

Looking into Service Coordination

Moving from Pediatric to Adult Health Care

Continuing Education Module



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✓ Learn ✓ See ✓ Do

Skills for Moving from Pediatric to Adult Health Care

- Scheduling an Appointment
- Getting Health Insurance
- Deciding About Guardianship
- Speaking up at the Doctor's Office
- Understanding Your Disability
- Managing Medications
- Keeping a Health Summary
- Looking into Service Coordination
- Setting Health Goals
- Finding Community Resources

Welcome!

This education module provides information that families and professionals can use to help youths who have developmental disabilities to explore the benefits of Medicaid service coordination.

Looking into Service Coordination:

Skill attainment for this topic is defined when the adolescent or young adult is able to:

- ✓ Define person-centered planning
- ✓ Identify strengths and interests with the help of a Medicaid service coordinator (MSC)
- ✓ Diagram a “Circle of Support” and incorporate this into an Individual Service Plan (ISP)
- ✓ List goals on the ISP and discuss steps for reaching these goals with the MSC
- ✓ Meet with the MSC to track progress toward reaching goals

This continuing education module is part of a 10-unit curriculum that was developed for families, health care providers, service coordinators and other professionals who would like to facilitate the transition from pediatric to adult health care for youths who have developmental disabilities. Adolescence and young adulthood is a time of tremendous change, not just physically, but also in terms of social and emotional development, and due to transitions in services, supports and health care providers. The Healthy Transitions curriculum provides a context for mutual understanding and collaboration during this complex time.

The curriculum is organized around 10 key skills that youths need to develop in order to transition to adult health care. The skills are not sequential. They can be developed over time, between the ages of 14-25 years. The Healthy Transitions checklist (see “script pad”) can be used to track accomplishments. Each module provides strategies that families and professionals can use to help youths to develop a particular skill. The curriculum emphasizes self-determination and the active involvement of young adults who have developmental disabilities in their own health care.

The modules begin with a vignette that illustrates a transition “success story”. This is followed by didactic information and a list of references and resources for skill development. A table with “tips for collaboration” lists concrete steps that youths, families, service coordinators, and health care providers can take in order to facilitate the transition process. A self-assessment quiz is included at the end of each module.

In addition to the Continuing Education Modules, the Healthy Transitions project offers Lessons Plans, Videos and a Moderator Guide for educators that can be used in group settings with young adults. Our website also features a secure network of personal health sites called **MY PLACE** that link youths to a personal transition team for care coordination, planning, and setting priorities during the transition to adulthood.

Please visit us at HealthyTransitionsNY.org to find out more. We welcome feedback!

Lisa

Lisa is a 22-year old young woman who graduated from high school with an Individualized Education Plan (IEP) diploma. She lives with her parents. She has become increasingly isolated since high school graduation.

Lisa is interested in working with people and would like to resume the social activities that were available to her when she was in high school. She has an intellectual disability that affects her options for employment. She uses a motorized wheelchair and is able to get around independently. However, she needs support from one-to-one staff for various personal care needs.

The chief concern at her annual health visit is her social isolation. She does not have access to services that would allow her to be more productive and active in her community.

Lisa's physician makes a referral to the Office for People with Developmental Disabilities (OPWDD) to establish eligibility for Medicaid service coordination. Once this is in place, Lisa and her service coordinator initiate person centered planning. Together they identify Lisa's strengths and interests, meaningful activities, and places in the community that are important to Lisa. The service coordinator helps Lisa to access resources and services in order to reach her goals.



Looking into Service Coordination Learning Objectives:

1. Summarize how eligibility for Medicaid service coordination is determined by the New York State Office for People with Developmental Disabilities.
2. Recognize strategies for effective collaboration between health care teams and Medicaid service coordinators.
3. List three main activities performed by a Medicaid service coordinator.
4. List the components of an Individualized Service Plan.
5. Describe how a service coordinator can assist a health care team to establish a wellness program for an individual who has a developmental disability.



Looking into Service Coordination

The Medical Home

The patient-centered medical home is a comprehensive approach to primary care that explicitly recognizes the role that patients and families play in their own health care. The medical home addresses not just the medical needs but also the information needs and psychosocial needs of patients and families. This model of care has demonstrated improved health outcomes, cost savings, and greater satisfaction with care for both patients and physicians. Interestingly, pediatricians who cared for children with chronic conditions and developmental disabilities developed the medical home concept. Over time, the American Academy of Family Physicians (AAFP), American College of Physicians (ACP), and the American Osteopathic Association (AOA) have recognized the medical home model as “standard of care” across the lifespan for patients who have complex health care needs. Joint Principles of the Patient-Centered Medical Home are summarized below.

Joint Principles of the Patient-Centered Medical Home

- **Personal physician:** “each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.”
- **Physician directed medical practice:** “the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.”
- **Whole person orientation:** “the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals.”
- **Care is coordinated and/or integrated**, for example across specialists, hospitals, home health agencies, and nursing homes.
- **Quality and safety** are assured by a care planning process, evidence-based medicine, clinical decision-support tools, performance measurement, active participation of patients in decision-making, information technology, a voluntary recognition process, quality improvement activities, and other measures.
- **Enhanced access** to care is available (e.g., via “open scheduling, expanded hours and new options for communication”).
- **Payment** must “appropriately recognize[s] the added value provided to patients who have a patient-centered medical home.” For instance, payment should reflect the value of “work that falls outside of the face-to-face visit,” should “support adoption and use of health information technology for quality improvement,” and should “recognize case mix differences in the patient population being treated within the practice.”

Source: *Joint Principles of the Patient Centered Medical Home*
Position Statement of the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA)
<http://www.medicalhomeinfo.org/joint%20Statement.pdf>

Care Coordination

A core feature of the medical home is the coordination of care among providers and across systems of care. One of the most promising ways to accomplish this for patients who have developmental disabilities is to link the medical home with existing care coordination systems that are available to people with developmental disabilities in New York State. This key service is accessed through a variety of local, state, and federally funded programs, depending upon the age of the individual.

Ages 0-3

Early Intervention is a federally funded program administered via local County Health Departments that provides developmental assessment, therapies, and service coordination for qualifying infants and toddlers aged 0-3 years.

Ages 3-21

After age 3 years, children and adolescents with developmental disabilities typically receive developmental services via their local school districts. For pre-school aged children this is operationalized via the district's Committee for Pre-School Special Education (CPSE). For children aged 5-21 years, services are administered via the district's Committee for Special Education (CSE).

Adulthood, Across the Lifespan

Adults with developmental disabilities access service coordination and other habilitation services via a statewide system that is administered by the New York State Office for People with Developmental Disabilities (OPWDD). This system is organized into 13 regional Developmental Disability Services Offices (OPWDD/DDS). Although the OPWDD/DDS primarily serves adults who have developmental disabilities, Medicaid service coordination is available to children and adolescents as well. In fact, it can be very helpful to involve the OPWDD early on, during the school years, in order to facilitate the transition to adulthood. Service coordination is critical for successful system navigation at this complex time, particularly vis-à-vis medical care.

Medicaid Service Coordination:

Medicaid Service Coordinators are experts at accessing community-based habilitation services and supports, including those relevant during the transition to adulthood. Medicaid service coordinators know how to identify and tap into the natural supports in a particular neighborhood. Medicaid service coordinators are knowledgeable about insurance programs and can assist with eligibility determination for Medicaid waiver services (for more information on this topic, please see "Getting Health Insurance" module). If there is confusion about whether an individual is eligible for Medicaid waiver services, the service coordinator is the person to ask. Medicaid service coordinators also assist with record keeping and paperwork to qualify for services. They conduct face-to-face meetings with the individual in order to develop and follow-through on specific goals, including health related goals.

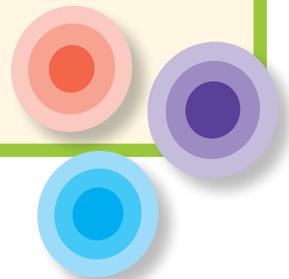
Plan of Care Support Services:

The OPWDD also provides service coordination via a program called Plan of Care Support Services. This is available for individuals who receive services via the Home and Community Based Medicaid Waiver and who do not want or need ongoing and comprehensive service coordination. Plan of Care Support Services allow an individual and his/her family to continue to receive the same Medicaid and developmental disability services that are provided by traditional Medicaid Service Coordination. However, meetings with the service coordinator are less frequent (twice annually) and assistance with accessing community services is provided on an as-needed basis. Most youths who have developmental disabilities benefit from Medicaid Service Coordination to address evolving needs during their transition to adulthood. It is possible to switch back and forth between the two care coordination models.

The table on the next page lists specific ways in which a service coordinator can collaborate with the health care team.

Ways in Which a Service Coordinator Can Collaborate with Health Care Teams

- Submit paperwork for enrollment in Medicaid waiver programs
- Participate in meetings to help advocate for the individual
- Include health goals in the Individual Service Plan
- Assist with arranging transportation for health visits
- Set up home health services and/or self directed care
- Refer to clinical services via the OPWDD such as behavioral specialists and physical therapists
- Access dental care
- Access nutrition counseling
- Access recreation/fitness programs in the community
- Assist with obtaining adaptive equipment
- Assist with obtaining home modifications
- Refer to education, habilitation, vocational, and employment programs
- Assist in securing financial benefits and resources
- Assist in maintaining family unity by referral to Family Support Services
- Secure respite for families
- Make referrals for housing options and residential services
- “One number to call” for accessing community based supports and services



Who is Eligible for Medicaid Service Coordination?

Children, adolescents, and adults with developmental disabilities who meet eligibility criteria for OPWDD services and who receive Medicaid or are Medicaid-eligible can qualify for service coordination via the OPWDD.

Qualifying diagnoses that are recognized by the New York State Office for People with Developmental Disabilities for eligibility determination include:

- **Intellectual Disability (Mental Retardation)**
- **Cerebral Palsy**
- **Epilepsy**
- **Neurological Impairment**
- **Autism**
- **Familial Dysautonomia**

Individuals are ineligible if they are already enrolled in other comprehensive Medicaid long-term care service coordination programs, or if they reside in Intermediate Care Facilities, Developmental Centers, Psychiatric Hospitals, Small Residential Units, Nursing Facilities or Hospitals. To qualify for Medicaid service coordination the individual must also demonstrate a need for ongoing and comprehensive service coordination. Individuals who do not qualify for Medicaid may be eligible for service coordination via one of the Medicaid waiver programs. Either way, the process begins with eligibility determination for OPWDD services.

Eligibility Determination for OPWDD services:

There are 13 regional Developmental Disabilities Services Offices (DDSO's) across New York State. Contacting the local DDSO is the first step toward receiving services from OPWDD. Staff at the regional DDSO can discuss funding options, services, and how to access programs for individuals with developmental disabilities. The table on page 8 summarizes the steps along the way, and key documents and people who can facilitate the process.



1. Assemble Documents for Eligibility Determination

Who Can Help?

1. Office for People with Developmental Disabilities (OPWDD) Transmittal Form

http://www.omr.state.ny.us/wt/images/wt_transmittal_form.pdf

Check item #14 in section #4 if you are interested in service coordination

Anyone

2. Documentation of Cognitive Functioning

Kaufman Assessment Battery for Children
 Leiter International Performance Scale
 Stanford-Binet Scales
 Wechsler Series of Intelligence Scales

Schools

Request copies of
 Psycho-educational testing &
 Individualized Education Plan
 from school district.

3. Documentation of Adaptive Functioning (required if IQ >60)

AAMR Adaptive Behavior Scale (School version only)
 Adaptive Behavior Assessment System
 Comprehensive Test of Adaptive Behavior
 Vineland Adaptive Behavior Scale

Developmental Pediatrician

Psychologist

4. Documentation of Qualifying Diagnosis

New York State Mental Hygiene Law, Subdivision 22 of section 1.03:

http://www.omr.state.ny.us/document/hp_brochures_factsaboutdd.jsp

Physician or Psychologist

Documents diagnosis and that
 onset was prior to age 22

2. Submit Documents to Local Developmental Disabilities Service Office (DDSO)

Find your local DDSO on the OPWDD locator map: http://www.omr.state.ny.us/ws/ws_linemap.jsp

3. Eligibility Determination by the DDSO

1st Step Review DDSO responds in writing. There are three possible outcomes: 1) eligibility or provisional eligibility is determined; 2) request is incomplete and additional records are needed; or, 3) request is forwarded for a 2nd Step Review by an interdisciplinary team.

2nd Step Review Interdisciplinary team at local DDSO reviews all materials. There are three possible outcomes: 1) eligibility is determined; 2) request was incomplete and additional records are needed; or 3) eligibility is denied because individual does not meet criteria for Developmental Disability. In this case, a letter will be sent to the family offering a face to face discussion, 3rd Step Review, or a Medicaid Fair Hearing.

- A Medicaid Fair Hearing is only offered if Medicaid funded services were requested on the Transmittal Form.
- Reviews usually take place within 90 days. Reply promptly if you are asked for more information.
- Contact your local Developmental Disabilities Service Office (DDSO) for questions or if there is a delay.

3rd Step Review The Eligibility Committee, at the New York City Regional Office or at the Upstate Regional Office in Albany, reviews materials and forwards its recommendation to the local DDSO.

The local DDSO informs the family of any changes. The DDSO decision is final unless the family requests a Medicaid Fair Hearing. Medicaid Fair Hearings take place at the NYS Office of Temporary and Disability Assistance. The hearing only resolves the single issue of developmental disability diagnosis. The family must make the request for a hearing within 60 days of Notice of Determination. The OPWDD does NOT schedule the Medicaid Fair Hearing.

4. Access OPWDD Services and Establish Service Coordination

- For a list of OPWDD services go to: <http://www.omr.state.ny.us/ws/servlets/WsNavigationServlet>
- Call local agencies or contact your local DDSO to set up service coordination:
http://www.omr.state.ny.us/wt/manuals/mscvm/wt_msc_coordinators.jsp

Note: The Enrollment in Medicaid Waiver requires additional paperwork. A service coordinator can help with this.

Individualized Service Planning

Service coordination starts with an Individual/Family interview in order to develop an “Individualized Service Plan” with and for the person. The initial meeting with a service coordinator is guided by core values of community inclusion and self-determination. The individual hires and signs an annual agreement with the service coordinator that lists goals and that outlines how these goals will be accomplished. Goals are identified by a process called person centered planning, which is an approach for learning about people with developmental disabilities that helps them to discover their interests and abilities, while openly acknowledging the disability. Person-centered planning identifies and builds on the strengths of the individual. It is the responsibility of the individual to identify meaningful goals, called “valued outcomes”. It is the role of the service coordinator to develop strategies and to access resources and services for achieving these goals. *The table below lists components of the Individual Service Plan.* Once the Individualized Service Plan has been created, the Medicaid service coordinator meets face-to face with the individual at least three times annually. Meetings can take place wherever it is convenient for the individual, but they must take place in the person’s home at least once per year. This helps the service coordinator to understand the practical, day-to-day needs and activities of an individual. Meetings are conducted to review progress on goals and to assure that the services are in alignment with the individual’s valued outcomes.

Advocacy

The role of Service Coordinator is to LISTEN to the person. The service coordinator helps to explore what the person wants and needs in life and assists with meeting these goals. The service coordinator puts services into place to meet these goals. It’s important for families to know, however, that the service coordinator does not actually provide services directly. The service coordinator advocates for the individual’s rights, including health and safety in the environment in which they live. The service coordinator makes sure that the individual is aware of his/her ability to choose. A key responsibility for the service coordinator is to share knowledge about community resources so that the individual can make an informed choice.

Record Keeping

The Medicaid service coordinator is responsible for maintaining a service coordination record. This includes enrollment documents, written evaluations, the Individual Service Plan, and service coordination notes. For individuals who reside in OPWDD certified group homes, the Medicaid service coordinator is responsible for drafting and updating an Individual Plan of Protection. Medicaid service coordinators are also responsible for submitting paperwork to ensure that an individual’s Medicaid eligibility is maintained.

Components of the Individualized Service Plan

- A profile of the person being served.
- A summary of the safe guards need by that person to be safe.
- A list of the valued outcomes identified by the person.
- A description of the services needed to support the valued outcomes.
- A list of the natural supports and resources available in the community.

Note: An individualized service plan may also include an individual plan of protective oversight (IPOP) if there are medical or behavioral concerns.

Who Provides Medicaid service coordination?

Many local agencies provide Medicaid service coordination. Medicaid service coordination is also available directly from DDSO. The service coordinator belongs to a team that is supervised by a qualified Medicaid service coordinator supervisor. Staff that provide direct services (such as day habilitation) cannot also provide service coordination. Furthermore, program managers with direct control over a service that a person receives may not directly supervise that person's Medicaid service coordinator. Safeguards and procedures for discontinuation of a service coordination contract are outlined in the MSC handbook, available on the internet at http://www.omr.state.ny.us/wt/manuals/mscvm/wt_msc_pref.jsp#top/

Professional Qualifications for Medicaid Service Coordinators

Minimal Education Level:

- **Associate's degree or higher in health or human service field, or an RN degree.**
Note: A candidate for a bachelor's degree may meet this educational requirement by providing a letter from his/her college verifying that the candidate has completed course work equivalent to an Associate's degree in total credits received and number of credits earned in a health or human service field.

Minimal Experiential Level:

- **Minimum one year experience working with people with developmental disabilities or minimum one year experience as a service coordinator with any population.**
- **Supervisors of Medicaid service coordination teams are required to have a bachelor's degree in health or human services as well as previous experience.**

Training Requirements:

- **All Medicaid service coordinators are required to complete core training within 6 months of employment. In addition, they are required to complete 15 hours of continuing education annually.**

The table above lists professional qualifications and training requirements of Medicaid service coordinators.

In Summary

Medicaid service coordinators can be a tremendous resource for health care teams that wish to provide high quality medical homes for patients who have developmental disabilities. They are the "one number to call" for any and all questions about community supports, advocacy, and habilitation services for patients who have developmental disabilities. Medicaid service coordinators conduct face-to-face meetings with an individual in order to develop and follow-through on specific goals, including health related goals. To establish Medicaid service coordination for a patient who has a developmental disability, contact your regional Developmental Disabilities Service Office.



**Adolescent/
Young Adult**

- Decide whether you want your health care team to share information with your service coordinator. If so, be sure to sign the HIPAA consent form.
- Discuss your self care skills with your service coordinator. The service coordinator can help you to find ways to become more independent.
- Discuss health goals with your service coordinator. Add these to your Individualized Service Plan.



Family

- Submit paperwork for OPWDD eligibility by age 14, or sooner. This way the service coordinator can help with the transition process.
- Save school records such as the Individualized Education Plans and Psychoeducational Testing Reports. These documents may be used to determine eligibility for OPWDD services.
- Remember that the primary role of the service coordinator is to advocate. If the service coordinator is not effective, discuss this with the MSC supervisor.



**Health Care
Providers**

- Assign a member of your health care team to serve as office liaison with Medicaid service coordinators in the community.
- Refer patients who have developmental disabilities to the regional Developmental Disabilities Service Office to establish eligibility for Medicaid service coordination.
- Ask for a copy of the the Individualized Service Plan and/or the Plan of Protective Oversight.



**Service
Coordinators**

- Suggest that self care skills and other health related goals be included in the Individualized Service Plan.
- Explore sports and exercise opportunities in the community.
- Suggest nutritional counseling for individuals who are overweight.
- Keep health care teams updated about services in the community.
- Contact the health care team if you need help advocating for an individual who has a developmental disability.

References and Resources

Capacity Works

Books and posters developed by Dr. Beth Mount that inspire person-centered work.

<http://www.capacityworks.com/index.html>

Care Coordination: Integrating Health and Related Systems of Care for Children With Special Health Care Needs

American Academy of Pediatrics Policy Statement, Committee on Children with Disabilities, PEDIATRICS Vol. 104 No.4 October 1999, pp. 978-981.

<http://aappolicy.aappublications.org/cgi/content/full/pediatrics;104/4/978>

Consumer advocate informational booklet about rights of individuals who receive services from the New York State Office for People with Developmental Disabilities (OPWDD)

by Jack Kaylie, Consumer Advocate, March, 2009.

http://www.omr.state.ny.us/wt/publications/wt_publications_knowyourrights1.pdf

Joint Principles of the Patient Centered Medical Home

Position Statement of the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA)

<http://www.medicalhomeinfo.org/joint%20Statement.pdf>

NYS OPWDD Catalog of Training and Talent Development Programs

List includes required courses for Medicaid service coordinators published by the New York State Office for People with Developmental Disabilities (OPWDD)

<http://www.omr.state.ny.us/wp/index.jsp>

NYS OPWDD Medical Service Coordination Vendor Manual

Forms, guidelines, trainings, and procedures for Medicaid Service Coordinators published by the New York State Office for People with Developmental Disabilities (OPWDD).

http://www.omr.state.ny.us/wt/manuals/mscvm/wt_msc_toc.jsp#top

Quality Mall

This website highlights literature and information on best practices regarding person-centered services supporting people with developmental disabilities.

<http://qualitymall.org>

Tools for Coordinating Care

National Center for Medical Home Implementation, American Academy of Pediatrics

<http://www.medicalhomeinfo.org/tools/coordinating%20care.html>

Understanding Medicaid Service Coordination

An 8-page booklet about Medicaid service coordination published by Parent to Parent of New York State.

www.parenttoparentnys.org/Services/MSc/mscbooklet.htm

Quiz

- 1. Qualifying diagnoses that are recognized by the New York State Office for People with Developmental Disabilities (OPWDD) for eligibility determination include all of the following except:**
 - a. Intellectual Disability (Mental Retardation)
 - b. Epilepsy
 - c. Autism
 - d. Familial Dysautonomia
 - e. Attention Deficit Hyperactivity Disorder
- 2. Strategies for effective collaboration between health care teams and Medicaid service coordinators include:**
 - a. Referral of patients who have developmental disabilities to the regional Developmental Disabilities Service Office to establish eligibility for service coordination.
 - b. Including self care skills and other health goals in the Individualized Service Plan.
 - c. Assigning a member of the health care team to serve as office liaison with Medicaid service coordinators in the community.
 - d. All of the above.
- 3. Three major activities performed by a Medicaid service coordinator are:**
 - a. Individualized service planning, advocacy, record keeping
 - b. Monthly meetings, scheduling appointments, picking up prescription
 - c. Group home supervision, transportation, medication management
 - d. Family counseling, guardianship, respite
 - e. Day habilitation, transportation, job training
- 4. Components of the Individualized Service Plan include all of the following except:**
 - a. A profile of the person being served.
 - b. A summary of the safe guards need by that person to be safe.
 - c. A list of the valued outcomes identified by the person.
 - d. Description of the services and community resources that support valued outcomes.
 - e. An itemized list of health care encounters billed to Medicaid
- 5. A service coordinator can help to develop a wellness program by:**
 - a. Discussing individual preferences for regular physical activity.
 - b. Submitting paperwork to fund membership at a local fitness club.
 - c. Identifying transportation options to a local swimming pool.
 - d. Setting up nutritional counseling via the OPWDD.
 - e. All of the above.

Answer key: 1(e); 2(e); 3(a); 4(e); 5(e)

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