



**Form B
Design Team Meeting Summary**

Design Team Meeting Minutes/Summary:

Date of Meeting: June 20, 2011

Care Coordination

Design Team Meeting Attendees:

Present:

- Jill Gentile
- Robert Budd
- Bill Bird
- Nick Cappoletti
- Donna Colonna
- Jane Davis-Bunt
- Maria Bediako
- Maggie Hoffman
- Michael Kennedy
- Hope Levy
- Eric Pasternak
- Sheryl WhiteScott
- Susan Wanamaker

Absent:

- Patrick Dollard
- Paloma Hernandez
- Marcia Heckel
- Michael Mascari
- Michael Northrop
- Carol Rodat
- Jeff Wise

Discussion Topics

Summary of Main Discussion Points, Considerations, Recommendations, Next Steps, etc.

Whole Group Discussion: What is not working in the current system?

The group brainstormed and presented their ideas about what aspects of the current care coordination system are not working. They then categorized these ideas into the following themes:

- Access to the system
 - MSC does not always have knowledge or expertise of available services, especially across systems
 - Having a crisis is sometimes the only way to access the system
 - Often receive either too much or not enough support
 - Often can't get a hold of service coordinator in a timely manner due to caseload
 - Lack of back-up when coordinator is not available
- Care Coordinator Qualifications
 - High turnover rates for service coordinators
 - High caseloads
 - Limited education and awareness of issues specific to individuals' needs
 - Limited training and entry level qualifications
 - Lack of consensus on guidelines for care for individuals





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	<ul style="list-style-type: none"> ○ Difficulty to find partners who really understand self-direction ○ Service coordinators often don't understand how fiscal issues affect service availability ○ Knowledge limited to OPWDD services ○ Lack of sensitivity to cultural needs • Cross System Coordination <ul style="list-style-type: none"> ○ Care coordination is often not independent from service provision – potential for conflict of interest. There is some pressure to push people toward certain providers ○ Fragmentation of care and a lack of bridges between behavioral, medical, pediatric, early intervention and primary care ○ Redundancies of oversight between OPWDD, DSS, Homecare, health care, etc ○ Segregated service providers ○ Lack of expertise in area of behavioral interventions ○ Limited use of technology to make connections ○ Limited crisis intervention services ○ Lack of coordination between day activities or work and home and health services • Person Centered Plan <ul style="list-style-type: none"> ○ Often there is not sufficient time to complete the true person centered planning process ○ Individual's plan, data, benchmarks should be created by the individual ○ Does not create empowerment to deliver on goals and outcomes • Fiscal <ul style="list-style-type: none"> ○ Need a stable, predictable reimbursement structure that is easy to understand, flexible, and responsive to individual need ○ Regional disconnect between upstate and downstate ○ Cost prohibitive to providers to provide the more specialized services • Quality <ul style="list-style-type: none"> ○ Too much time spent on compliance and regulation
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	<ul style="list-style-type: none"> ○ Requires too much assessment of need versus delivery of services ○ Outcomes are hard to measure and are not consistent across services ○ Individuals must receive 90 days of MSC whether they want or need it • Suggestions for the future system <ul style="list-style-type: none"> ○ Create a proactive frame of reference that connects individual to all system/natural supports and changing needs of life ○ Create a single point of engagement for information, access, advocacy, and mentorship
<p>Small Group Break-Out: What considerations should be integrated into any model of comprehensive care coordination/case management for people with developmental disabilities (and various subpopulations, e.g., children, aging, forensic/risk, medically involved, medically frail, etc.) in a care management environment ?</p>	<ul style="list-style-type: none"> • Sustainability • Need to be able to easily transition into increased support between incidents • There needs to be enough time to establish the relationship • Should be weighted in terms of what level of intensity and reimbursement • Equity of access to the services (funding) • Needs to be coordination with technology and mentoring • Continuity through technology (EI already doing it • Portability of information through technology • When something is not working where do they go • Unified quality of service with measurable metrics
<p>Small Group Break Out: Consider whether the person’s needs assessment should correlate to the type/intensity/level/model of comprehensive care coordination.</p>	<ul style="list-style-type: none"> • Flexible and cross trained • Choice and know what the choices are • Some need more intensity and this should be provided • Independent quality assessment • Needs assessment to define dollars • A system change to balance the scales of currently assigned dollars • A mechanism to allow for permanent need changes • Episodic care management for emergencies • National benchmarks may be helpful • Technical Assistance may be needed for what needs assessment tools are being used in other states to implement budgeting





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<p>Small Group Break Out: What choices should the individual have (e.g., choice of care coordination providers; choice of services provided under the care coordination model; choice of health, behavioral health and/or long-term service providers; and choice of specific services and resulting outcomes to be delivered through the People First Waiver)?</p>	<ul style="list-style-type: none"> • Yes to all. How do we empower the individual to have that choice and to make that choice work • Coordination model needs to have some teeth • Choice is not absolute, but we don't want a managed care entity to be able to tell individuals that valid choices are off the table. • Flexibility is crucial
<p>Small Group Break Out: Consider roles and responsibilities of the care coordination provider and person(s) delivering the service (must address assurance and monitoring of health and safety (a component of the HCBS quality framework)).</p>	<ul style="list-style-type: none"> • Health home service coordination should be a team or a circle of support which can expand and/or contract depending on individual needs. There should still be choice within teams. • In quality metrics, care coordination is responsible to hold providers and selves accountable • Purchasing need not be from historical/traditional providers, but can expand on the definition of workers as well. Mental health model utilizes peer services
<p>Small Group Break Out: What are the components of the system that should be independent from comprehensive care coordination (e.g., service authorization, resource allocation, service delivery, etc.)?</p>	<ul style="list-style-type: none"> • Eligibility • Needs assessment • There is potential for advocacy both within and outside of the care coordination role
<p>Small Group Break Out: Given that advocacy is an important component of the current service coordination model, how should this function be addressed in a comprehensive care coordination model?</p>	<ul style="list-style-type: none"> • At the direction of the individual/family • The group questioned if advocacy should be within or outside of comprehensive care coordination based on the need for impartiality to be maintained

Action Items		
<u>Action Item</u>	<u>Owner</u>	<u>Due Date</u>
Needs assessments from other states. What s working in other states?	Jill Gentile and Robert Budd	July 13, 2011





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Connect with Access Design team.		
Optional VC presentation on managed care models for long term care. What is working in other states? Connect with People First Waiver team to determine method to gather and share information.	Jill Gentile and Robert Budd	July 13, 2011
Additional Documents of Reference		

Next Meeting:

- **July 13, 2011**
- **10am - 2pm**
- **75 Morton Street, New York, NY**

