attention to allowable ongoing services and determine through the planning process if these services will address the needs of the participant.

For example, some waiver services in OBRA have language that states the waiver service is only provided to individuals aged 21 and over. For individuals aged 18 to 20, these particular services are funded through Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), not OBRA. For the initial ISP review, the SC should complete a needs assessment to determine if any other ongoing waiver services available to participants under the age of 21 are required.

When a participant is approaching the age of 21, the SC should also complete a needs assessment to determine if any of the other additional ongoing waiver services available to participants aged 21 and over are required.

### Service Waiver Links

The best place to find the most current waiver and program information is by accessing the actual CMS-approved waiver and OLTL bulletin information. All services, provider requirements, limitations, amendments, and other critical information are listed. SCs can use “search” and “find” tools to find information quickly. The link and pathway for the waivers and OLTL bulletins is listed in the Resources Document.

## Conducting the Planning Meeting

As a reminder, person-centered planning and service plan development is a collaborative process among the participant, representatives of the participant if chosen, the SC, and others as identified by the participant. This process is person-centered. The service plan must address the participant’s goals (including those related to employment and community engagement), needs, strengths, and preferences.

In addition, the participant’s choice of service model, service type, and service provider is also fundamental to personalized planning.

As part of the process, SCs must:

* Conduct the meeting using a person-centered approach.
* Personalize the service planning.
* Inform the participant of available service delivery options.
* Assist the participant in identifying and managing risks and barriers.
* Assist the participant in developing back-up and emergency plans.
* Provide assurances of participant choice.
* Discuss roles the participant plays in implementing and monitoring the service plan, including frequency and nature of the SC’s contact.

### Gathering Information

The process requires SCs to gather a significant amount of information from participants, without overwhelming them with questions. A best practice is to ask open-ended questions and gather information based on listening to participants talk about their lives.

Based on discussions with SCs, the following are suggested questions to ask when developing a personalized service plan:

* Over the past year, what has been happening in your life?
* How safe do you feel and why?
* Please tell me about a typical day in your life.
* How do you feel about what you do during the day? Where you live? Who you live with?
* What are the things/areas in your life that you want to remain the same as they are today? What do you want to change?
* How do you feel about having a job? What would you like to do for employment?
* What do you like to do for fun?
* What kinds of community activities do you participate in?
* Could you tell me more about that?

### Encouraging Participants to Open Up

You just reviewed examples of open-ended questions that can encourage participants to provide critical, unique information about their lives and goals.

Please pause of a moment and think about how you might encourage someone to “open up” about themselves.

## ISP Process Knowledge Check Lesson 1

Now check your understanding by answering these review questions.

1. True or False? The Service Coordinator must meet face to face with the participant within two (2) business days of receiving the participant's completed information packet.

Please pause.

The correct answer is False. The SC must schedule a meeting with the participant within two (2) business days. The meeting need not occur within two days.

2. Regardless of the program, service plan development is a what kind of process with the participant?

Directed

Collaborative

Intensive

Medical

Needs-based

Please pause.

The correct answer is collaborative. Service plan development is a collaborative process among the participant, a representative of the participant if chosen, the SC, and others as identified by the participant.

3. True or False? If a participant is unavailable or unresponsive to the Service Coordinator's request to schedule a planning meeting and the Service Coordinator documents attempts to schedule the meeting (noting times and dates), that is sufficient to meet OLTL requirements.

Please pause.

The correct answer is True. If the SC makes attempts to schedule the planning meeting and documents all attempts, including times and dates of the attempts, OLTL regulations for prompt planning are considered met.

4. Which document(s) must Service Coordinators review before the service planning meeting?

Functional Eligibility Determination

Physician Certification Form

Needs Assessment

PA-752

Service Authorization Form

Please pause.

The correct answer is the Functional Eligibility Determination. To prepare for a planning meeting, SCs should thoroughly review the Functional Eligibility Determination (FED). This document is completed in the enrollment process.

5. True or False? Service Coordinators must meet with participants alone. Others are not invited to the planning meeting.

Please pause.

The correct answer is False. Participants may choose to have others involved in the meeting. Others may only be involved at the invitation of the participant.

6. True or False? The OLTL Individual Service Plan form is simply a tool. It is not required.

Please pause.

The correct answer is False. The OLTL Individual Service Plan form is required by OLTL as the single common form for Act 150 and OBRA.

# OLTL Individual Service Plan (ISP) Form

In the second lesson, we will review the OLTL Individual Service Plan (ISP) form.

So where does all this information about a person’s goals and services end up? As noted in the Pa. Code regulations, all the service plan information must be captured onto a standard service plan form and documented in HCSIS.

The required form is the state-issued OLTL ISP form and is available electronically. The state-issued ISP form is required for OBRA by CMS and is the basis of how we’ll review the plan development process. It is also required for Act 150.

For more information about the ISP form, please review the updated Service Plan bulletin and updated ISP form. A link to the bulletin is available in the Resources Document.

## ISP Form – Page 1

Let’s take a closer look at each section of the form and what information is required to be documented. Page one of the ISP form is broken into six sections for review purposes.

### Demographics and Directions

The first page of the ISP form starts with demographic data and a place to include driving directions. Directions are a crucial part of the plan for several reasons.

First, electronic direction services may not always provide accurate directions to a private residence. To avoid co-worker confusion and delays, always include directions from your location to the participant’s residence . . . especially “last mile” references and landmarks if there is any room for misinterpretation.

Second, these directions can be shared with service providers when authorizing services to ensure that providers can find participants’ residences quickly and easily.

### Individual Back-up Plans

The next section requires SCs to document the Individual Back-up Plan. An Individual Back-up Plan prepares participants if their individual service provider is not available. It identifies the actions to be taken if their services are delayed, interrupted, or unavailable. The plan should address all services that are critical for participants to reach their goals, especially those that relate to their health and safety.

An Individual Back-up Plan outlines the steps that participants and/or SCs will take if their providers are unable to deliver services. For example, what happens when a care worker does not show up to assist a participant with preparing meals?

Based on the participant’s preferences, there are multiple strategies available for back-up services. These can include using alternative agencies, family members, or informal supports to step in and provide services. Please note that there are risks associated with using informal support systems that may or may not be available on demand.

Also, using a Personal Emergency Response System (PERS) is not a back-up strategy. A PERS unit can notify emergency personnel of a situation where there is no caregiver, but the PERS does not provide the actual support needed.

#### Individual Back-up Plans – Documentation

The plan should identify the names of the primary and back-up service providers and ensure that back-up providers are informed of service delivery needs. In addition, the plan must document who to contact and what steps to take if the back-up activities identified in the service plan are not working effectively. If a participant’s Individual Back-up Plan fails, they may use another agency or service to provide emergency back-up coverage.

When an Individual Back-up Plan fails, the SC is accountable for responding and must step in to see that services are continued. The response must result in continuity of services up to and including the SCEs providing temporary support.

Service Coordination is a 24 hour per day service. This means the SCE must provide coverage so that participants can call at any time of day or day of week and receive the support they need. A plan failure that results in a risk to health or safety is a reportable critical incident.

#### Individual Back-up Plan Responsibilities

Not only are Individual Back-up Plans important for the health and safety of participants, but they are required and have specific responsibilities.

Agency Responsibility

If the participant uses an agency, the agency is responsible for staffing all shifts. “The preferred care worker called in sick” is not an excuse to fail to provide services that day.

Participant Responsibility

If participants hire their own care workers, they must have multiple layers of back-up to ensure health and safety. Participants must know how to contact the back-ups.

SC Responsibility

SCs review the service plan quarterly, or more often if needed, to validate that the strategies and back-up plans are working and are current.

For example, if a neighbor is listed as the back-up, call the neighbor to ensure that he still lives there and is aware that he is the back-up person. SCs must update back-up plans as necessary, especially if the back-up has failed at any point.

SCs and SCEs are ultimately responsible for a participant's continuity of care and services.

Back-up planning is crucial to ensure the health and safety of participants. It requires special attention if there are few agencies in the participant’s area or if the participant chooses to hire their own care workers.

### Emergency Back-up Plans

This section requires SCs to document the Emergency Back-up Plan.

An Emergency Back-up Plan prepares participants for general emergency events. These plans address events like power outages, fires, inclement weather, travel restrictions, evacuations, and other similar events. Individuals with long-term care needs require additional planning to prepare for these events. Federal and state emergency management agencies (FEMA/PEMA) provide guidance on emergency planning that SCs can incorporate into their discussions with the participant.

Emergency Back-up Plans are person-centered and should include strategies to address both common emergencies and the participants’ needs in those types of emergencies. “Call 911” could be used in addition to other strategies that address specific participant needs in these situations.

#### Emergency Planning Examples

Emergency Back-up Plans (also known as Emergency Preparedness plans) are used during events that affect more people than the participant.

Take a moment to review some examples of emergencies that participants and SCs must plan for and questions that you, the SC, should be asking.

Power Outages

Problem: Power outages could affect elevator access, ventilators, refrigeration of medication, the ability to ambulate safely, and other key functions.

Questions to Consider:

* What will happen to medications if the refrigerator is off?
* How can participants safely move around their homes with no light?

Weather Emergencies

Problem: Weather emergencies can affect the ability of participants to access services outside the home and can also affect the ability of care workers to reach the participant's home.

Questions to Consider:

* How will participants get the services they need if roads are closed or dangerous?
* What if public transit is offline?

Evacuations

Problem: Mandatory evacuations in case of fire, flood, or other regional emergencies.

Questions to Consider:

* How are participants going to exit their residence safely?
* Where will they go if they cannot return soon?
* What should they be prepared to take with them at a moment’s notice?

Geographic Emergencies

In each geographic area, there are common types of emergencies that are likely, such as power outages, fires, and snow. Other areas may have additional challenges related to flooding. Remember to be aware of and anticipate potential emergencies for your participants’ geographic area.

#### Emergency Back-up Plans – Assistance

It is important for SCs to be familiar with the likely types of emergencies and be able to review and plan with participants to address these emergencies. The American Red Cross, FEMA, and PEMA all have tools and resources to assist people in planning.

Also, SCs should contact their local emergency and first responders. often at the county level. Local emergency managers need to be aware of people with special emergency needs so that they can respond effectively and accurately. SCs must take steps to make sure this was communicated.

### Representative Contacts

Representative contacts are those people who are empowered to make decisions with or on behalf of participants. Ensure that full contact information is documented for all representative contacts.

### Primary Language

Primary language is critical. Navigating home and community services is challenging enough without the added burden of not being able to communicate accurately and effectively. If the participant’s primary language is not English, ensure that translation services are available.

### Goals and Strengths Overview

The next section is required not only for initial planning, but also as a reference for ongoing monitoring and support. The participant’s overall goals and strengths are essential to developing the plan. Goals, needs, and strengths are required by the Pa. Code and by CMS.

All services in the plan must be related to a goal, but why? They are necessary to assess how well the plan (and the investment of public funds) is working for the participant. Goals focus the participant and SC’s attention on the future and on what is possible for the person.

#### Goals

So, how do you develop goals with the participant? Goals are often discovered in two ways. One is to talk about things that the participant would like to be able to do that they may have difficulty in doing now. Another way is through a general discussion of risk in the person’s life.

For example, if a person with a diabetes diagnosis can no longer cook for themselves, their health is at risk, and the disease could worsen without some kind of service or support. Part of a long-term goal for disease management could be improved nutrition.

In another example, if a person can no longer leave their house to do things, they may be at greater risk of isolation and depression or anxiety. Part of an overall mental health goal could be improved contacts in the community.

#### Strengths

Participant strengths can be personal and environmental. They are necessary to the plan as a gauge of capabilities for self-support and participant involvement.

For example, if Tina is able to manage all of her own medications (purchasing them, administering them, and monitoring their effects), that is a strength. If she is alert, oriented, and can direct or manage all of her own financial and household activities, that is a strength. If she has family members within a 5-mile radius of her home who can visit and provide some levels of support, that is a strength. If she lives in affordable, accessible housing, that is a strength.

#### Household Composition

Household composition documentation is important for two reasons. First, it is helpful for SCs to know who lives in the home, who may answer the door or phone, and who may be available to provide informal service and support. Second, household composition is checked in relation to informal supports listed in the service plan.

If Mary has three adolescent or adult children living in her household who will provide some level of informal support, this information should be recorded as informal supports in the service plan.

SCs should encourage use of informal supports as part of the plan. SCs must note if people in the household are unwilling or unable to provide support.

## OLTL ISP Form - Page 1 Knowledge Check

Now check your understanding by answering these review questions.

1. True or False? An Individual Back-up Plan prepares the participant in the event that their service providers are unable to deliver services.

Please pause.

The correct answer is True. Strategies for an Individual Back-up Plans may include:

* Informal supports to provide assistance with safety or health emergencies.
* The use of family, friends, or agency staff.

2. True or False? If a participant's Individual Back-up Plan fails, he or she will not receive services.

Please pause.

The correct answer is False. If a participant's Individual Back-up Plan fails, he or she may use another agency or service to provide emergency back-up coverage.

The SC is accountable for responding and must step in to see that services are continued. The SCE may need to provide temporary support. SCEs must provide coverage so that participants can call at any time of day or day of week and receive the support they need. A plan failure that results in a risk to health or safety is a reportable critical incident.

3. An emergency plan prepares participants for emergency events, such as power outages, inclement weather, evacuations, etc.

Where can a Service Coordinator go for guidance on emergency planning?

(Select all that apply.)

National Emergency Responders Agency (NERA)

Federal Emergency Management Agency (FEMA)

American Red Cross

Pennsylvania Fire Police Academy (PFPA)

Pennsylvania Emergency Management Agency (PEMA)

Please pause.

The correct answer is The American Red Cross, the Federal Emergency Management Agency (FEMA), and the Pennsylvania Emergency Management Agency (PEMA) all have tools and resources to assist in emergency planning. SCs should also contact their local emergency and first responders to make them aware of emergency needs.

4. Select the correct answer. An Individual Back-up Plan prepares the participant in the event that:

There is a fire or evacuation.

The service provider or direct care worker is not available.

There is a power outage.

The local EMS performs a standard audit.

Please pause.

The correct answer is that an Individual Back-up Plan prepares participants in the event that their service provider is not available. It identifies the actions to be taken in the event that services are delayed, interrupted, or unavailable.

5. True or False? Service Coordinators must only review the Individual Back-up Plan twice per year.

Please pause.

The correct answer is False. SCs must review the Individual Back-up Plan at least quarterly.

6. True or False? All services in a service plan must be related to a goal.

Please pause.

The correct answer is True. Goals, needs, and strengths are required by the Pennsylvania Code and by CMS. All services in the plan must be related to a goal.

## ISP Form – Page 2

Page two of the ISP form allows you to document important information such as List of Assessed Needs, Community Resources, Informal Supports, Third Party Liability, and Non-Waiver/Program Services. Page two of the ISP form is broken into two sections for review purposes.

### Identified Needs

This section sets the stage for the services and supports that will be included in the service plan. These four lists (Identified Needs, Community Resources, Informal Supports, and Third Party Liability) provide a snapshot of what participants need and what is currently available to meet their needs without a plan in place. The services noted later in the plan fill the gaps identified in this part of the service plan.

The Identified Needs section provides an overview of the participant's assessed needs and the non-waiver resources available to meet those needs. This list is the summary of all things that a participant requires to live independently and to meet their goals.

Assessed needs are listed and categorized as “Met,” “Partially Met,” or “Unmet.” Services can only be included for needs that are “Partially Met” or “Unmet.” For a need to be documented as “Met,” it must be met without any formal, informal, or other services. The participant must be able to meet the need independently. This list assumes that no service plan or services are in place. It identifies gaps and is the basis for the services provided in a plan.

#### Identified Needs – Example

For example, if Jane has a goal of managing her chronic disease and part of that includes taking medication at regular intervals, medication management (including administration) would be a need.

If Jane can purchase, unpack, schedule, administer, and check the effects of her medications, her need is “Met.” She can perform these tasks independently and SCs can note how she fully meets her needs.

If Jane has cognitive issues and can do everything except remember the pill schedule, her need is only “Partially Met.” If it is her husband who cues her to take her pills, her need is still only “Partially Met” because she requires third-party assistance. SCs would note how her need is met. This would trigger discussion about what to do if her husband is not available to remind her to take her medications.

If, due to debilitating arthritis, Jane cannot independently purchase, unpack, or administer her medications and has no one in the household to assist, her need is “Unmet.” The waiver and non-waiver services assigned in the next section fill the gaps in Jane’s identified needs.

At the time of plan renewal, SCs should develop this list as though no plan is in place. For example, when “Met” needs are not addressed in service plans. Or when services may only be assigned to “Unmet” or “Partially Met” needs.

### Resources, Supports, and TPL

The lists of Community Resources, Informal Supports, and Third Party Liability/Resources should reflect your discussions with the participant and be consistent with the goals, needs, and strengths discovered in the FED and needs assessment. Let’s review items that must be completed as part of the service plan.

#### Community Resources

Community Resources are service and support organizations that help the participant meet needs. If there are no local support organizations to provide support, please document that fact.

#### Informal Supports

Informal Supports are people (family, friends, colleagues) who can provide the support needed for the participant to remain independent.

Informal supports must be individuals who are available, willing, and able to provide the specific services noted on the service plan in the amount, scope, type, duration and frequency required and in the manner specified in service definitions. SCs are required to assess the viability of informal supports on a regular basis.

A husband may cue a person to take medications. A neighbor may cook dinner for a person twice per week. A club member may provide a ride to the store once per week. If a person does not have informal support, SCs must document that.

#### TPL/TPR

Third Party Liabilities (TPL) and Third Party Resources (TPR) are other sources of funding for long-term care.

TPL/TPR must be accessed and exhausted before waiver funding can be applied. Waiver programs are payers of last resort.

### Document Non-Waiver Services

After needs, current support, and gaps are identified, SCs move to the next step in the planning process: identifying and documenting a participant’s non-waiver and program services. SCs assist people in accessing services regardless of funding source. In this section, they document how the participant and the SC agree to access non-waiver and program-funded services. Waivers are “payers of last resort.” So, all other services must be accessed, exhausted, and documented here.

As we discovered previously, there are many non-waiver services and supports available to meet participants’ long-term care needs. These include:

* EPSDT services for individuals under the age of 21,
* MA services for registered nurse or licensed practical nursing care,
* Programs through the Office of Vocational Rehabilitation (OVR),
* Transportation provided by community organizations,
* Physical therapy services available through the participant’s health insurance,
* Companion services provided by local houses of worship,
* Recovery support as part of worker’s compensation or legal settlements,
* Services through the Veteran’s Administration and the Department of Military and Veterans Affairs, and
* Medical Assistance for Workers with Disabilities (MAWD).

Even though waiver funds are not used, all of these services must be documented for several reasons. First, SCs must document that non-waiver services were accessed and exhausted before waiver services were assigned. Second, if the non-waiver service becomes unavailable, the SC may be able to assign waiver services as a back-up or replacement.

Non-waiver services must be aligned with goals and must note the participants’ preferences. SCs must also document type, scope, amount, duration, frequency, risks, and mitigation strategies. Let’s take a look at the first steps in that documentation.

#### Goals

Goals are the intended outcome of the service or support. Goals could include statements related to maintaining independence, good nutrition, hygiene, social interaction, managing chronic diseases, employment, and others.

#### Identified Needs

Identified Needs are the gaps in a participant’s ability to achieve the goals.

Needs could include activities related to Activities of Daily Living, such as bathing, grooming, eating, and transferring.

Needs could also include activities related to Instrumental Activities of Daily Living (tasks related to maintaining independence), such as cleaning, transportation, and financial management.

#### Action Steps

The Action Steps are the services provided based on the individual’s identified needs and stated goals (desired outcomes).

Information from the individual’s personal profile, FED, and needs assessment should be used to assist with planning.

Services should not be duplicated within the Action Steps.

#### Provider/ Responsible Party

The Provider/Responsible Party is the individual or entity responsible for providing support to the participant.

#### Preferences

Preferences include the participant’s wishes in terms of how services are delivered.

Preferences could include the days of the week services are provided, gender of personal assistants, and other considerations.

#### Documenting Frequency and Duration

Times of day and days of week for non-waiver services are also critical to note to expedite transferring to waiver services if needed.

Frequency and duration note the amount of time needed for the Action Steps or Service and how often the steps or activities must be performed. The question arises: “Why document detailed frequencies and durations for things that the state doesn’t pay for? What does it matter?” Being as detailed and accurate as possible is important for several reasons.

First, accuracy here is essential in case a non-waiver service becomes unavailable. If Michelle’s husband is providing 20 hours per week of transferring and grooming support, what happens if he is hospitalized? The number of hours documented assists in identifying back-up resources and in justifying moving to waiver services if something happens.

Second, accuracy of non-waiver services is necessary to determine hours and scope for respite services.

Third, accuracy of frequency and duration ensures that there are no duplication of services.

#### Managing Barriers and Risks

We discussed barriers and risks at a high level as they relate to developing goals and identifying needs in the planning process. Those risks often relate to the health and safety of participants if they do not receive support. Those risks are often noted in the Needs Assessment and are reflected in the goals and needs in the service plan.

Another “risk discussion” to have with the participant relates to the risks involved with how a participant chooses to manage their services. Preferences and providers can present risks. Those risks are documented in this section.

For example, a risk associated with good nutrition could be a participant’s preference to prepare meals even though they have left the stove on and caused fires in the past. Caregiver burnout is a risk associated with preferring only family members to provide support with no back-up or relief. Service interruptions could be a risk if a participant chooses to hire a care worker who lives far away or who has many other obligations.

Risks and barriers must be noted along with mitigation strategies. Participants may agree or disagree with the existence of the risk and the mitigation strategy. A person can disagree that eating cereal for three meals per day is a health risk or that relying on a neighbor for the only hot meal each day could be risky. Participants have the right to accept risks and address them as they see fit. However, participants cannot accept risks that endanger themselves and others.

For example, a participant, who uses oxygen and chooses to smoke, cannot accept the risk of an explosion and the potential harm to care workers and others in the household. In addition, if a participant accepts a risk that jeopardizes their health or safety, the SC must review this with the supervisor. OLTL is available to consult with the SC and supervisor as needed.

SCs must document the existence of the risks and barriers. The risk discussion documentation must include the topics discussed, the dates of discussions, the people involved, and the risks accepted and mitigated.

For a full discussion of a participant’s rights and responsibilities, please refer to the Participant Information Packet.

## OLTL ISP Form - Page 2 Knowledge Check

Now check your understanding by answering these review questions.

1. True or False? Non-waiver services are covered first in the planning document because they must be accessed and exhausted before waiver services can be used.

Please pause.

The correct answer is True. Non-waiver services are covered first in the planning document because they must be accessed and exhausted before waiver services can be used.

2. Page two of the Service Plan form sets the stage for services and supports that will be included in the service plan. Which of these items provides an overview of the participant's assessed needs and the non-waiver resources available to meet those needs?

Identified Needs

Community Resources

Informal Supports

TPL (Third Party Liabilities)

Please pause.

The correct answer is that identified needs provides an overview of the participant's assessed needs and the non-waiver resources available to meet those needs.

3. Which of these items is people (family, friends, colleagues) who can provide the support needed for the participant to remain independent?

Identified Needs

Community Resources

Informal Supports

TPL (Third Party Liabilities)

Please pause.

The correct answer is that informal supports are people (family, friends, colleagues) who can provide the support needed for the participant to remain independent.

4. True or False? The list of Identified Assessed Needs assumes that no service plan or services are in place.

Please pause.

The correct answer is True. The list of Identified Assessed Needs is the basis for the services provided in a plan. The list assumes that no service plan or services are in place.

5. True or False? Services can be included for a participant's needs that are "Met," "Partially Met," or "Unmet."

Please pause.

The correct answer is False. Services can only be included for needs that are "Partially Met" or "Unmet." Remember that for a need to be documented as "Met," it must be met without any formal, informal, or other services.

6. True or False? If a person's needs are currently being met by family members, the needs are listed as "Met" in the List Identified Assessed Needs section.

Please pause.

The correct answer False. For a need to be "Met," it must be met without any formal, informal, or other services.

## ISP Form - Pages 3-4

After documenting non-waiver services, SCs follow the same process to document waiver services. Additional fields in this section include the provider and the service model.

The specific direct care service providers are noted in the service plan. Participants who do not already have their providers selected, can select their providers from a randomly-generated list that SCs provide as part of the planning process. SCs pull the list from the COMPASS website. SCs ask participants to select a ranked list of providers in case the first-choice provider is not accepting new participants at the time of plan approval. Please note that participants may select multiple providers to deliver services.

Can SCs select providers if participants don’t know what to do? No. The participant must make the selection. SCs can assist participants in terms of sharing best practices in selecting providers and help them make decisions without exerting undue or unfair influence in favor of a specific provider.

For example, Mrs. J says, “How do I pick? Who do I select? You’re the expert!”

The SC can reply with, “I’d be happy to help.”

People are typically happy with providers that have good references and experience, as well as local staff. Be sure to consider how many people work for the agency and what their “sick-day” coverage might be like.

Mrs. J counters with, “But what if I don’t like the person? I hate having strangers in my home.”

The SC can reply with, “Many providers encourage people to interview their staff before making a decision and can assign new care workers if the original one does not work out. Remember, you have the right to change your agency at any time.”

SCs cannot guide participants to an individual provider. That would be a conflict of interest. SCs can assist people in decision making and ensure that they know their rights and obligations.

Service models refer to the Agency or Employer Authority model of managing and directing one’s services. SCs should note the participant’s choice and any risks or barriers that the SC and the participant discussed related to their choices.

#### Waiver Services Barriers, Risks, and Mitigation

Frequency and duration are noted by time of day and day of week. This is essential to ensuring that participants receive the services they need. Service providers and care workers must provide the amount of services at the correct frequency. Failure to do so could result in a risk to the participant’s health or safety and can be a reportable incident.

Barriers and risks are associated with waiver and program services, as well as non-waiver services. As we learned earlier, all risks must be noted and mitigation strategies discussed.

* A risk with an agency that has limited local staff could be the inability to cover a shift during flu season.
* A risk of hiring and managing one’s “flighty” cousin as a care worker might be reliability of service.
* A risk or barrier of meeting most nutrition goals at a local senior center might be transportation or inclement weather closures.

SCs are responsible for identifying and reviewing the barriers and risks associated with participants’ choices, as well as mitigation strategies.

Participants have the right to accept risks. SCs must document all aspects and outcomes of the risk discussion.

If participants make choices that the SC thinks will endanger their health or safety, the SC should note and review this with the supervisor and consult with OLTL if needed.

## ISP Form – Page 5

The last page of the ISP form is the signature page. The signature page is essential to ensure that SCs have provided participants with all information, guidance, and choices required by state and federal rules.

At the top is a “summary” section where SCs note any outstanding needs, risks, or barriers that were not addressed in the planning process. Unaddressed needs could be a result of the participant's choice and preferences, or they could be based on a lack of resources available to meet the needs. SCs review the risks of leaving the needs unaddressed.

SCs discuss possible mitigation strategies with participants and document the outcome of the discussion. SCs also note any additional supports that are needed.

The next section is where participants “check the box” to note that they received the required service planning forms. Participants also indicate that risks were discussed and that they agree with the mitigation strategies. The participant and others sign the plan.

This documentation is critical. It can flag potential risks to health and safety and documents the participant acceptance of the risks at the time of planning.

### Signature Page – Common Errors

Take a moment to review some common errors on the signature page.

Signatures and dates are missing.

* Unsigned by participant or SC
* Signatures without dates
* No signatures or dates from others who participated
* Date Completed does not match service notes
* Unaddressed needs/risks/barriers identified during the assessment process

Sections are frequently blank or have been marked N/A.

* Mitigation Strategy (How are barriers being addressed/ reduced?)
* Additional Supports (Are additional supports needed?)

Service plan type is incorrect.

Forms are not checked off.

Forms may be checked off, but they are not in the file.

## OLTL ISP Form - Pages 3-5 Knowledge Check

Now check your understanding by answering these review questions.

1. True or False? Non-waiver services are not required to be documented because waiver funds are not being used for these services.

Please pause.

The correct answer is False. Even though waiver funds are not used, all of these services must be documented. SCs must document that non-waiver services were accessed and exhausted before waiver services were assigned. Also, if the non-waiver service becomes unavailable, the SC may be able to assign waiver services as a back-up or replacement.

2. Whether documenting non-waiver, or waiver services, specific information must be collected and documented. Which term describes the intended outcome of the service or support?

Goals

Identified Needs

Action Steps

Provider/Responsible Party

Preferences/Service Model

Please pause.

The correct answer is that goals are the intended outcome of the service or support.

3. Which term includes the participant's wishes in terms of how services are delivered?

Goals

Identified Needs

Action Steps

Provider/Responsible Party

Preferences/Service Model

Please pause.

The correct answer is that preferences and the service model include participant's wishes in terms of how services are delivered.

4. Which term is developed based on the individual's identified needs and stated goals?

Goals

Identified Needs

Action Steps

Provider/Responsible Party

Preferences/Service Model

Please pause.

The correct answer is action steps are developed based on the individual's identified needs and stated goals.

5. True or False? Participants must agree with assessed risks and must agree to a mitigation strategy for the service plan to be implemented.

Please pause.

The correct answer is False. Participants may disagree with the assessed risk and/or mitigation strategy. SCs must note that the conversation took place and that the participant disagreed. If the SC believes this poses a threat to health and safety, the SC should contact their supervisor and OLTL for clarification.

6. True or False? The Non-Waiver and Waiver sections of the OLTL ISP form collect the same type of information.

Please pause.

The correct answer is True. Aside from documenting the chosen service model in the OLTL Waiver/Program Services section of the form, the other information collected is the same.

7. True or False? While Service Coordinators may not choose for participants, they may guide them to a reputable provider.

Please pause.

The correct answer is False. SCs cannot guide participants to an individual provider. That would be a conflict of interest. They can assist people in decision-making and ensure participants know their rights and obligations.

8. True or False? The signature page documents that participants have received all information, guidance, and choices as required by state and federal rules.

Please pause.

The correct answer is True. The signature page is essential to ensure that SCs have provided participants with all appropriate information, guidance, and choices that state and federal rules require.

# ISP Submittal and Approval Process

Once the planning meeting is conducted and the ISP form is completed, the SC finalizes the ISP form for supervisor review by organizing and entering the service plan information into HCSIS. If a Registered Nurse consultation is necessary due to a participant’s medical issues, the SC must document this. A Registered Nurse signature directly on the service plan is not required to start services.

There are critical timeframes for SCs and supervisors associated with this. SCs document the dates when the service plan development steps were completed. They also document any variances in completing the service plan within the established timeframes in the Service Notes section of HCSIS.

After reviewing the service plan, the supervisor will approve, authorize, and submit the service plan to OLTL by no later than 15 business days from the date on which the SC received the completed enrollment package from the Independent Enrollment Broker.

## OLTL Review and Determination

OLTL then reviews the ISP and makes a determination. If OLTL determines that the planning requirements are not met, they contact the Supervisor and the SC to inform them of any deficiencies, discrepancies, or corrections. The SC makes corrections to the plan and resubmits it to OLTL.

The SC must review the modified plan with the participant, over the phone or in person, as soon as possible after notification from OLTL. SCs should discuss the participant’s right to appeal. The SC must obtain the participant’s (or a representative’s) signature on the modified service plan and on the Right to Appeal form.

In the event that OLTL denies services, the SC will provide the participant with the reason(s) for denial in writing and the Right to Appeal form.

## Participant Notification

If the plan is approved, SCs must give participants written notification within two business days of receiving authorization of the service plan. SCs provide a copy of the OLTL-approved, signed service plan to the participant and keep a copy in the participant’s file at the SCE.

The SC also provides the individual with the Participant Information Packet. The Participant Information Packet is a state-issued document that describes rights and responsibilities. The Participant Information Packet explains:

* Participant rights related to applying for, planning for, and using services, as well as filing complaints & grievances.
* Participant responsibilities that individuals must meet to receive services.
* Participant choice at all stages of planning and receiving services.
* Contact information for participants.
* MA fraud and abuse policies.
* Roles and responsibilities of service coordinators. Provider Notification.

Also, within two business days of approval, SCs must notify the chosen direct service providers using the OLTL Service Authorization Form. SCs must be as specific and detailed as possible in completing the form. SCs should pay special attention to describing duration, frequency, circumstances, and desired outcomes of the service.

## ISP Process Knowledge Check Lesson 2

Now check your understanding by answering these review questions.

1. The service plan must be submitted to OLTL within how many business days from the date that the Service Coordinator received the enrollment package?

15 days

25 days

30 days

45 days

Please pause.

The correct answer is 15 days. These steps of the process must be completed no later than 15 days from the date on which the SC received the completed enrollment package from the IEB. If the timeframes cannot be met, SCs should document the reasons and note times and dates of steps and barriers.

2. True or False? OLTL determines if planning requirements are met. If the plan has to be modified, the SC should review the modified plan with the participant ASAP.

Please pause.

The correct answer is True. If the plan has to be modified, the SC must review the modified plan with the participant over the phone or in person as soon as possible after notification from OLTL.

3. If OLTL denies services, the Service Coordinator must provide the participant the reason(s) for denial in writing. What form must the Service Coordinator also provide to the participant?

Right to Appeal Form

Service Authorization Form

Individual Service Plan Form

Physician Certification Form

Please pause.

The correct answer is that the SC must provide the participant the reason(s) for denial and the Right to Appeal Form.

4. True or False? If a plan is approved, the SC must provide the participant with the Participant Information Packet. This packet is a customized packet based on the needs of the participant.

Please pause.

The correct answer is False. The Participant Information Packet is a standard document. It explains:

* Participant rights related to applying for, planning for, and using services, as well as filing complaints and grievances.
* Participant responsibilities that individuals must meet to receive services.
* Participant choice at all stages of planning and receiving services.
* Contact information for participants.
* Medical Assistance fraud and abuse policies.
* Roles and responsibilities of SCs.

# Developing Service Plans Summary

In this module, we reviewed how to develop and document service plans with a special focus on assessing needs, documenting services, discussing risks, and ensuring that all forms are completed accurately. Please review the Resources Document for this module for additional information.

# Congratulations!

Congratulations. You’ve completed the OLTL Service Coordination Developing Service Plans training.

If you have read the contents of the entire module, register your completion of this module by going to this [webpage](https://oltl.deringconsulting.com/service-coordination-developing-service-plans-training-completion/).