

# MSC E-VISORY

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State of New York Office for People With Developmental Disabilities  
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Distributed by: Division of Person-Centered Supports  
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The MSC E-Visory is an electronic advisory which provides pertinent and timely information about programs and services available to individuals receiving MSC. Announcements about MSC training, conferences and meetings appear regularly. **MSC Supervisors: Please share this issue with all MSC Service Coordinators and others as appropriate.** In order to receive an email notification when a new MSC E-Visory is posted, please sign up for our mailing list (listserv). Listserv information and past issues can be accessed via the following link:  
[http://www.opwdd.ny.gov/wt/publications/wt\\_publications\\_mscevisories\\_index.jsp](http://www.opwdd.ny.gov/wt/publications/wt_publications_mscevisories_index.jsp)

## In This Issue:

### Revised Guidance: Ongoing and Comprehensive Need for Medicaid Service Coordination

Attached to this e-visory is a revised version of the Ongoing and Comprehensive Guidance that was issued on March 13, 2012. This revision, dated March 16, 2012, includes the following important statement regarding the rights of Willowbrook Class Members:

*Willowbrook Class Members are deemed to be in need of ongoing and comprehensive service coordination as a result of the findings, rights and obligations set forth in the Permanent Injunction dated March 11, 1993. The following assessment process does not apply to class members who seek enrollment or continued participation in MSC.*

Any questions regarding this guidance may be directed to Eric Pasternak, OPWDD Division of Person-Centered Supports at 518-474-1274 or [eric.pasternak@opwdd.ny.gov](mailto:eric.pasternak@opwdd.ny.gov)

### National Core Indicators

As a result of participating in the National Core Indicators (NCI) project for the fifth year, OPWDD will be interviewing approximately 2,000 individuals statewide using an Adult Consumer Survey to learn more about system-wide performance on various indicators, and individual satisfaction with services and supports. The purpose of this E-Visory is to inform Medicaid Service Coordination providers of survey activities that their service coordinators are being asked to assist with. Service coordinators will be providing OPWDD with contact and demographic information regarding some individuals on their caseload.

Some service coordinators will receive a **Pre-Survey and Background Information** form to complete on behalf of one of the individuals they serve. Not all service coordinators will be asked to participate because the sample size is 2,000 for the survey year 2011-2012. Not all will require the assistance of the service coordinator. In fact, only a small percentage of service coordinators will receive this request from OPWDD. Even if a service coordinator is asked to participate, it is likely they will only be responding on behalf of one or two people. Thus the workload related to this project is very small for service coordinators and providers.

Attached is a document that answers frequently asked questions about NCI that service coordinators might have. Even though only a small percentage of service coordinators will be affected, please share this with all service coordinators so they will understand what NCI is about should they be contacted for assistance.



## What does the Need for “Ongoing and Comprehensive” Service Coordination Mean?

To receive Medicaid Service Coordination a person must demonstrate that they have a need for ongoing and comprehensive service coordination. The following information provides clarification on what is meant by “ongoing and comprehensive” and is to be used as a guide in determining whether a particular individual meets that need. Also included in this guidance is a worksheet that may be used to assist when making such a determination.

Note: Willowbrook Class Members are deemed to be in need of ongoing and comprehensive service coordination as a result of the findings, rights and obligations set forth in the Permanent Injunction dated March 11, 1993. The following assessment process does not apply to class members who seek enrollment or continued participation in MSC.

1. The person’s need for service coordination is clearly ongoing and not episodic.
  - MSC is not to be used solely for establishing eligibility for the HCBS Waiver in order to obtain Medicaid.
  - The individual requesting services does not already have their needs met through natural and other supports already in place.
  - The person has needs that are so significant as to need the ongoing assistance of a service coordinator to maintain/prevent setbacks that are likely to result in crisis or the need for higher level services or the loss of necessary supports and services.
  
2. The person’s need for service coordination is “comprehensive”, meaning all inclusive or covering widely. This means that the person demonstrates at least one of the following:
  - Unmet needs in multiple areas or life domains in which the assistance of a service coordinator is necessary.
  - Health and safety or the person’s general well-being would potentially be jeopardized if not for the ongoing interventions, monitoring, advocacy and assistance specifically provided by the service coordinator.
  - Major life changes or changes in the person’s daily life activities that have occurred over the last six months or are likely to occur within the next 12-18 months.
  - Reconfiguration of services that have occurred over the last six months or are likely to occur within the next 12-18 months.

Examples of reconfigured services and/or major life/daily life activity changes include but are not limited to: valued outcomes that indicate movement from a certified residence to one’s own home or apartment; seeking to obtain employment; and transitioning to more individualized self-directed services.

3. The ongoing assistance of a service coordinator is necessary for the timely and effective arrangement of needed services/supports (including health and safety related

services/supports and monitoring/advocacy) and helping to sustain those services/supports and/or the ability to explore services/supports that will likely result in more individualized and less restrictive services/support options. This ongoing assistance is facilitated through activities associated with: (a) plan development, **AND** (b) plan implementation, **AND** (c) plan maintenance and monitoring.

- This means that it is likely that the service coordinator can successfully assist the person with their ongoing and comprehensive needs within a reasonable period of time by developing, implementing, and monitoring/maintaining the plan of care and arranging for service linkages for the person and providing other allowable service coordination interventions/actions (assessment, service plan development, implementation, monitoring, maintenance, referrals and linkages, and advocacy).
- This can also mean that the person needs the relationship, ongoing assistance, and encouragement provided by a service coordinator to be challenged to think about and explore more individualized and/or less restrictive service options (e.g., moving out of a certified residence) that they may not have ever considered in the absence of this relationship and ongoing communication with their service coordinator. These interactions and discussions must be clearly documented in the service coordination record.
- The service coordination records need to clearly indicate that without specific identified service coordination interventions, the person would be prevented from accessing and maintaining needed community resources necessary for health, safety, community integration, and quality of life and therefore health services, residential placement, and other needed supports/services would be in jeopardy and regression would occur or the person would be prevented from exploring options that would enable them to live a meaningful life.

#### **Expectations for Ongoing and Comprehensive Service Coordination:**

- Over time, through the ongoing and comprehensive service planning process, the service coordination records should show that unmet needs become met needs as a result of service coordination activities.
- Over time, a person's valued outcomes and service configurations will likely show changes due to the ongoing and comprehensive planning and implementation work between the person and their service coordinator.
- When individuals are already enrolled in MSC, if the service coordination records do not show any changes to valued outcomes and corresponding supports and services within a reasonable amount of time (e.g., such as 12-18 months) and/or there is no other indications in the service coordination records that indicate that progress is being made or that demonstrates that the service coordination staff interventions/activities are helping to sustain the person in his/her community or are otherwise, useful and not duplicative of what other services and supports are required to provide and/or what parents of minor children are reasonably expected to provide (e.g., health monitoring in 24 hour certified settings; for minor children under the age of 18, parents should be monitoring that routine health services are obtained/received), it can be reasonably assumed that the ongoing assistance of a service coordinator is not necessary.
- Individuals who are waiver enrolled and who are no longer eligible for MSC will be withdrawn from MSC and transferred to Plan of Care Support Services (PCSS). All withdrawals from MSC must be carried out in accordance with due process procedures as outlined in the MSC Vendor Manual.



## Medicaid Service Coordination (MSC) Assessment of the Need for Ongoing and Comprehensive Service Coordination

This worksheet may be used to assist in making the determination as to whether a person meets the need for ongoing and comprehensive service coordination. Complete the following items and the accompanying checklist.

Name of Individual: \_\_\_\_\_

**1. Identify all services and supports the person currently receives.**

	Current Services/Supports Received	Funding Source	Describe how the person currently accesses these services, i.e. who helps the person obtain/maintain these services?
1.			
2.			
3.			
4.			
5.			

**2. Identify the person's unmet needs for which the assistance of a service coordinator is necessary. For each unmet need describe anticipated actions by the service coordinator that will assist the person to meet this need, and the anticipated timeframe that is likely for this need to be met (in months).**

	Unmet Need	Service Coordinator Actions	Time Frame
1.			
2.			
3.			
4.			
5.			

**3. Clearly describe potential and/or likely consequences/implications for the individual if they were to not receive MSC.**

	Yes	No
<p>1. Is the person's need for service coordination clearly ongoing and not episodic in nature?</p> <p>MSC is not to be used solely to establish eligibility for HCBS Waiver services to obtain Medicaid. The individual requesting services does not already have their needs met through natural or other supports that are already in place.</p>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the person's need for service coordination comprehensive?		
a. Does the person exhibit unmet needs in multiple areas or life domains?	<input type="checkbox"/>	<input type="checkbox"/>
b. Are the person's needs so significant as to need the ongoing assistance of a service coordinator to maintain/prevent setbacks that are likely to result in crisis or the need for higher level services or the loss of necessary supports and services if not for the interventions and assistance specifically provided by the service coordinator?	<input type="checkbox"/>	<input type="checkbox"/>
c. Would the person's health and safety or general well-being be potentially jeopardized if not for the <u>ongoing</u> interventions, monitoring, advocacy and assistance specifically provided by the service coordinator?	<input type="checkbox"/>	<input type="checkbox"/>
d. Has the person experienced major life changes or changes in daily life activities that have occurred over the last six months or are anticipated in the next 12-18 months?	<input type="checkbox"/>	<input type="checkbox"/>
e. Has the person experienced a reconfiguration of services over the last six months or is a reconfiguration of services anticipated in the next 12-18 months?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the ongoing assistance of a service coordinator necessary for the timely and effective arrangement of needed services/supports and helping to sustain those services/supports and/or the ability to explore services/supports that will likely result in more individualized and less restrictive services/support options?		
a. Is it likely that the service coordinator can successfully assist the person with their ongoing and comprehensive needs within a reasonable period of time by performing allowable service coordination functions?	<input type="checkbox"/>	<input type="checkbox"/>
b. Does the person need the relationship, ongoing assistance, and encouragement provided by a service coordinator to be challenged to think about and explore more individualized and/or less restrictive service options?	<input type="checkbox"/>	<input type="checkbox"/>
c. In the absence of service coordination, would the person be prevented from accessing and maintaining needed community resources necessary for health, safety, community integration, and quality of life and therefore health services, residential placement, and other needed supports/services would be in jeopardy and regression would occur or the person would be prevented from exploring options that would enable them to live a meaningful life?	<input type="checkbox"/>	<input type="checkbox"/>

The individual meets the need for ongoing and comprehensive service coordination if:

- The answer to 1 is yes.  
**AND**
- At least one yes in a-e for number 2.  
**AND**
- At least one yes in a-c for number 3.

Indicate whether the individual meets the need for ongoing and comprehensive service coordination?	
Yes <input type="checkbox"/>	No <input type="checkbox"/>

Completed by: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Agency: \_\_\_\_\_

## National Core Indicators:

### **Frequently Asked Questions from Service Coordinators**

#### **1. What are the National Core Indicators?**

The National Core Indicators (NCI) project is a collaboration among participating National Association of State Directors of Developmental Disability Services (NASDDDS) member state agencies and the Human Services Research Institute (HSRI). The aim of the initiative is to develop nationally recognized performance and outcome indicators that will enable developmental disabilities policy makers to benchmark the performance of their state against the performance of other states. NCI also enables each participating state developmental disabilities agency to track system performance and outcomes from year to year on a consistent basis.

As a result of participating in the project, states have created performance monitoring systems, identified common performance indicators, worked out comparable data collection strategies, and shared results. Many of the state agencies use NCI as a key component within their quality management systems. This multi-state collaborative effort to improve performance is unprecedented.

#### **2. How is NYS participation in NCI going to benefit individuals with developmental disabilities?**

One of the key data collection tools that OPWDD will utilize is the Adult Consumer Survey. The Adult Consumer Survey asks individuals questions about their satisfaction with home, health, work, staff, service access, relationships, safety, choice, and community inclusion. Based on the input provided by people with developmental disabilities, OPWDD will assess how well the developmental disability service delivery system is meeting individual needs. By participating in NCI, OPWDD hopes to forward its mission of "Putting People First" and create a quality management system that is person-centered.

#### **3. What is the role of the Medicaid Service Coordinator (MSC)?**

Medicaid Service Coordinators will contact the individuals to let them know that they have been selected to participate in a survey conducted by OPWDD and that an interviewer will contact them to schedule a face-to-face interview. Service coordinators also have the very important role of completing the **NCI Pre-Survey and Background Information** forms, in order to assist the DDSO staff to schedule and perform the interviews. Service coordinators may provide interviewers with ongoing assistance if there are challenges contacting individuals or if there is additional information needed. Service coordinators will NOT be doing the interviews.

#### **4. What will the MSC receive from the DDSO?**

1. Pre-Survey and Background Information Forms
2. The return address of the DDSO NCI Liaison
3. A letter introducing the NCI Project
4. Instructions for completing the Pre-Survey and Background Information

## **5. What do service coordinators do once they receive the Pre-Survey and Background Information?**

Service coordinators should first read through the instructions and look over the documents they received from the DDSO to ensure their packet is complete. Then the service coordinators can begin answering the questions in the **Pre-Survey and Background Information** forms. Most questions request contact information or demographic information about the individual being served. Many service coordinators will be able to answer the questions based on their knowledge of the person and information contained in the MSC record. **Service Coordinators should review and answer every question in only the Pre-Survey and Background Information document. Please do not leave blanks.** As previously stated, not all service coordinators will be asked to participate in this project, and it is anticipated this activity will take less than an hour to complete.

The DDSO will have entered the name of the person and TABS ID into the **Pre-Survey and Background Information** form. The Pre-Survey section contains the name of the individual on page 4. The survey code will be found on page 9, at the beginning of the **Background Information** section.

## **6. What if there is a question that I don't understand or if I'm not sure what to do?**

First ask your supervisor for some direction. He or she might be able to help you find the information you need to complete the questions. You can also contact your DDSO NCI Liaison for assistance or clarification. For some questions you may have to contact other staff who provide services to the individual. For example, to complete questions about employment and wages, you may have to contact the person's job coach.

## **7. What should I tell the person I support and/or their advocate about the survey?**

When you speak with them about the survey process, you should tell them that they will be contacted by someone from OPWDD who is conducting interviews for a Consumer Survey. OPWDD wants to ask them questions about their experiences receiving supports and services. This interview will help OPWDD improve services and supports for people with developmental disabilities. Their participation would be greatly appreciated and should only take one hour of their time. Their answers to the survey will remain confidential and will not change the services that they currently receive.

## **8. What if the individual being interviewed wants me to participate in the interview?**

As a best practice, service coordinators are not present during the interviews because there are questions about service coordination and individuals may not respond honestly if the service coordinator is present. It may create a bias and skew the survey results. If you are asked to be present, assist the person to find someone else he or she trusts to help them participate.

## **9. What if the individual I support doesn't want to participate?**

The individual has the right to refuse to participate in the Adult Consumer Survey. It is completely voluntary and there will be no negative consequences for not participating.

**10. What if the advocate/guardian doesn't want the person to participate?**

Again, participation is voluntary. If the advocate/guardian has the authority to represent the best interests of the individual, then it is their right to not participate.

**11. Should I keep a copy of the Pre-Survey and Background Information?**

It is not necessary for service coordinators to keep a copy of this document.

**12. What if I don't think the person has the ability to be directly interviewed?**

The Adult Consumer Survey is for everyone with a developmental disability, no matter their ability level. The first section of the interview is for individuals who can answer the questions by themselves. If an individual is not capable of answering the questions by him or herself, then the questions are skipped. In the second part of the interview, individuals are able to answer the questions with help from another person. A person who knows the individual really well must participate in this section of the interview. This method will help OPWDD use the Consumer Survey to represent everyone receiving services, regardless of ability level.

**13. Who will be answering the questions on behalf of the individual if they are unable or unwilling to respond for themselves?**

As noted in the answer to the question (Q.12) above, Section II of the Consumer Survey allows for a proxy (i.e., a representative) to answer questions on the individual's behalf. This person should be someone who knows the individual really well, including knowledge of their daily schedule. The proxy could be a family member, circle of support member, guardian, advocate, friend, or direct support professional.

**14. How will the interviewers accommodate the individual's personal preferences for meeting time, place, etc?**

The DDSO interviewers will contact the individuals or their advocate/guardian to set up the interviews. Based on each person's preferences and schedule, the interviewer will set up a meeting time and place where the individual feels most comfortable. This may be in the person's home, community, or day program.

**15. How will the individual's information remain confidential?**

Each individual selected to be part of the interviews is assigned a unique identifying number called the "Survey Code". Each person will be identified by the survey code and no one else besides OPWDD staff working closely with the NCI project will know who the person is. HSRI will not be able to trace the answers to the Adult Consumer Survey back to the individual who completed the questions.

**16. Who do I send the completed Pre-Survey and Background Information to?**

When you have finished filling out the **Pre-Survey and Background Information**, and have informed the individual that OPWDD will be contacting him or her to schedule and interview, please send the completed documents back to your DDSO NCI Liaison.

**17. When is this information due back to the DDSO?**

The completed Pre-Survey and Background Information must be returned to the DDSO Liaisons within the designated time frame you are given. Service coordinators must help us meet this deadline so the interviewers and others involved in the project can meet their deadlines.

**18. Have there been any changes made to the data collection process for this year?**

In previous years, interviews for individuals living in certified residential sites (IRAs, CRs and ICFs) were completed by the Division of Quality Improvement as part of the recertification process. This year, the DDSOs will complete these interviews, along with the other service categories they are responsible for. Residences will be contacted by a representative from their local DDSO to schedule interviews.

**19. How can I learn more about the National Core Indicators?**

If service coordinators are interested in learning more about NCI, please check out the website at <http://www.hsri.org/nci/>. There are reports and additional documents describing the project.