

Training Wheels Are Off: New York's Transition to Managed Care for Individuals with I/DD



HCBS Conference
August 28, 2019



Today's Presenters



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Disclaimers

The information provided in this presentation is only intended for NY IDD CCO HHs benchmarking and overall systems improvement purposes. It is not intended for use in clinical decision-making and the findings have not been independently validated. It was generated during the program's regulatory start up period with policy, technical, and training considerations during implementation. Where noted, data has been self-reported and captured by care managers.



 A large, dark blue circular graphic with the word "AGENDA" in bold, dark blue, uppercase letters centered inside.

- Overview of Medicaid Redesign in NY
To achieve more integrated, holistic, and flexible service planning, communication, and monitoring
- Introduction to Advance Care Alliance NY
Care Coordination Organization / Health Home for Individuals with Intellectual and Developmental Disabilities
- Introduction MediSked
Health IT Vendor / Partner
- Results from Year 1
- Lessons Learned
- The Road Ahead

New York Medicaid Redesign - IDD Transformation



2014

Phase 0:
The first FIDA-IDD care management program in the US is formed

Phase I:
I/DD targeted HCBS and I/DD populations are transitioned to Care Coordination Organization Care Management

Phase II:
Voluntary enrollment in I/DD specialized managed care plans with I/DD benefit

Phase III:
Mandatory enrollment into managed care plans

2022

Waiver Transition and Managed Care Timeline (New York)

Current Phase: Transition to Care Coordination Organizations / Health Homes

- October 6, 2017 - Health Home Application to Serve Individuals with I/DD
- November 30, 2017 - Due Date to Submit Health Home Applications
- December 2017 - February, June 2018 - Health Home Readiness and Approvals
- July 2018 - Health Home Go-Live

Next Phase: Transition to Managed Care

- Office for People with Developmental Disabilities (OPWDD) Managed Care Requirements/Standards (Part I) for Comment (*DRAFT*)
- Application Submission from Plans Due to NYS
- Onsite Readiness Reviews Begin
- State Announces Approved Specialized I/DD Plans
- I/DD Specialized Managed Care Plans (SIPs-PL) Voluntary Enrollment
- Expansion to Mandatory Enrollment Begins (Downstate then Upstate)

What is People First Care Coordination?

A connected group of health care and service providers for developmental disabilities working together – for individuals and families

- Care Coordination Organizations (CCOs) are new organizations designed by providers with I/DD experience to:
 - Create a more holistic, comprehensive, and person-centered level of service
 - Coordinate services across multiple systems, primary care, behavioral health, and community-based services
 - Develop and manage specialized Person-Centered Life Plans, with the individual and family, based on his/her needs
 - Increase accountability for a person's well-being by driving valued outcomes



Requirements for CCO/HHs

1. Person-Centered Comprehensive Assessment

2. Integrated CQL Personal Outcome Measures (POMs)

3. Integrated Health and Safety Supports, Individual Protective Oversight Plans (IPOP)

4. OPWDD Integration including Care Coordination Data Dictionary Compliance

5. Use of Electronic Life Plan

6. Electronic Care Coordination System with Communications Among Circle of Supports

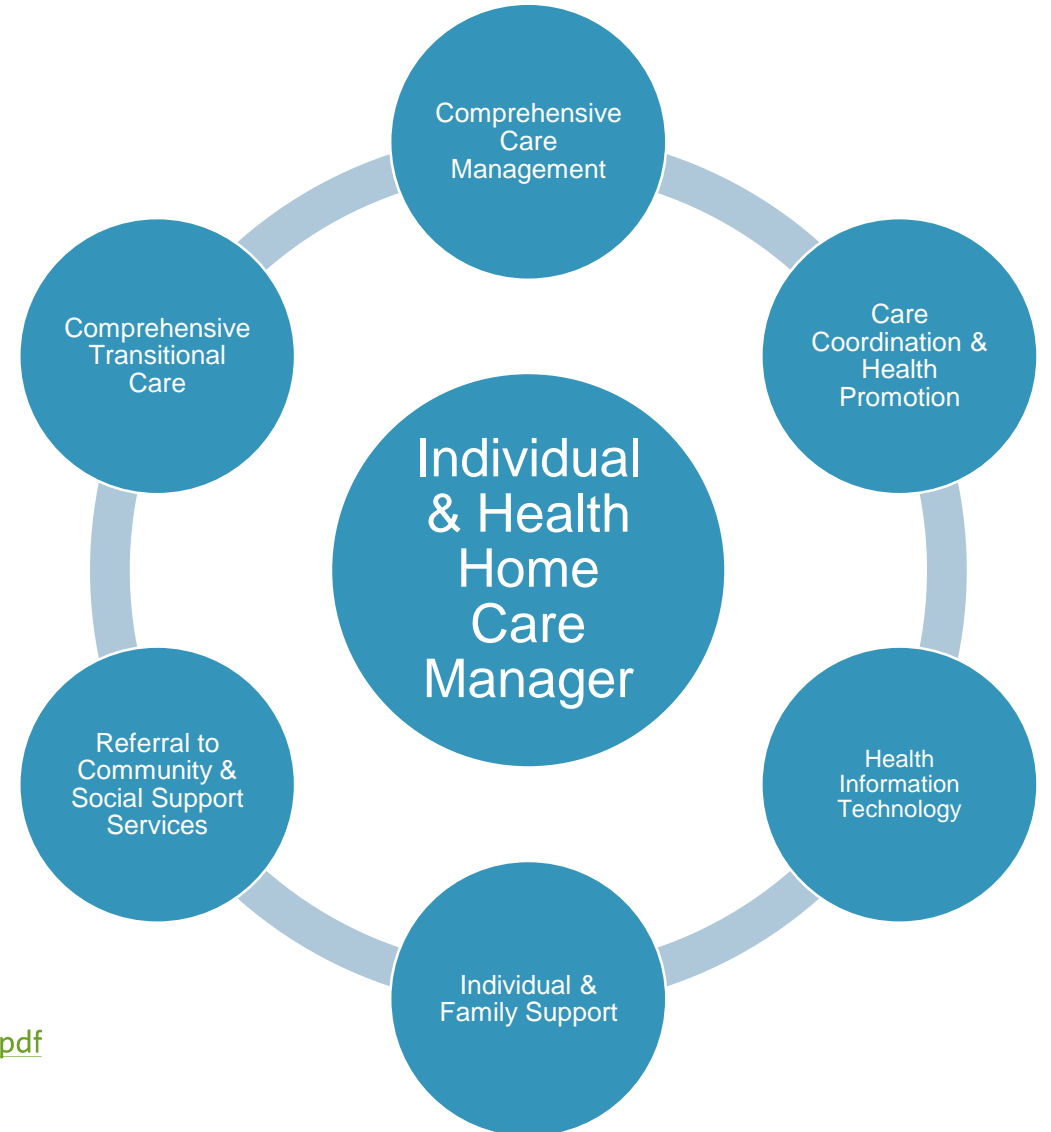
7. Meets I/DD Health Home Requirements

8. Data Exchange with Regional Health Information Organizations (RHIOs)



Goals and Core Services of the CCOs

1. Enhance person-centered planning and focus on outcomes
2. Create a foundation of person-centered planning for specialized DD managed care
3. Eliminate conflict of interest
4. Incorporate a person's services in a single Life Plan overseen by a care manager
5. Incentivize performance
6. Keep the same level of family involvement as before
7. Develop/train Medicaid Service Coordinators (MSCs) as Care Managers

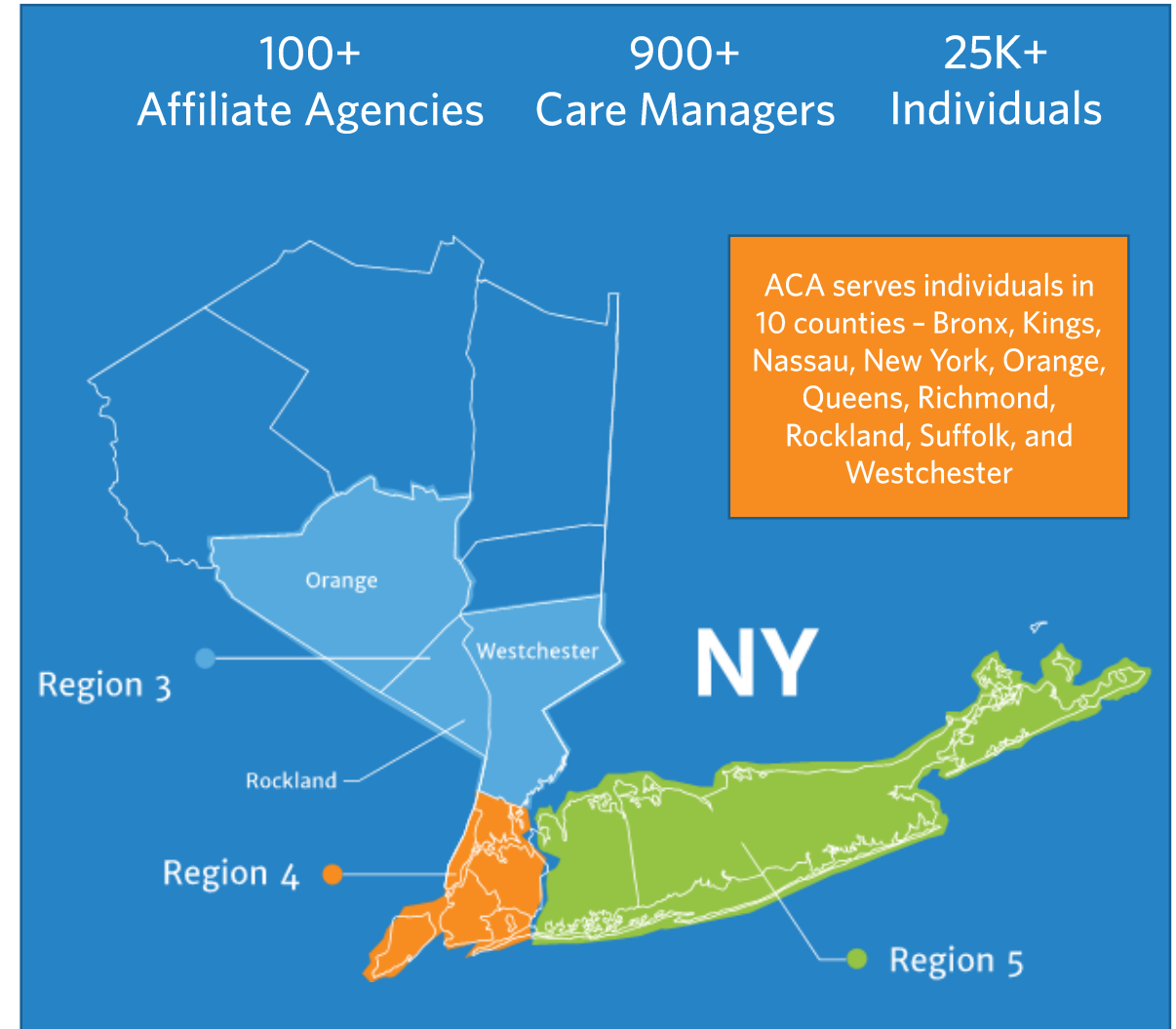


Source: https://opwdd.ny.gov/sites/default/files/documents/MSCInformationalSession1_121317_0.pdf

Advanced Care Alliance



- **CCO/HH** that supports 25,000 people with I/DD and their families across New York City, Long Island, and the Lower Hudson Valley
- As the only not-for-profit CCO in New York, ACA is a mission-centered organization dedicated to providing the **support and services** people need to lead an active, healthy, and fulfilling life
- ACA's agencies provide high-quality services to people with I/DD and their families, funded and overseen by NY OPWDD





ACA's Core Values

ACA's core values are grounded in an approach that fosters and encourages:

- Choice and Empowerment
- Active Family Engagement/Circle of Support
- Individualized Supports in a Home of Your Choice
- Access to Successful Employment Opportunities
- Community Involvement and Meaningful Relationships
- A Healthy Lifestyle with Supports to Ensure Personal Safety

About medisked

MediSked is the leading brand in holistic solutions that improve lives, drive efficiencies, and generate innovations for human service organizations that support our community.

Founded in 2003

**Over 100 employees
(all in US)**

**Offices in NY
and MD**

4 platforms

**Over 350,000
people supported**

**\$2 Billion in claims
processed
annually**

**Clients across 39
states**

**Regularly audited
for NIST 800-53
compliance**

**System security
and software
development
lifecycle controls
exceed standards**

**Experience with
adapting to
regulatory change
rapidly**

**High acuity
population focus**

**Person-Centered
approach**



IT Requirements and NIST 800-53 Controls

- PHI contained in the CCO environment is classified as Medicaid Confidential Data (MCD)
 - Requires NYS Moderate-Plus System Security Plan (SSP) controls
- SSP includes 402 security controls across 18 domains



Access Control (AC)	System and Communications Protection (SC)	Identity and Authorization (IA)	Configuration Management (CM)	Audit and Accountability (AU)	Awareness and Training (AT)	Security Assessment and Authorization (CA)	Contingency Planning (CP)	Incident Response (IR)
Maintenance (MA)	Media Protection (MP)	Physical and Environmental Protection (PE)	Planning (PL)	Program Management (PM)	Personnel Security (PS)	Risk Assessment (RA)	System and Services Acquisition (SA)	System and Information Security (SI)

IT Requirements and NIST 800-53 Controls

Security Intelligence & Analytics

Infrastructure

- Next Generation Firewalls - Cisco ASA, Palo Alto, Unifi
- Anti Malware - ProofPoint Email Gateway and Trend Deep Security
- Intrusion Detection & Prevention - Palo Alto / AWS WAF / Trend Deep Security
- Network Advanced Threat Protection - AWS WAF, Palo Alto,
- Web Application Firewalls - AWS & Palo Alto Application Risk Rating Analysis

Applications

- Phishing Tests - Auto-generation phishing message and training
- Security Awareness Training - ADP & Restricted Intelligence Videos
- Intranet - Information Security Website with Policies, Procedures, Awareness
- Security Risk Management Services - CORL, JIRA, SharePoint
- Advanced Threat Protection - Microsoft Defender ATP & Trend Deep Security

Data Loss Protection

- Full Disk Encryption for Workstations - BitLocker
- Mobile Device Management - Microsoft Intune MDM Platform
- Security Information Event Management w/real-time monitor/alert
- Secure Remote Access - Multi-Factor / 2FA Authentication / Centrify
- Security Vulnerability Assessment Solutions - Qualys and AWS Inspector

Advanced Threat & Security Research



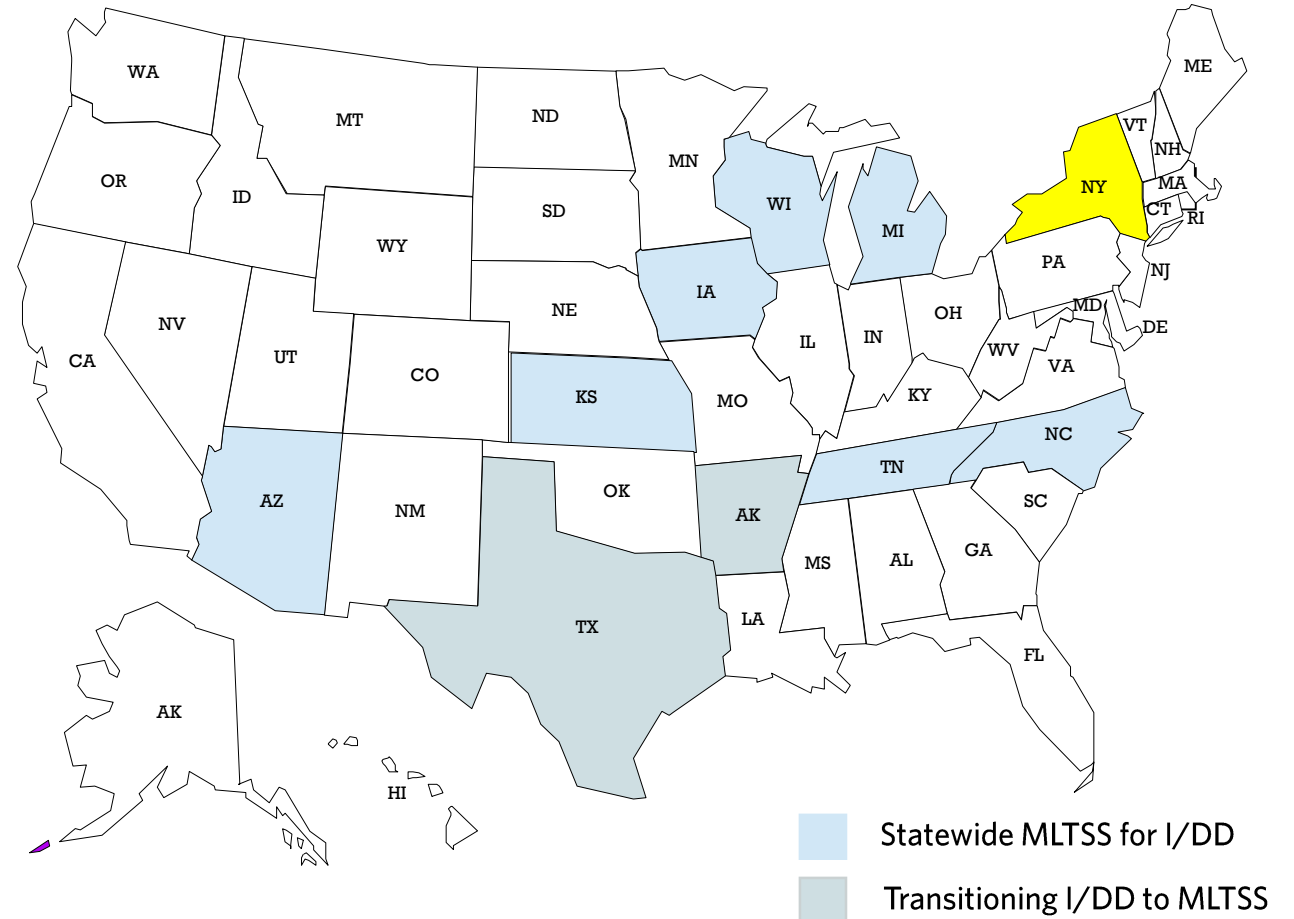
Trends in MLTSS for I/DD across the US

- 7 states with statewide MLTSS for I/DD

1. Arizona
2. Michigan
3. Wisconsin
4. North Carolina
5. Kansas
6. Iowa
7. Tennessee

- 3 states in transition to MLTSS

1. Arkansas
2. New York
3. Texas



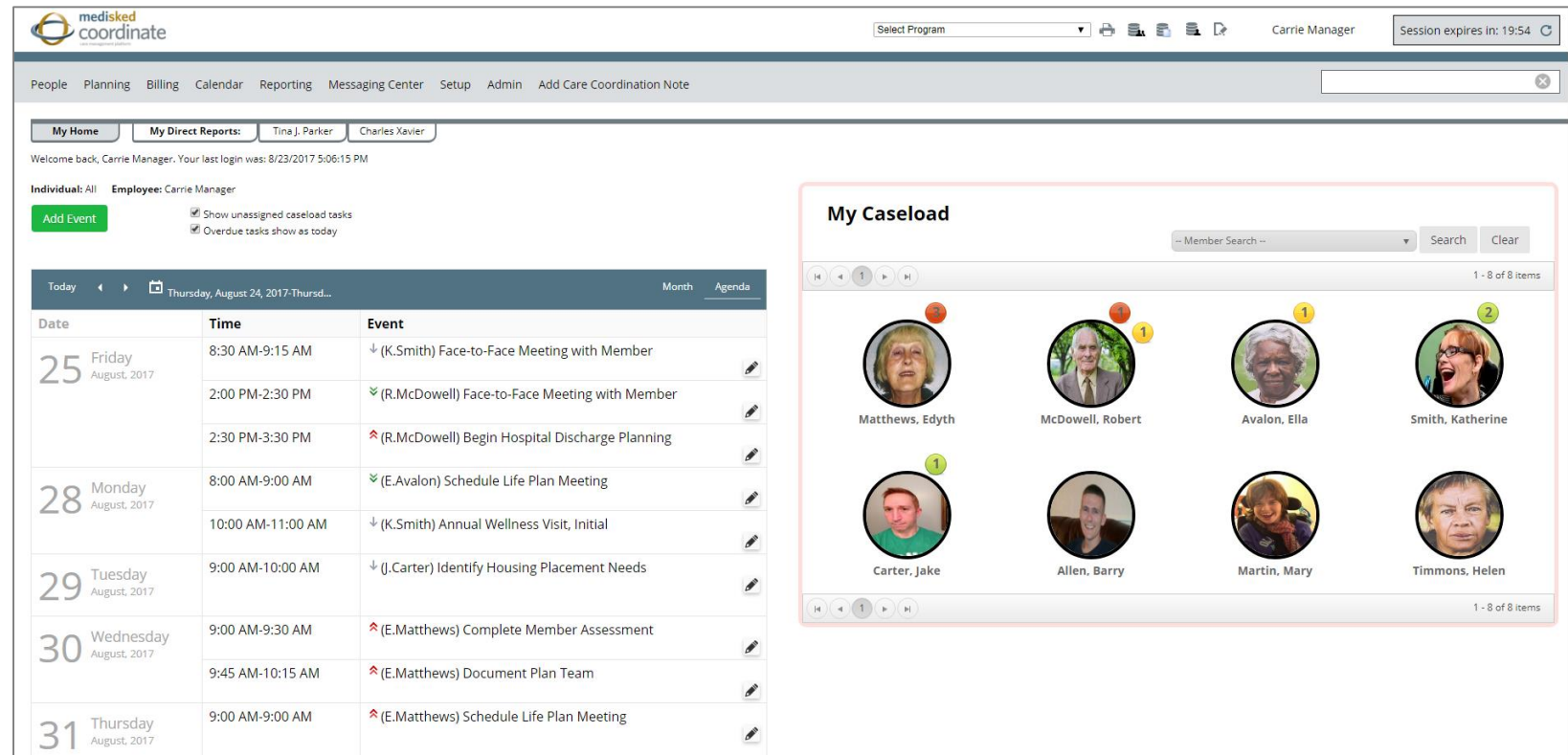
THE TECHNOLOGY SOLUTION

MediSked Coordinate - Care Management Platform

MediSked Coordinate is the platform dedicated to the daily activities of Care Management and is used daily by Care Managers, along with other CCO/HH employees

Activities include:

- Individual Record Management
- Plan Development
- Event/Contact Logging
- Information Sharing
- Reporting
- Task Workflows
- Note Audit
- Billing



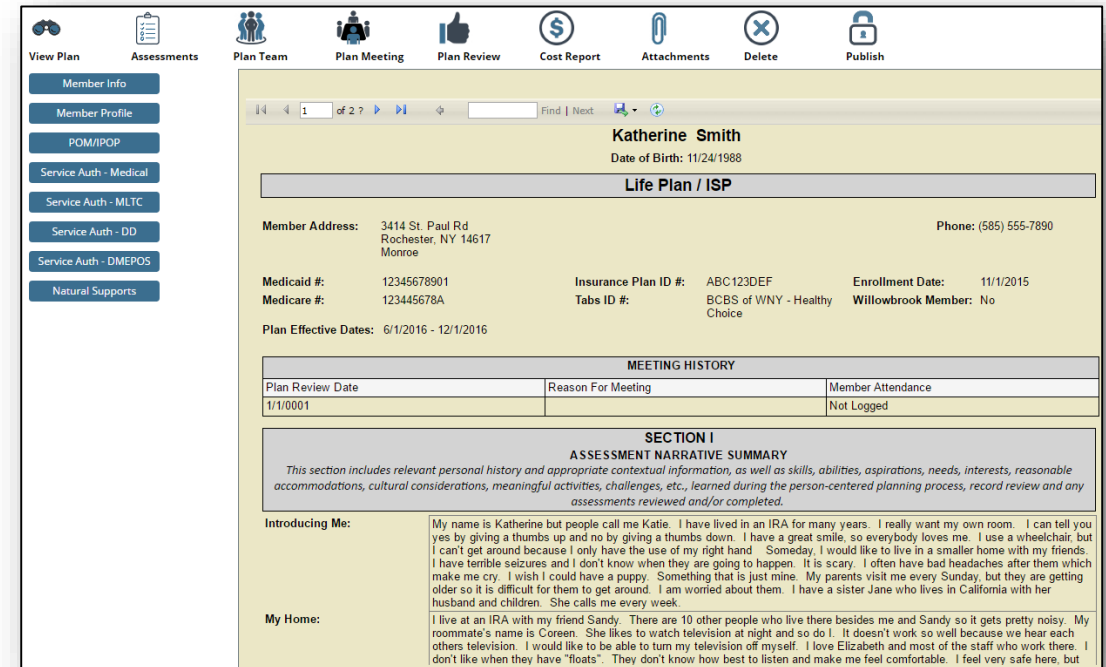
The screenshot displays the MediSked Coordinate web application interface. At the top, there is a navigation menu with options: People, Planning, Billing, Calendar, Reporting, Messaging Center, Setup, Admin, and Add Care Coordination Note. Below the menu, there are tabs for 'My Home' and 'My Direct Reports' (listing Tina J. Parker and Charles Xavier). A welcome message for 'Carrie Manager' is displayed. The main content area is divided into two sections: 'My Caseload' and a calendar view. The 'My Caseload' section shows a grid of member profiles with names like Matthews, Edyth; McDowell, Robert; Avalon, Ella; Smith, Katherine; Carter, Jake; Allen, Barry; Martin, Mary; and Timmons, Helen. The calendar view shows a schedule of events for August 2017, including meetings and assessments.

Date	Time	Event
25 Friday August, 2017	8:30 AM-9:15 AM	↓ (K.Smith) Face-to-Face Meeting with Member
	2:00 PM-2:30 PM	✓ (R.McDowell) Face-to-Face Meeting with Member
	2:30 PM-3:30 PM	⚠ (R.McDowell) Begin Hospital Discharge Planning
28 Monday August, 2017	8:00 AM-9:00 AM	✓ (E.Avalon) Schedule Life Plan Meeting
	10:00 AM-11:00 AM	↓ (K.Smith) Annual Wellness Visit, Initial
29 Tuesday August, 2017	9:00 AM-10:00 AM	↓ (J.Carter) Identify Housing Placement Needs
30 Wednesday August, 2017	9:00 AM-9:30 AM	⚠ (E.Matthews) Complete Member Assessment
	9:45 AM-10:15 AM	⚠ (E.Matthews) Document Plan Team
31 Thursday August, 2017	9:00 AM-9:00 AM	⚠ (E.Matthews) Schedule Life Plan Meeting



MediSked Coordinate - Life Plan Development

- Medicaid Service Coordination Moved to CCO on 7/1/2018
 - Basic HCBS Care Management
 - HH Comprehensive Care Management
- The provider continues to develop habilitation plan and provide summaries to CCO
 - CCOs create, edit, and review current or past Life Plans and associated service delivery information, including:
 - Personal outcome measures (POMs)
 - Individualized plans of protective care
 - Needed supports and services
 - Plan progress toward goals and valued outcomes
 - Integrated with IAM assessment to dynamically populate Life Plan
 - CCOs document, edit, and review plan meetings, attendance, and minutes
 - CCOs share draft and completed Life Plans with the individual and members of his or her IDT using the MediSked Person-Centered Portal



The screenshot shows the MediSked interface for a Life Plan / ISP. The top navigation bar includes icons for View Plan, Assessments, Plan Team, Plan Meeting, Plan Review, Cost Report, Attachments, Delete, and Publish. A left sidebar contains buttons for Member Info, Member Profile, POM/POP, Service Auth - Medical, Service Auth - MLTC, Service Auth - DD, Service Auth - DMEPOS, and Natural Supports.

The main content area displays the following information for **Katherine Smith** (Date of Birth: 11/24/1988):

- Member Address:** 3414 St. Paul Rd, Rochester, NY 14617, Monroe. **Phone:** (585) 555-7890
- Medicaid #:** 12345678901
- Medicare #:** 123445678A
- Insurance Plan ID #:** ABC123DEF
- Enrollment Date:** 11/1/2015
- BCBS of WNY - Healthy Choice**
- Willowbrook Member:** No
- Plan Effective Dates:** 6/1/2016 - 12/1/2016

MEETING HISTORY

Plan Review Date	Reason For Meeting	Member Attendance
1/1/0001		Not Logged

SECTION I ASSESSMENT NARRATIVE SUMMARY

This section includes relevant personal history and appropriate contextual information, as well as skills, abilities, aspirations, needs, interests, reasonable accommodations, cultural considerations, meaningful activities, challenges, etc., learned during the person-centered planning process, record review and any assessments reviewed and/or completed.

Introducing Me: My name is Katherine but people call me Katie. I have lived in an IRA for many years. I really want my own room. I can tell you yes by giving a thumbs up and no by giving a thumbs down. I have a great smile, so everybody loves me. I use a wheelchair, but I can't get around because I only have the use of my right hand. Someday, I would like to live in a smaller home with my friends. I have terrible seizures and I don't know when they are going to happen. It is scary. I often have bad headaches after them which make me cry. I wish I could have a puppy. Something that is just mine. My parents visit me every Sunday, but they are getting older so it is difficult for them to get around. I am worried about them. I have a sister Jane who lives in California with her husband and children. She calls me every week.

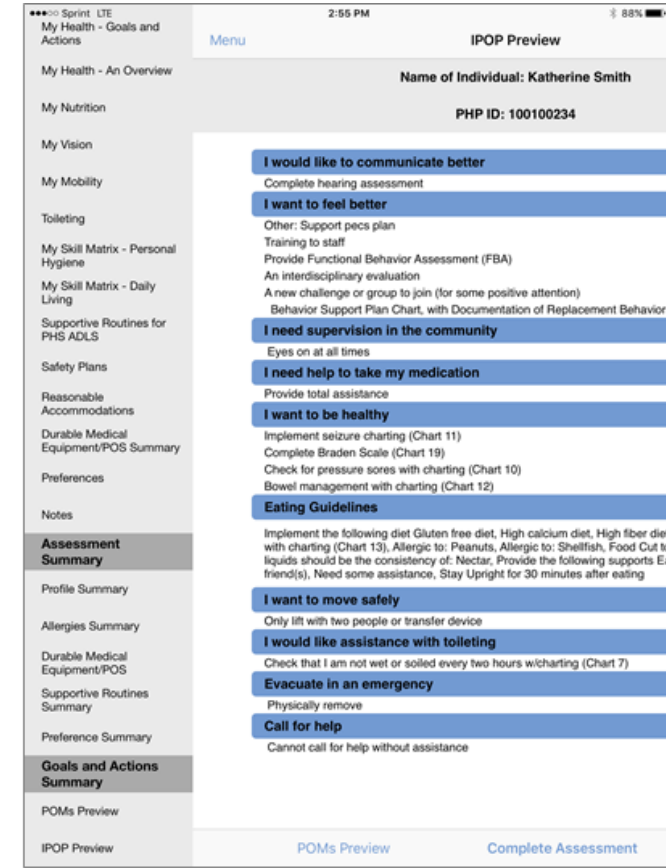
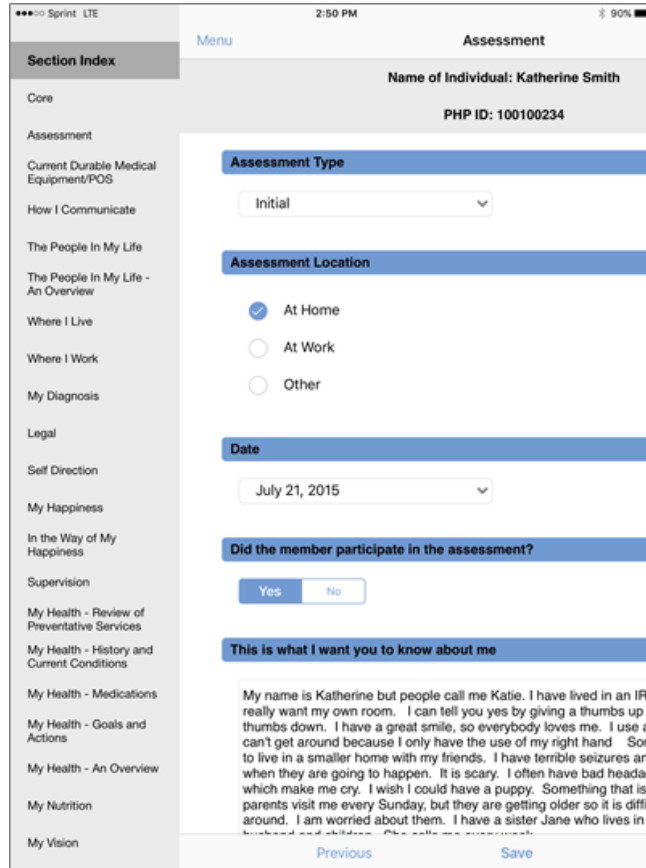
My Home: I live at an IRA with my friend Sandy. There are 10 other people who live there besides me and Sandy so it gets pretty noisy. My roommate's name is Coreen. She likes to watch television at night and so do I. It doesn't work so well because we hear each others television. I would like to be able to turn my television off myself. I love Elizabeth and most of the staff who work there. I don't like when they have "floats". They don't know how best to listen and make me feel comfortable. I feel very safe here, but



IAM Assessment



- Determines services to meet people's hopes and dreams as well as traditional health and safety requirements
- Provides a list of specific goals and actions for natural supports and service providers to follow.
- Integrates the Council for Quality and Leadership's Personal Outcome Measures (CQL POMs)
- Gathers important information into standard printouts
- Provides a list of preferences and supportive routines for individuals with more significant challenges
- Represents the powerful voice of the person with I/DD



Comprehensive IAM Assessments Populate Life Plan

IPOP Preview
 Name of Individual: Katherine Smith
 PHP ID: 100100234

I would like to communicate better
 Complete hearing assessment

I want to feel better
 Other: Support pecs plan
 Training of staff
 Provide Functional Behavior Assessment (FBA)
 An interdisciplinary evaluation
 A new challenge or group to join (for some positive attention)
 Behavior Support Plan Chart, with Documentation of Replacement Behavior

I need supervision in the community
 Eyes on at all times

I need help to take my medication
 Provide total assistance

I want to be healthy
 Implement seizure charting (Chart 11)
 Complete Braden Scale (Chart 19)
 Check for pressure sores with charting (Chart 10)
 Bowel management with charting (Chart 12)

Eating Guidelines
 Implement the following diet Gluten free diet, High calcium diet, High fiber diet with charting (Chart 13), Allergic to: Peanuts, Allergic to: Shellfish, Food Cut to liquids should be the consistency of: Nectar, Provide the following supports Eat friend(s), Need some assistance, Stay Upright for 30 minutes after eating

I want to move safely
 Only lift with two people or transfer device

I would like assistance with toileting
 Check that I am not wet or soiled every two hours w/charting (Chart 7)

Evacuate in an emergency
 Physically remove

Call for help
 Cannot call for help without assistance

[POMs Preview](#) [Complete Assessment](#)



Selection Save Save and Continue View Assignments

POMs New POM

Selection	Goal(?)	Action Type	Add/Decline Reason	Add Actions
<input checked="" type="checkbox"/>	People are connected to natural supports			New Goal
<input checked="" type="checkbox"/>	See my friends and family more often			New Action-Step
	Other: Arrange for skype with sister	Goal		
<input checked="" type="checkbox"/>	People have intimate relationships			New Goal
<input checked="" type="checkbox"/>	Have a boyfriend/girlfriend			New Action-Step
<input checked="" type="checkbox"/>	Assist with joining a dating site	Support		
<input checked="" type="checkbox"/>	Teach dating skills	Goal		
<input checked="" type="checkbox"/>	Teach social skills	Goal		
<input checked="" type="checkbox"/>	People have the best possible health			New Goal
<input checked="" type="checkbox"/>	Look differently			New Action-Step
<input checked="" type="checkbox"/>	Provide an exercise program	Goal		
<input checked="" type="checkbox"/>	People choose where and with whom they live			New Goal
<input checked="" type="checkbox"/>	I want my own room			New Action-Step
<input checked="" type="checkbox"/>	Explore/investigate options for change with the person (e.g. possible room changes, living alone, other living arrangements, etc.)	Support		
<input checked="" type="checkbox"/>	Other: Push panel for tv control and headphones	Goal		
<input checked="" type="checkbox"/>	People choose personal goals			New Goal
<input checked="" type="checkbox"/>	Be more independent			New Action-Step
<input checked="" type="checkbox"/>	Determine preferences	Support		

Assessment dynamically populates care management platform to assist Care Manager in:

- Scheduling and facilitating planning meetings
- Life Plan approval process
- Sharing information with service provider agencies



Person-Centered Portal

Name	Member ID	Medicaid ID	Insuran... Plan	Enroll... Date	Care Manager (Phone)
Harris, Bill	AAA55555	HI543217	Comprehen... Services Waiver	08/01/2016	Bittner, Noel (585-123-4567)
McDowell, Robert	CCC87654	XYZ123456	Medicaid	02/01/2016	Manager, Carrie ((123) 456-0098)
Smith, Janet	BBB34567	12348156KM	Developmen... Disabilities Adult Waiver	08/17/2015	Dinolfo, Russell (8081111111)
Smith, Katherine	YHD54563	XY12345A	Medicaid	03/01/2015	Manager, Carrie ((123) 456-0098)
Timmons,		3316-2-985	Medicaid	04/01/2016	Manager, Carrie

Katherine T Smith's Access Portal

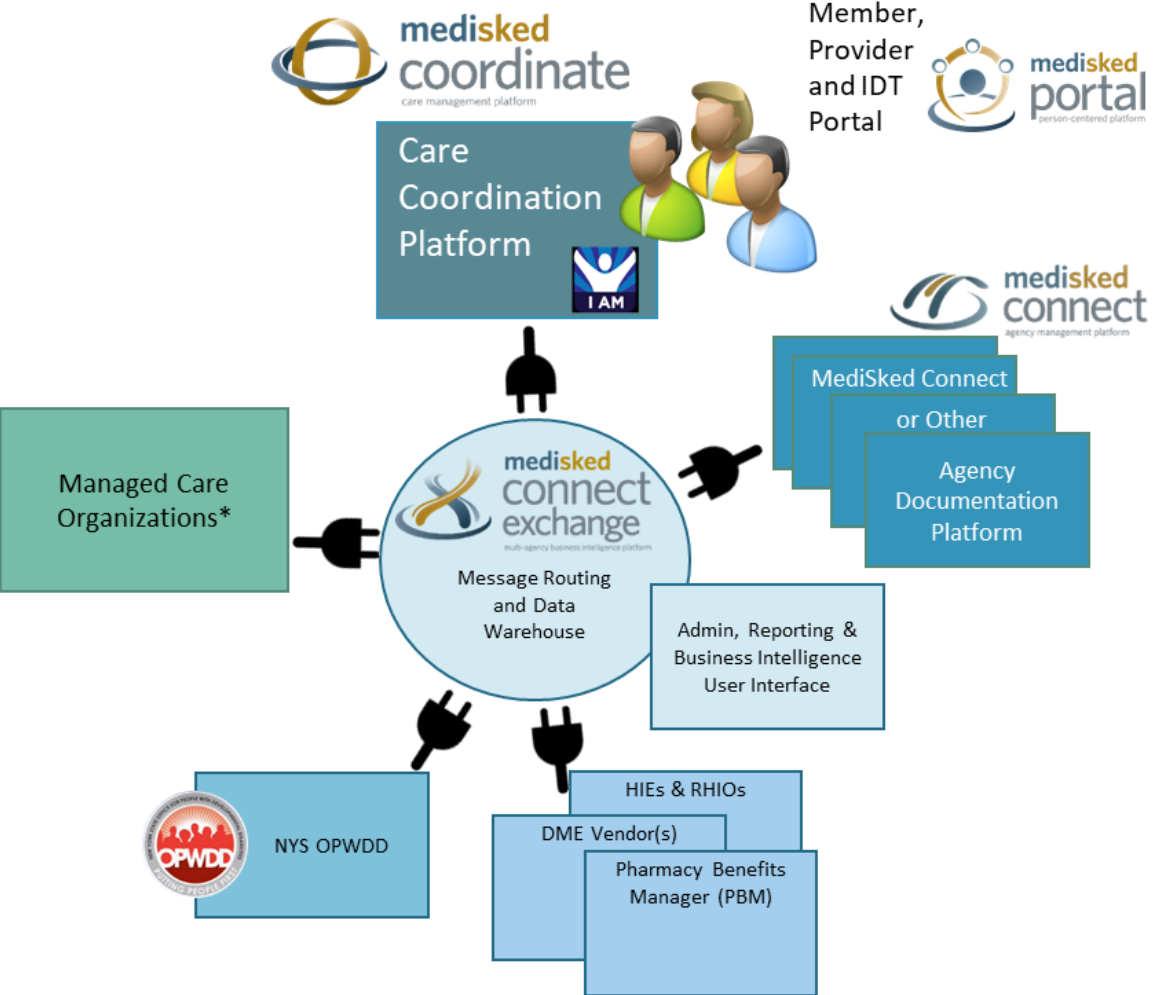
- Charts (3)
- My Assessments (3)
- Monthly Summaries
- My Plans
- Forms (9+)
- Message Center (4)

Katherine T Smith

- Web-based tool that allows people, providers, and any family member a person chooses to get a clear, complete view of life and records to track plans, services, and even message directly with the Care Manager
- List view shares individuals that are associated with that provider/member agency
- Family members/natural supports/other service providers may be granted access
- Securely view and share information (messages, forms, charts, plans) depending on the level of access



MediSked Connect Exchange



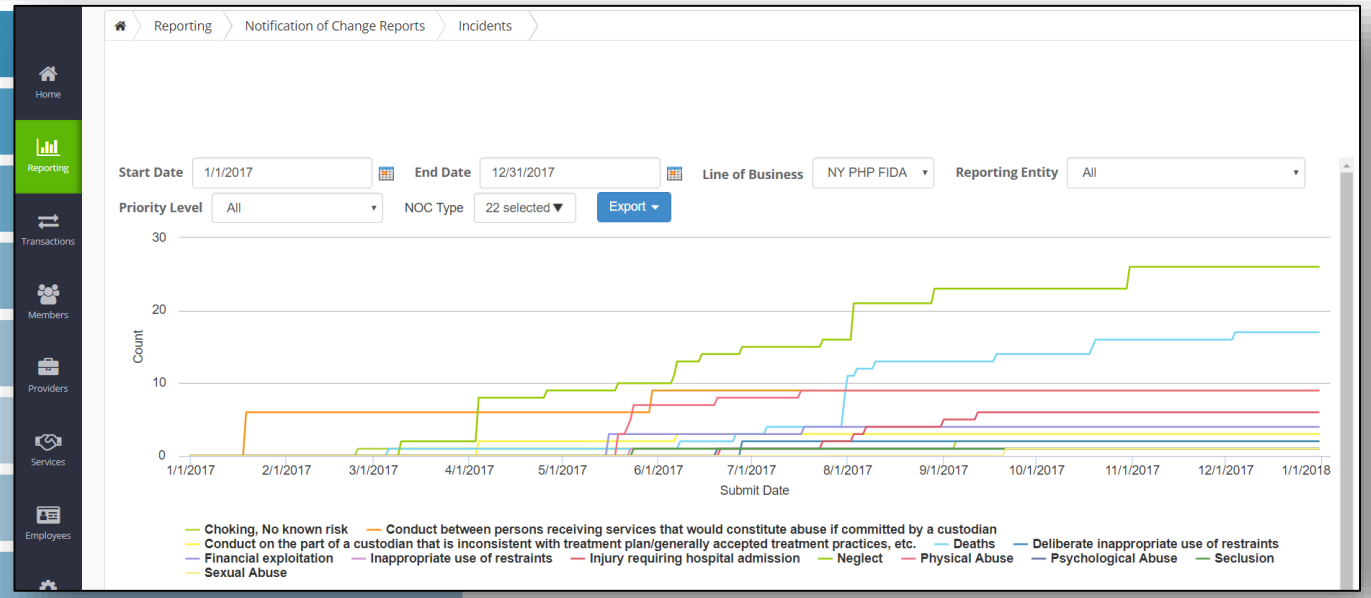
A multi-agency business intelligence platform being leveraged to expand the breadth of available data and supercharge traditional care coordination tools and workflows in New York and beyond.

- Enables real-time population management and enterprise reporting for CCO/HH across their membership
- Includes powerful reporting tools and a custom report builder to allow CCO/HH entities to view trends and outcomes across the state



NY IDD CCO HH Quality Measures

- Inpatient stays
- Emergency room visits
- Disease-Related Care for Chronic Conditions
- Preventive Care
- Transitional Care
- CQL POMs (3 Personal Goals, 2 POMs)
- Implementation of Personal Safeguards (IPOP)
- Transitioning to a More Integrated Setting
- Employment
- Self Direction
- Bladder and Bowel Continence
- Falls
- Choking
- Supporting Individuals' Transition from Institutional Settings to Community Settings



DATA FINDINGS

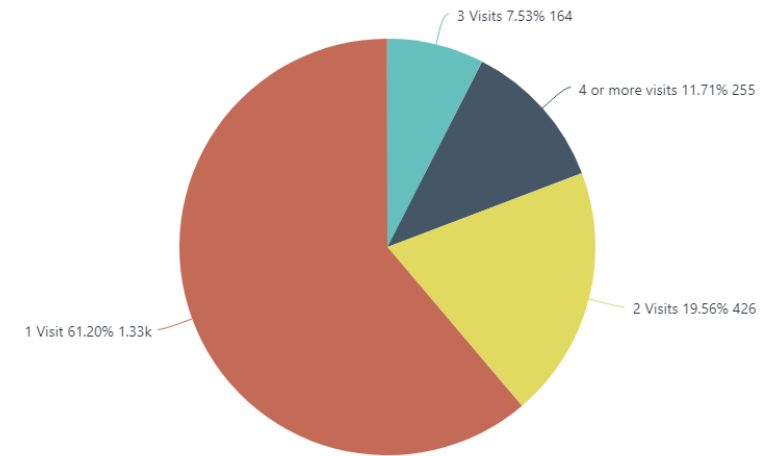
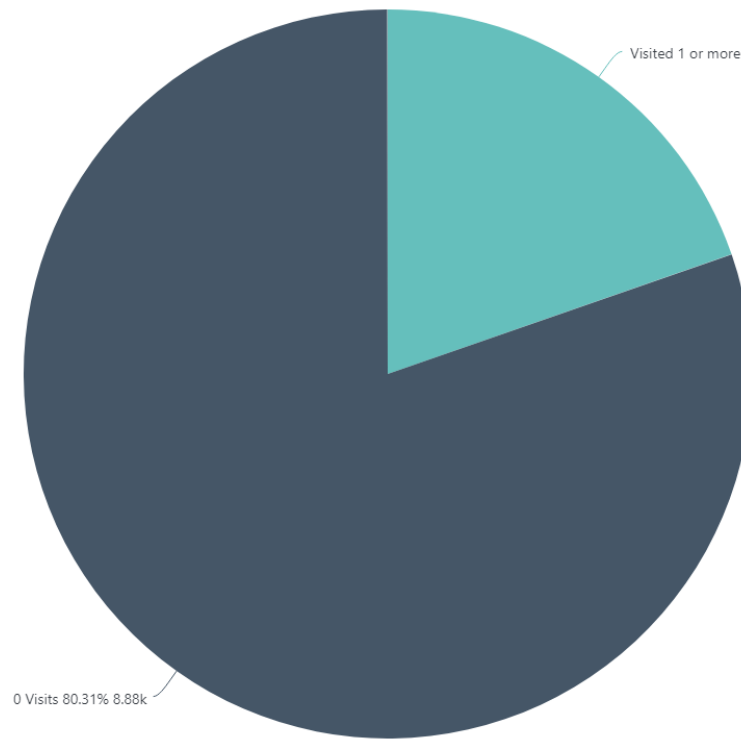
Emergency Room (ER/ED) Visits

Category	Data Source
Emergency Room Visits	Number of people enrolled that were at the Emergency Room 1, 2, 3, or 4 or more times in the last 12 months

Most enrollees have not been hospitalized in the past 12 months

- 19.7% were admitted to the ED in the last year, but of those 61.2% only had to do so once

Number of ER Visits Per Tier 1-4 Enrollee at ACA



Self-reported
Data Powered by



Tops Reasons for ER/ED Visits

Top Reasons for ER Visits – General Population

1. Stomach and abdominal pain, cramps, spasms
2. Chest pain
3. Fever
4. Cough
5. Headache

Source: CDC, National Center for Health Statistics,
https://www.cdc.gov/nchs/hus/contents2017.htm?search=Emergency_department_visits,

Top Reasons for ER Visits – ACA

1. Illness
2. Psychiatric/Behavioral Episode
3. Fracture
4. Seizure
5. Fall

Source: NY IDD CCO HH - results have not been formally validated

Self-reported
Data Powered by



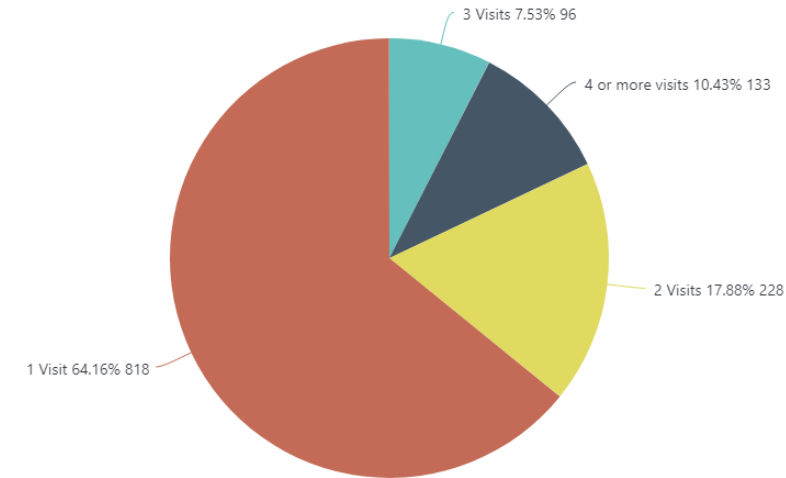
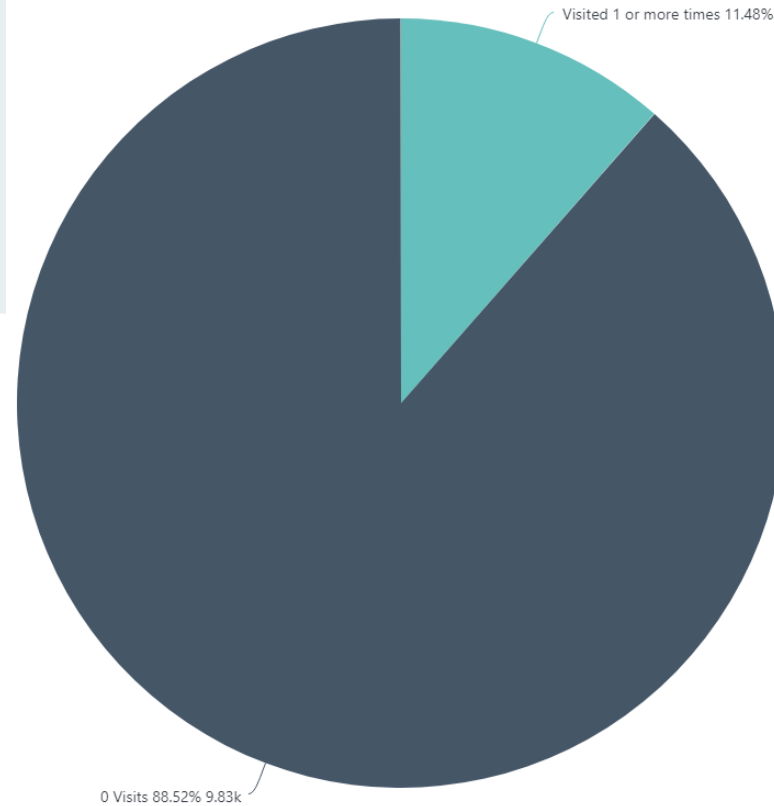
Hospitalizations

Category	Data Source
Hospitalizations	Number of people enrolled that stayed overnight in the hospital in the last 12 months

Most enrollees have not been hospitalized in the past 12 months

- 11.4% have been hospitalized at least once

Number of Hospitalizations Per Tier 1-4 Enrollee at ACA



Self-reported
Data Powered by



Top Reasons for Hospitalizations

Top Reasons for Hospitalizations General Population

1. Liveborn
2. Septicemia
3. Osteoarthritis
4. Congestive Heart Failure
5. Pneumonia

Source: AHRQ, Healthcare Cost and Utilization Project
<https://www.hcup-us.ahrq.gov/faststats/NationalDiagnosesServletvisits>,

Top Reasons for Hospitalizations ACA

1. Illness
2. Psychiatric/Behavioral Episode
3. Fracture
4. Surgery
5. Seizure

Source: NY IDD CCO HH - results have not been formally validated

Self-reported
Data Powered by



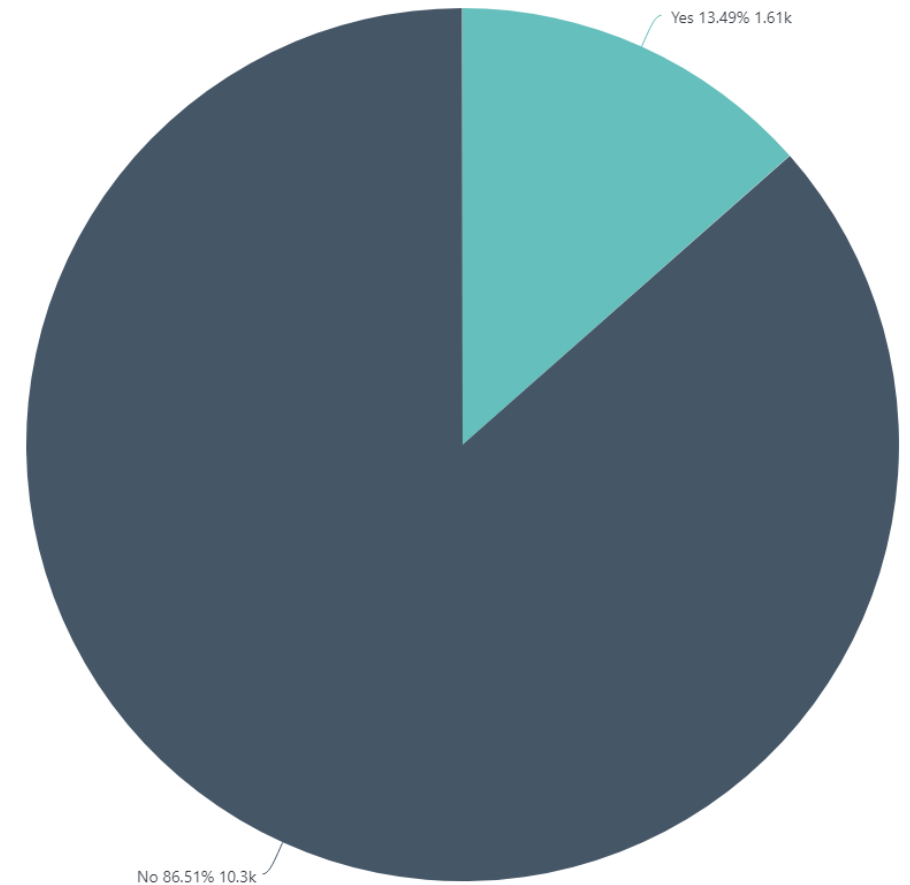
Choke Risk Analysis

Category	Data Source
Choke Risk	Number of people at risk for choking

Choke risk = 13.5%

Once identified as choke risk, Life Plans are updated to include safeguards (modified consistency of foods, additional supervision, etc.)

Choke Risk Per Tier 1-4 Enrollee at ACA

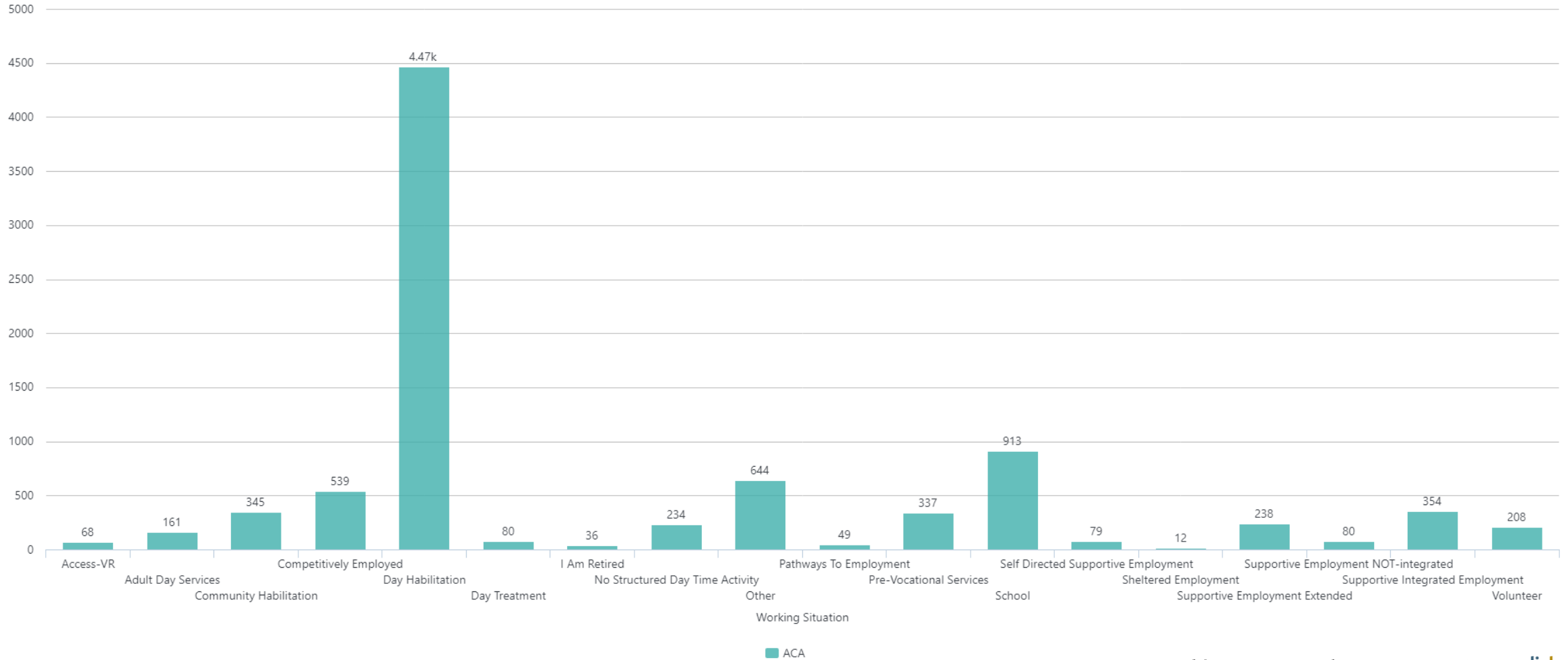


Self-reported
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Work or Day Situation

Type of Work for Tier 1-4 Enrollees at ACA



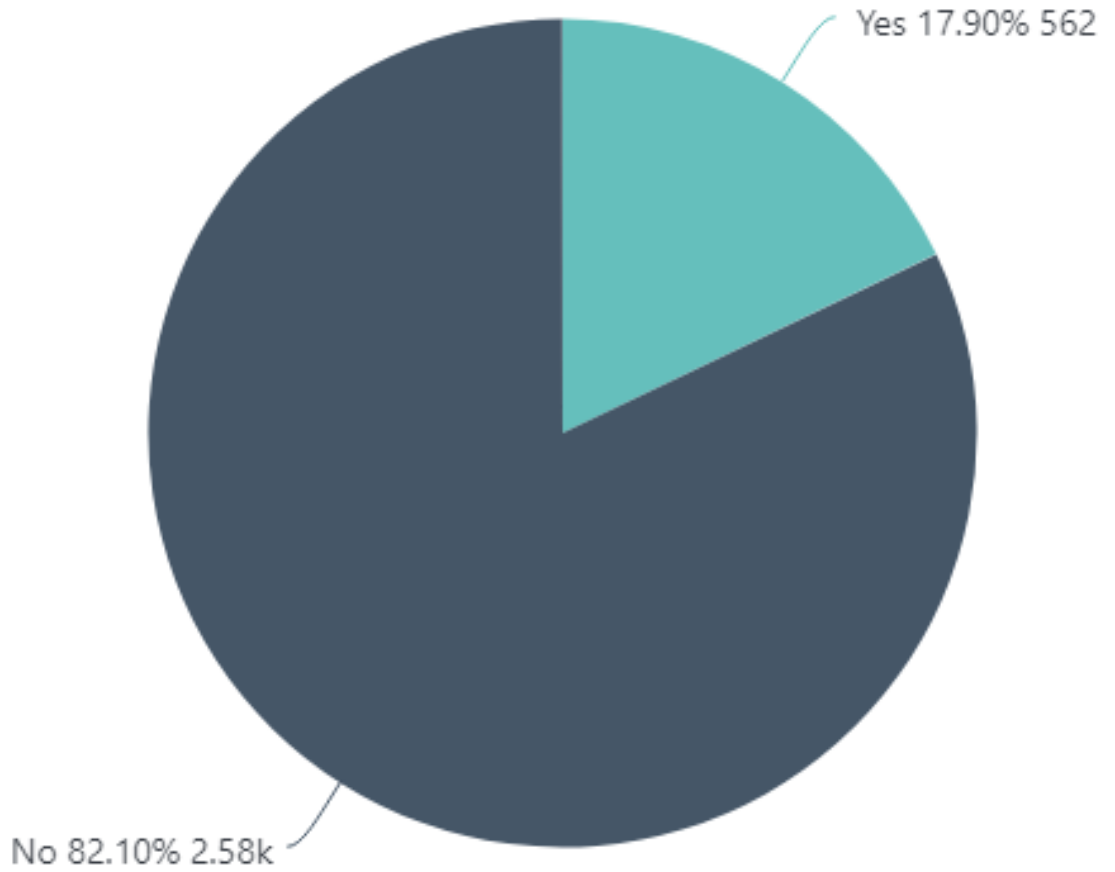
Category	Data Source
Type of Work or Day Situation	Number of people in each work/day category

Self-reported
Data Powered by



Desire to Change Work or Day Status

Tier 1-4 Enrollees Who Want to Change Their Work or Day Situation at ACA



17.9% of people indicate a desire to change their work status for different reasons including:

- Desire for a real job
- Want to earn more money
- Want to explore available options
- Want to participate in integrated employment or volunteering

Self-reported
Data Powered by



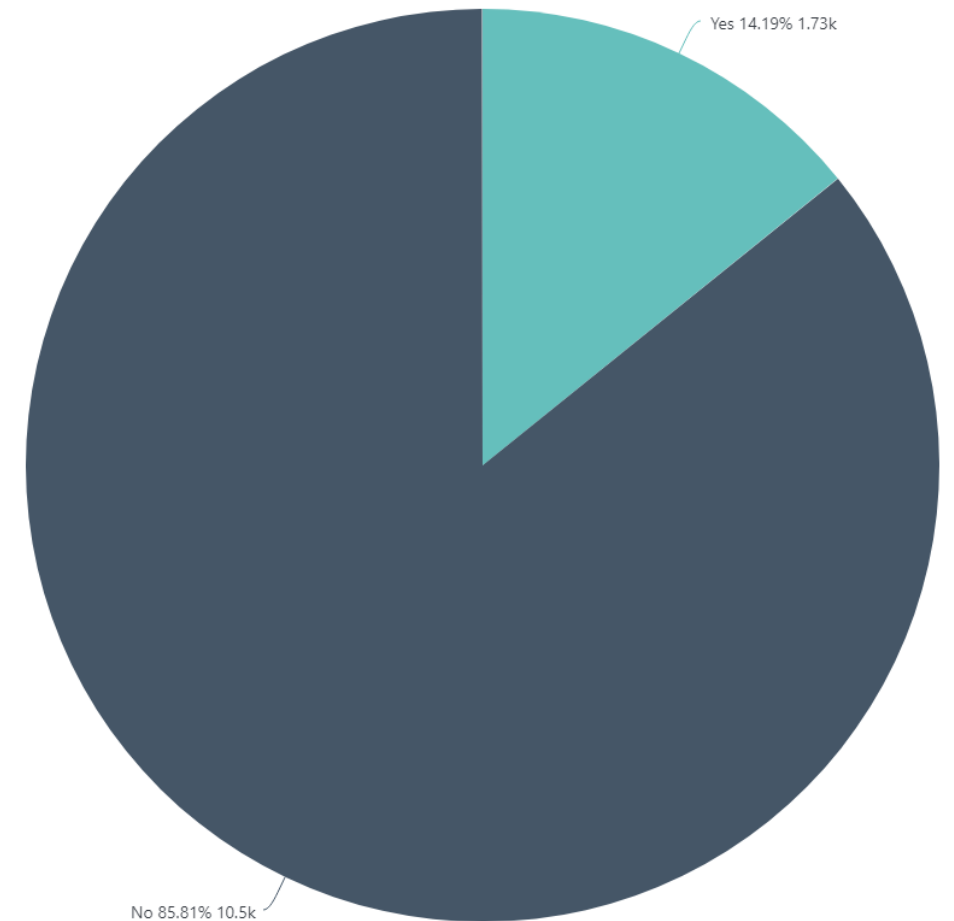
Living Situation Satisfaction

% of Tier 1-4 Enrollees at ACA Who Want to Improve Their Living Situation

Category	Data Source
Living Situation	Number of people who like/dislike where they live

14.2% indicated they would want to improve their living situation

- ACA identified 12 individuals that:
 - Live in a supervised group home setting
 - Have indicated they want to change their living situation
 - Can reportedly be left alone for 4+ hours
- Although this is a small number of individuals, the cost of residential services for these 12 people is approximately \$1.8M/year

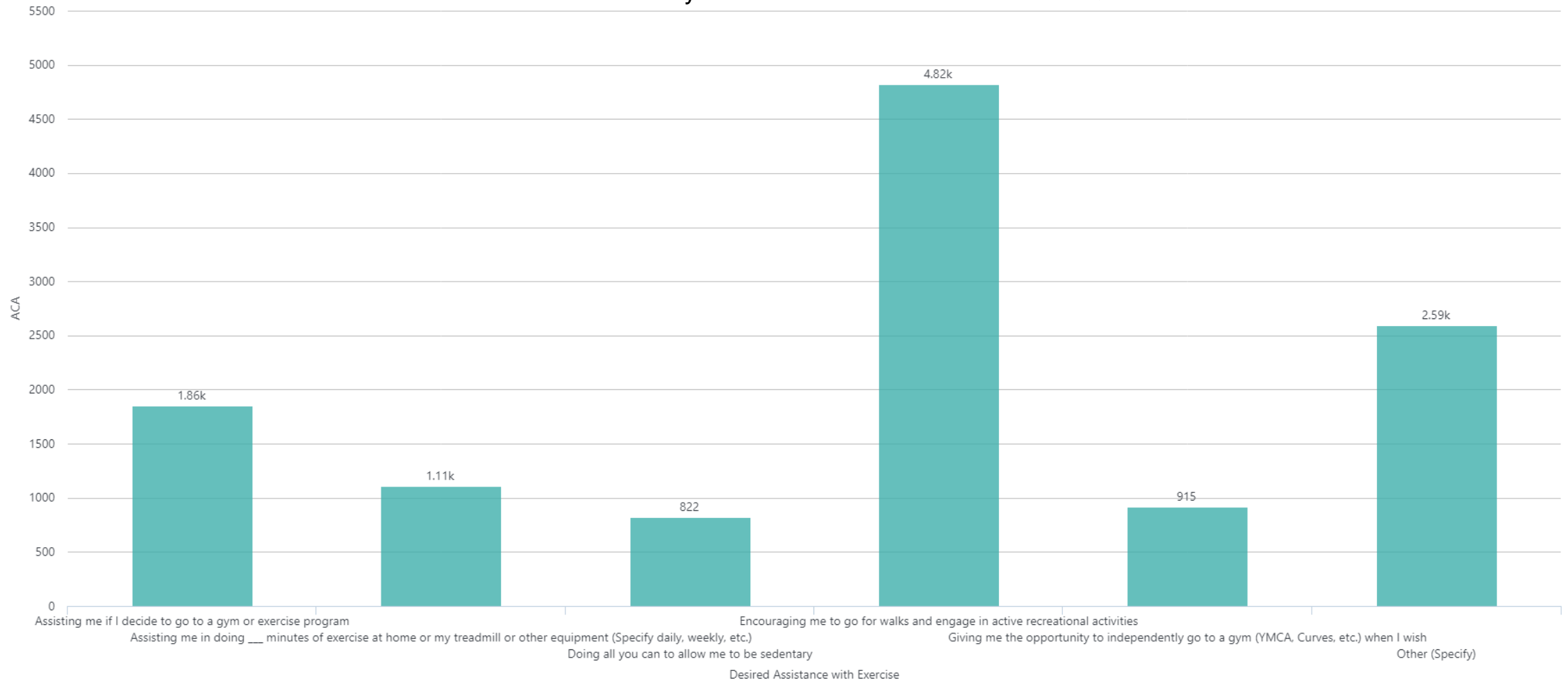


Self-reported
Data Powered by



Exercise Assistance

Assistance Desired by Tier 1-4 Enrollees with Exercise at ACA

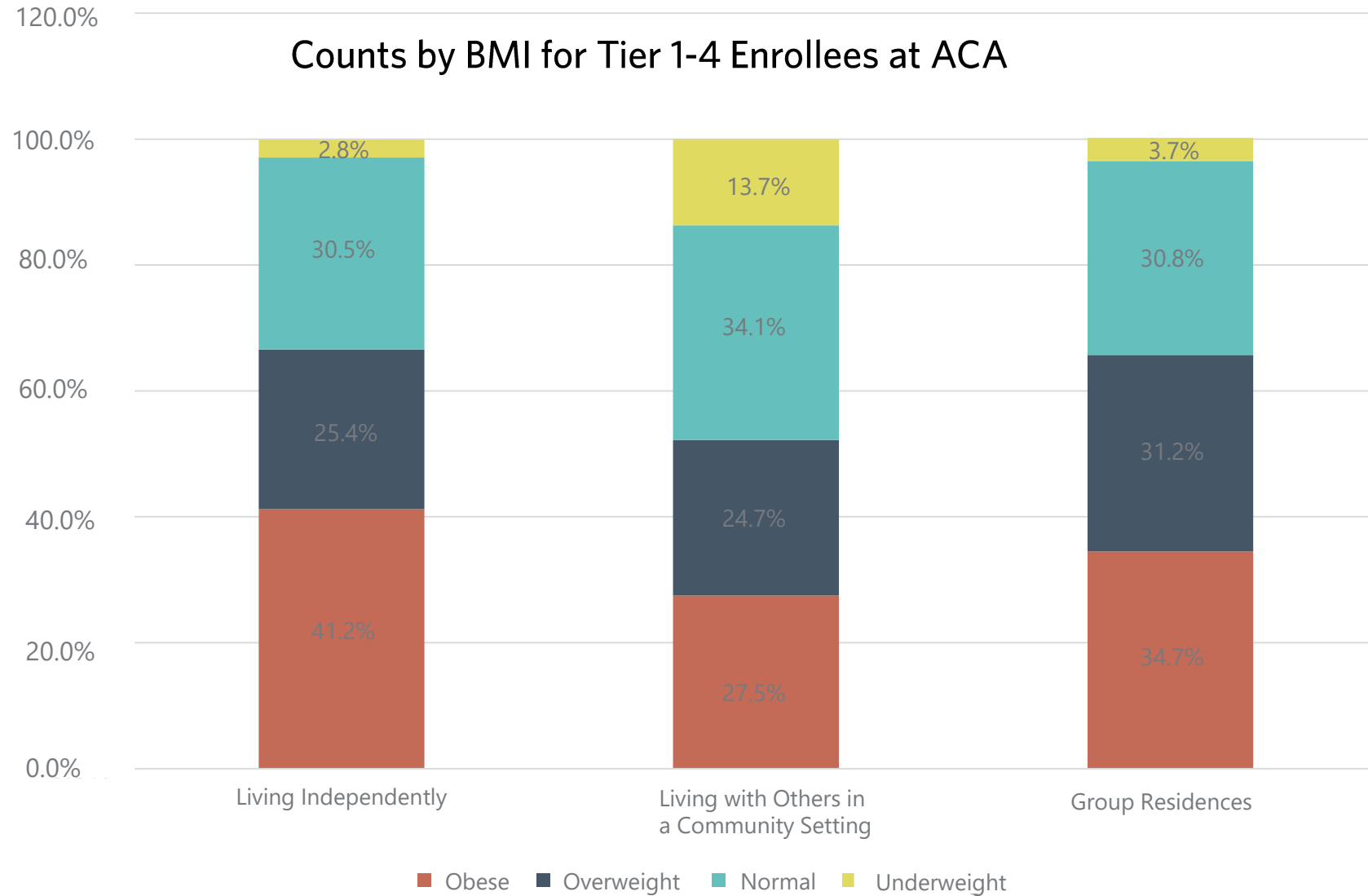


Category	Data Source
Assistance Desired by Individuals with Exercise	Number of people who may or may not require assistance with exercise

Self-reported Data Powered by



BMI by Living Situation



Self-reported
Data Powered by



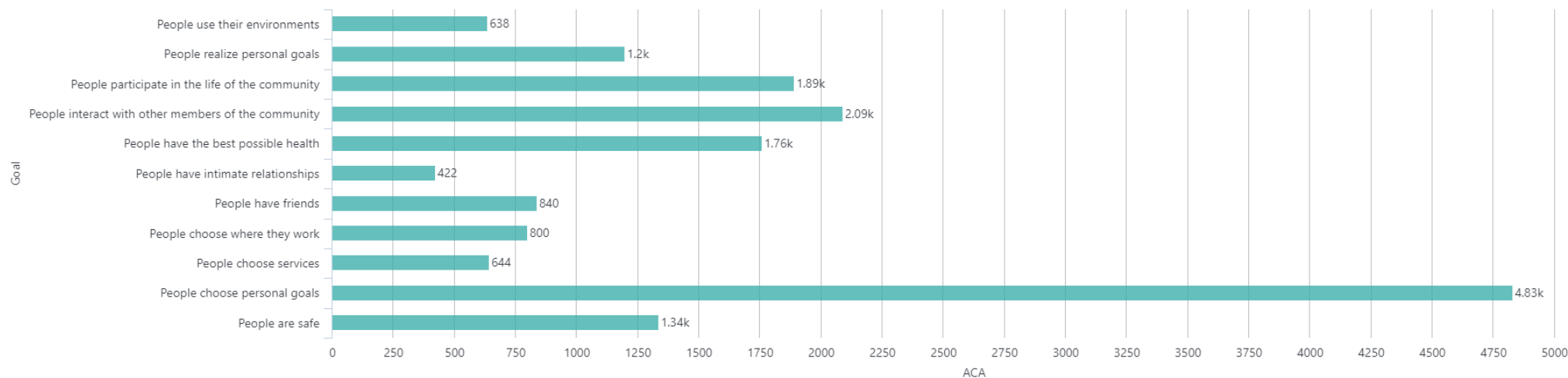
CQL Personal Outcome Measures

1. People are safe
2. People are free from abuse and neglect
3. People have the best possible health
4. People experience continuity and security
5. People are treated fairly
6. People exercise rights
7. People are respected
8. People use their environments
9. People live in integrated environments
10. People interact with other members of the community

11. People participate in the life of the community
12. People are connected to natural support networks
13. People have friends
14. People have intimate relationships
15. People decide when to share personal information
16. People perform different social roles
17. People choose where and with whom they live
18. People choose where they work
19. People choose their services
20. People choose personal goals
21. People realize personal goals

Source: <https://c-q-l.org/the-cql-difference/personal-outcome-measures>

Count of Tier 1-4 Enrollees with each POM at ACA

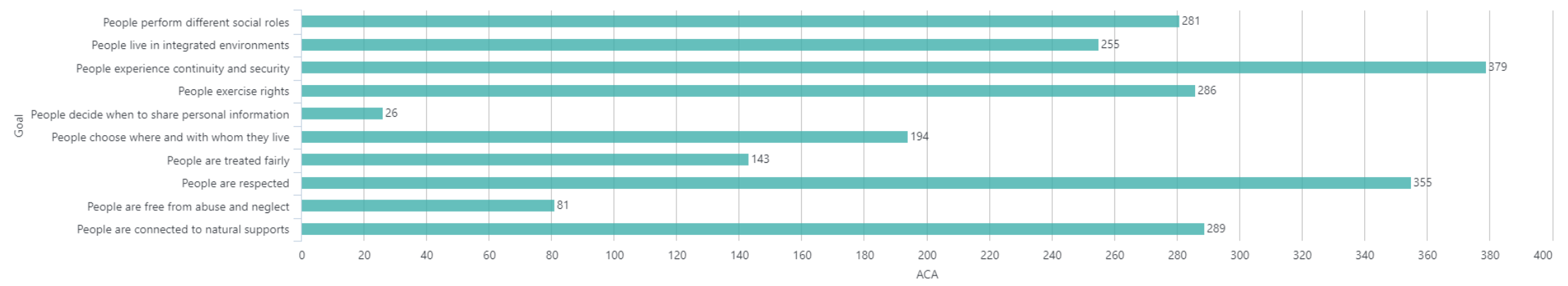


Life Plan/ISP
Data Powered by



CQL Personal Outcome Measures (cont.)

Count of Tier 1-4 Enrollees with each POM at ACA



LESSONS --- LEARNED

Lessons Learned

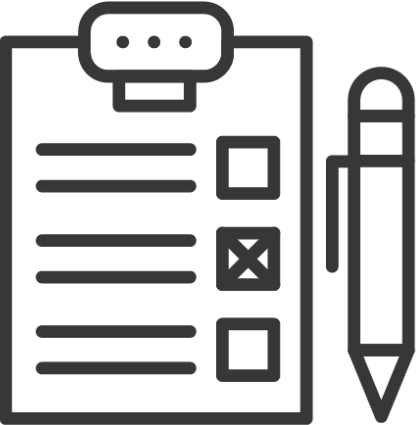
Looking back on the first year, we know that most of the turbulence is behind us and that with teamwork and perseverance the obstacles can be overcome, and the envisioned transformation can be achieved

- Things may take more time than expected
- The individuals we support come first – everything else comes second
- The state has been flexible
 - Portal, security controls, and consent controls require more time to codify
 - The state has given flexibility on roll-out dates and has been very supportive in the planning and consideration process

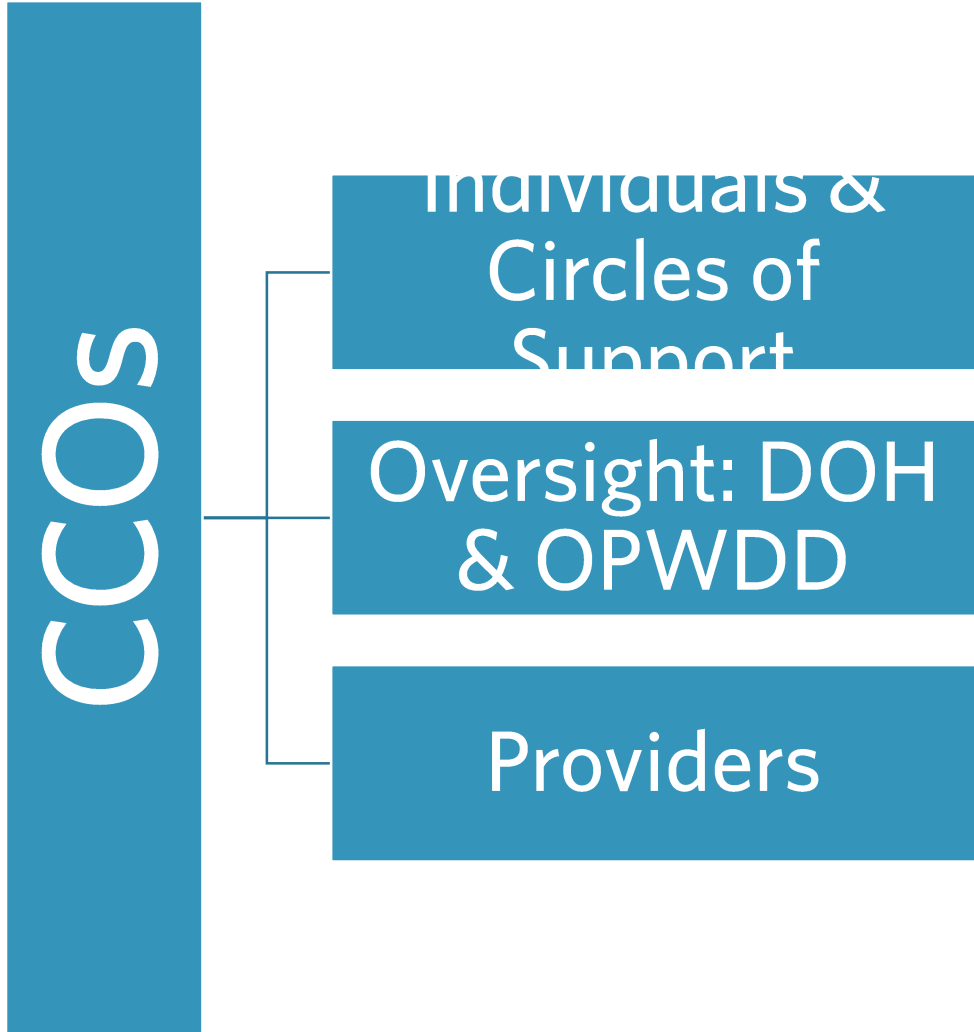


Lessons Learned: Policy

- Include all stakeholders (individuals, families, providers, care coordinators, payors) in planning and communication
- Keep an active forum for dialogue and partner with the state agencies regulating policies
- Circumstances will come up that are not explicitly predetermined in existing regulations that need to be worked out together
- Ongoing guidance and clarification is necessary to ease the transition



Stakeholders



- NY has over 700 well-established HCBS waiver providers with a strong history of supporting individuals and circles of support
 - Change management is ongoing and adds time to this process
- No interruption to billing
- Concern over compliance
- Adapting to new ways of doing things
- It's not just care management and CCOs
 - For example, providers not accepting plans

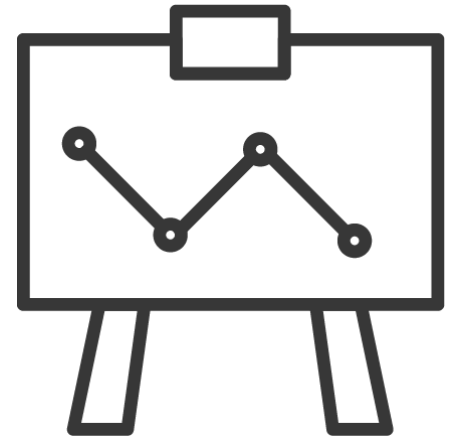
Lessons Learned: Technology

- Security Requirements
- Internet Connectivity
- Pilot to help with learning and fine tuning the end solution
- Have a troubleshooting team on standby
- Be prepared for disruption and a learning curve to get to the 'new norm'
- Allow adequate time for testing
- Communicate frequently, but also target communication for needed information to the right people
- Cultural Competencies
- Having a vendor that is a subject matter expert on core program functions



Lessons Learned: Training

- Change management needs to be an active and ongoing undertaking
- Be flexible during times of change and keep an eye towards getting to the future goal
- Be prepared for disruption and a learning curve to get to the 'new norm'
- Provide educational resources for individuals, care management staff, provider staff, and families



ACA Staff Onboarding and Training

- 1 Values, Person Centeredness & Communication
- 2 Building Relationships and Establishing Communication within Care Coordination Team & Among Providers
- 3 Promoting Community Orientation
- 4 Cultural Competency
- 5 Knowledge of Developmental Disabilities, Chronic Disease & Social Determinants of Health
- 6 Knowledge of Community Supports and Services, New Models of Care, and Healthcare Trends
- 7 Understanding Ethics & Professional Boundaries
- 8 Promoting Quality Improvement
- 9 Understanding Health Information Technology
- 10 Proficiency in Documentation & Confidentiality

ANNUAL

- PRAISE
- Tuberculosis
- Fire Safety
- Personal Allowance, training presented by OPWDD
- Benefits & Entitlement, training presented by OPWDD
 - Medicaid
 - Medicare
 - Social Security
 - Supplemental Security Income

ONCE

- Foundations of OPWDD
- Prevention of Choking and Aspiration

AS NEEDED

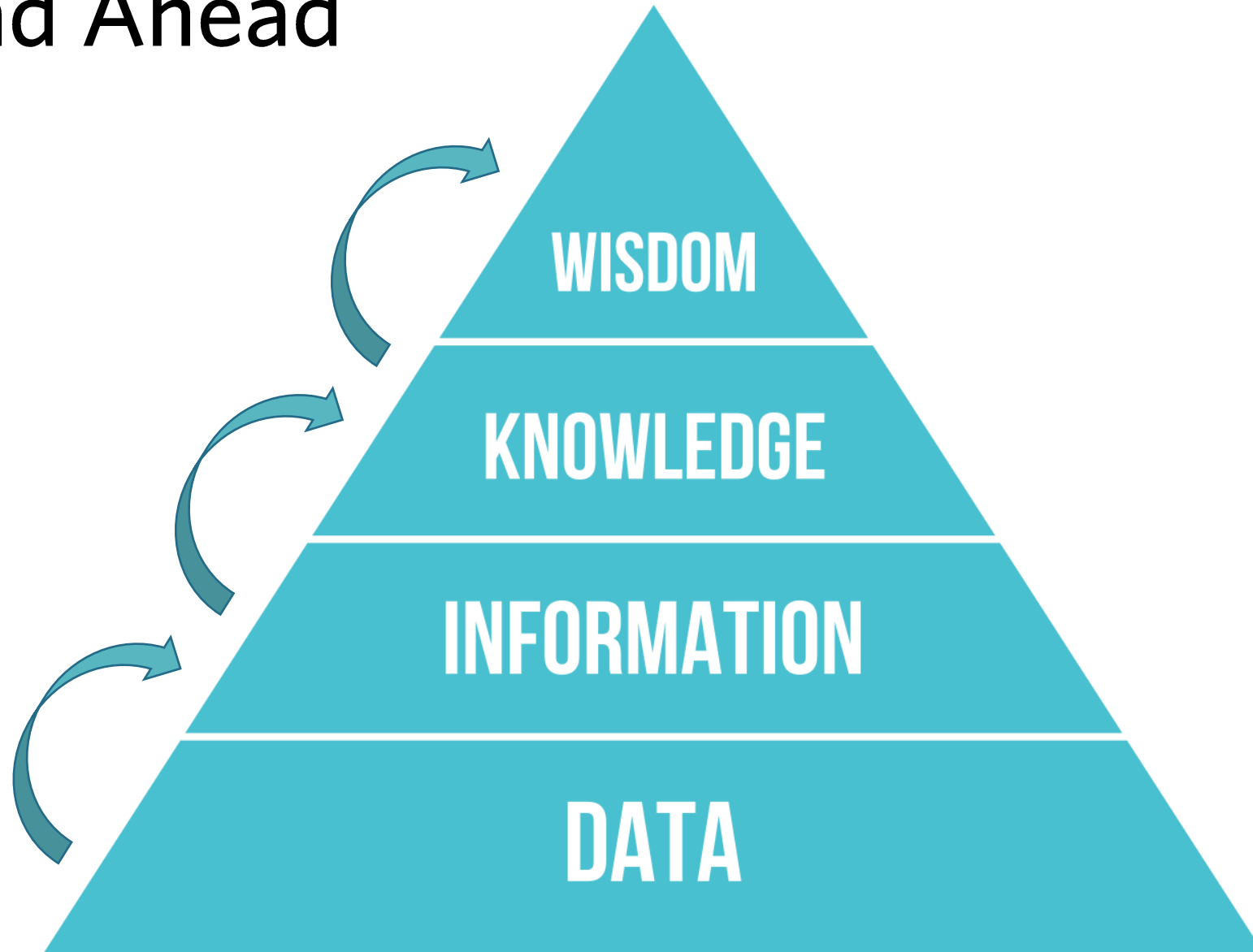
- Overview of Services for Willowbrook Class Members, training presented by OPWDD

EVERY 3 YEARS OR WITH REGULATORY CHANGES

- Supplemental Nutrition Assistance Program - SNAP, training presented by OPWDD
- Liability For Services Trainings, training presented by OPWDD



The Road Ahead



The Road Ahead

Strategies ACA is looking towards in the next quarters:

- Utilize RHIO alerts to improve linkages to Primary Care Physicians
- Use the data collected during the first year to establish a baseline upon which we can conduct CQI projects
- Access additional sources such as claims data to get to know our population even better and improve the quality of services



THANK YOU QUESTIONS?

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