CCO/HH Care Manager Checklist

Individual's Name: _____

Date of Birth: _____ TABS ID: _____

Care Managers, or a designee of the Care Manager whose responsibility is to educate individuals and their families on CCO/HH services (i.e., CCO/HH Intake staff member) will be required to complete the CCO/HH Care Manager Checklist. This checklist must be completed to initiate and bill for CCO/HH services and done in partnership with the individual and their family/designated representative. This checklist assists with identifying and understanding the individual/family's current service needs and educates the individual/family on CCO/HH services. The checklist must be completed face-to-face or via telephone within thirty (30) days of CCO/HH enrollment, except for individuals who transitioned from MSC/PCSS on July 1, 2018. Care Managers (or their designee) also have the option of completing the checklist at the time the CCO/HH consent forms are reviewed and signed by the individual/family. This process is essential to the successful delivery of the Health Home core services and will also identify any additional service needs of the individual. Individuals may change CCO/HHs at any time and a new checklist will need to be completed within thirty (30) days of enrollment into the new CCO/HH.

Upon completion of each task, this checklist must be signed and dated by the person who completed the tasks. Additionally, it is required that the Care Manager sign and date the checklist whether they completed it independently or it was completed by their designee. It is best practice to have the signature of the individual or their involved family member/designated representative, but it is not required.

Enrollment in CCO/HH is effective: _____
(month/day/year)

<u>Step One:</u> Information Gathering

Upon enrollment into the CCO/HH Care Manager must complete the following steps for everyone on their case load, if the information is available:

- ☐ Obtain or request any relevant plans or person-centered planning meeting information from other systems (i.e., Individualized Education Plan (IEP), 504 Plan, discharge plans developed by hospitals, nursing homes, correctional facilities, assessments which may include are but not limited to: clinical assessments and/or State approved functional needs assessments).
- ☐ Obtain available OPWDD assessment information, including the DDP2 and CAS summaries, from the OPWDD IT system (CHOICES).
- ☐ Confirm and identify the members of the individual's care planning team in which the primary DD providers (i.e. residential, day, and community habilitation providers) are mandatory members.
- ☐ Confirm and identify all providers responsible for providing care to the individual. These providers include but are not limited to: medical, behavioral health, DD, LTSS and social and community services providers.
- ☐ Schedule the date, time and location of the Life Plan review meeting and the care planning team members who will be participating.

Date of Person-Centered-Planning Meeting:

CCO/HH Care Manager Checklist

Individual's Name: _____

Step Two: CCO/HHs are required to provide the following six Health Home core services.

The tasks referenced below are examples of core service activities that must be reviewed during the initial CCO/HH enrollment period. Care Managers are responsible for identifying the individual/family's service needs and educating the individual/family on CCO/HH services.

Comprehensive Care Management

- ☐ Inform individual and their family of the Care Manager's responsibility to create, document, execute and update the individualized, person-centered Life Plan.
- ☐ Identify the individual's current service needs, providers, supports, goals, and engagement activities.

Care Coordination and Health Promotion

- ☐ Educate individual and their family on engagement and decision-making to promote independent living, as well as education on wellness promotion and prevention programs.
- ☐ Coordinate and arrange for the provision of current and additional needed services and ensure treatment adherence.

Comprehensive Transitional Care (note: CCO/HH services may be billed to eMedNY within thirty (30) days of discharge from a hospital or institutional setting).

- ☐ Notify individual and their family of the established networks with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings.
- ☐ Is the individual currently residing in a health facility? (i.e. hospital or residential/rehabilitation setting? ☐ Yes ☐ No
  If yes, are the appropriate procedures currently in place to ensure timely access to follow-up care post discharge? ☐ Yes ☐ No

Individual and Family

- ☐ Educate individual and their family on support and self-help resources to increase knowledge, engagement, self-management and to improve adherence to prescribed treatment.
  Currently, does the individual and family require additional education and support services? ☐ Yes ☐ No

Referral to Community and Social Supports

- ☐ Advise individual and their family of available community-based resources and explain the Care Manager's role in managing appropriate referrals, access, engagement, follow-up and coordination.
  Currently, does individual require additional community-based resource support? ☐ Yes ☐ No

Use of Health Information Technology (HIT) to Link Services

- ☐ Inform individual and their family of the purpose and utilization of HIT.
- ☐ Has the individual signed a consent to share personal information? ☐ Yes ☐ No

CCO/HH Care Manager Checklist

X _____ _____
Care Manager's Signature Date

X _____ _____
Care Manager Designee's Signature Date

X _____ _____
Individual/Family's Signature Date