



Introduction

The Care Coordination team was established for the period of August-October 2012 to review and finalize specific recommendations for the People First program design components that are needed to develop and implement the OPWDD DISCO pilots.

To develop recommendations the Care Coordination team worked within the framework of certain guiding principles. They also confirmed care coordination's core functions to establish a common reference point when determining how recommendations lend itself to improving care coordination and meeting the needs of individuals served.

Guiding Principles

The Care Coordination Entity will operate under the following guiding principles. Performance measures will be developed to ensure progress towards these principles:

- Employment First
- Most Integrated Settings
- Self Direction
- Customer Satisfaction
- Informed Choice
- Health, Safety and Dignity of Risk

Core Functions of Care Coordination

The Care Coordination Entity is responsible for the following functions:

- Central Point of Contact
- Advocacy
- Linkage and Referral
- Coordination with Service Providers
- Care Planning
- Assessment
- Monitoring
- Record Keeping
- Eligibility and Benefits Maintenance
- Cost Management

Note:

Care Coordination is an overall function or entity. It is not a person; it is a team. There will be a Lead Coordinator role with minimum responsibilities and qualifications but overall Care

Coordination and the Core Functions mentioned above may be delivered upon by any number of variations of personnel depending on how the Care Coordination entity designs it.

Core Responsibilities of the Lead Care Coordinator

The lead care coordinator is responsible for the oversight and coordination of the entire Care Coordination team and the person's services and ensuring that the plan of care is properly implemented and that the person's needs are met.

Lead Care Coordinator Qualifications

The lead care coordinator must have at least a bachelor's degree (in any field) and at least one year of experience with people with developmental disabilities. "Grandfathering" should not be allowed.

Competencies and Training

Care Coordination entities must have processes in place to ensure that lead care coordinators and team members exhibit or have training to gain the following competencies. In addition, care coordination entities must ensure that the care coordination team has training in areas specific to the person and any regulatory requirements.

Competencies that should be developed are:

- Knowledge of service system; including community and natural supports and services, and entitlements and benefits; and of individuals with developmental disabilities
- Able to communicate effectively to the individual and to others which includes the ability to explain to the individual the service system and options available
- Core attitude that the person is a partner in the process
- Ability to develop a relationship with the individual
- Able to advocate for what the person needs
- Able to get the services and supports for individuals to live the life of their choice. This includes
 - The ability to navigate through the DISCO's layers of management
 - The ability to breakdown silos and reach out across different service systems (education, mental health, medical, etc.)
 - Comfortable with reaching out to experts in different areas
- Able to develop an effective plan that reflects the individuals needs and desires but also meets any standards set by the state
- Ability to evaluate and follow up that the person's needs (including health and safety) are being met and that what is important to the person is ongoing

- Implement the care plan to achieve the outcomes of the person while looking while being mindful of the most integrated and cost effective manner to do this
- Professionalism
 - Participate in opportunities for continued training and education
 - Use self evaluation to ensure ongoing professional growth
 - Demonstrate professional work habits including dependability, time management, independence and responsibility

A care coordination entity needs to have metrics and quality reviews in place that focus on outcomes thus providing flexibility in developing trainings that would drive the competencies listed above.

Quality Outcome Measures

Quality outcome measures need to be developed that are important to individuals who receive care coordination and that will provide feedback so New York State can evaluate the effectiveness of care coordination. Measures need to be well-defined so that care coordination entities know what they need to achieve and what types of data need to be maintained. Some of the areas that should be measured as they relate to care coordination include employment, self-direction, integrated living settings, informed choice, and health and safety/dignity of risk. Some of the measures recommended include:

- Percent of people who achieve a career-related goal described in their plan within the service plan year.
- Number of people who identify as not wanting to be in a 24/7 setting that are then being supported in less than 24/7 settings.
- Care Coordinators provide education on the self direction process utilized by the DISCO to 100 percent of people served.
- Percent of people served who self-direct some or all of their services
- Percent of service plans in which the plans support the individual's valued outcomes and include preferred activities.
- Percent of individuals sampled where the individual responded that he/she was given a choice of providers.
- Percent of plans in which the identified supports are provided to meet the assessed needs and risks of participants.
- Percent of individuals who received needed health care services based upon their plan.

Documentation and Monitoring

Plans should identify the appropriate supports the person needs to reach outcomes and describe how those outcomes are to be met. The elements that must be in a comprehensive plan for the person are:

- Description of the person (e.g. skills, strengths, interests)
- The Individual's outcomes and the observable/measurable action steps taken to achieve those outcomes.
- Services and Supports needed.
- Wellness and safety supports.
- Documentation expectations as to how outcomes/goals will be achieved

It is recommended that the care coordination entity sees the person a minimum of three times per year. However, the individual and the care coordination team may agree to fewer face-to-face meetings. These visits are to ensure that the services are meeting the person's needs and that the plan is being implemented properly.

Caseloads within DISCOs need to be flexible, so that DISCOs can develop models that best meet the individuals' needs and the organization's needs. DISCOs should have policies and procedures in place to ensure that care coordinators and the teams can effectively manage caseloads.

Care Planning

Plans must be person centered and updated as needed with at least two reviews per year. The targeted work team has identified practices for person centered planning that must be included in the planning process. The following characteristics are essential to the successful use of a person centered planning process with an individual:

- **Person-Directed.** The individual directs the planning process (with necessary supports and accommodations) and decides when and where planning meetings are held, what is discussed, and who is invited.
- **Person-Centered.** The planning process focuses on the individual, not the system or the individual's family, guardian, or friends. The individual's goals, interests, desires, and preferences are identified with an optimistic view of the future and plans for a satisfying life. Services and supports are responsive to the person's needs.
- **Outcome-Based.** Outcomes in pursuit of the individual's preferences and goals are identified as well as services and supports that enable the individual to achieve his or her goals, plans, and desires and any training needed for the providers of those services and supports. The way for measuring progress toward achievement of outcomes is identified.
- **Information, Support and Accommodations.** As needed, the individual receives comprehensive and unbiased information on the array of services, community resources, and available providers. Support and accommodations to assist the individual to participate in the process are provided.
- **Wellness and Dignity of Risk.** Issues of wellness, well-being, health and primary care coordination or integration, supports needed for an individual to continue to live

independently as he or she desires, and other concerns specific to the individual's personal health and safety are discussed and plans to address them are developed.

- **Participation of those that the individual selects.** Through the pre-planning process, the individual selects friends, family members and others to support him or her through the person-centered planning process. Pre-planning and planning help the individual explore who is currently in his or her life and what needs to be done to cultivate and strengthen desired relationships.
- **Community Integrated.** The support of family, neighbors, friends, and co-workers is encouraged and the "generic" community supports are used by the individual when possible. The person lives in the most community integrated setting possible, is a contributing member of the community, exercises his/her rights and responsibilities, and is actively involved in the community and has natural-community relationships to the extent that he/she wants.

The following characteristics are essential for organizations responsible for providing supports and services through person centered planning:

- **Individual Awareness and Knowledge.** The managed care entity provides accessible and easily understood information, support and when necessary, training to individuals using services and supports and those who assist them so that they are aware of their right to person centered planning, the essential elements of person centered planning, the benefits of this approach and the support available to help them succeed.
- **Person-Centered Culture.** The managed care entity provides leadership, policy direction, and activities for implementing person-centered planning at all levels of the organization. Organizational language, values, allocation of resources, and behavior reflect a person-centered orientation.
- **Training.** The managed care entity has a process to identify and train staff at all levels on the philosophy of person centered planning. Staff who are directly involved in person centered planning are provided with additional training.
- **Roles and Responsibilities.** As an individualized process, person centered planning allows each individual to identify and work with chosen people and other supports. Roles and responsibilities for facilitation, planning, and developing the plan are identified; the plan describes who is responsible for implementing and monitoring each component of the plan.
- **Quality Management.** The managed care entity's quality management system includes a systemic approach for measuring the effectiveness of person centered planning and identifying barriers to successful person-centered planning. The best practices for supporting individuals through person centered planning are identified and implemented (what is working and what is not working in supporting individuals). Organizational expectations and standards are in place to assure the individual is supported in directing the process and ensure that person centered planning is consistently done well.