NEW YORK STATE OF OPPORTUNITY.

Office for People With Developmental Disabilities

Overview of Care Coordination Organization (CCO) Care Management

April 2021

Welcome

- Choice of OPWDD Service
- Care Coordination Organizations (CCO)/IDD Health Home
- Choice of CCO & Enrollment Process
- Overview of the CCO Health Home Service

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Overview of Office for People With Developmental Disabilities OPWDD

- The New York State agency that authorizes services for people in NYS who have intellectual or developmental disabilities.
- Helps people with developmental disabilities live richer lives in the most integrated community settings possible.
- Services are provided not only by OPWDD but also by hundreds of nonprofit agencies across NYS that OPWDD certifies and regulates.
- Care Coordination Organizations (CCOs) assist most people with the coordination of their services.

Who Does OPWDD Serve?

Individuals with a developmental disability:

1. A condition that occurs anytime from birth until the age of 22, including:
   - Intellectual Disability,
   - Cerebral Palsy,
   - Epilepsy,
   - Neurological Impairment,
   - Autism,
   - Familial Dysautonomia,
   - Prader-Willi Syndrome
2. The condition is expected to be permanent.
3. The condition affects the person's ability to function in society.

Referral for Children's Services

- If a child is either served by a Children's Heath Home and/or is enrolled in the Children's Waiver, then the initial point of contact for OPWDD services is the DDRO Children's Liaison.
- For all other children, the initial point of contact is the DDRO Front Door.

OPWDD Children's Liaisons

Region/Counties	Contact Information
Region 1: Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Wyoming, Yates, Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans	childrensliaisonregion1@opwdd.ny.gov
Region 2: Broome, Chenango, Delaware, Otsego, Tioga, Tompkins, Cayuga, Cortland, Onondaga, Oswego, Herkimer, Lewis, Madison, Oneida, Clinton, Essex, Franklin, Hamilton, Jefferson, St. Lawrence	childrensliaisonregion2@opwdd.ny.gov
Region 3: Fulton, Montgomery, Saratoga, Schenectady, Schoharie, Warren, Washington, Albany, Rensselaer, Orange, Sullivan, Rockland, Westchester, Columbia, Dutchess, Greene, Putnam, Ulster	childrensliaisonregion3@opwdd.ny.gov
Region 4: Queens, Kings, New York, Bronx, Richmond	childrensliaisonregion4@opwdd.ny.gov
Region 5: Nassau, Suffolk	Childrensliaisonregion5@opwdd.ny.gov

What is the Front Door?

OPWDD's Front Door is:

- The way OPWDD connects people to the services they want and need.
- Based on the idea that people with developmental disabilities have the right to:
  - ✓ Enjoy meaningful relationships,
  - ✓ Experience personal growth,
  - ✓ Participate in their community, and
  - ✓ Live as independently as possible with supportive services.
- A way to help people make choices about their services and how they are provided.

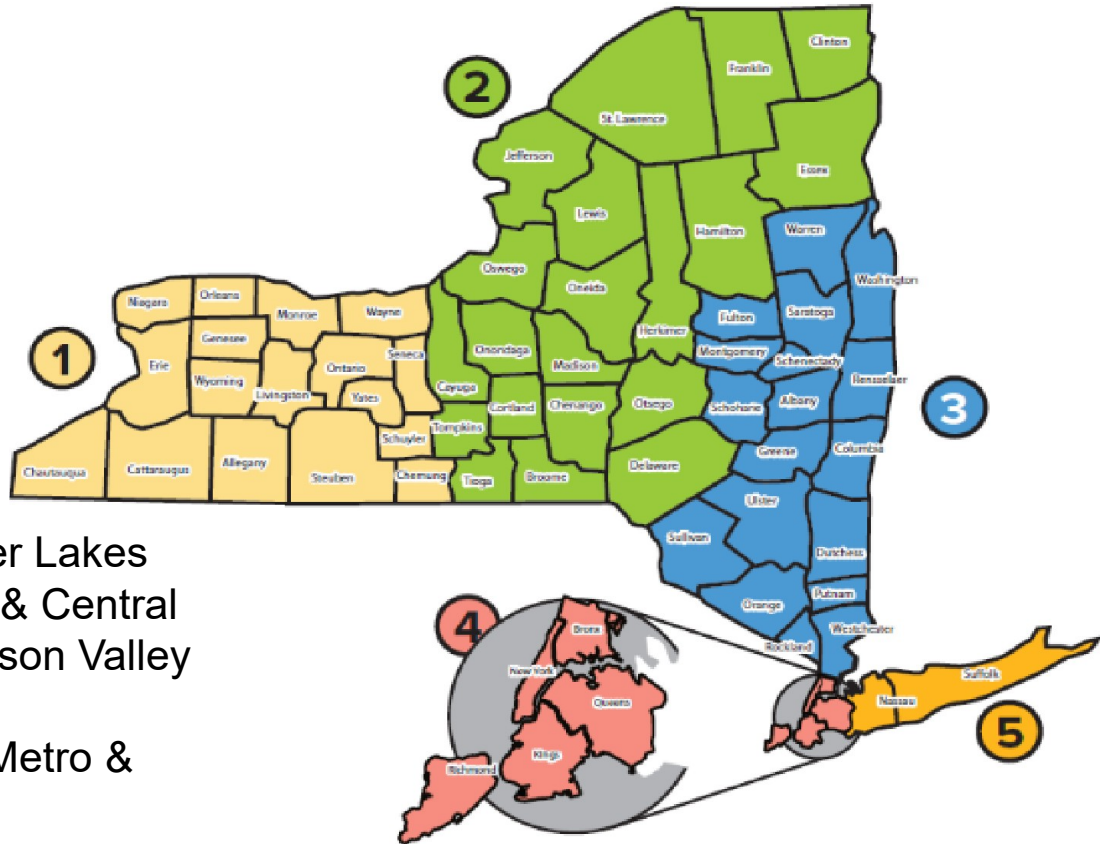
The Front Door Process Helps With Many Choices an Individual and Their Family Will Need to Make

Choices about:

- The Care Coordination Organization (CCO) they will work with, and
- The type of care coordination they want,
- The types of services they need,
- Whether to self-direct their services, or not, and
- Which available agencies they would like to deliver your services.

5 Developmental Disabilities Regional Offices

Voluntary Agency Coordination & Oversight



(1) Western NY & Finger Lakes
(2) Broome, Sunmount & Central
(3) Capital District, Hudson Valley & Taconic
(4) Queens, Brooklyn, Metro & Staten Island
(5) Long Island

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Enrollment in DOH Children's Waiver & OPWDD Comprehensive Waiver

- A child **CANNOT** be enrolled in both the DOH Children's Waiver and the OPWDD Comprehensive Waiver.
- If a child meets the eligibility criteria for both waivers they must decide which waiver best meets their needs.

DOH Children's Waiver Services vs. OPWDD HCBS Waiver Services

DOH Children's Waiver

- Habilitation (Community and Day)
- Prevocational Services
- Supported Employment
- Respite (Planned and Crisis)
- Adaptive and Assistive Equipment
- Vehicle Modifications
- Environmental Modifications
- Caregiver/Family Supports and Services
- Community Self-Advocacy Training and Support
- Palliative Care
- Customized Goods and Services
- Non-Medical Transportation

OPWDD Comp Waiver

- Habilitation (Residential, Day, Community)
- Prevocational Services
- Supported Employment
- Pathway to Employment
- Respite
- Assistive Technology – Adaptive Devices
- Environmental Modifications
- Vehicle Modifications
- Family Education and Training
- Services to Support Self-Direction
  - Fiscal Intermediary (FI)
  - Support Brokerage
  - Individual Directed Goods and Services
- Community Transition Services
- Live-In Caregiver
- Intensive Behavioral Support

CCO Care Management

- Care Management:
  1. Is required in order to get some OPWDD services,
  2. Is required to ensure individuals who enroll in OPWDD's HCBS waiver receive the appropriate services and supports,
  3. Is a good idea to make sure you get the supports and services you need.
- Care managers work for Care Coordination Organizations (CCOs).
- Care managers are professionals who provide care management and coordinate services.

Care Coordination Organizations

- Beginning on July 1, 2018, OPWDD embraced a new era of People First Care Coordination which has its foundation in the creation of CCOs. CCOs are responsible for the provision of conflict-free care management services.
- CCO care management services were designed to provide comprehensive person-centered care planning using a network of care manager and providers (team approach).
- Enhanced care coordination and integration of primary, acute and behavioral health services and,
- Connections to community services and supports, housing, social services and family services.

What Are CCOs?

- Organizations formed by providers of developmental disability services to provide OPWDD care management services.
- An individual and their family can choose the CCO they want from at least two CCOs in their county.
- In the OPWDD system, they can choose the type of care management they want:
  - Health Home Care Management Services, or
  - Basic HCBS Plan Support

The 7 CCOs

- Advance Care Alliance
- Care Design
- LIFEPlan
- Person Centered Services
- Prime Care Coordination
- Southern Tier Connect
- Tri-County Care

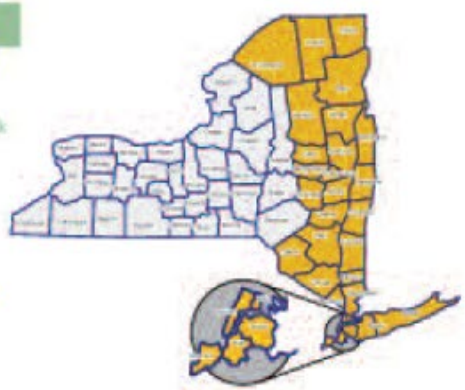
Coverage Map:
https://opwdd.ny.gov/system/files/documents/2020/06/cco_coverage_chart.pdf

CCOs and Coverage Area

ACA/NY
ADVANCE CARE ALLIANCE

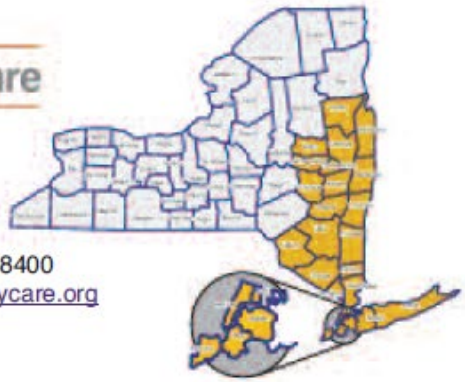
833-MYACANY (833-692-2269)
www.advancecarealliance.org

CAREdesign
making supports work



518-235-1888
www.caredesignny.org

Tri-County Care



844-504-8400
www.tricountycare.org

Prime Care Coordination

844-347-3168
www.primecareny.org

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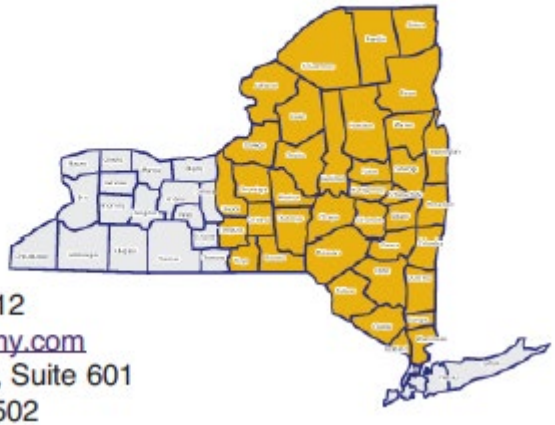
CCOs and Coverage Area

LIFEPlan CCO NY
Centered on Resources for Life

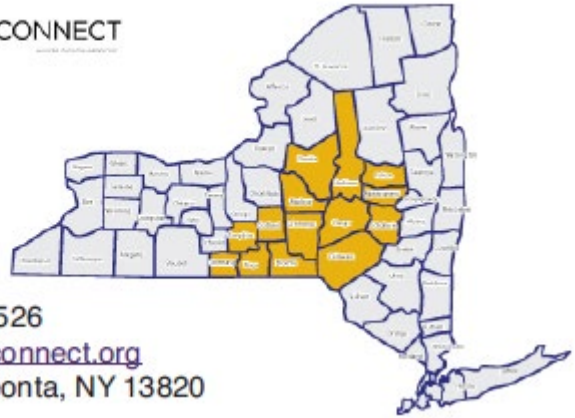


315-565-2612
http://lifeplanccony.com
258 Genesee Street, Suite 601
Utica, NY 13502

PERSON CENTERED SERVICES
Reach Your Potential

888-977-7030
www.personcenteredservices.com
701 Seneca Street, Suite 140F
Buffalo, NY 14210

SOUTHERNTIERCONNECT



607-376-7526
www.southerntierconnect.org
5588 State Hwy 7, Oneonta, NY 13820

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Health Home Care Management and Basic HCBS Plan Support Services

Health Home Care Management

- Coordinates OPWDD supports and services,
- Coordinates access to behavioral health services,
- Coordinates access to medical, and dental services,
- Identifies community-based resources,
- Uses technology to link services,
- Connects care providers,
- Takes the burden of navigating systems from families.

Basic HCBS Plan Support

- Coordinates OPWDD supports and services; assessment of needs, development of a Care Plan, referral to services, and monitoring activities.

Enrollment Criteria

- CCO enrollment can occur when:
  - OPWDD eligibility is confirmed
  - Level of Care eligibility is determined
  - Medicaid is obtained
- CCO enrollment is always the 1st day of the month following the enrollment criteria being met

OPWDD LCED

Evaluates:

- Evidence of a developmental disability
- Disabilities manifested before age 22
- Evidence of a severe behavior problem (not required)
- Health care need (not required)
- Adaptive behavior deficit in one ore more of the following areas:
  - Communication
  - Learning
  - Mobility
  - Independent living
  - Self-Direction

Health Homes Provide Six Core Care Management Functions

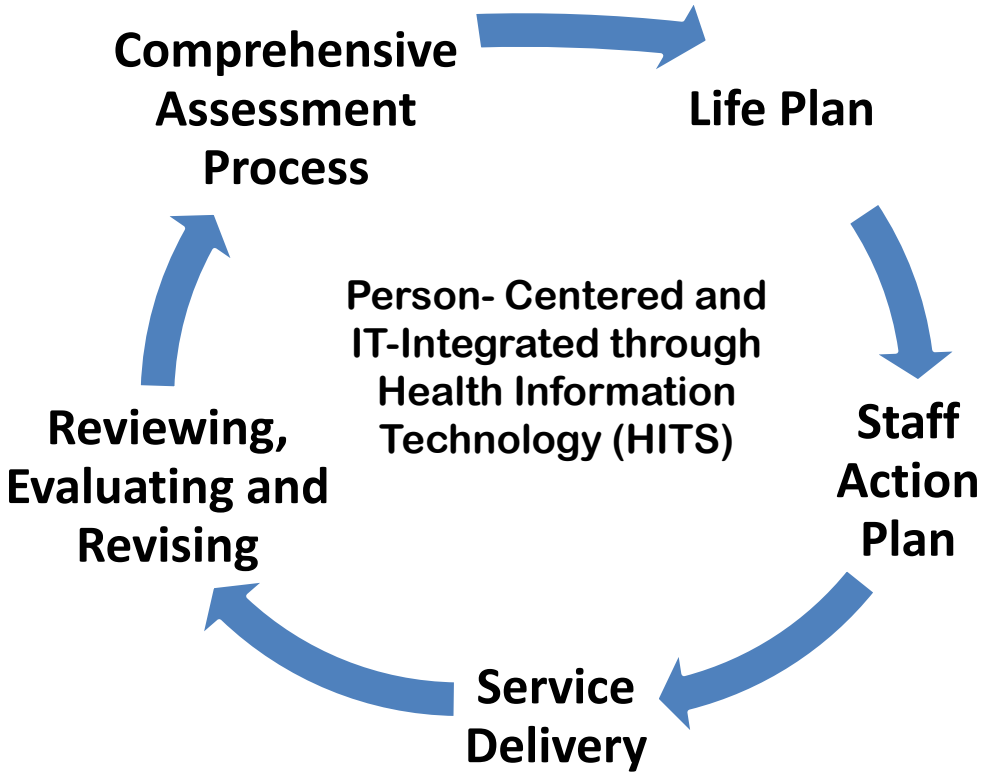
Six Core Health Home Services

1. **Comprehensive care management** -- initial & ongoing assessment and care management services – to support individual outcomes & **integration** of habilitation, primary, behavioral and specialty health care and community support services, using a comprehensive person-centered care plan called a Life Plan
2. **Care coordination and health promotion** — education and engagement in making decision that promotes independence and wellbeing through the implementation of the Life Plan and its continuous monitoring
3. **Comprehensive transitional care** from inpatient to other settings, including appropriate follow-up

Six Core Health Home Services

4. **Individual and family and caregivers support** Coordination of information and services to supp- ort each individual and their family and/or representative to maintain quality of life, with a focus on community living options
5. **Referral to community and social support services**, to ensure that community resources are utilized, as individuals pursue meaningful activities consistent with their Life Plans and
6. **The use of health information technology** CCOs are required to meet the HIT standards in the delivery of the Health Home core services. This includes an electronic Life Plan

Review of the Life Planning Process Cycle The Person and Person-Centered Planning is Always the Driving Force



The Life Plan defines the Person's goals/valued outcomes and individual safeguards and how these relate to what is most meaningful to the person.

The Life Planning process is designed to create consistency at the point of service delivery by organizing goals within the 21 Personal Outcome Areas. This is one of the major reasons for the use of new technology.

What are Habilitation Services?

- Habilitation Services are designed to assist in acquiring, retaining, and improving self-help socialization and adaptive skills necessary to reside successfully in home and community-based settings.

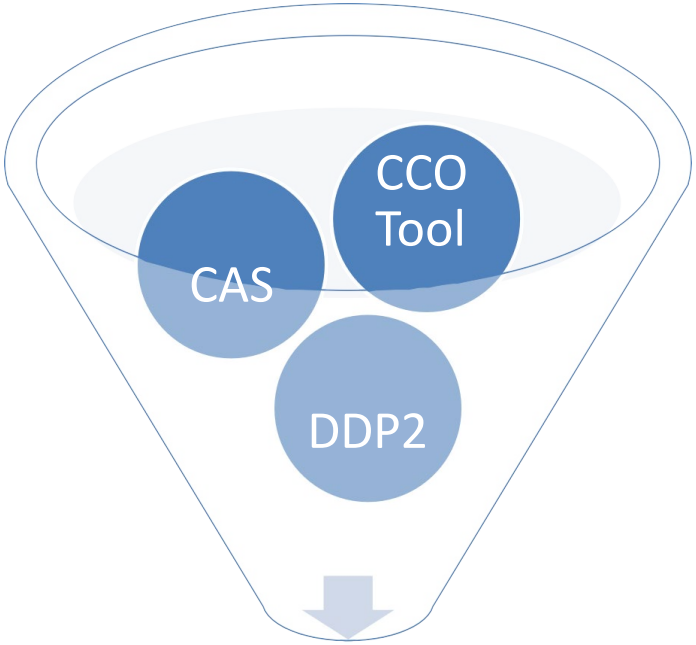
Providers Develop Staff Action Plans to Implement Habilitation Services

- A Staff Action Plan is required for each Habilitation service received by the person.
- The Staff Action Plan describes how habilitation staff will assist the individual to achieve his/her defined habilitation goals/valued outcomes from the Life Plan.

Comprehensive Assessment Process

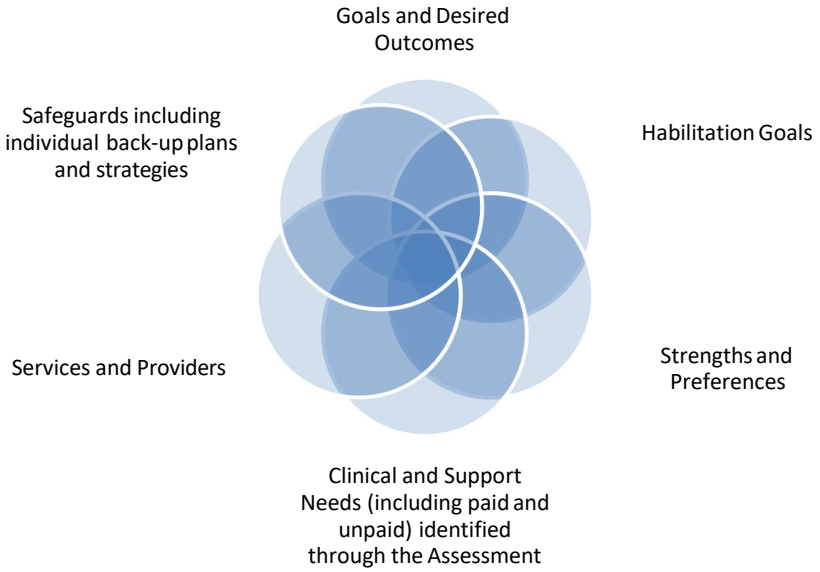
- Care Management enrollees must be comprehensively assessed (within 60 days of enrollment and annually thereafter), using one or more tools to identify

  - ✓ Developmental disability
  - ✓ Medical
  - ✓ Mental health
  - ✓ Behavioral health
  - ✓ Chemical dependency
  - ✓ Social and emotional needs



Tools Included in the Comprehensive Assessment Process

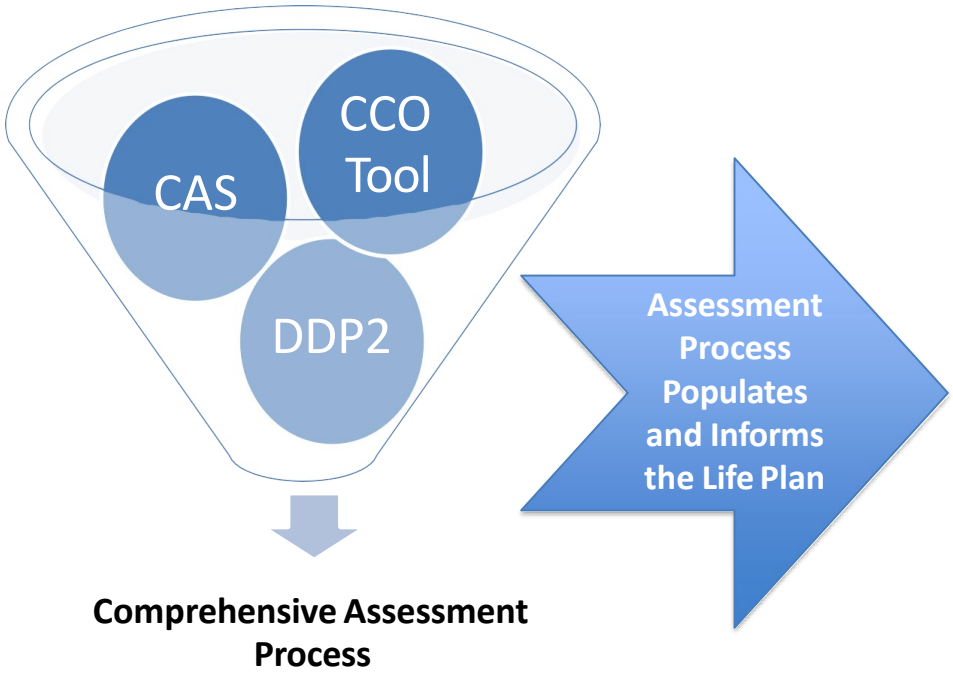
Person-Centered Life Plan Development:



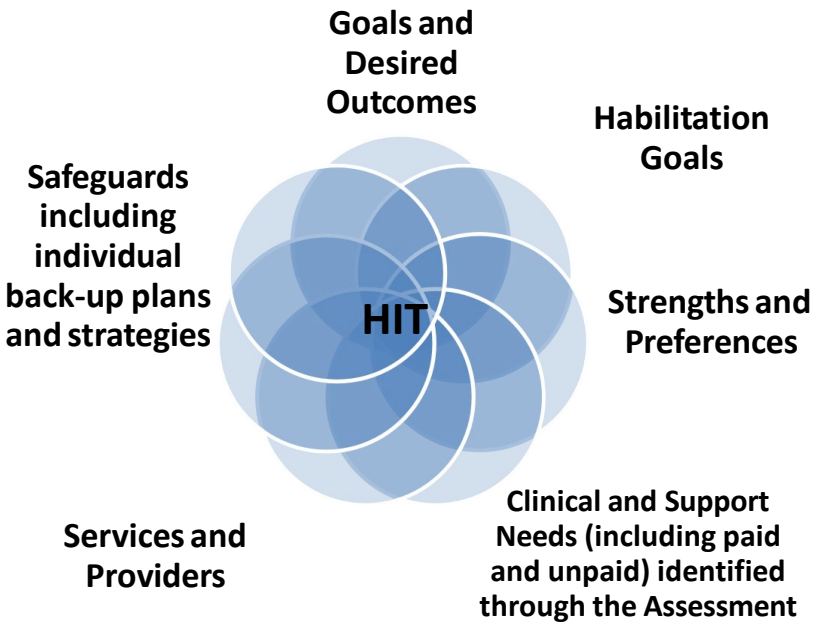
- ✓ Collaborative and recurring process driven by the person
- ✓ Describes who the person is and what he/she wants to accomplish and who/what will help the individual accomplish their goals/valued outcomes
- ✓ Integrates all services and natural supports
- ✓ Understandable to the person
- ✓ Must be finalized and agreed to with the person's informed consent

The Life Plan is person-driven and a living document subject to continuous updating and monitoring by the Care Manager

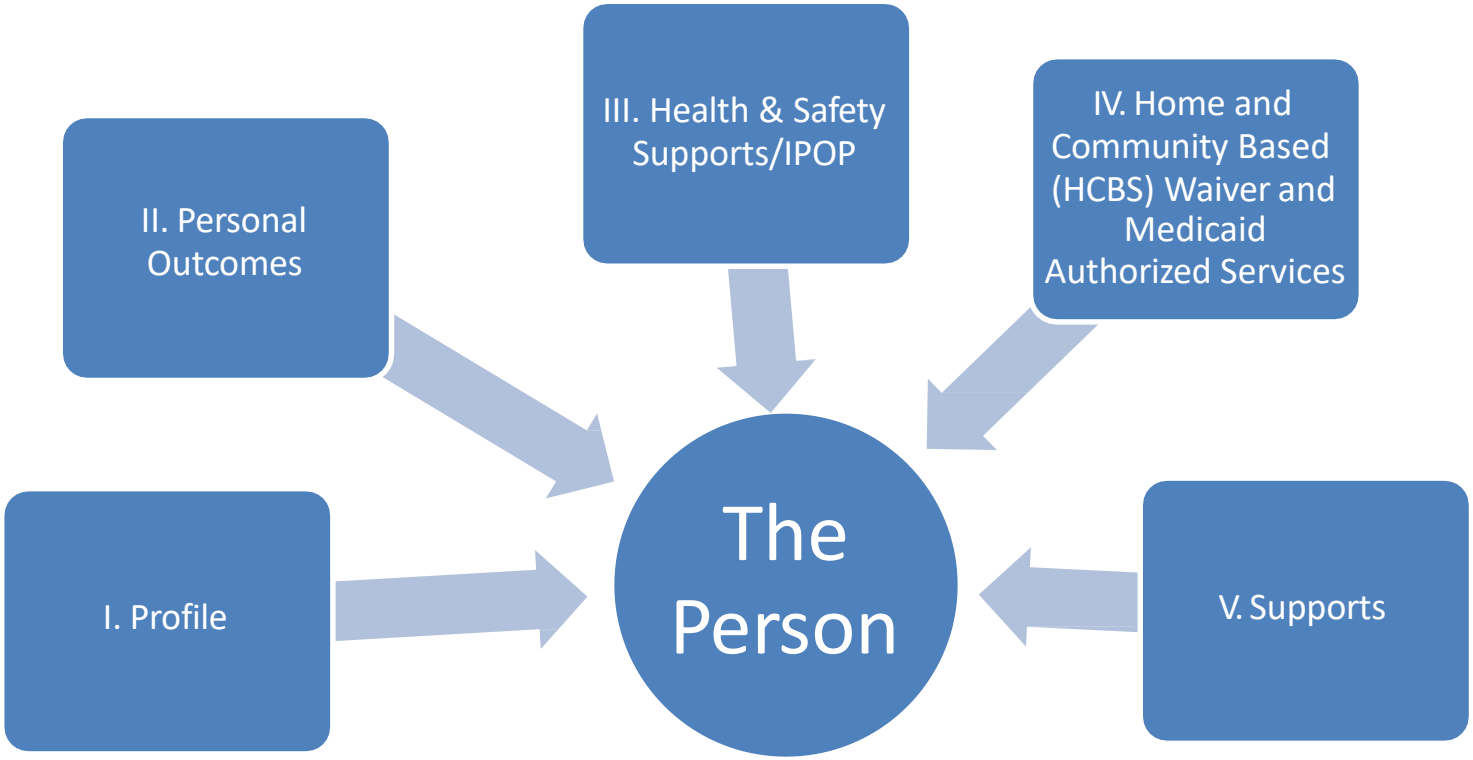
Person-Centered Planning and Health Information Technology (HIT) is Integral



Life Plan



Life Plan Sections



OPWDD Outcome Areas-System Measures

Does the person live and receive services in the most integrated setting?

Does the person have community participation experiences that are meaningful to him/her?

Does the person have meaningful relationships with friends, family and others that are important to him/her?

Does the person experience personal health, safety and growth opportunities?

Does the person exercise choice and decision making in his/her life and with his/her daily schedule to the extent possible?

Upcoming Series Trainings

Children's Webinar Series for May 2021 with OPWDD

Required for Health Home Serving Children's care managers, Lead HHSC, and OPWDD Children's Liaisons. Recommended for HCBS providers

- **Obtaining and Maintaining LCED for Children's Waiver Participants** on Wednesday **May 12, 2021 1:00 PM EDT** at: https://attendee.gotowebinar.com/register/8997610828175148816

- **Collaboration process and steps between OPWDD and Children's Waiver for Eligibility of DD/MF and DD in Foster Care** on Wednesday **May 19, 2021 1:00 PM EDT** at: https://attendee.gotowebinar.com/register/7577622347228204816

- **Transfer Process between the Children's Waiver and OPWDD Comprehensive Waiver** on Wednesday **May 26, 2021 1:00 PM EDT** at: https://attendee.gotowebinar.com/register/6022689704692592656

For More Information

OPWDD Website
https://opwdd.ny.gov/

OPWDD Front Door
https://opwdd.ny.gov/get-started/front-door

Care Management
https://opwdd.ny.gov/providers/care-management

For questions please contact:
hhidd@health.ny.gov