IDD Care Coordination and the Provider Network: Working Together

Cardinal Innovations
HEALTHCARE SOLUTIONS
Quality Driven. Solution Focused. Member Inspired.

Disclaimer

Information provided in this presentation pertains only to the counties in the Cardinal Innovations Healthcare Solutions Region. This information is specific to the Cardinal Innovations Region and may not apply to other LME, MCOs, providers, stakeholders or individuals outside the Cardinal Innovations catchment area.

Presentation slides are brief, bullet-points of information and should not be used out of context.

Care Coordination is:

- A managed care administrative function
- Designed to proactively intervene and ensure optimal care for **Special Needs Populations**

- Care Coordinators **coordinate** and **monitor** care
  - Across the continuum of healthcare providers
  - Across various care settings, including healthcare
  - Work in conjunction with the individual, providers, and others to improve outcomes for the individual and make the best use of healthcare dollars.

This is both a risk management and a quality management function which has a significant impact on both the management of resources and the quality of care for an individual.

Care Coordination is not….

- Not A Service
  - Is not "approved" or "authorized" in the ISP
  - Does not duplicate activities of service providers (i.e. Community Guide)
- Not Intended for the following:
  - Working on skill building with individuals and families
  - Development of short-range goals
  - Providing transportation
  - Locating housing or jobs

Special Needs Populations

The Special Needs Populations in the 1915(b)(c) waivers are population cohorts defined by specific patterns:

- diagnostic
- functional
- demographic and/or service utilization

These patterns are indicators of risk and need for assessment to determine need for further treatment to ensure optimal care. The goal of the Managed Care Waiver is to identify these individuals and intervene in order to ensure that they receive both appropriate assessment and medically necessary services.

Special Needs Populations

- Individuals enrolled in the NC Innovations Waiver
- Individuals with intellectual/developmental disabilities who are functionally eligible for ICF-MR level of care (but are not enrolled in NC Innovations or living in an ICF)
- Individuals with IDD who are currently in, or have been within the past 30 days, a facility operated by the Department of Juvenile Justice and Delinquency for whom Cardinal Innovations has received notification of discharge

How Long is Care Coordination Provided?

Long Term/Short Term

Long Term Care Coordination

- Provided for the duration of an individual's enrollment in NC Innovations Waiver
  - Assessment
  - Planning/Plan Development
  - Monitoring/Coordination of Care
  - Linkage/Referral

Short Term Care Coordination

- Episodic
- To address specific issue/concern

Short Term Care Coordination: Who's Eligible?

-- Individuals with intellectual/developmental disabilities who are functionally eligible for ICF-MR level of care (but are not enrolled in NC Innovations or living in an ICF)

-- Individuals with IDD who are currently in, or have been within the past 30 days, a facility operated by the Department of Juvenile Justice and Delinquency for who Cardinal Innovations has received notification of discharge

Short Term Care Coordination: Examples of Hands-On Support

- PASRR referrals – assessment of needs, service linkage as applicable
- Transition support between residential settings - most often as result of a discharge notice
- Crisis support – linkage to available resources to help prevent or stabilize crisis
- Discharge planning/linkage (hospital, jail/detention, NC START)

IDD Care Coordination- Core Functions

Assessment

Complete or Secure Needed Assessments

- Risk/Support Needs Assessment
- Assessment of Personal Goals/Dreams
- Assuring access to specialized assessments (medical, psychological, equipment needs, etc.)

Planning/Plan Development

- Ensuring that individual/family has information on all available service options and providers
- Facilitation of team meetings/communications
- Development of Individual Support Plan and Individual Budget
- Updating/revising ISP as needed

Linkage and Referral

-- MH/DD/SA Services

-- Medical Home

-- Other Medicaid Services (e.g. medical, durable medical equipment)

Monitoring

- Health & Safety
- Plan Implementation
- Medicaid Status
- Satisfaction

How Monitoring Occurs:

Methods and Frequencies

Minimum Monitoring Requirements

(specific to NC Innovations Waiver participants)

-- New Waiver Participants: monthly face-to-face for first six months, and then on a schedule agreed to by the team

-- Participants whose services are provided by guardians and relatives living in the home receive monthly face-to-face monitoring visits

-- Participants who live in residential settings (inclusive of AFL's) receive monthly face-to-face monitoring visits

-- Participants who choose to participate in Individual/Family Directed Supports option receive monthly face-to-face monitoring visits

Individuals who do not fall in either of these categories receive monthly telephonic monitoring and a minimum of quarterly face-to-face monitoring

Monitoring Methods

Direct Observation of Service Delivery

-- Care Coordinators monitor the delivery of each service in the setting in which each service occurs

-- Allows the Care Coordinator to see how individual responds to strategies being implemented, and to assess amount of progress being made

Discussion/Dialogue

-- Includes telephonic and face to face discussion with individuals/families and providers to ensure that individual's needs are being met

Monitoring Methods

Review of Service Documentation

-- Review of service documentation on- site during monitoring visits

-- If documentation is not available for on-site review, Care Coordinators may request that copies be sent to them for review

-- Documentation reviewed can include: QP notes, short range goals, service notes/grids, etc.

Review of Claims Submitted

-- Used for monitoring services that are typically difficult to monitor in person (Specialized Consultative Services, Respite, Home Modifications, etc.)

-- Used to identify potential service deviations

-- Not the only source for monitoring for service deviations (as there can be a 90-day lag time for claims submitted)

Monitoring (continued)

-- Participants and providers must allow Care Coordinator to have face-to-face contact with the participant as required by the waiver and as documented in the ISP (visits may be scheduled and unscheduled)

-- Monitoring takes place in all settings and as outlined in the ISP

-- Standard Monitoring Checklist is used

Registry of Unmet Needs (for NC Innovations)

All individuals currently on the Registry of Unmet Needs receive monitoring and telephonic support as needed

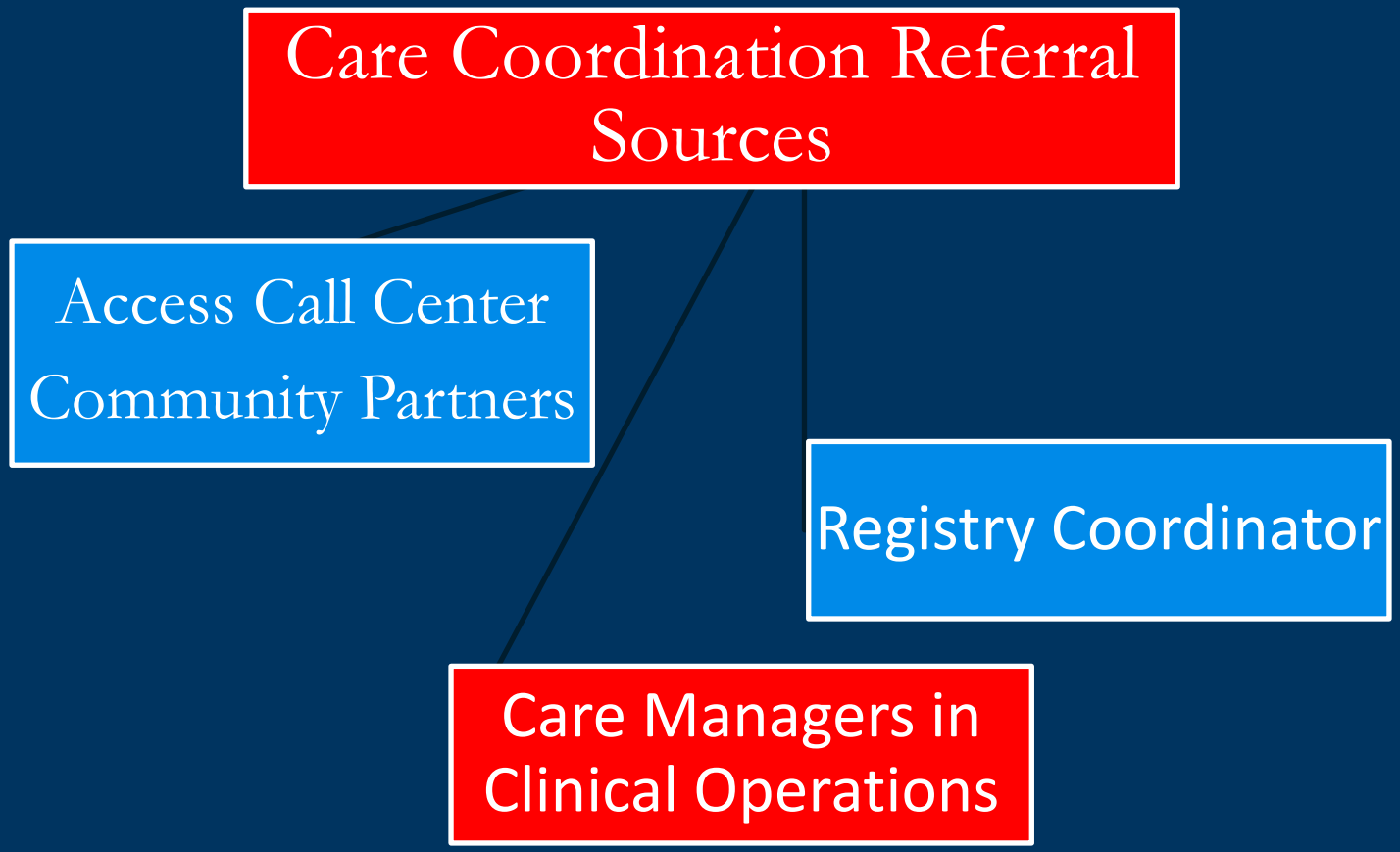
-- Registry Coordinator serves as point of contact for any questions/concerns and monitors needs

-- Telephonic assistance provided, including referrals to MH/DD/SA supports as needed

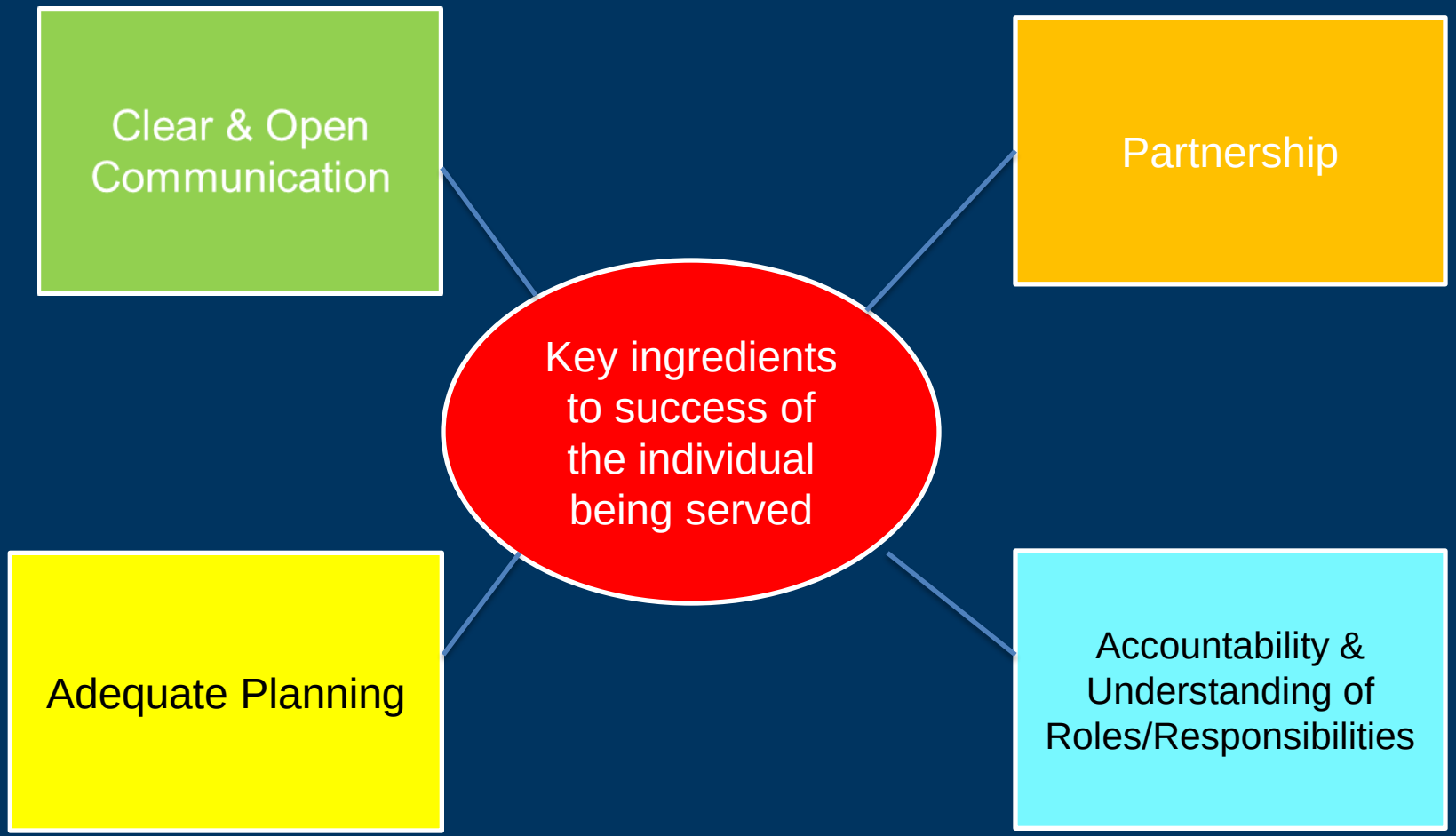
-- Annual updates of information/assessment of need

-- Registry Coordinator refers for short-term face-to-face Care Coordination as needed

Who Can Refer to Care Coordination



Care Coordination and the Provider Network



IDD Care Coordination Directory

Go to external website: www.cardinalinnovations.org

Click on "About Us", "Departments and Initiatives," "Care Coordination"

From here, you may select the appropriate Community Operations Center, or the Corporate Office for a list of Care Coordination staff and their contact information

Questions