



Care Coordination Team Meeting Summary

Care Coordination Design Team	Date of Meeting: July 13, 2011
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<p>Present:</p> <ul style="list-style-type: none"> • Jill Gentile • Robert Budd • Bill Bird • Nick Cappoletti • Donna Colonna • Jane Davis-Bunt • Marcia Heckel • Maggie Hoffman • Michael Kennedy 	<ul style="list-style-type: none"> • Lois Kilkenny • Hope Levy • Michael Mascari • Eric Pasternak • Carol Rodat • Anne Swartwout • Sheryl WhiteScott • Maria Bediako 	<p>Absent:</p> <ul style="list-style-type: none"> ○ Patrick Dollard ○ Poloma Hernandez ○ Bob Lopez ○ Michael Northrop ○ Susan Wanamaker
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Discussion Topics	Summary of Main Discussion Points, Considerations, Recommendations, Next Steps, etc.
<p>Updates from other Design Teams & Review and Approval of the June 20th Summary</p>	<ul style="list-style-type: none"> • Access and Choice Design Team <ul style="list-style-type: none"> ○ Any Assessment tool must have a strengths-based approach, include community inclusion and be person-centered. ○ Technical workgroup formed to review current assessments used by other states • Services and Benefits Design Team <ul style="list-style-type: none"> ○ Services must be timely, flexible, responsive, and fluid. They must be person-centered and strengths based. ○ Self-directed services should be widely available. ○ Services must be responsive to individuals with behaviors and to individuals who want to be employed. • Quality Design Team <ul style="list-style-type: none"> ○ Focus on individual outcomes and satisfaction with supports instead of compliance ○ The areas of health, home, relationships and



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	<p>meaningful activity were identified as the variables that require measurement when applying a quality framework.</p> <ul style="list-style-type: none"> ○ Development of a rating system for providers using 1-5 scale. Providers with a lower score would be more closely monitored. • Fiscal Sustainability <ul style="list-style-type: none"> ○ Funding mechanism should be flexible and there must be accountable care systems. ○ The system will no longer be a fee-for-service, but instead be a capitation model
<p>Review of Design Team Parameters</p>	<ul style="list-style-type: none"> • The group agreed with the design team parameters, but expressed the following concerns: <ul style="list-style-type: none"> ○ Provider network should be comprehensive enough to give individuals a choice of providers and ensure access to culturally competent care. ○ How do we ensure independent advocacy for people who may need assistance within our system? ○ How does advocacy function, and how is it provided within the People First Waiver?
<p>Examine and Discuss the Health Home DOH State Plan Amendment that describes its Care Coordination design</p>	<ul style="list-style-type: none"> • Care Coordination needs to have collaboration between providers, i.e. a team approach. The Care Coordinator needs to have authority and access to providers that deliver care for an individual. • Care Coordination needs to start with the person: what does the person need and how can he/she be supported • Health Home entities should be evaluated for quality provision of person-centered services. • Entities that provide Care Coordination need to understand the OPWDD population and have experience working with the population. • Health Homes for individuals with DD need to have close ties and understanding of the communities in which a person lives in order to best coordinate with social services, health providers, and long term support services. • The model must include an IT system with interoperability that can be used across systems and funding streams. • Care coordination should begin implementation with a



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	<p>focus on coordination related to an individual’s developmental disability. Coordination related to medical needs should be implemented in a later phase.</p>
<p>Examine and discuss who the stakeholders are in a Care Coordination model and what the roles of those stakeholders are</p>	<ul style="list-style-type: none"> • Individuals and families <ul style="list-style-type: none"> ○ The group discussed scenarios for four types of individuals: 1) Individuals living in a certified residence, 2) Individuals who are children, 3) Individuals who live on their own, 4) Individuals who are adults but live with family ○ Individuals must help choose who does their care coordination. Individuals must help choose the people that are necessary to be a part of the care coordination team. • The Care Coordinator(s) <ul style="list-style-type: none"> ○ The Care Coordinator(s) must ensure that individuals have their needs met in all parts of their lives. ○ The Care Coordinator(s) must coordinate the medical/health needs of the individuals and be able to coordinate comprehensive services. • Managed Care Organization (MCO) <ul style="list-style-type: none"> ○ Helps to provide oversight of the care coordination function ○ Ensures that care coordination provides unbiased access to the full array of network service providers • Provider of direct services <ul style="list-style-type: none"> ○ Needs to be responsive to the Care Plan ○ Should not be in a position to bias choice of providers or a person’s decision to change providers • New York State <ul style="list-style-type: none"> ○ Oversight of independent assessment that drives the planning done by the Care Coordinator ○ Oversight of Care Coordination to ensure that the individual’s needs are being met as determined in the assessment and described in the Care Plan ○ Create/allow for flexible environments to help Care Coordinators direct an individual to the services he/she needs



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<p>The group discussed and answered the charter questions: how can comprehensive Care Coordination enhance person-centered planning, individual responsibility, and self-determination and how can we better incorporate the strengths of the family in the development of the Comprehensive Care Plan</p>	<ul style="list-style-type: none"> • Care coordination can enhance person-centered planning, individual responsibility, and self-determination by using the results of the initial assessment as a means to achieve personal outcomes and by showing the individual services and supports of which he/she may not have been aware. • Care Coordinators need to be competent and well-trained in person-centered techniques. • The Care Coordinator needs to include and be able to facilitate team meetings with families, peers, and other natural supports. • The state needs to use evidenced-based outcomes, help to create a single point of entry (no wrong door) and allow for interconnectivity between the service systems.
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Action Items		
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<u>Action Item</u>	<u>Owner</u>	<u>Due Date</u>
Discuss other state structures for care coordination in managed care and create a visual diagram of proposed structure(s) to share with the group at the next design team meeting	Jane Davis-Bunt, Maggie Hoffman, Nick Cappoletti, Michael Kennedy, Maria Bediako, Anne Swartwout	July 20, 2011
The group will send names to Maria for recommendations to be on the Technical workgroup that will examine individual budgets in a managed care environment.	Maria Bediako	July 15, 2011
Form a technical workgroup to draft care coordination performance standards that would be included in an RFP for an entity that wanted to act as a care management/managed care organization in the people first waiver	Maria Bediako & Jill Gentile	July 27, 2011

Additional Documents of Reference
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New York State Plan Amendment on Health Homes



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Next Meeting:

**July 27, 2011, 10:30 am – 4pm
44 Holland Ave, Albany, NY**