



CCO and Provider Partnership Meeting Minutes

March 2026

Mission Statement: Connect people to the care, support, and opportunities that maximize their quality of life.

Vision: A community where all people lead fulfilling lives.

Core Values: People, Integrity, and Trust

Partnership Purpose: A group of Provider and CCO professionals that work together to improve processes and deliver high quality services for individuals and families with I/DD.

CCO Liaison:

I. Clinical Conversations

- **Guest Speaker: Katie Reed, Clinical Team Nurse Manager**
- Review of new resource document shared by clinical; included in meeting minutes
- Discussions around barriers that we are seeing from our end, and how we can collaborate further with agencies to create a more streamlined process for our members
- Review of what the clinical teams role in supporting members and Care Coordinators is

II. Updates

- CAS/CANs information will begin being sent to points of contact in April 2026
 - This will include information for mutually supported members that have a CAS/CANs coming up
 - Life Plan invitations will no longer be sent via the physical document; if a member or their family prefers this method, we can accommodate, but providers will no longer be receiving a physical document
 - Reminder that if you are aware that a meeting should be coming up and have not received an outlook calendar invite from the Care Coordinator, connect with them to request it
- Request to providers: If there are changes to points of contact within the agency, please let Provider Relations know so that we can update the information internally

III. Internal Staffing Updates

- Rochester & Eastern Region
 - Emily Klotz is the new Associate Vice President of Care Coordination for the Rochester area
 - Oversee: Elizabeth Klepes, Melissa Hartwell, Michele Lowes, Nayithe Jalowayski
 - Melissa Hartwell has been hired as the new Local Director in Rochester, filling Emily Klotz's previous role
- Southern Tier

- Jennifer Clark is now the Associate Vice President of the Southern Tier region
 - Oversee: Ardeen Rigerman-Raglan, Carrie Strawder, Kila Cook, Scott Estee, Stanly Johns
- Western Region
- Diane Kauffman will now be reporting to Shanua Parkinson and will be a part of the Western region
- Cathy Varano is our new Chief Administrative Officer

IV. Reminders

- Incident reporting
- Care Coordinators are required to make note of the Justice Center confirmation number when there is notice made to them that an incident has been filed, if the Justice Center number can not be provided the Care Coordinator will be calling them to confirm that the call was made
- Conversations with Care Coordinators
- When Care Coordinators are conducting their outreach, we ask that there be more in-depth responses to update questions to assist with the Life Plan preparation process and to monitor the member's goals, supports, needs, etc.
- Life Plan draft & the purpose
- If you are receiving the draft, please ensure that the information and changes are being send to the Care Coordinators prior to the meeting, or are brought to the Life Plan meeting; this is to avoid any delays in getting the Life Plan sent for finalization and to create a more person-centered meeting for the member

V. Section 5 Discussion

- Review of the section 5 requirements
- Providers: Are there specifics that your agency requests for contacts to be listed?
 - Are they requirements, or preferences?

VI. Operations Updates

- Reminder that the Single Point of Contact (SPOC) is used for Life Plans that are **finalized – if the plan has not been finalized, contact should be with Care Coordinator**
 - If you are in the Portal, you can check who the current Care Coordinator is and if the plan has been finalized; if the plan is not visible in the Portal, it has not been finalized
 - If you are not in the Portal and the plan is past the 45 days, connect with the Care Coordinator first before connecting with the SPOC – escalate to Supervisor as needed
- Clarification on documentation upload timeframe
 - If you are uploading to the Portal, there is no time delay post-Life Plan meeting to upload
 - If you are not uploading to the portal, we are still requiring the time delay post-Life Plan meeting to send documents to the SPOC
 - This is to be mindful of the inflow of documents and e-mails to the SPOC e-mail inbox

- Distribution of Life Plan from Single Point of Contact can take up to 7 business days
- If Portal access is available, best practice is to gather Life Plan from Portal
- Addendum requests for Portal users
 - If you are signing in the Portal are required an addendum, connect with the Life Plan SPOC to request the addendum
- If you receive a Life Plan for a service that you are no longer providing, let the SPOC know and they will connect with the CC to remove the service in section 4
 - Please also confirm that the DDP1 was completed to remove the services in CHOICES, as we are now pulling authorizations from DDP1 dates

VII. Provider Portal

- Portal Flow
 - Portal Account
 - a. If you have an account and are having any issues such as:
 1. Unable to sign a Life Plan
 2. Unable to view a member and or/a member is on your account that should not be
 3. Unable to access your account
 4. Unable to upload a document and/or a document has been uploaded incorrectly
 - Life Plan SPOC
 - a. Requesting an addendum
 - b. A Life Plan is finalized and you are waiting on distribution
 - c. Sending Life Plan supporting documents
 - Care Coordinator
 - a. Portal User – If the plan is not visible in the Portal and is either approaching or past the 45th day to get an update on the status
 - b. Non-Portal User – If the plan is approaching or past the 45th day and you have not yet received the finalized copy from our SPOC
 - Provider Relations
 - a. You are unaware of who your portal liaison is
 - b. You are looking to attend a portal walkthrough training
 - c. You are not in the portal, and are looking for Care Coordinator contact information
 - d. Looking to escalate a situation

VIII. Agency Openings

- Content analytics from our agency openings page housed internally have been trending positively since the beginning of this process
- If you have openings you'd like to share with Care Coordination, send to Provider Relations before the last day of the month to be included in the following month

IX. Agency/Provider Relations 1:1 Meetings

- Provider relations and/or local directors are available to meet 1:1 with agencies per request
- Focus on agency specific concerns, process improvements between agencies and person Centered Services
- Smaller group to openly discuss concerns / positive feedback /etc., that may not be appropriate for larger meetings

East / Southern Tier: Katelyn Luke-Moore

klukemoore@personcenteredservices.com

Cayuga, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates

West / Southern Tier: Maria Kirkpatrick

mkirkpatrick@personcenteredservices.com

Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming

X. Additional Information and Resources

- Service Announcement Reminder: [Service Announcements - Person Centered Services](#)
 - If you have any upcoming events you would like Care Coordination to be aware of, please complete the service announcement form
 - If you have an additional attachment, e-mail Provider Relations: providerrelations@personcenteredservices.com

XI. Community Resource Tool: [Community Resource Tool - Person Centered Services](#) has transitioned to the Disability Services NY: [Services for Intellectual and Developmental Disabilities in NY State | Disability Services NY Directory](#)

- A tool that assists in your search for day programming, employment support, or other resources for people with intellectual and developmental disabilities
- You can find opportunities in your region by using the **DSNY**
- If you have any questions, concerns or notice that something does not look right for you, please contact us at providerrelations@personcenteredservices.com



Health Home Care Coordination Basics for Providers and Working with Our Clinical Team

What is a health home?

A "health home" is not a geographic or physical place. It is a group of health care and service providers (interdisciplinary team) working together to ensure people get the care and services they need to stay healthy.

Health homes are about the whole person and supporting or linking people to the services and supports to assist with all areas of their life — not just OPWDD service providers and not just health care services.

How did we get here?

Beginning July 1st, 2018 there was a transition from Medicaid Service Coordination (MSC) to Health Home Care Coordination (HH/CCO).

This transition was part of the Medicaid Redesign Plan by New York State with the aim of preparing the Office for People with Developmental Disabilities (OPWDD) service delivery system for the overall transition to Managed Care and ensuring conflict-free care management.

How is this relevant to working with nursing teams?

Working under a health home requires Care Coordinators to maintain a complete record of the person to ensure that all health-related outcomes are being met. This requires communication, collaboration, and an understanding of each team member's role in the mutually supported person's care.

At Person Centered Services, we have a team of Clinicians, Criminal Justice Specialists, and Social Determinants of Health Specialists who work alongside Care Coordinators to assess and review documents and records related to the person's needs. These specialists may reach out with a request for additional information when there are complex needs being addressed.

It is important that all team members have an understanding of the role of the Clinical team to prevent any barriers or delays in the person receiving the care and support they need to maintain their health and safety.

How can we work together to remove barriers and bridge gaps?

Familiarize your teams with our Clinical staff, so that when a member from our Clinical team reaches out, your staff are well-equipped to understand the purpose of the communication and we can work together.

When there is staff turn-over, share this information with new staff coming in so they are prepared for any incoming contact from our Clinical team.

If possible, have a prepared contact from your staff that can be shared with our Clinical team in the event that additional level of support is needed.

Clinical Leadership Contact Information

Jennifer Allen, Clinical Team Director | jallen@personcenteredservices.com | 716-331-0435

Katie Reed, Clinical Team Nurse Manager | kreed@personcenteredservices.com | 585-689-7234

Kristen Janik, Manager, Behavioral Health | kjanik@personcenteredservices.com | 716-225-3762

