



Care Coordination Design Team Meeting Summary

Care Coordination Design Team

Date of Meeting: July 27, 2011

Present:

- Maria Bediako
- Bill Bird
- Robert Budd
- Nick Cappoletti
- Donna Colonna
- Jane Davis-Bunt
- Jill Gentile
- Lois Kilkenny
- Marcia Heckel

- Hope Levy
- Bob Lopez
- Michael Kennedy
- Eric Pasternak
- Carol Rodat
- Anne Swartwout
- Sheryl WhiteScott
- Jeff Wise

Absent:

- Poloma Hernandez
- Maggie Hoffman
- Michael Mascari
- Michael Northrop
- Susan Wanamaker

Discussion Topics

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

Review Minutes and Action Item Updates; Approve July 13th Summary

- The design team approved the July 13th summary with the addition of the following recommendation: care coordination for individuals within OPWDD’s service system must encompass health care needs and the coordination of those needs.

Viewing of Commissioner Burke’s PACE Interview

- Members of the design team viewed Commissioner Courtney Burke’s interview with Jo-Ann Costantino, CEO of The Eddy, a not-for-profit network of healthcare services that operates under the Program for All Inclusive Care for the Elderly (PACE). The PACE program is an alternative option to a nursing home and provides services to individuals that allow them to remain in their communities.
- The interview focused on how coordination occurs through PACE with the goal of looking at the person in terms of “total care” and to deal with chronic conditions before they get worse.
- Care coordinators encourage the participation of family



Courtney Burke
Commissioner



Andrew M. Cuomo
Governor



Nirav R. Shah, M.D.
Commissioner



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	<p>members and neighbors by presenting the opportunity to provide informal supports as part of an individual’s care plan.</p> <ul style="list-style-type: none"> • Entities that operate through PACE are required to have a “participant council” that is comprised of volunteers and board members. • Quality indicators within PACE include: the number of falls, hospitalizations, and medical errors. • PACE programs are a partnership between the individual and the care coordination entity. Individuals, care coordinators, and service providers work together to communicate when unexpected situations occur. A team is available all the time to discuss what services the individual needs.
<p>Discussion of Care Coordination Structures Under Managed Care</p>	<ul style="list-style-type: none"> • A subgroup of the Care Coordination Design Team met to discuss potential structures for care coordination under the People First Waiver (see attached document with complete subgroup recommendations that were brought forth at the design team meeting).The subgroup’s minutes were reviewed and approved. • The design team came to the agreement that reimbursement for care coordination does not necessarily have to be universally applied through the administrative cost, but could be based on the level of care coordination that a person needs. Ultimately, reimbursement must ensure that outcomes are met and should not penalize those with more complex care coordination needs. • Incentives devised under the 1115 waiver should encourage resource development, innovation and quality improvement. • The use of reassessment and instances where reassessment was conducted under the purview of care coordination entities was also discussed. A review of reassessments done by care coordination entities should be conducted to look at the case mix of individuals and





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	<p>evaluate if those individuals' needs were actually changing.</p> <ul style="list-style-type: none"> • Allowing individuals to have a choice between care coordination providers (when possible) is crucial because the competition that this creates will incentivize measures to improve quality amongst all care coordinators. Moreover, individuals should also be able to have choice of care coordination personnel and the ability to change coordinators if needed.
<p>Design Components of Care Coordination Structure in NY Using Analysis of Current System and Information from Other States</p>	<ul style="list-style-type: none"> • The design team drafted recommendations for the essential components of care coordination based on discussions from previous design team meetings. After identifying these components, the design team looked at how other care coordination entities (such as those described in the New York Department of Health's State Plan Amendment and in information from the State of Colorado) addressed these components of care coordination. Please see the attached "Table of Essential Components of Care Coordination" for details of the discussion. Information from an online survey for group members will be added to the table at the August 10th Design Team Meeting. • OPWDD should set the educational and experiential standards for care coordinators and require Managed Care Organizations to ensure that these standards are met. There should be flexibility to allow for change as needs of individuals or the service system change. • Staff positions within the realm of care coordination should not be viewed as entry-level. Specific reimbursement levels and requirements should be created for these positions to attract high quality applicants. • A provision may be needed that requires retraining and/or the addition of ancillary roles such as a community integration specialist as the developmental disability system in New York transitions from MSC to care coordination.





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	<ul style="list-style-type: none"> • Ongoing training should be provided for care coordinators so they can: (1) remain updated on the population of individuals with developmental disabilities, (2) learn about the availability of new services and (3) strengthen their use of person-centered methodologies. • The needs of individuals must come first within care coordination teams. Furthermore, self-direction must be a core value of Managed Care Organizations and the care coordination process. All individuals must have the opportunity to self-direct. • As the implementation of care coordination draws near, a new workgroup should look at standardizing guidelines, tools and policies relating to the individual’s care plan. • Independent reviews and surveys of care coordination must be conducted by outside entities. • Transition planning must be completed to address how OPWDD will move from a fee for service system to one of care management under the 1115 waiver. How will care coordination be transitioned?
<p>Questions for Other Design Teams</p>	<ul style="list-style-type: none"> • How do you ensure that providers/MCOs do not go bankrupt? Examine a pool of reserves or stop/loss. Current long term managed care organizations are held to a 3% margin. Is this an acceptable margin to allow for fiscal viability of the coordinating entity? • How do we ensure that MCO’s encourage self-direction? What types of standards and incentives will there be for this? • How will the system build and maintain a health information technology that meets the needs of all stakeholders and allows for real time sharing of information and data?





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Action Items		
<u>Action Item</u>	<u>Owner</u>	<u>Due Date</u>
Update and complete the Essential Components Chart and put it on SurveyMonkey for design team to provide additional feedback.	Maria and Anne	July 29, 2011
Additional Documents of Reference		
Essential components of care coordination chart & subcommittee meeting minutes		

Next Meeting:

August 10, 2011

10:30am – 4:00pm

Russell Road Albany, New York, NY



Courtney Burke
Commissioner



Andrew M. Cuomo
Governor



Nirav R. Shah, M.D.
Commissioner