Topic: Agency-wide service delivery standards	**Department:** All programs
Original effective date: 4/7/11	**Last revision date:** 5/22/25
Owner: VP for Quality and Compliance	**Frequency of reviews:** Annual
Internal/Regulatory Reference(s) (all that apply): The following OPWDD ADMs: 2018-09R, 2019-07, 2019-06, 20174-02R, 2017-01, 2016-01, 2015-05, 2015-01, 2014-01, 2006-01	
Related documents/Links: Please see references within the document	

Policy: It is the policy of The Arc of Monroe that business, administrative and support functions promote personal and organizational outcomes. It is the policy of The Arc that people's support plans lead to person-centered and person-directed services and supports.

Additional Information: It's important that the services and supports we provide as an agency are done correctly and within regulatory requirements. This ensures that the people we support get the very best we can provide, while also making sure we are able to get paid by the government for those services and supports.

Service delivery is based on a person-centered planning methodology. This means that all service delivery and support begins with the person being supported. In collaboration with them, we design the type and scope of services and supports we will provide based on the person's individual preferences while focusing on skill development or reducing the likelihood that someone will lose skills already attained. Our goal is always to support people in being as independent as possible and in ways they prefer. This includes our support of individualized routines and person-centered utilization of community resources. Schedules are designed with both the person's interests and support needs in consideration. Public transportation, volunteers and/or natural supports are used as appropriate and available to help people establish and sustain community access and belonging. There is no "one-size-fits-all" approach. It should not be presumed that what works for one person will work for someone else. This approach speaks to our commitment to quality of care and support for the people we work with. We continue to strive to provide the best support possible. Please also cross reference the policy, "Medical/Clinical Necessity," for more information.

This policy applies to persons affected by the agency's Medicaid risk in this area (to the degree that they are so affected) including employees, managers, contractors, agents, subcontractors, and independent contractors, students, interns, and volunteers, hereafter referred to as "affected individuals."

Procedure	
Task:	**Responsible party:**
General Guidelines:	
1. Affected individuals have an obligation to understand what a person-centered approach looks like for their role and the supports they provide. In addition, they must understand the service delivery standards for the supports and services they are providing, including documentation standards and procedures.	Affected individuals

2. It is expected that treatment plans, service plans, Staff Action Plans, or similar plans ("service plans") be reviewed every 6 months. They must be reviewed twice within 12 months. While it is in the best interest of the coordination of services and supports that these reviews align with a person's Life Plan review (where applicable), a semi-annual review of the plans that we develop must occur whether or not a Life Plan review happens.	Staff responsible for writing plans; Their supervisors
3. Service plans will be signed by people who need to sign them, whether by regulation or best practice.	Affected individuals
4. Affected individuals are expected to document services they provide by the end of their shift unless there are extenuating circumstances. At the very latest, services must be documented within 5 calendar days of when the service was provided (regardless of holidays or weekends). Situations exceeding that timeframe will be evaluated in regards to associated billing by the appropriate vice president or designee (COO).	Affected individuals
5. Service documentation needs to be signed correctly to ensure that we can use it to get paid and justify the funds we receive.	Affected individuals
6. Service documentation must match the service plan, consistent with individual program requirements.	Affected individuals
7. It must be clearly evident in the person's record that they continue to require the specific service or support (or the current level) being provided or proposed. Providing services that are deemed unnecessary to the person could be considered misuse of governmental funds or, if done deliberately, fraud. Doing so could result in paybacks, fines or penalties. Please cross reference the policy on "Medical/Clinical Necessity" for more information.	Affected individuals
8. Service documentation must capture information on the person's response to services provided, consistent with individual program requirements.	Affected individuals
9. Service documentation needs to include all of the necessary elements required for us to get paid by the government. Depending on the service, this may include the following (not all will apply to all supports and services): *Date and time the service was provided *Where the service was provided *How many people were being provided services at the same time (group size) *The number of services provided *The type of service provided *The duration of services provided *The code for the type of service you provided *Signature of the staff person completing the service *The date the documentation was signed	Affected individuals
10. Affected individuals cannot document a service or support that never happened. This includes documenting one thing when something else actually happened, or exaggerating or embellishing what really occurred.	Affected individuals

11. HCBS waiver services have additional requirements. Affected individuals are required to ensure that these requirements are met, as indicated below. Waiver services include: *Res Hab *Day Hab *Community Prevoc *SEMP (OPWDD) *Community Hab *Respite Other requirements include: *A Life Plan, which gives permission for the person to get the service and for us to bill. This authorizes us to provide the waiver service. *A Staff Action Plan, which is the waiver program's service plan. It is created from the Life Plan. It has to list at least 1 valued outcome that is also listed in the Life Plan. A valued outcome is what the person hopes to get from having the service. Goals as listed in the Life Plan must be included in the Staff Action Plan. *There is a Level of Care Eligibility Determination (LCED) signed within the past 365 days. These are completed by the Care Coordinator, but staff need to look for them in CHOICES or ask for copies if they don't get them.	Affected individuals; Manager
12. Programs are required to set up the necessary systems, processes and procedures to ensure that all service delivery standards as described in this policy are met consistently. If they realize that the systems aren't working, they have an obligation to update, revise or replace the systems to make sure they will.	Manager
13. Reviews, audits or other checks will be done periodically to see how well programs are following the rules. These may be done by members of management, Quality or Operations Coordinators, the QI Manager, the VP for Quality and Compliance, or other qualified parties as assigned. They may also be done by outside parties. This may involve review of plans and documentation, policies and procedures, and other systems within the program. It may also include interviews with people. Please cross reference the policy, "Monitoring and Audits" for additional information.	Manager; Quality/ Operations Coordinator; QI Manager, VP for Quality and Compliance, Outside party
Manager Responsibilities:	
1. Managers have a primary responsibility to ensure that staff within their programs understand person-centered approaches, that supports and services are consistently provided within requirements, and that systems, processes and procedures have been established to do so consistently.	Manager
2. Managers have a responsibility to actively respond to any indications that service delivery standards are not consistently being met. This may	Manager

include interviews with staff, review of documentation, or process review. Based on the results of this fact finding, disciplinary actions may be taken as appropriate. While these tasks may be assigned or delegated to another staff person, the manager retains the responsibility for the correction or resolution	
Quality/Operations Coordinators:	
1. Quality/Operations Coordinators have general responsibility for the monitoring and auditing of key elements of service delivery standards for their program, service or support – consistent with the program's internal standards and processes.	Quality/Operations Coordinator
2. Quality/Operations Coordinators are also instrumental in helping program staff and leadership understand the regulatory requirements for their programs, as well as the quality standards under which services and supports should be provided.	Quality/Operations Coordinator
3. Quality/Operations Coordinators generally also play a key role in the development and maintenance of a program's policies and procedures, ensuring that they are accurate and consistent with current practice.	Quality/Operations Coordinator
VP for Quality and Compliance:	
1. The VP for Quality and Compliance acts as the agency's Compliance Officer, as required in NYS law.	VP for Quality and Compliance
2. Has primary responsibility for administering the agency's compliance program, and related policies and procedures.	VP for Quality and Compliance
3. Acts as a resource for agency staff, managers, Quality Coordinators and leadership related to ensuring service delivery standards are met consistently.	VP for Quality and Compliance
4. Is kept informed and supports external audits that relate to billing or compliance, as appropriate.	VP for Quality and Compliance

Document revision record:

Revision Date	Release Date	Reason for change	Approver
5/25/12	5/25/12	Reasons for changes are not documented	P Dancer
10/24/14	10/24/14	Added formal policy at the top of the document	P Dancer
4/28/17	4/28/17	Revised to reflect structure around centralized QI department	P Dancer
11/89/18	11/89/18	Reasons for changes are not documented	P Dancer
10/18/19	10/18/19	Transitioned to the new procedural format	P Dancer
12/30/20	12/30/20	Took out references to ISPs	P Dancer
6/23/21	7/13/21	Fleshed out information and added discrete sections for managers, QCs and the VPQC	ICC
6/30/22	6/30/22	Added "of Monroe" after Arc, corrected contemporaneous timeframe to 7 calendar days, added reference to operations coordinators	ICC

3/15/23	3/15/23	Added person-centered language and guidance in the additional information section; specific reference to quality of care; specified whom this policy applies to	ICC
7/26/23	7/26/23	Added a link to another document; removed reference to ISP	ICC
4/11/24	4/11/24	Updated to reflect 5 vs. 7 calendar days	ICC
6/27/24	7/18/24	Added statement that semi-annual plan reviews must occur whether or not Life Plan reviews occur; clarified the statement regarding signing plans; added QI Manager and VPQC as parties that may audit; added cross reference to Auditing policy; added that disciplinary action may be taken if service delivery standards are not being met	ICC
5/22/25	7/23/25	Expanded references to person-centered approaches; added clarifying information regarding the link between Life plans and Staff Action Plans; added additional clarifying information	ICC