Understanding CCOs Role in Health Care

Provider Webinar

June 14, 2022

What We Believe as a CCO/HH

As a Care Coordination Organization/Health Home, we believe and approach our work with the following driving forces:

- Individuals and families are at the center of all we do
- We work for individuals and families
- We value what individuals and families say
- We are responsive to the needs, requests, and life changes of individuals and families
- We are focused on outcomes that meet individuals' needs
- We are strong advocates and protect each individuals' rights
- We maintain diverse, culturally sensitive Provider networks

Two Types of CCO Services

Health Home Care Management

- This is the more comprehensive service.
- Focuses on not only OPWDD/Waiver services, but also physical health, behavioral health and overall whole person integrated care.

Basic Plan Support

- A much more stripped-down service.
- Coordinates only OPWDD supports and services.
- 2 months of service for Life Plan reviews, and 2 optional/additional months of service for an "unexpected need".

The role in healthcare is specific to those **people enrolled in Health Home Care Management**. That is the group we will be addressing today.

Goal of Health Home Care Management

The CCO is a specialized type of Health Home designed to support the unique needs of individuals with I/DD.

The goal is to provide enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), developmental disability and long-term services and supports for persons with I/DD.

The CCO as a Health Home

In addition to the OPWDD Waiver services, the Life Plan includes sections addressing medical, behavioral health, community and social supports, and other services.

- Care Managers in a CCO work with individuals and their families **to ensure health care <u>and</u> developmental disability service providers support** accessing services that lead to healthy, well–rounded and fulfilling lives.
- With the consent of the individual and/or their family/representative, **health records will be shared among providers** to ensure the individual receives unduplicated supports and services.

6 Core Health Home Services

- ✓ Comprehensive Care Management;
- **Care coordination and health promotion**;
- **Comprehensive transitional care from inpatient to other settings, including appropriate follow-up**;
- ✓ Individual and family support, which includes authorized representatives;
- ✓ Referral to community and social support services
- ✓ The use of Health Information Technology (HIT) to link services.

Additional Requirements of CCOs

- Coordinate and provide **access to mental health and substance abuse services**
- **Coordinate Transitional Care includes appropriate follow-up from inpatient to other settings,** such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care; or from an in patient setting to going back to living with family.
- **Coordinate and provide access to chronic disease management,** including self management support to individuals and their families
- **Establish a continuous quality improvement program, evaluation of increased coordination of care and chronic disease management**
  on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Role of the CCO Health Home Care Manager

The expectation around the role is that the activities of the Care Manager will support:

- ✓ Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
- ✓ Access to the appropriate health care providers
- ✓ Access to resources that will promote better health related to that person's specific needs/diagnoses
- ✓ Supporting self management goals
- ✓ Support with **adherence to treatment plans/medication regimes**
- ✓ Identification and removal of barriers that prevent good care and good health
- ✓ An active role in transitional care planning and follow up – which includes discharge planning from ER/hospital.

Medication Adherence

This is a newer area of focus for Care Managers at Care Design NY.

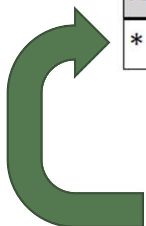
- ✓ Following treatment recommendations from healthcare providers is a critical area to managing chronic conditions and staying well and healthy.
- ✓ As a part of whole person integrated care – this falls under the Core Health Home service of **Care Coordination and Health Promotion**.
- ✓ Care Management activities include assessing, evaluating, developing, and initiating plans of support, and monitoring all medications and medication adherence

The goal here is to ensure that members are following treatment recommendations – including medications. Care Managers can assess and identify barriers that may prevent a person from being adherent to their medication regime and intervene to attempt to remove those barriers.

Medication Adherence in the Life Plan

- ✓ Care Managers will begin listing member medications more consistently at the end of the Life Plan as we roll out training this summer.
- ✓ This list should not be the "source of truth" and the person's doctors orders would always reflect the most current medication regime.
- ✓ The medications listed come from a database (RX Norm) and may not be verbatim to the doctor's orders.
- ✓ Care Managers are not expected to repeat this information in the My Health and My Medications – but should note why the person might be taking medication; ie: Rita takes medication for GERD.

Member Medications						
Name	Strength	Form	Frequency	Quantity	Route	Effective Dates
* The above list is Member reported and believed to be accurate as of the date of Plan publication.						



Care Managers are not expected to amend the LP for any medication changes between semi-annual LP meetings – unless something very significant affecting person's overall health.

Role of the CCO Health Home Care Manager

As you can see from the Core Health Home Services and additional requirements, the CCO Health Home Care Manager role requires an enhanced function in supporting individuals to have positive health outcomes.

The CCO Health Home Care **Manager is not a clinical role**, and there is no expectation that the Care Manager is a licensed professional.

Social Determinants of Health

CCO Care Managers focus on the whole person and support many other areas that impact on a person's health.

- ✓Housing
- ✓Food
- ✓Education
- ✓Employment
- ✓Benefits
- ✓Transportation
- ✓Social Supports

In Scope/Out of Scope for the Care Manager

- It would be **out of scope** for a Health Home Care Manager to give opinions regarding a clinical complaint or diagnosis

- It would be **in scope** for a Health Home Care Manager to schedule a follow up appointment with the PCP to discuss concerns or assist with scheduling an appointment with a different provider for a second opinion, as needed

In Scope/Out of Scope for the Care Manager

- It would be **out of scope** for a Health Home Care Manager to develop a menu plan for a person with diabetes

- It would be **in scope** for a Health Home Care Manager to link a person with a nutritionist/dietician to develop a menu plan to better manage their diabetes

In Scope/Out of Scope for the Care Manager

- It would be **out of scope** for a Health Home Care Manager to physically provide behavioral interventions.

- It would be **in scope** for a Health Home Care Manager to apply for behavioral supports, ie: counseling, IBS, CSIDD, etc.

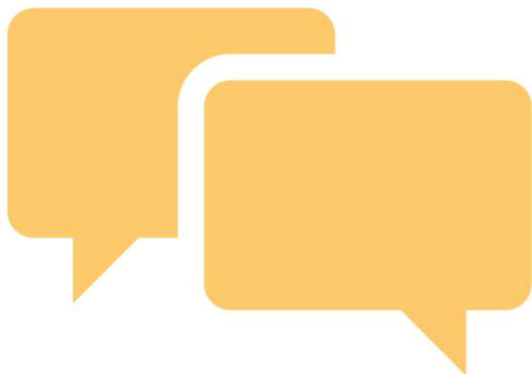
CDNY Health Home Service Supports

CDNY has Clinical Support teams to assist and support the work done by Care Managers and Supervisors:

- **Behavioral Health Supports** work with Care Managers to advocate for, coordinate, integrate, and monitor behavioral health care services for people enrolled in the Health Home. They also work with the various regional CSIDD teams in all CDNY regions to ensure maximum utilization and effectiveness of this support.
- **Health Care Supports** support Care Managers to advocate for, coordinate, integrate, and monitor health care services for individuals enrolled in the Health Home. They also act as a resource to Care Managers who need assistance with complex or problematic health care issues with members.
- **Specialized Supports** work with community and state agencies such as Office of Mental Health, Office of Children and Family Services, OASAS, NYC agencies or State Educational Department to assist members who need cross system collaboration to meet their needs.

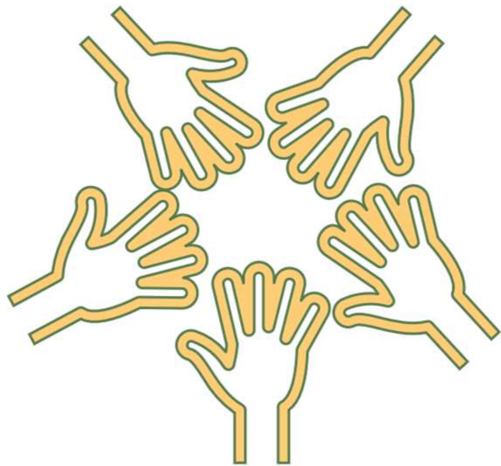
How CCOs and Providers Can Collaborate

Communication is key. We all hold valuable information to best support the person jointly served.



- **Share Information.** Care Manager's use the DOH consent forms to list all providers of care, so we have authorization to share information to best coordinate care.
  - **CMs will need to request and obtain specific documentation** to ensure coordination of care. (such documents include behavior support plan, hospital discharge paperwork, med reconciliation, etc).
- **Coordination of activities is important,** so we are not duplicating efforts.

How CCOs can Support Providers



- ✓Linkage of individuals to identified and needed services and supports
- ✓Ensure completion of needed paperwork for seamless care transitions
- ✓Participate in and help coordinate an individual's discharge planning or other transitional needs
- ✓Identify and address barriers to care or support needs

Questions?

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