CCO PROTOCOL FOR IDENTIFICATION AND PRIORITIZATION OF INDIVIDUALS WITH HIGH MEDICAL, SUPPORT, OR RESOURCE NEEDS

OVERVIEW

Care Coordination Organizations (CCOs) are committed to the delivery of high-quality comprehensive care coordination during this time of public health emergency. The CCO's will work in collaboration with OPWDD providers, medical providers, mental health providers and community resources, to ensure all members receive needed supports, services and resources necessary to maintain health and wellbeing. Thorough and on-going contact with all members, including those receiving Basic HCBS Services, to assess risk level and support/service needs is an essential component of comprehensive care coordination during this time. Care Managers will initiate contact with all members, including those in Basic level service, for the purposes of screening for risk factors and coordinating supports and services.

Some members may be at increased risk of serious illness due to COVID-19, or at risk of not obtaining or maintaining necessary services and supports that ensure their health and wellbeing. These members will be identified by the CCO; a protocol will be implemented to ensure increased frequency of contact from a Care Manager that is sufficient to address the member's health and safety needs. The member has the right to refuse an increase of frequency of contact with care manager, if so, the Care Manager will document the declination of increased supports.

In situations where a member has emergent or urgent needs, an in-person contact may be necessary by the Care Manager, local authorities or emergency personnel. CCOs will ensure precautions will be employed for the safety of both the member and the care management staff responding to the situation.

CRITERIA FOR IDENTIFICATION OF MEMBERS WITH HIGH NEEDS

For members who live in the community, presenting with the risk factors identified below, Care Managers will assure a frequency of contact sufficient to keep the member healthy and safe. The Care Manager will assess needs, health, and overall status through the use of a specific assessment tool to track and document any changes and identify any increased needs in key areas related to the health and safety of the member.

Risk Factors:

- **Medical Risk** – People who may be at increased risk for serious illness from COVID-19
  - Blood disorders (e.g., sickle cell disease or on blood thinners)
  - Chronic kidney disease as defined by your doctor. Patient has been told to avoid or reduce the dose of medications because kidney disease, or is under treatment for kidney disease, including receiving dialysis
  - Chronic liver disease as defined by your doctor. (e.g., cirrhosis, chronic hepatitis) Patient has been told to avoid or reduce the dose of medications because liver disease or is under treatment for liver disease
  - Compromised immune system (immunosuppression) (e.g., seeing a doctor for cancer and treatment such as chemotherapy or radiation, received an organ or bone marrow transplant, taking high doses of corticosteroids or other immunosuppressant medications, HIV or AIDS)
  - Current/Recent pregnancy
  - Endocrine disorders (e.g., diabetes mellitus)
  - Metabolic disorders (such as inherited metabolic disorders and mitochondrial disorders)
  - Heart disease (such as congenital heart disease, congestive heart failure and coronary artery disease)
  - Lung disease including asthma or chronic obstructive pulmonary disease (chronic bronchitis or emphysema) or other chronic conditions associated with impaired lung function or that require home oxygen
  - Neurological disorder diagnosis of stroke, epilepsy or cerebral palsy
  - Age 65 and older

- **Support Risk** – Supports/Services to maintain health and safety
  - OPWDD Waiver Services/Supports
    - Temporary reduction/disruption/suspension in any waiver provider services which effects health and safety of the person.
  - Medical/Health/Community Supports
    - Temporary reduction/disruption/suspension of in-home, non-waiver, services which effects health and safety of the person.
    - Medical/physical condition requires out of home care (examples: physical therapy, occupational therapy, wound care needs)
  - Natural/Family Support
    - Aging or failing health of caregiver/no alternative available
    - Homeless or in imminent danger of being so/Transient living environment
    - Abusive or neglectful situation constituting imminent risk of harm

- **Resource Risk** – Provisions/Supplies to maintain health and safety
  - Limited access to essential supports
    - Medication or oxygen/oxygen supplies
    - Medical supplies
    - Food
    - Transportation which effects health and safety of the person
    - Necessary provisions and supplies

CRITERIA THAT MAY TRIGGER IN PERSON CONTACT WITH MEMBER OR ENGAGEMENT WITH LOCAL AUTHORITIES OR EMERGENCY PERSONNEL

- Individuals who live in the community, have already identified risk factors, are absent natural supports and where we have not been able to make contact via telephone or video conferencing.
- Urgent or Emergency situations which effects the health and safety of the person where there are no natural or other supports available to meet the needs of the person will be evaluated on a case-by-case basis and approved via the protocols established by each CCO.

Prior to conducting an in-person visit, the care manager will screen the member, in accordance with CDC guidance. If the member screens positive, the care manager will coordinate with the member and appropriate health care providers to ensure that the member is referred to the appropriate medical personnel.

Care Coordination Organizations will ensure that Care Managers are screened, prior to conducting an in-person visit for symptoms or contacts that might have put them at risk.