Care Coordination Design Team

Sub Group Meeting – July 20, 2011

Essential Components of Care Coordination:

Regardless of the structure of the care management environment, care coordination needs to address the following essential components.

- The Care Coordination entity must have the following functions: (from North Carolina)
  - Provide information on primary, preventative, and other medical providers
  - Assist in locating and accessing social, educational, natural and community resources that are related to achieving person-centered plan goals
  - Assist the person in forming and sustaining the relationships that allow the person to experience meaningful community integration and inclusion
  - Provide advocacy and collaboration with other individuals to support the life goals of the person with DD
  - Support the individual and family in preparing, participating in and implementing the person-centered plan
- The assessment tool is not completed by the care coordination team but is separate and apart from care coordinator.
- Care coordination is community based and has knowledge of the community. For example, you can't have a call center in Manhattan serve individuals in Buffalo.
- Care coordination entity is a not-for-profit.
- Choice needs to be available and the spectrum of choice and amount of service coordination is flexible based on the needs of the individual.
- 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.
- Care coordinators must be qualified to address the unique needs of individuals with developmental disabilities. The care coordination entity should also have a panel of qualified cross-system experts available to provide knowledge in areas needed by the individual. Examples include:
  - Medical needs
  - Mental health needs
  - Substance abuse needs
  - Behavioral needs
- Care coordination entity needs to be a stable resource and have a consistent knowledge of an individual's history even when there is staff turnover.
- Care coordination entity should reduce redundancies in oversight and "hoops to jump through" to access the services.
- Utilize the person centered planning methodology in support brokering under the CSS program as a guide for care coordination under the People First Waiver.

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- Individuals should have a choice of care coordinators and a mechanism to change coordinators.

Potential Pilots for Care Coordination Structures:

- Consider different levels of intensity for care coordination function based on a person's need.
    - For people who self direct within a managed care framework integrate the fiscal intermediary and support broker functions with the care management organization.
- Role of support broker
    - Member of the care coordination team
    - Linked with fiscal intermediary

Implementation Questions for other Design Teams/Technical Workgroups:

- Could we, as a model, consider a firewall, so that an individual doesn't need to make a choice between increased care coordination during times of increased need and amount of service provided? (See potential pilot for care coordination carve out rate.)
- Many different hospital health care networks are huge and separate from each other. They often don't share records and have very different requirements. In managed care what happens as we blend these medical services under the purview of the care coordinators of the People First waiver? How much time do we expect care coordinators to be spending to help educate and blend individual's current medical services into the 1115 waiver?
- How do we assure that the flexibility exists within the system to move individuals to least restrictive settings?
- How will choice of care coordinator occur? What is the process for switching care coordination entities?