CCO/HH- Care Coordination Organizations

What they are ….and what to expect

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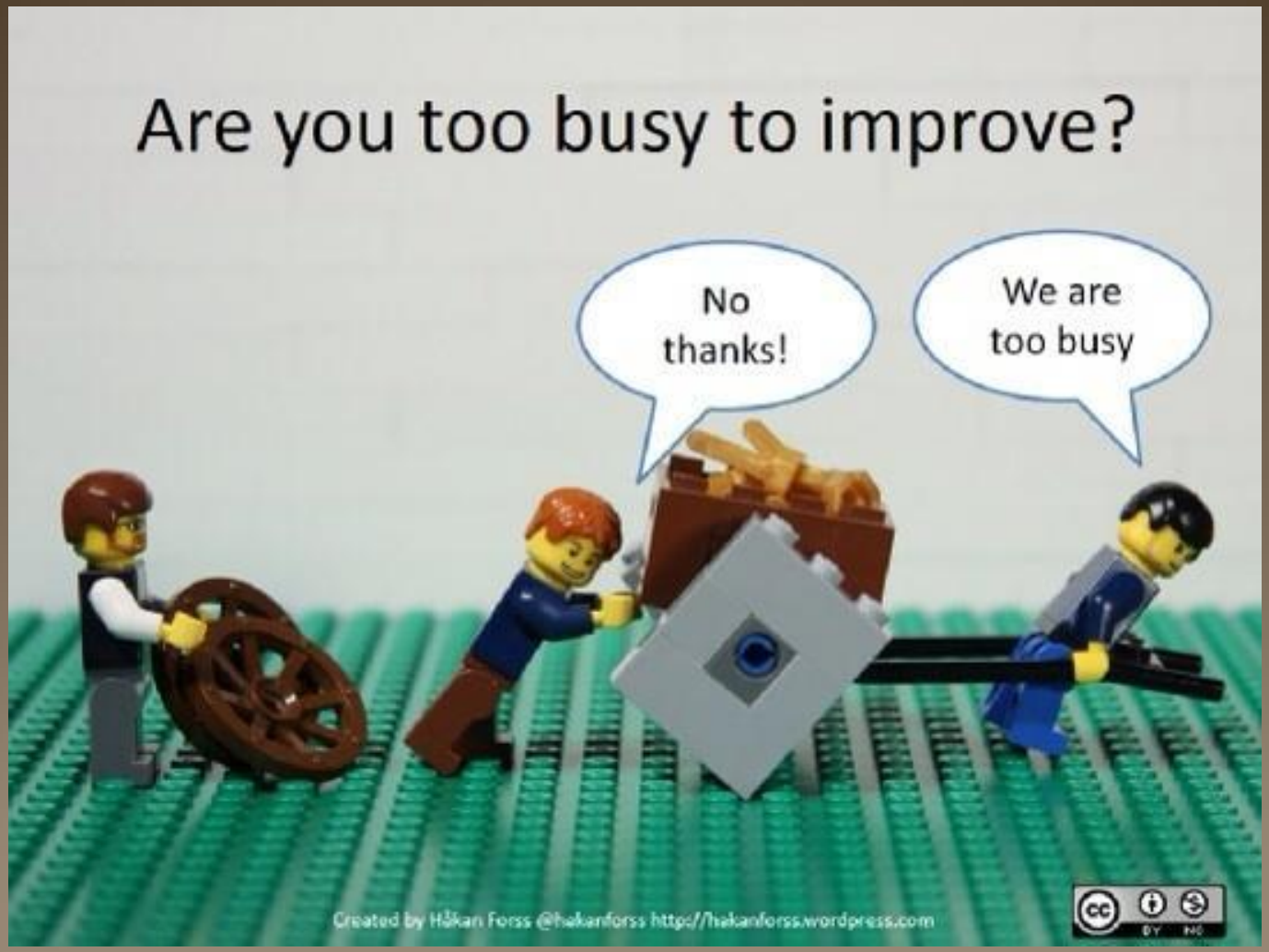
WHY DO THINGS
HAVE TO
CHAAAAANGE

The current role of the MSC

- Supporting people in obtaining services
- Scheduling and involvement in ISP
- Assistance with placements

Change

- Move out of our comfort zone and *understand* that this change is necessary
- **Pros and cons**- If the *pros* win, we are more motivated to change
- If we feel ***pushed***, we dig in our heels and fight it!


Are you too busy to improve?
No thanks!
We are too busy
Created by Håkan Forss @hakanforss http://hakanforss.wordpress.com

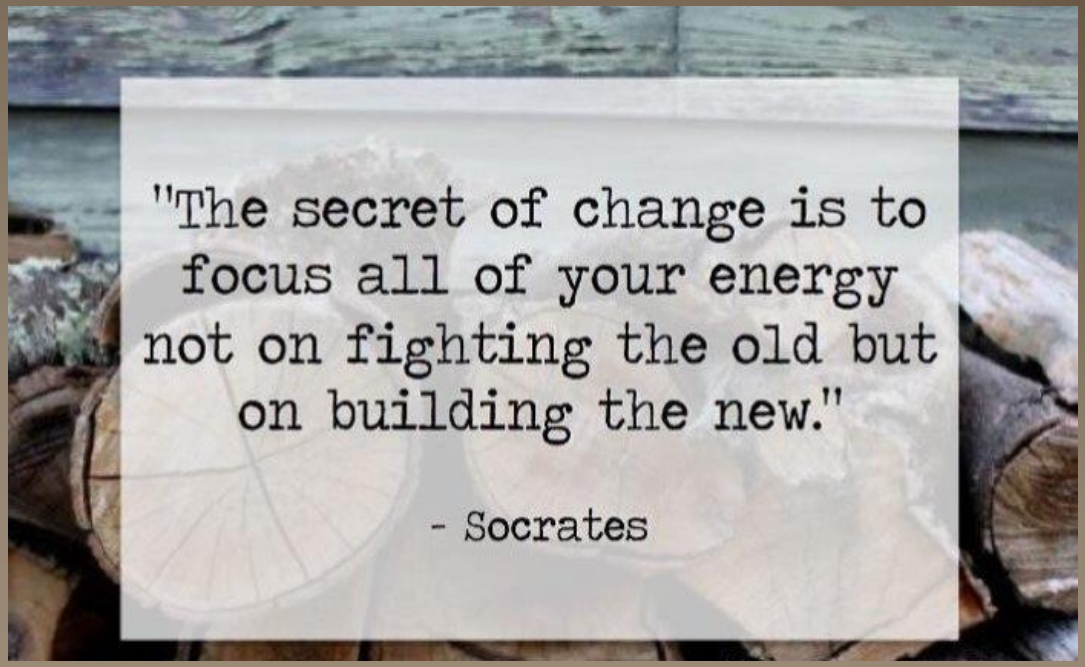
Change

Change is process. A transition.

- Scary- what lies ahead?
- Process takes time, understanding, and work; everyone processes it differently
- Support- training, coaching and yes….making mistakes
- People develop their own solutions or system that works for them
- Clear picture of the goal- FOCUS on goals

As change happens

- Accept the change; maintain change into the future
- ***Change is continuous and constant***
- Our jobs are dynamic




Change is mandatory for
extraordinary results.

What is a CCO/HH?

Care Coordination Organization/Health homes

- They unite I/DD supports with important health and wellness services to provide people with a life plan.

CCO/Health homes

- DOH
- OPWDD
- CCO's will provide person centered care management, planning and coordination of services
- Establish life plan which includes- health, behavioral services, preventative care, community supports, social supports and other services

Why now?

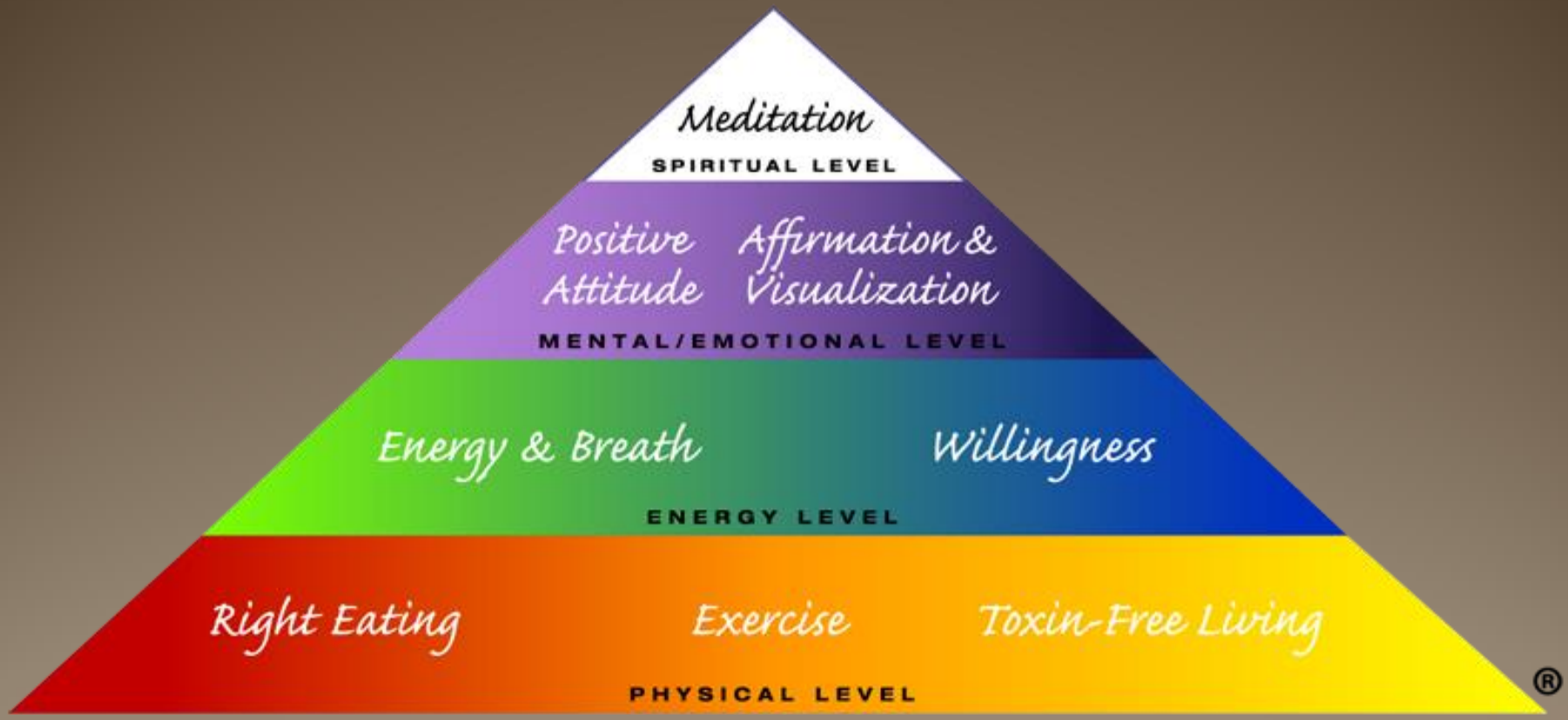
- NYS is transitioning Medicaid service coordination to a conflict free model
- CMS wants to ensure:
  - Focus on outcome and efficiencies
  - Records centralized

Health Home

- Not a home
- Cloud with all the services in this “health home”

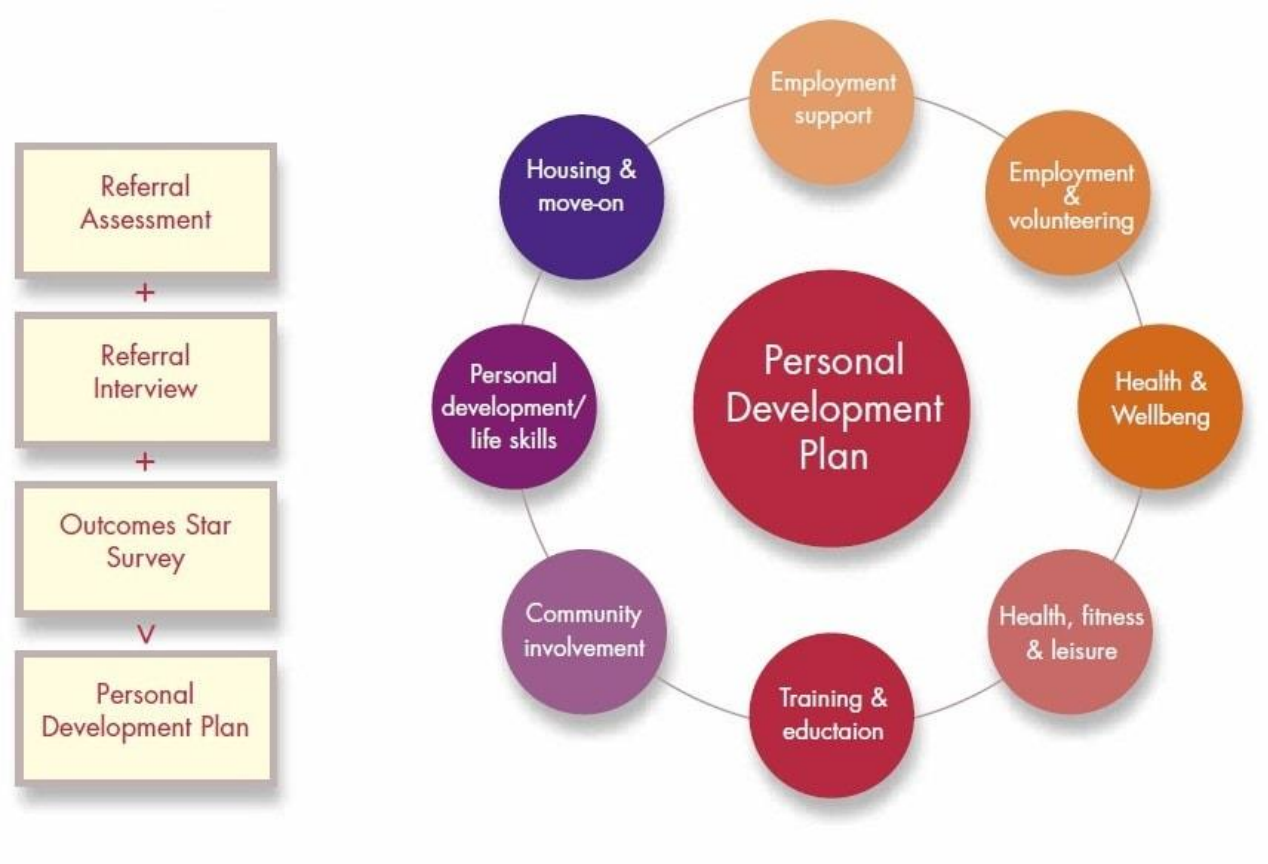
Cultural Competency

Holistic outlook- health, behavior and community



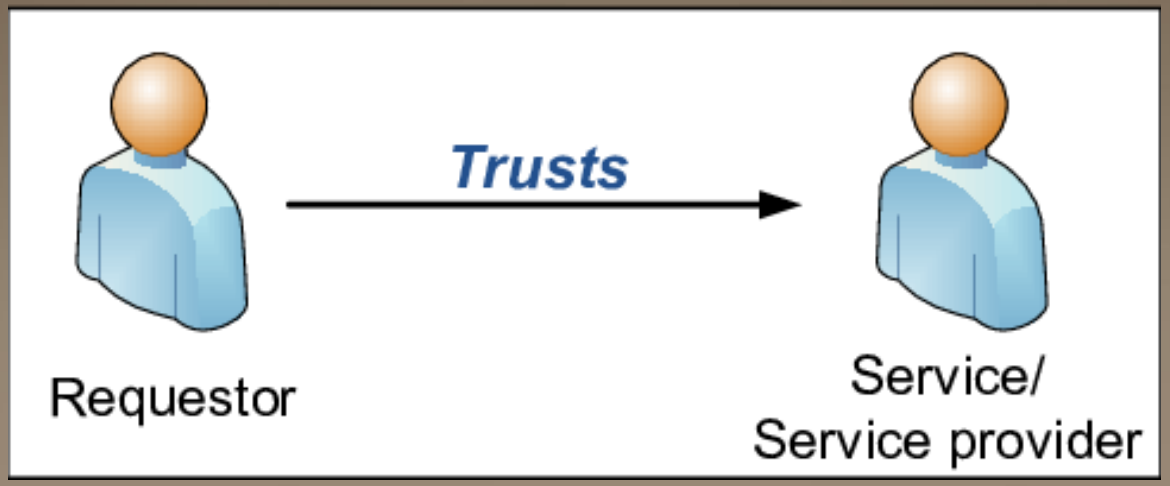
Why the change?

- More robust integrated systems which brings together all aspects into one LIFE PLAN



Why the change?

- Prep for managed care system
- Enrollment is optional but it's the only way to get full services
- Continuity of relationships with MSC is encouraged

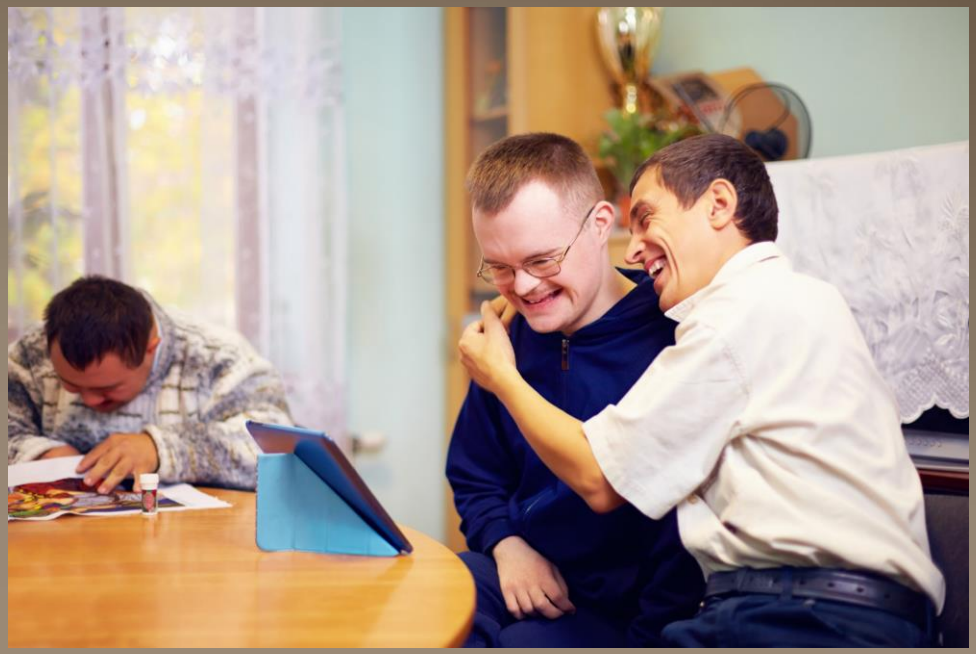


Two Decisions to Make

- What CCO/HH do I want to join?
- What service do I want- care coordination or basic HCBS
- 100,000
- 3,000
- I am just going to keep the MSC service. I am not switching to a CCO.

Tri County Care or TCC

- Parent Organization 25 years of service to people with I/DD
- We are comprised of 45 affiliates
- Region 3- Capital, Mid-Hudson, Taconic
- Region 4- NYC, Staten Island, Queen, Bronx, Brooklyn
- Region 5- Long Island
- Why Tri County?



In and of the Community

- Parent and Provider committees
- Best practice
- Ideas for development
- Meet regularly
- Share goals
- Continuity of relationships- providers, families, communities and neighborhoods

How is this going to affect me?

- As a person supported
- As a family member
- As a DSP
- As a current MSC
- As a provider

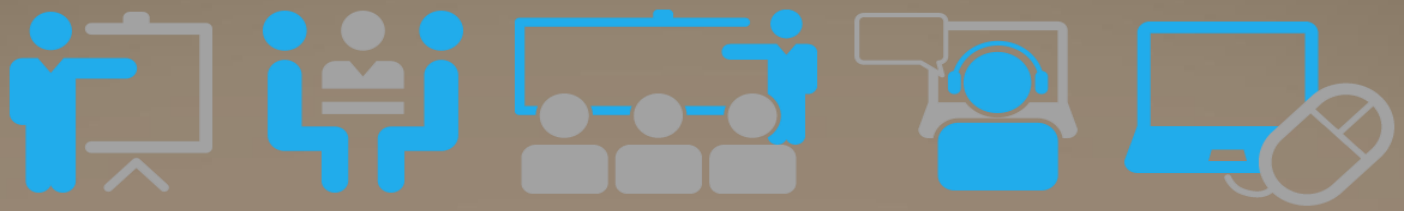
Access to plan

- Electronic health records to ensure full integration of care but HIPAA laws strictly adhered to
- Network of partnership with doctors and health care providers across the board
- Services will NOT

be removed

MSC transition

- We will work with prior MSC's
- We will provide training for current MSC's
- Now through July of 2019
- First year might be housed in current organization
- MSC's to become Care Coordinators/managers

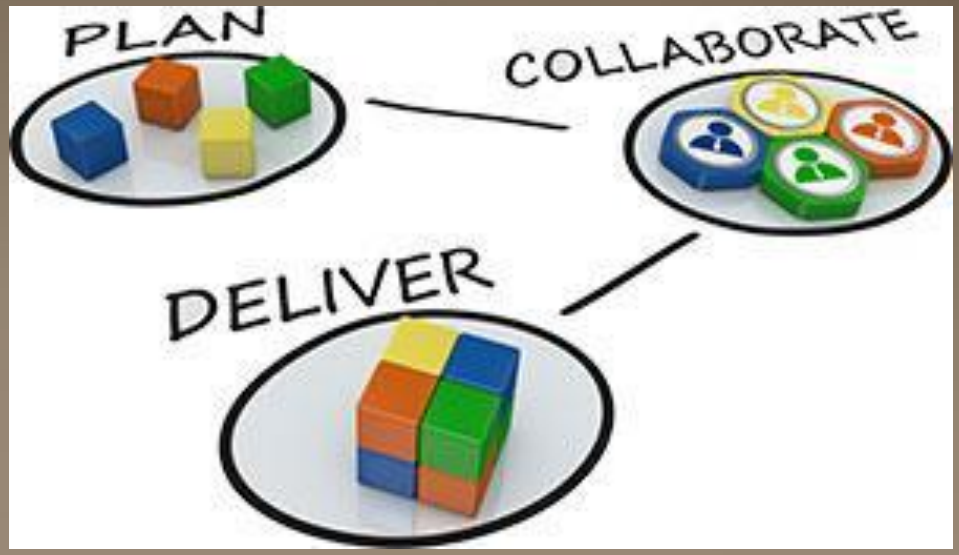


How can we help?

- Parent
  - Will you make decisions for me?
  - Will you change my doctors?
  - Will you pay for my personal trainer?
  - If something happens to me, will you make decisions?
- CCO
  - Resource
  - Network
  - Team
  - Support

DSP role- interaction with the IDT team

- Care coordinator helps develop plan, and DSP is the vehicle that helps deliver that plan
- DSP's assist people in living that plan



What actually changes?

- MSC's used to be a support service, now they are the at the heart of service development and integration
- They can truly help people lead better quality lives
- They will have more resources and tools with which to work
- They will have a support network
  - Nurses
  - Social worker
  - Medical director
  - Psychiatric consultant
  - Comprehensive IT system (with reminders)

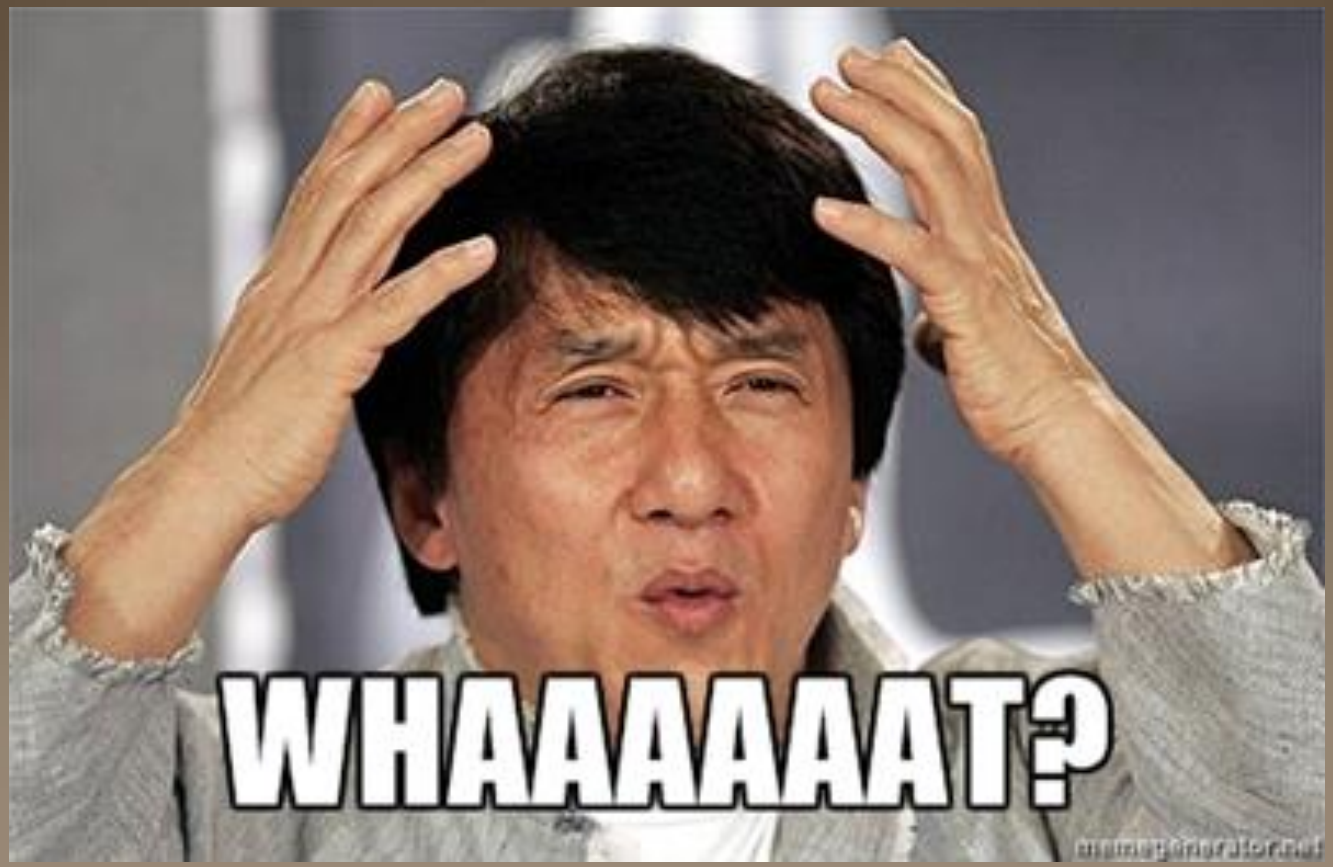
Explain the transition process

- Education and training for MSC's
  - POMS used for person supported
  - Online access and use of new tool- practice
  - How do I help the person supported read, understand and get involved in the life plan?

As my job changes, what happens to me?

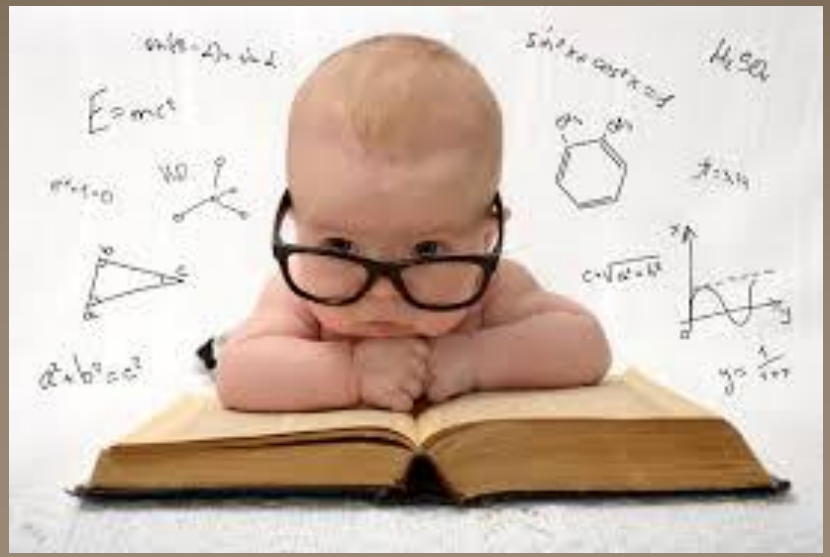
- I work from home
- I have flexible hours
- I don't know anything about Medisked or this new "Life Plan"
- How is my salary going to change?
- What about my benefits?
- What will my caseload look like?
- What do I tell the families?
- Am I going to lose my job?

What if I don’t understand the plan?



What can I do to make this transition a positive one?

Try being
INFORMED
instead of just
OPINIONATED.




Replace fear of the unknown with curiosity
EVERY DAY, GETTING BETTER

Thank you for listening.

Questions???