Care Coordination for Individuals with Intellectual and Developmental Disabilities

TIP SHEET

WHAT IS IT?

Individuals with intellectual and developmental disabilities who are eligible, receive supports and services from The Office for People With Developmental Disabilities often called OPWDD. Coordination of these services is one of the supports.

Care Coordination Organizations (CCO's) coordinate both home and community based services for individuals with disabilities as well as health and wellness services. New York State, in support of a Federal mandate, has directed this initiative in an effort to ensure that the agencies providing direct services to individuals do not also provide the service coordination.

WHO DOES IT AFFECT?

Prior to July 1, 2018 services were provided by Medicaid Service Coordinators (MSC's). After July 1 st services will be provided by Care Coordination Organizations. The professionals who coordinate services will no longer work for the agencies that provide services. Each organization may have different titles for these individuals such as Care Coordinator or Care Manager of Health Home Care Manager. Their titles may be different but the roles are the same.

This person will assist with:

- Coordination of Services across systems which includes OPWDD related services for individuals with intellectual or developmental disabilities, behavioral health services and medical services.
- Development, Monitoring and Updating the Life Plan (previously known as an Individualized Service Plan or ISP)
- Linkage, Referral and Advocacy for services and supports
- Life transitions such as high school to adult services, hospitalization to discharge, and more.

WHAT SHOULD YOU DO NEXT?

If not already connected with a Care Coordination Organization, the individual or caregiver must complete the enrollment form and choose a Care Coordination Organization you want to work with. There are two levels of support. For those with high needs the Basic Home and Community Based Serves Plan of Support provides comprehensive care management. The Health Home Care Management Plan develops and monitors a care plan.

PARENT NETWORK OF WESTERN NEW YORK
includenyc Love, equity, and access for young people with disabilities
STARBRIDGE For the Hope and the How
NYS Transition Partners, an RSA-funded Parent Information Center

Care Coordination for Individuals with Intellectual and Developmental Disabilities

TIP SHEET

WHAT SHOULD YOU DO NEXT? (CONT.)

Health Home Care Management vs. Basic HCBS Plan Support	Health Home Care management	Basic HCBS Plan Support
Develops Care Plan and Reviews Bi-Annually	✓	✓
Monitors Health and Safety	✓	✓
Coordinated Access to Behavioral Health Services	✓	
Coordinated Access to Medical and Dental Services	✓	
Identifies Community-Based Resources	✓	
Uses Technology to Link Your Services	✓	
Connects Your Care Providers	✓	
Takes Burden of Navigating Systems from Families and Individuals	✓	
Anticipates Future Needs	✓	

The new responsibilities of the coordinator should lessen the difficulties individuals and families face as they navigate across systems and organizations. Access to electronic records will also be available to individuals and families.