



Essential Components of Care Coordination

Essential Components of Care Coordination	Recommended OPWDD Policies
Access to the System	
Care Coordinator has expertise and knowledge of services and the community in which the individual lives.	<ul style="list-style-type: none"> • There should be a regional component to the structure of the coordinating entity to assure that the care coordination team understands local issues important to individuals such as transportation, availability of providers, Willowbrook entitlements for services, etc. • Care Coordinating entities should have procedures and methodologies in place to assist care coordinators in finding and developing neighborhood resources.
Individuals gain access prior to crises occurring.	<ul style="list-style-type: none"> • Care coordination entity should complete outreach to other systems serving individuals with developmental disabilities, such as SE and Early Intervention, prior to individuals leaving those systems to ensure continuity of care.
Individuals need to receive the right amount of service (not too much or too little).	<ul style="list-style-type: none"> • There should be a balance between mandating membership on a care coordination team with allowing the flexibility of having the team members there only when you need them. • The coordinating entity must allow individuals the ability to (1)choose which experts participate on their care coordination team and (2)to switch team members. • The level of care coordination provided should be based on the level of need in the assessment and the person’s need at the time of coordination. • Care coordinating entities will need to ensure that any court ordered entitlements are met and provided to the individual.
Care coordinators need to be available in a timely manner and backup provided when the regular coordinator is not available.	<ul style="list-style-type: none"> • Each individual will have access to a core care coordination team with a designated team lead that has expertise in working with people who have developmental disabilities. Each member of this team should meet/know the individual. • Care coordinating entities need to have back-up plans and crisis response protocols developed to have a coordinator available 24 hours a day and put in place procedures to access services in emergency situations. Care Coordinating entities will determine when emergency services are necessary and then determine where those services can be accessed.
Care Coordinator Qualifications	
Consistency in care (e.g. care	<ul style="list-style-type: none"> • Each individual will have access to a core care coordination team with a designated team lead that has expertise in working



<p>coordinator’s not keep changing).</p>	<p>with people who have developmental disabilities. Each member of this team should meet/know the individual.</p> <ul style="list-style-type: none"> • The designated team lead should not be considered an entry-level position. • The coordinating entity will recruit and hire a panel of professionals with different expertise and specialty backgrounds, (i.e., nurse, education specialist, employment expert. These professionals will be available to participate on care coordination teams as dictated by the individual’s care plan. • The coordinating entity should have available representation from self-advocates, families of people with developmental disabilities (this would include families and individuals who are actually being served by the care coordinating entity), and experts in cultural diversity and language to provide expertise and advocacy as needed. • There should be a balance between mandating membership on a care coordination team with allowing the flexibility of having the team members there only when you need them. • The coordinating entity must allow individuals the ability to (1)choose which experts participate on their care coordination team and (2)to switch team members.
<p>Ability to manage caseloads effectively.</p>	<ul style="list-style-type: none"> • The coordinating entity will manage caseloads by allowing flexibility of the teams. Caseload should be related to the intensity of individuals’ needs. The coordinating entity will be responsible to balance care coordination resources. Higher the need, the lower the caseload. • Holding care coordination entities to meeting the individual outcomes (i.e. quality) will help to hold entities to a reasonable case load level.
<p>Education and awareness of the individual’s needs, cultural background and the OPWDD population.</p>	<ul style="list-style-type: none"> • The designated care coordination team lead cannot be an entry level position. It is recommended that this individual have a bachelor’s degree or have a certain number of years of experience in the field and a demonstrated capacity to complete necessary care coordination tasks. The lead must be, other team members cannot “make up” this experience & education. • Any licensed professional on the care coordination team will be held to their professional licensing standards. • Team members have to meet regularly and everyone has to know the individual.
<p>Ongoing training for coordinators.</p>	<ul style="list-style-type: none"> • Members of the care coordination team must receive continuing education as defined by OPWDD. Training topical areas should include person centered methodologies, available services, and the needs of the DD population. • Any licensed professional on the care coordination team will be held to their professional licensing standards for continuing education and should not be restricted from assisting an individual if they have met their licensing standards. • There should be a central educational repository with a listing of all available trainings and a record of courses completed. • Standards for continuing education should not be prohibitive to implementation. • Ongoing training should include training that is specific to an individual’s needs (e.g. Ticket to Work, psychiatric-dual diagnoses). • Training shall include as appropriate information on the Willowbrook entitlements for services.



<p>Understanding of self-direction.</p>	<ul style="list-style-type: none"> • The care coordination team must have an understanding of self-direction in the DD system. • Individuals must be offered the choice of self-directing services. If an individual chooses this option, the coordinating entity must determine the most appropriate way to support the individual’s choice. • Require self-advocacy and self-determination training for care coordination team members, including individuals. • Care coordination entities should demonstrate that they have specific procedures for ensuring self-direction.
<p>Standardized guidelines of care coordination for the individual.</p>	<ul style="list-style-type: none"> • Policies, guidelines, and tools used to develop, gather feedback on, and implement individual care plans should have some level of statewide standardization. • If a standard changes, care coordination entities and individuals must be made aware of the change. • Policies, guidelines, and tools should be available on the internet. • Tools should allow for a balance in spending time with the person and completing necessary paperwork. • Allow for methods and approaches to be flexible and not prescriptive, so that innovative and effective approaches can be used to meet the needs of the individuals.
<p>Cross System Coordination</p>	
<p>There is no conflict of interest between coordination and service delivery.</p>	<ul style="list-style-type: none"> • There must be a firewall between the coordinating entity and the direct provider of services to avoid self-referrals and potential conflicts of interest. • The oversight entity must monitor the coordination of services and provision of services to ensure that conflict of interest is limited. • For areas where there are potential conflicts of interest, entities need to have processes in place for appeals, grievances, and training of individuals on these processes
<p>Holistic and comprehensive approach to services (i.e. services need to intersect and meet all parts of an individual’s life.)</p>	<ul style="list-style-type: none"> • The coordinating entity will recruit and hire a panel of professionals with different expertise and specialty backgrounds, i.e., nurse, education specialist, employment expert. These professionals will be available to participate on care coordination teams as dictated by the individual’s care plan. • Respond to individuals as they age and be able to access and provide services as needs change (e.g. NYSOFA).
<p>Reduce the redundancies of oversight by other systems.</p>	<ul style="list-style-type: none"> • The care coordination panel of experts must maintain an understanding of other service systems that could assist in meeting the needs of individuals with developmental disabilities, for example Early Intervention, DOE, OMH, SED, NYSOFA, OCFS, etc. • There needs to be access to all service systems to meet the needs of the individual and reduce redundancy.



<p>Care coordinators provide information on medical providers.</p>	<ul style="list-style-type: none"> • The coordinating entity will recruit and hire a professional with expertise in the medical needs of individuals with developmental disabilities and knowledge of medical providers in the region. • This medical professional will participate in the panel of experts on the care coordination team as needed based on individual service plans.
<p>Care Coordinators assist in locating and accessing natural and community resources.</p>	<ul style="list-style-type: none"> • Current Medicaid Service Coordinators can provide this portion of care coordination as a member of the care coordination team. • A class member will have a community inclusion strategy based on his or her interests, preferences and need; person centered frequency and variety; and documentation to confirm implementation. • Care coordinating entities should have procedures and methodologies in place to assist care coordinators in finding and developing neighborhood resources.
<p>Care Coordinators assist the person in forming and sustaining relationships.</p>	<ul style="list-style-type: none"> • Current Medicaid Service Coordinators can provide this portion of care coordination as a member of the care coordination team.
<p>Availability of cross-system experts to assist the care coordinator.</p>	<ul style="list-style-type: none"> • The coordinating entity will recruit and hire a panel of professionals with different expertise and specialty backgrounds, i.e., nurse, education specialist, employment expert. These professionals will be available to participate on care coordination teams as dictated by the individual’s care plan.
<p>Person Centered Plan</p>	
<p>Tools and time to complete a plan using a person-centered plan.</p>	<ul style="list-style-type: none"> • The person and family members must be essential and contributing members to the development of the care plan. • Screening and the assessment occur before a service is provided. The assessment comes first and the plan is written prior to any services. Having the service does not drive the rush to complete the plan, i.e. to protect billing the ISP will be written to “authorize” the service. • Need to have a process for a person centered plan. • Reaching out to the person first and then planning for the services, will allow for the time and thoughtful completion of a plan. • Working with people before there is a crisis or emergency.
<p>Individualized benchmarks to ensure that the plan meets the individual’s outcomes.</p>	<ul style="list-style-type: none"> • True person centered methodology is being utilized. • Policies, guidelines, and tools to create the person centered plan must elicit individual goals and outcomes and incorporate benchmarks to ensure that progress is made in the achievement of these goals and outcomes. • Identified outcomes and benchmarks must be measurable.



	<ul style="list-style-type: none"> • The coordinating entity should put supports and services in place to achieve individual outcomes. • Outcomes need to be written that acknowledge the risk that an individual accepts when self-directing his or her own services.
Incentives to ensure that care coordinators deliver on outcomes.	<ul style="list-style-type: none"> • There needs to be choice of care coordinators so that entities want to improve on outcomes so they don't lose out on serving individuals. • The individual service plan must articulate outcomes agreed upon by the individual and the care coordination team. • Results of aggregated consumer satisfaction surveys should be transparent to individuals and families. • Acceptable performance standards for the coordinating entity must be made available. • If performance measures are not met, monthly payments and/or operating licenses could be at risk. • Incentives should be provided when benchmarks and outcomes are met.
Choice needs to be available and the spectrum of choice is flexible based on the needs of the individual, including care coordination.	<ul style="list-style-type: none"> • A core value of the MCO and any coordinating entity should be to offer choice and make a reasonable effort to meet the individual's choice of service provider or care coordinator <i>and/or delivery of services</i>. • Coordinating entities must make the attempt to have a range of providers available to promote choice and allow for self-directions as often as possible. • The MCO should be required to contract with a certain number of providers based on demographics of the area. Individuals should be able to choose a functionally independent care coordinator if such a person is available.
Organizational	
Stable and predictable reimbursement structure.	<ul style="list-style-type: none"> • The care coordination reimbursement could potentially be separate from the overall PMPM capitated rate so that care coordination can be flexible and responsive to the individuals' needs. • Part of the reimbursement for care coordination should consider training as one of the elements included. • The assessment should impact the rate that someone receives for care coordination. • Require MCOs to maintain a reserve of funds to pay providers of services. This reserve can be accomplished via pooling resources from more than one MCO.
Flexible and responsive to individual's needs.	<ul style="list-style-type: none"> • Care coordination is reflective of individual's needs as they change over time. This means that, in a managed care environment, access to direct care and services is not impacted by whether a person needs more or less care coordination. • Technology needs to be in place so that a care coordinator can have access and share medical records and planning records, so that there is better coordination and delivery of services.



Quality	
Realistic and Measurable Outcomes.	<ul style="list-style-type: none"> • Policies, guidelines, and tools to create the person centered plan must elicit individual goals and outcomes and incorporate benchmarks to ensure that progress is made in the achievement of these goals and outcomes. • Identified outcomes and benchmarks must be measurable. • Acceptable performance standards for the coordinating entity must be made available. • If performance measures are not met, monthly payments and/or operating licenses could be at risk.
Focus on quality and less on compliance.	<ul style="list-style-type: none"> • The individual service plan must articulate outcomes agreed upon by the individual and the care coordination team. • Results of aggregated consumer satisfaction surveys should be transparent to individuals and families. • Quality measures should look at culture change as well as achievement of individual’s goals, for example, moving individuals to the least restrictive setting. • Outcomes need to be written that acknowledge the risk that an individual accepts when self-directing his or her own services.
Advocacy	
Independent Advocacy	<ul style="list-style-type: none"> • An advocacy body should be established that is separate from the care coordination entity, and service providers.
Internal Advocacy	<ul style="list-style-type: none"> • The coordinating entity should have available representation from self-advocates, families of people with developmental disabilities, and experts in cultural diversity and language to provide expertise and advocacy as needed. • Quality measures can be implemented that ensure a component of advocacy is in the care planning process.
Willowbrook	
Compliance with expectations for services as stipulated by the Willowbrook Permanent Injunction and subsequent court orders.	<ul style="list-style-type: none"> • Care coordination for Willowbrook class members will include an annual plan of services based on current assessments. • Team reviews will be convened on a semi-annual basis or more often as needed. • The care coordination team will include a designated Willowbrook care coordination entity at a ratio equivalent no greater than 1:20 who is a Qualified Mental Retardation Professional (QMRP) not employed by an agency that provides residential or day services to the class member unless the class member or the class member’s advocate chooses a functionally independent QMRP, if such a person is available. • The designated Willowbrook care coordination entity will: <ul style="list-style-type: none"> ○ provide monitoring and follow up to ensure the plan of services is developed, implemented and reassessed appropriately; ○ take an active role in advocating for the implementation of the class member’s rights and entitlements for services as well as those per class membership, including but not limited to <i>Safety and Physical Environment, Staffing, Active</i>



	<p><i>Representation, Active Treatment, Appropriate Services, Community Inclusion, Informed Consent, and Protection from Harm;</i></p> <ul style="list-style-type: none">○ make face to face visits at least monthly; and○ proactively advocate for the class member and be actively involved in notification to Willowbrook interested parties, including preparation of due process notices.
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Resources:

Social Work Leadership Institute, Division of the New York Academy of Medicine. (2008, October). Toward the Development of Care Coordination Standards: An analysis of Care Coordination in Programs for Older Adults and People with Disabilities. Prepared for NYS Department of Health and the NYS Office for the Aging. October 2008. Retrieved from <http://www.searchedac.org/resources/NYS%20DOH%20-SOFA%20Care%20Coordination%20Report.pdf>

Colorado Department of Public Health and Environment. (August 2010). HCP Care Coordination Policies and Guidelines. Retrieved from <http://www.cdphe.state.co.us/ps/hcp/form/carecoordination/HCP%20Care%20Coordination%20Forms%202010/6-1-10%20HCP%20CC%20Policy%20and%20Guideline.pdf>

New York State Department of Health. (2011, July 30). Draft NYS Health Home State Plan Amendment for Individuals with Chronic Conditions. Retrieved from http://www.health.state.ny.us/health_care/medicaid/program/medicaid_health_homes/docs/nys_health_home_spa_draft.pdf

Online Survey. (2011, August 8). Essential Components Chart. Responses received from Maggie Hoffman, William Cooke, Marcia Heckel, Carol Rodat, and Lois Dawn Kilkenny.

Willowbrook Permanent Injunction.