



### Care Coordination Design Team Meeting Summary

**Care Coordination Design Team**

**Date of Meeting: August 10, 2011**

**Present:**

- Maria Bediako
- Bill Bird
- Nick Cappoletti
- Donna Colonna
- Jill Gentile
- Marcia Heckel
- Maggie Hoffman
- Hope Levy
- Bob Lopez
- Eric Pasternak
- Denise Pensky
- Anne Swartwout
- Sheryl WhiteScott
- Jeff Wise

**Absent:**

- Carol Rodat
- Lois Kilkenny
- Jane Davis-Bunt
- Robert Budd
- Poloma Hernandez
- Michael Kennedy
- Susan Wanamaker
- Michael Mascari
- Michael Northrop

**Discussion Topics**

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

Review Minutes and Action Items Updates and Confirm agreement with the Design Team Summary from July 27<sup>th</sup> meeting

- Need to update the July 27<sup>th</sup> summary to include Donna Colonna & Marcia Heckel as present.
- Broaden the discussion on transition in the summary
- Provided updates on the other design teams.

Examine and discuss team recommendations for Essential Components of Care Coordination

- The team discussed some of the following topics regarding transition:
  - Emphasizing the importance of supporting community living for individuals in a broad range of certified and non-certified settings.
  - Increasing the number of neighborhood physicians and psychiatrists willing to serve individuals with developmental disabilities as patients.
  - Having technology so agencies can access medical records and other records to improve the coordination of services.

Evaluate work completed by the Technical Workgroup

- The group offered additional questions for the technical workgroup to consider:
  - When care coordinating entities differ in size, are the expectations different on the number and type of



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	<p>experts that are available to be on a care coordination team?</p> <ul style="list-style-type: none"> <li>• How often should it be reviewed and what triggers a review of the plan?</li> <li>• What elements need to be addressed in the Care Plan, e.g. needs, measurable outcomes, and services/supports?</li> <li>• Need to provide organizations with enough time to train care coordinators and to demonstrate that outcomes are being met through care coordination.</li> </ul>
<p>Discuss Charter Question 6, “What are quality and individual outcome measures that could be used to demonstrate effective comprehensive care coordination,” and connections with Quality Design team</p>	<ul style="list-style-type: none"> <li>• The team felt that the care coordinating entity could not measure its own quality. Reviews need to be independent, occur at varied times, and ensure anonymity for individuals who are asked to participate.</li> <li>• The Quality Design Team is recommending a “1-5” rating system for agencies. The Care Coordination Design Team is suggesting a similar strategy for evaluating care coordination entities.</li> <li>• Individuals/Families must be made aware of the measurements, so that they can identify a “good” care coordination entity.</li> <li>• Reviews must include a method to identify when needs have been identified, but are not being met (e.g. in CSS the monthly narrative note asks questions specific to this). In other words, how does a reviewer know when the care coordinator is not doing his/her job?</li> </ul>
<p>Make recommendations for presentation of work completed to Steering Committee</p>	<p>The team wanted the following points made:</p> <ul style="list-style-type: none"> <li>• Reinforce that the People First Waiver is not adopting a medical model but rather a model that will coordinate care across the full spectrum of a person’s needs. Although we will look at models, like PACE, which are more medical, this is for comparison and to learn from them, not to replicate them.</li> <li>• The need for a firewall between services delivered and care coordination.</li> <li>• That care coordination should result in the achievement of a person’s outcomes and should not just be a gatekeeper for cost containment.</li> <li>• That care coordination needs to be responsive to an individual when changes occur and that the</li> </ul>





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	reimbursement model should not hinder this. <ul style="list-style-type: none"> <li>That there is a need for choice and advocacy within care coordination.</li> </ul>	
Other considerations and questions	<ul style="list-style-type: none"> <li>How are service levels and funding assigned after an individual is deemed eligible?</li> <li>How is the base of services determined for individuals (some individuals may be assessed at a lower level than what is currently being spent)?</li> <li>The court ordered requirements for members of the Willowbrook Class will be honored within the People First Waiver.</li> </ul>	
Identify action items and next steps	<ul style="list-style-type: none"> <li>What are the important items for transition from the current OPWDD system to the Managed Care?</li> <li>Send out the survey requesting information on the essential components to other stakeholders that are not on the design team.</li> </ul>	
<b>Action Items</b>		
<u><b>Action Item</b></u>	<u><b>Owner</b></u>	<u><b>Due Date</b></u>
Develop how Willowbrook class members' coordination needs might be met within a care coordinatin entity	Maria Bediako & Denise Pensky	August 31, 2011
Look at Essential Components and DQM's protocol for the quality measurements. Update chart to include quality measurements	Maria Bediako & Anne Swartwout	August 31, 2011
Team members continue to send out the survey on the essential components to stakeholders for additional input	Maria Bediako	August 31, 2011
<b>Additional Documents of Reference</b>		
Essential Components of Care Coordination		

**Next Meeting:**

**August 31, 2011**  
**10:30am – 4:00pm**  
**75 Morton St, New York, NY**



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