connections

HEALTH NETWORK

CHOICES MADE **EASY**

Strategy for DISCO Program

- Goals
  - Administrative Simplification
  - Financial Integration
  - Habilitative Model consistent with DOH's "Care Management for All" approach

Objectives

- Plans of Scale
- Person-centered focus
- Coordinated Care
- Quality
- Compliant
- Service

Mission Statement

CONNECTIONS HEALTH NETWORK, an affiliate of NYSARC, Inc., is dedicated to managing and coordinating lifelong, person-centered supports and services that promote health, independence and community participation for all, particularly people with intellectual and other developmental disabilities.

- **Connections Health Network** is committed to the highest standards of excellence in care coordination, service design and delivery.
- **Connections Health Network** delivers quality supports and services efficiently through a network of systems, providers, and care managers on behalf of our Members.
- **Connections Health Network** is developed to individually tailor supports and services which promote positive outcomes – meeting aspirations in every aspect of life for all Members we serve.
- **Connections Health Network** maximizes the quality of life, health and independence for people with intellectual and other developmental disabilities through advocacy for and access to supports, services and other resources that foster the unique growth and development of every network Member

CHN Member Benefits

- Fosters Member independence
- Provides self-direction and individualized budgeting
- Promotes person-centered planning
- Encourages competitive employment/volunteerism
- Provides Members, their families and caregivers with greater flexibility in meeting health and long-term care needs
- Offers greater menu of available supports and services
- Assists in improving or delaying declines in Member's health status
- Better coordinates Medicaid benefits and expenditures for covered services

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Managing CHANGE

Managing CHOICES

Supports and Services

OPWDD Services

CURRENT SERVICES

- **Voluntary operated OPWDD Waiver Services, including:**
  Residential Services, Day Habilitation, Supported Employment
- **Voluntary operated Day Treatment**
- **Voluntary operated Intermediate Care Facilities (ICF/MR)**
- **Clinical Services, limited to:**
  Occupational Therapy, Physical Therapy, Speech & Language Pathology, Clinical Social Work, Psychology, Nutrition, Rehab Counseling, Podiatry, and Dentistry, Care Management and Coordination

Supports and Services

DOH Services

NEW SERVICES

- Adult Day Health
- Assisted Living Facility
- Dentistry
- DME and Hearing Aides
- Home Health Care, including: Nursing Care, Home Health Aides, PT, OT, Speech, Medical Social Services, Home-Delivered Congregate Meals, Social Day Care
- Non Emergency Transportation
- Optometry/Eye glasses
- OT, PT, SLP
- Personal Care
- Personal Emergency Response System (PERS)
- Private Duty Nursing Services
- Psychology/Clinical Social Work
- Respiratory Therapy
- Skilled Nursing Facility

Supports and Services

OMH/OASAS Services

NEW SERVICES

- OASAS inpatient
- OMH Institutional Program (PC/RTF) & private psychiatric hospitalizations
- Psychology and Clinical Social Work
- OMH Day Treatment
- Personalized Oriented Recovery Services (PROS)

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Model of Care

Model of Care (cont'd)

- Built on a "person-centered planning" service philosophy.
- Provides an integrated multi-faceted care management program across all service continuums which are "high touch" and collaborative.
- Designed to recognize strengths of NYSARC system (resources, programs and staff) while enhancing use of proven, outcome-based care management measures to meet an individual's goals.
- Each CHN Member is assigned a dedicated Care Manager who proactively works to promote a person-centered, goal-oriented plan.
- Each CHN Member's family, advocate(s), caregiver(s), and providers are integral to the development of support services and care plan.

Model of Care (cont'd)

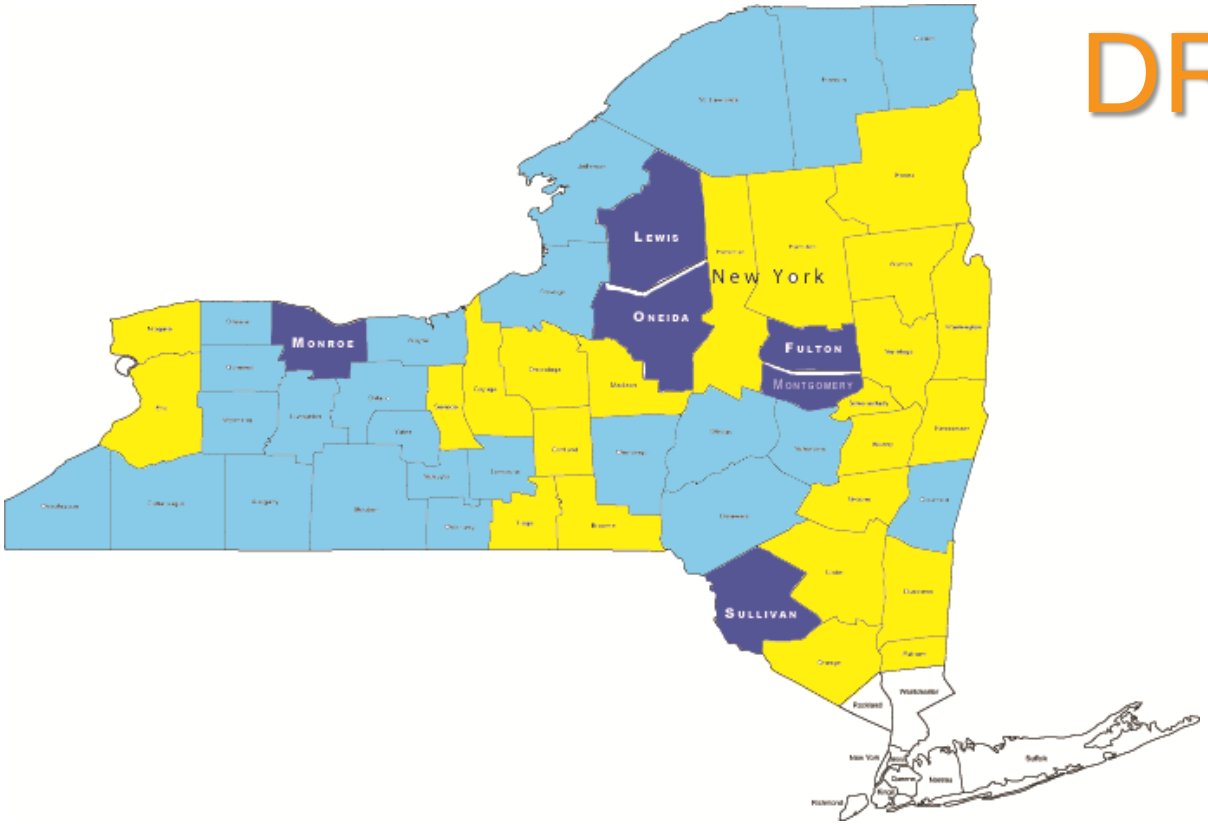
- CHN has developed a new Service position to meet requirements noted by NYS for program transformation:
  - Requires extensive experience & working knowledge of I/DD population
  - Be a Plan-trained active member of Care Planning Team
  - Will manage subsets of members who require enhanced planning, coordination and referral to supports and services
- Support & Services Care Plans are inclusive of: habilitative, health, social, community, and psychological assessments
- CHN Member is contacted for support every 6 weeks, on average
- CHN Member receives an home visit once every 3 months, on average

Elderplan MCO

- Line of business Elderplan has formed to provide administrative services to other managed care plans
- Elderplan will provide CHN with administrative infrastructure and managed care applications
- Systems and processes are designed for compliance with current MLTC and Medicare regulations, and preparations for FIDA underway
- Offers CHN the ability to rapidly launch, grow and scale an established partner

CHN Future Service Areas

DRAFT



Initial Service Area

2014 Expansion

2015 Expansion