

## **Part 1 Care Coordination Practice Guidelines**

Table of Contents

I. Core Functions of Care Coordination ..... 3

II. Person Centered Elements ..... 6

III. Face-to-Face..... 9

IV. Competencies and Training ..... 9

V. Case Loads ..... 10

VI. Conflict Free Case Management..... 10

VII. Willowbrook members ..... 11

VIII. Self-Direction Concepts ..... 12

DRAFT

## I. Core Functions of Care Coordination

Care Coordination is an overall function or entity. It is not a person; it is a team. There shall be a Lead Care Coordinator assigned to each individual. The Lead Care Coordinator has primary responsibility of oversight and coordination of the individual's funded and unfunded supports as well as oversight and coordination of the entire Care Coordination Team. The Lead Care Coordinator is responsible for ensuring that the Plan of Care is properly implemented and that the person's needs and personal outcomes are met.

The Care Coordination Team consists of the Lead Care Coordinator and other specific people as identified by the individual and those people with relevant expertise and experience appropriate to address the needs and maximize the choices of the assigned individual (i.e. advocate(s), circle members, friends, family, specialists, nurses, social workers, therapists, and providers). It is the responsibility of the Care Coordination entity to develop policies and procedures outlining the minimum required members of the Care Coordination Team and ensuring that the individual is directing those who are a part of the team and determining the members that are appropriate based on an individual's needs.

The following overall core functions may be delivered upon by a variation of personnel. The Care Coordination entity may hire or contract out services for the provision of all or some of these core functions, as outlined in the Care Coordination entity's policies.

- Central Point of Contact
- Assessment
- Care Planning
- Linkage and Referral
- Coordination with Service Providers
- Advocacy
- Monitoring
- Eligibility and Benefits Maintenance
- Cost Management
- Record Keeping

1. **Central Point of Contact.** The Lead Care Coordinator is the central point of contact for the assigned individual, or is responsible for assigning a central point of contact and overseeing that assigned central point of contact.

The central point of contact is a function designed to enhance the relationship between the individual and the Care Coordination entity. The central point of contact is responsible for:

- Orienting individuals to the services and benefits in which they are entitled to, including how to access them;
- Assisting individuals with problems and questions;
- Assisting individual with complaints and grievances in an effective and efficient manner.

2. **Assessment.** The Care Coordination entity is responsible for conducting initial assessments and ongoing reassessments at regular intervals and as needed for each individual to identify areas of need, evaluate Personal Outcome Measures (POMs) as appropriate and update the Plan of Care. The Care Coordination Entity should assess the member's habilitative, physical, behavioral, functional, and psychosocial need.
  - Within 10 business days of notice of the individual's enrollment into the DISCO, the Lead Care Coordinator shall ensure that a face-to-face meeting is conducted with the individual to review existing assessments and perform any additional assessments.
  - In addition to assessments that the Care Coordination entity may require, the Care Coordination entity will utilize a standardized assessment tool, known as the NYS Coordinated Assessment System, as dictated by OPWDD to inform the planning process and to assess needs.
  - The Care Coordination entity is encouraged to utilize personal outcome measures to develop and improve the Individualized Service Plan.
  - For those who are HCBS waiver enrolled an annual Level of Care Eligibility Determination (LCED) must be completed.
  
3. **Care Planning.** It is the responsibility of the Care Coordination entity to develop a Person Centered Plan of Care (also referred to as the Individualized Service Plan) that builds on information collected through the assessment process and includes such activities as ensuring that the individual is directing the planning and is actively participating along with others to develop goals and identify courses of action to respond to the assessed needs of the individual.
  - The Plan of Care should be reviewed and revised as necessary at regular intervals; at least twice annually to ensure the plan is up-to-date and supports and service(s) are consistent with the needs and goals of the individual;
  - Each Plan of Care must be reviewed and revised as necessary when there is a significant change in the individual's life and support needs;
  - Plan of Care reviews should include the individual, their circle of support, direct support professionals, clinical support staff, and other pertinent people as identified by the person receiving supports and their Lead Care Coordinator/Care Coordination Team;
  - The Plan of Care review should include discussion on the services and supports that have been provided and the adequacy of the supports to achieve the individual's personal outcome measures and health and safety needs;
  - Any additional plans should be received within a reasonable time frame and included with the ISP;
  - The ISP and all attachments should be distributed to relevant parties within a reasonable timeframe;
  - The Care Coordination Team will utilize a person centered planning process in the development of the Plan of Care. Refer to [Person Centered Elements](#) for more information on person centered planning.
  
4. **Linkage and Referral.** This includes activities that help link an eligible individual with medical, social, educational providers and other programs, supports, and services, including natural and community supports that will assist the person in attaining their needs and outcomes.

- The Care Coordination Team will work with the individual to determine the methodology for the service(s) and/or support(s) that will be provided as outlined in the Plan of Care;
  - It is the responsibility of the Lead Care Coordinator/Care Coordination Team to make all proper referrals to potential service providers in order to maximize opportunities and choice for the individual to access the supports and services they want and need;
  - Lead Care Coordinator/Care Coordination Team will communicate/coordinate with community organizations that provide services that are important to the health, safety and well-being of individuals. This may include referrals to other agencies and assistance with applying for programs and benefits as needed;
  - It is the responsibility of the Care Coordination Team to perform all functions necessary to complete referrals and applications in full on behalf of the individual.
5. **Coordination with Service Providers.** Lead Care Coordinator/Care Coordination Team will maintain appropriate and on-going communication with the community, service providers, various service systems, and natural supports. Coordination and communication is important to monitor relevant information and documents as prescribed by the Care Coordination entity and/or oversight agencies. Relevant information and documents may include, but are not limited to changes in health, Medicaid status, program or service changes, incident reports, living arrangements. In coordination with service providers the Care Coordination entity must ensure that the individual is linked to and that referrals are made to appropriate medical, social, educational providers and other services that are capable of providing needed and desired services.
6. **Advocacy.** Lead Care Coordinator/Care Coordination Team actively supports, encourages, and/or negotiates to ensure that individuals' needs are met.
- Lead Care Coordinator/Care Coordination Team shall ensure that an individual's personal funds are being used to support preferences, choices and interests;
  - Lead Care Coordinator/Care Coordination Team shall be knowledgeable of the rights of individuals and mindful of developments within the life of individuals in order to actively monitor and advocate in instances when an individual's rights are being infringed upon;
  - The Lead Care Coordinator or an appropriate individual of the Care Coordination Team shall take all reasonable steps to ensure that all safety, health, welfare and fire safety needs are met. The Care Coordination Team shall ensure the individual has been informed of their rights and that those rights are upheld.
7. **Monitoring.** It is the responsibility of the Care Coordination entity to monitor activities, supports and services that are necessary to ensure that the Plan of Care is effectively implemented and adequately addresses the needs of the individual. The Care Coordinator also needs to adequately address an individual's expressed dissatisfaction with services and/or providers. Other areas that should be monitored are
- An individual's ability to pursue activities that are meaningful to them.
  - Wellness and dignity of risk needs. If an unmet health or safety need places the individual in imminent danger of being harmed, the Care Coordination entity is expected to take reasonable

measures to ensure that the individual remains safe until the situation is resolved (e.g. call for emergency assistance and remain on site until the situation is addressed).

- Incidents and allegations. The Lead Care Coordinator/Care Coordination Team shall follow all current requirements for reporting incidents and allegations.
- The individual's outcomes. Outcomes includes the the personal goals set by the individual, the timely access to services, support in the most integrated setting possible, and management of medical or behavioral health needs.
- Back-up plans are implemented and effectively working.
- Service gaps are evaluated to determine their cause and to minimize gaps going forward.

8. **Eligibility and Benefits Maintenance.** It is the responsibility of the Care Coordinator to monitor and ensure that all necessary documentation is completed so that the individual maintains uninterrupted enrollment and eligibility for all services and benefits. This includes, but is not limited to, Medicaid, Medicare, HCBS Waiver, Food Stamps, Supplemental Security Income (SSI) , and the Level of Care Eligibility Determination (LCED) for those enrolled in HCBS Waiver.

9. **Cost Management.** In order to continually monitor and review spending as it pertains to funded services and supports, it is the responsibility of the Care Coordination entity to develop a system of cost analysis and budget planning for each individual.

10. **Record Keeping.** Keeping accurate and current records that provide a chronological and ongoing record of relevant information on the individual, coordination activities and other services provided that assists with the delivery of person centered quality services.

- An individual's care coordination record should contain the following sections
  - All Eligibility/Enrollment Documentation
  - Assessments as appropriate for care planning
  - Written Evaluations
  - Plan of Care with all required attachments
  - Care Coordination notes
- The individual's record should be clear and comprehensive. These records/documents help to substantiate payment for federal and state audits.

## II. **Person Centered Elements**

### A. **The Person Centered Process**

A Person Centered Process (PCP) means a process that is lead by the individual and focuses on the capabilities and strengths of an individual in order to create a vision for a desirable future. It focuses on each person's gifts, talents, and skills, not on deficits and deficiencies. It is an ongoing process of social change wherein the coordinator ensures that the individual with disabilities directs the process and that the people who support that person and are identified by the individual participate in the process. PCP works to identify the individual's vision of his/her best life and to pursue that vision in his/her community.

Through a Person Centered Process, an individual and those who support him or her:

- a. Focus on the individual's life goals, interests, desires, preferences, strengths and abilities as the foundation for the planning process.
- b. Identify outcomes based on the individual's life goals, interests, strengths, abilities, desires and preferences.
- c. Make plans for the individual to work toward and achieve identified outcomes.
- d. Determine the services and supports the individual needs to work toward or achieve outcomes including services and supports available through other service systems.
- e. Develop a plan that directs the provision of supports and services to be provided through the managed care entity.

Person-centered planning is a highly individualized process designed to respond to the expressed needs/desires of the individual. The values and principles of the person-centered process are that:

- a. Every individual is presumed competent to direct the planning process, achieve his or her goals and outcomes, and build a meaningful life in the community.
- b. Every individual has strengths, can express preferences, and can make choices.
- c. The individual's choices and preferences are honored and considered, if not always implemented.
- d. Every individual contributes to his or her community, and has the ability to choose how supports and services enable him or her to meaningfully participate and contribute.
- e. Through the person-centered planning process, an individual maximizes independence, creates community connections, and works towards achieving his or her chosen outcomes.
- f. An individual's cultural background is recognized and valued in the person-centered planning process.

## **B. Standards for Person-Centered Planning**

The following characteristics are essential to the successful use of the PCP process with an individual and his/her allies.

1. **Person-Directed.** The individual leads the planning process (with necessary supports and accommodations). The person decides when and where planning meetings are held so that they occur at times and locations convenient to him or her. The individual chooses who is invited and what is discussed. The process has a method to request updates and provides information in a timely manner.
2. **Person-Centered.** The planning process focuses on the individual, not the system or the individual's family, guardian, or friends. Through listening to the individual and taking the time to understand the individual's goals, interests, desires, and preferences, a plan for a satisfying life can be developed and services and supports can be implemented that are responsive to the person's needs and support the person in meeting their goals, interests, etc. The planning process reflects cultural consideration. Strategies for resolving conflict or disagreement are included and used when necessary.
3. **Outcome-Based.** Outcomes in pursuit of the individual's preferences and goals are identified as well as services and supports that enable the individual to achieve his or her goals, plans, and desires and any training needed for the providers of those services and supports. The way for measuring progress toward achievement of outcomes is identified.
4. **Information, Support and Accommodations.** As needed, the individual receives comprehensive and unbiased information on the array of services, community resources, and available providers, so that she/he is enabled to make informed choices. Support and accommodations to assist the individual to participate in the process are provided. Information is provided in a manner that is understandable and accessible to the individual.
5. **Wellness and Dignity of Risk.** Issues of wellness, well-being, health and primary Care Coordination or integration, supports needed for an individual to continue to live independently

as he or she desires, and other concerns specific to the individual's personal health and safety are discussed and plans to address them are developed.

6. **Participation of those that the individual selects.** Through the pre-planning process, the individual selects friends, family members and others to support him or her through the person-centered planning process. Pre-planning and planning help the individual explore who is currently in his or her life and what needs to be done to cultivate and strengthen desired relationships.
7. **Community Integrated.** The support of family, neighbors, friends, and co-workers is encouraged and community supports available to the whole community are used by the individual when possible. The person has a choice and lives in the most community integrated setting possible, is a contributing member of the community including employment, exercises his/her rights and responsibilities, and is actively involved in the community and has natural-community relationships to the extent that he/she wants.

### C. **Organizational Standards**

The following characteristics are essential for organizations responsible for providing supports and services through PCP:

1. **Individual Awareness and Knowledge.** The managed care entity provides accessible and easily understood information, support and when necessary, training to individuals using services and supports and those who assist them so that they are aware of their right to PCP, the essential elements of PCP, the benefits of this approach and the support available to help them succeed.
2. **Person-Centered Culture.** The managed care entity provides leadership, policy direction, and activities for implementing person-centered planning at all levels of the organization. Organizational language, values, allocation of resources, and behavior reflect a person-centered orientation.
3. **Training.** The managed care entity has a process to identify and train staff at all levels on the philosophy of PCP. Staff who are directly involved in PCP are provided with additional ongoing training that teaches strategies for the actualization of the person centered principles.
4. **Roles and Responsibilities.** As an individualized process, PCP allows each individual to identify and work with chosen people and other supports. Roles and responsibilities for facilitation, planning, and developing the plan are identified; the plan describes who is responsible for implementing and monitoring each component of the plan.
5. **Quality Management.** The managed care entity's quality management system includes a systemic approach for measuring the effectiveness of PCP and identifying barriers to successful person-centered planning. The best practices for supporting individuals through PCP are identified and implemented (what is working and what is not working in supporting individuals). Organizational expectations and standards are in place to assure support as the individual directs the PCP process and ensures that PCP is consistently done well.

### D. **21 Personal Outcome Measures (POMs)**

The areas identified as most important for people receiving supports are defined within the Council on Quality and Leadership (CQL) Personal Outcomes Measures (POMs). As Plans of Care are developed attention to these identified areas should be incorporated into the planning process. POMs are defined by the person and therefore can have different definitions depending on the individual's choices, desires, views, and needs. POMs are arranged to identify three factors: who the person is because of their s/her experiences and decisions (MY Self), what the person does and with who he/she interacts (My World), and what kind of life the person does want (My Dreams). The specific POMs that relate to these factors are identified below:

1. Are connected to Natural Support Networks

2. Have Intimate Relationships
3. Have Best Possible Health
4. Are Safe
5. Exercise Rights
6. Are Treated Fairly
7. Free from Abuse and Neglect
8. Experience Continuity and Security
9. Decide when to share personal information
10. Choose where and with whom they live
11. Choose where they work
12. Use their environments
13. Live in integrated settings
14. Interact with other members of community
15. Perform different social roles
16. Choose services
17. Choose personal goals
18. Realize personal goals
19. Participate in the life of community
20. Have friends
21. Are respected

If the individual with his/her care coordination team identifies POMs that are meaningful to them and that could be met through services and supports, the care coordinator should work to focus supports in coordinated fashion to help the person achieve the identified outcome(s).

Organizations should provide a general overview on the meaning of each of the POMs so care coordinators can better identify the POM that best relates to support areas. DISCOs will be required to complete certified interviews of the POMs for a certain percentage of individuals that it serves. When a certified interview is completed for an individual, the care coordinator should use this information to help better inform the plan of care and make changes as necessary.

### **III. Face-to-Face**

The Care Coordinator needs to conduct the initial face-to-face meeting with the member within ten business days (or two weeks) of notice of the member's enrollment into the DISCO. This first meeting is used to review any existing assessments, perform any additional needed assessments, and provide information on self-direction and choice of providers.

At a minimum the Care Coordination entity should meet with the individual face-to-face three times in a calendar year unless the individual and the Care Coordination Team agree to another amount of face-to-face meetings.

#### **IV. Competencies and Training**

The Lead Care Coordinator must meet the following minimum requirements and no substitutions will be allowed:

- bachelor's degree (in any field); and
- at least one year of experience supporting people with developmental disabilities.

It is the responsibility of the Care Coordination entity to have processes in place to ensure that lead Care Coordinators and Care Coordination Team Members exhibit or have training to gain the competencies listed below. In addition, Care Coordination entities must ensure that the Care Coordination Team has training in areas specific to the person and any regulatory requirements.

Competencies that should be developed are:

- Knowledge of service system; including community and natural supports and services, and entitlements and benefits; and of individuals with developmental disabilities
- Able to communicate effectively with the individual and others which includes the ability to explain to the individual the service system and options available
- Core attitude that the person is a partner and directs the process to the extent possible
- Ability to develop a relationship with the individual
- Able to advocate for what the person needs and wants
- Able to get the services and supports for individuals to live the life of their choice. This includes
  - The ability to navigate through the DISCO's layers of management
  - The ability to breakdown silos and reach out across different service systems (education, mental health, medical, etc.)
  - Comfortable with reaching out to experts in different areas
- Able to develop an effective plan that reflects the individuals needs and desires but also meets any standards set by the state
- Ability to evaluate and follow up that the person's needs (including health and dignity of risk) are being met and that what is important to the person is ongoing
- Implement the Plan of Care to achieve the outcomes of the person while being mindful of the most integrated and cost effective manner to do so
- Professionalism
  - Participate in opportunities for continued training and education
  - Use self evaluation to ensure ongoing professional growth
  - Demonstrate professional work habits including dependability, time management, independence and responsibility

A Care Coordination entity needs to have metrics and quality reviews in place that focus on outcomes thus providing flexibility in developing trainings that would drive the competencies listed above.

Members of the Care Coordination Team should have access to professional development opportunities that enhance their ability to meet the above core competencies.

## V. Case Loads

Caseloads within DISCOs need to be flexible so that DISCOs can develop models that best meet the individuals' needs and the organization's needs. DISCOs should have policies and procedures in place to ensure that Lead Care Coordinators and the teams can effectively manage caseloads.

## VI. Conflict Free Case Management

Conflict Free Case Management inherently means that Care Coordinators and care coordination entities cannot be the providers of services as they are the authorizers of services. If any entity provides care coordination and provides services, firewalls must be in place so that there are not biases in referring individuals to one's own entity.

In addition, Care Coordinators must not be the ones who exclusively evaluate an individual's needs, i.e. they should not be conducting the standardized assessment tool (the Coordinated Assessment System).

OPWDD has set up several areas that maintain conflict-free case management. These are as follows:

- Informed Choice. Informed choice is when an individual has made a decision based on a good understanding of the options available and a good understanding of how that choice may affect his or her life. Individuals who have informed choice are better equipped to take an active role in improving their care coordination and services.
- Assessment. DISCOs and direct service providers will not conduct the initial Coordinated Assessment System. This will help to maintain that there is an independent entity that is evaluating an individual's needs. DISCOs and providers will be given access to results to assist with care planning. DISCOs are responsible for ensuring that reassessments are completed, but it should not be the Care Coordinator who completes it.
- Organizational Structure. DISCOs must have separate departments that perform care coordination functions and other managed care functions. Supervisory lines between departments cannot cross. This helps to ensure that care coordinators are not being influenced unduly to look for services that may not truly meet the needs of individuals.
- Grievance and appeals. A grievance and appeals process with which DISCOs must comply will be developed. DISCOs report to the State on a quarterly basis a summary of all grievances and appeals that were received in that quarter. The DISCOs' processing and resolution of grievances will be monitored. In addition, OPWDD will implement an Ombudsman Program that will provide assistance with grievance and appeals procedures. This process will ensure that any issues experienced with care coordination are resolved quickly and appropriately.
- OPWDD Oversight. OPWDD surveys providers and DISCOs and has other measures in place to ensure that conflict free case management is occurring. The agency also institutes special reviews to ensure individuals receive quality services. OPWDD continues to modify and improve its survey process to continue ensuring that individuals receive the services that they need.

## **VII. Willowbrook Class Members**

Members of the Willowbrook class will continue to have the following requirements that must be met:

- Active Representation
- Service Coordination Observation Report - SCOR(MSC7)
  - Must be filed two times in a calendar year, but not in consecutive quarters, even if there is no issue to report
- Assigned Case Manager
  - No greater than 1:20 ratio
  - Must be a QMRP
  - Must complete monthly caseload reporting form
- Face-to-Face/Home Visits
  - Must make every reasonable attempt to conduct a face-to-face meeting with every class member during each calendar month.
  - a face-to-face service meeting in the person's home is required at least once during each three month quarter of a calendar year. A calendar year is divided into four, three month quarters
- Training and Professional Development
  - service coordinators/supervisors providing service coordination to class members must attend 15 hours of professional development annually
- Documentation
  - Per part 633.4 a Notice of Individual Rights and Responsibilities must be completed and in the member's record;
  - Activity Plan must be reviewed and updated at least every six months
- Plan of Care
  - Requirements must continue to be followed as described in the MSC Vendor Manual and ADM#2010-03

## **VIII. Self-Direction Concepts**

### **A. Choice**

Remember that people served have a free choice of services, supports and method of service delivery. Individuals have the right to choice. Choice includes the individual's ability to choose providers and the supports and services that they need and the right to change aspects of those services and supports to the extent possible. Therefore, it is expected that agencies will work with the individuals to ensure that their choices are respected. The care coordinator needs to provide education to the individual regarding choice of providers for services, and include the provider's availability and willingness to deliver services. The Care Coordinator will need to obtain signed confirmation of the member's choice of providers

### **B. Self-Direction of Services**

Every individual must be explained what self-direction is and be offered the opportunity to direct some or all of their waiver services. Ongoing information regarding self-direction must be made available to the individual. Care Coordinators or a team member should discuss with the individual what

participant/self-direction means, the responsibilities of the individual and of the agency or agencies involved, and the types of self-direction opportunities.

Participant direction or self-direction of services means that the individual has the authority to exercise decision making authority over some or all of her/his services and accepts the responsibility for taking a direct role in managing them. Self-direction promotes personal choice and control over the delivery of services, including who provides services and how they are delivered. Self-direction is an alternative to provider management of services wherein a service provider has the responsibility for managing all aspects of service delivery in accordance with the Plan of Care.

Individuals should not be discouraged from the opportunity to self-direct based on their assessed "ability" or "capacity." Individuals may be unable to carry out some responsibilities by themselves, but it is the Care Coordination Team's role to assist the individual in having a circle of support and finding someone to assist them in completing the activities associated with self-direction.

This information should be made available in a timely manner and in a format that is understandable to the individual so that the individual can make an informed choice about whether to direct their services. Information provided must be consistent and may be furnished to individuals during the service plan development process, separate orientations or by other means.

### **C. Circle of Support**

The intent of the circle of support is to assist the person to identify valued outcomes as well as:

- Assist the person in seeking out supports and services to accomplish his or her goals and valued outcomes without imposing personal values or goals.
- Assist the person with planning.
- In order to protect the health and welfare of the person, assist in developing necessary safeguards.

When individuals direct their services and planning process, individuals have a circle of support. The circle of support is made up of paid and unpaid member that are chosen by the individual. Circles may include family, friends, clergy, community members, advocates, other self-advocates, a service coordinator, support broker, other direct care staff and/or professional staff. Required members are the individual, MSC, and Support Broker (if there is one).

Individuals have the right to choose who attends their service planning meetings. Circle of supports must meet minimally quarterly for those who self-direct. Not all circle of support members need to be at every meeting.