NEW YORK STATE OF OPPORTUNITY.

Office for People With Developmental Disabilities

People First Care Coordination
MSC Information Session

Info Sessions Update

Session 1 - People First Care Coordination: What MSCs Need to Know

- Posted on the OPWDD website

Session 3 – Jan. 10

- What is CCO/Health Home?

Session 4 – Jan. 24

- What is a Life Plan and How Does is Compare to an ISP?

For viewing or registration go to OPWDD website

https://opwdd.ny.gov/opwdd_services_supports/care_coordination_organizations

Info sessions count towards current required annual MSC professional development hours

Future Session Topics

CCO/HH Transition Plan - Page 46

- https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/draft_idd_1115_waiver.htm

Your Questions

– Many addressed in Transition Plan or FAQ

https://opwdd.ny.gov/opwdd_services_supports/care_coordination_organizations/faq

– Salary, benefits – Provided by CCOs

MSC Information Session 2

What is CCO/HH Comprehensive Care Management and How is it Different from the Work of Today's MSCs?

Kate Bishop
Director of Program Development
Division of Person-Centered Supports

Angie Francis
Statewide START and MSC Coordinator

Today's Session

- Review of several key points from Session 1
- An explanation of what Care Management is and the Health Home Core Services and Requirements

Health Home Core Services & Requirements

1. Comprehensive Care Management
2. Care Coordination and Health Promotion
3. Comprehensive Transitional Care
4. Individual and Family and Support
5. Referral to Community and Social Support Services
6. Use of Health Information Technology to Link Services

Comprehensive Care Management

Consists of the same developmental disabilities coordination work a Service Coordinator does today with the addition of integrating primary, behavioral and specialty health care and community supports services in a way that addresses all of an individual's clinical needs.

Example: Martin has a developmental disability, suffers from depression and was recently diagnosed with type 2 diabetes. His Care Manager, Ashley, works with Martin and his circle of support to develop a Life Plan that clearly identifies his needs and goals and helps him organize the provision of all needed services; including community habilitation, appointments with his mental health clinician and medication.

Care Coordination & Health Promotion

Provide education and training to individuals and families on self-management techniques for their chronic conditions to promote wellness and maximize independent living skills.

Example: After Martin was diagnosed with type 2 diabetes, Ashley provided Martin and his family information about the causes, treatments and ways to prevent diabetes. Ashley works with Martin to make healthier decisions, such as taking walks when feeling bored or having an apple for a snack instead of potato chips.

Comprehensive Transitional Care

(from inpatient to other settings, including appropriate follow-up)

Manage services for an individual and family/caregiver during a transition between levels of care (i.e. hospital stay) or when an individual is electing to transition to a new Health Home provider.

Example: Prior to Martin's discharge from a hospital stay, Ashley coordinated the necessary follow-up treatment, appointments and other services Martin needed and ensured that he attended and adhered to the treatment regimen. Ashley also communicated with all of Martins providers and members of his care team about his transition and the treatment he required post-discharge.

Individual & Family Support

(includes authorized representatives)

Coordinate information and services to support individuals and family/caregivers to maintain and promote quality of life.

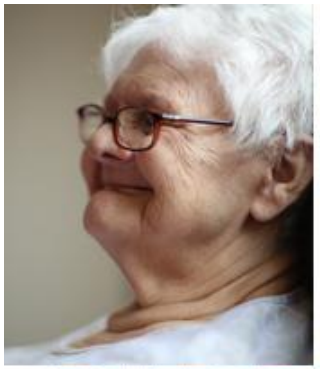
Example: Martin's mother recently lost her job and was struggling to purchase enough food to feed Martin and his two siblings. Ashley provided Martin's mother with information on the Supplemental Nutrition Assistance Program (SNAP) and provided assistance in completing the application to apply for food assistance benefits.

Referral to Community & Social Support Services

Provide information and assistance to refer individuals and family/caregivers to community based resources.

Example: Feeling the stress of his mother's job loss on top of his symptoms of depression, Martin began using drugs and alcohol to cope with his feelings. Ashley provided Martin with information about drug addiction and assisted him to enroll in an outpatient treatment program and provided his family with additional resources to help them manage.

Use of Health Information Technology (HIT) to Link Services



Use available information systems to communicate with the care team, update the Life Plan and conduct other Health Home processes.

Example: Using information technology systems, Ashley documents and updates Martin's Life Plan as his wants and needs changes while also using it to communicate with his care team about Martin's treatment and progress.

Status of Potential CCO/HHs & Next Steps

- All regions will have at least two CCOs
- Ten CCO Applications were submitted and are now under review

- NEXT Steps the State will be Taking:
  - December 1, 2017-February 28, 2018: Review and Approval of Health Home Applications to Serve individuals with I/DD by the State
  - March 1, 2018-June 30, 2018: Health Home and Network Partner Readiness Activities
  - July 1, 2018: Transition to CCO/HH Care Management for individuals with I/DD

Useful Documents

- Care Coordination Organization/Health Home (CCO/HH) Application to Serve Individuals with Intellectual and/or Developmental Disabilities

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/hhidd_application_part_1.pdf

- CCO/HH Frequently Asked Questions FAQ

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/cco-hh_faqs.htm

- Individuals with Intellectual and/or Developmental Disabilities (I/DD) 1115 Waiver Transition Plan

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/1115_draft_transition_plan_12_5_2017.pdf

NEW YORK STATE OF OPPORTUNITY.

Office for People With Developmental Disabilities

Thank you – Questions?

Care.coordination@opwdd.ny.gov