EI Targeted Case Management Task Force Meeting
March 7, 2011

Participants:
Adele Rohner, Alison Standring, Beth Tolley, Carol Burke, Chris Gregory, Cori Hill, Deana Buck, Jeff Beard, Jennifer McElwee, Jim Gillespie, Joyce Howard, Mary Ann Discenza, Mary Parke Holland, Pam Park, Sandra Church, Tammy Whitlock, Tim Capoldo, Vanessa Walik

Training/KSA Subgroup
The Training/KSA group has met twice. They looked at the knowledge, skills and abilities (KSA) requirements of other TCM and waiver programs as well as competencies for Part C Service Coordinators. They also looked at the December 2010 DBHDS report on case management which includes a table of requirements and competencies for case management for the various programs. The next step for the group is to translate the work they have done into knowledge, skills and abilities for early intervention service coordination/case management. The group will meet again this week and have an updated report at the 3/14 meeting.

The Training/KSA subgroup also discussed minimum requirements for case management and recommended that the full task force have a conversation about minimal requirements given the extensive requirements and responsibilities of case managers/service coordinators. It is unknown at this point about the number of Part C Service Coordinators who do not have a degree. Virginia's requirements are low in comparison to many states regarding qualification requirements for service coordinators. It was suggested that as the KSAs and requirements are being developed for EI case management, it is the opportune time to make changes in service coordinator requirements. The group felt that regulations could be tightened up later, but not relaxed later so this needs to be considered as requirements are put in place. Questions have arisen about whether current service coordinators could be grandfathered in if the requirements were changed. Other programs have grandfathered in existing case managers when the requirements changed.

The group who worked on the EI TCM last fall discussed requirements and landed on knowledge, skills and abilities rather than an educational requirement. This was at the request of Mary Ann Bergeron and the rationale was to prevent exclusion of parents who are good at service coordination, but who may not have a degree. Tammy would like for there to be a conversation with Mary Ann Bergeron if the group is recommending that the there be an educational requirement.

Some registered nurses don't have a bachelor's degree. College degree and quality of service coordination is not necessary directly linked. A concern was expressed that if a bachelor's degree is required, it may be hard to find service coordinators who meet the requirements. Discussion followed about requiring a bachelor's degree or equivalent knowledge, skills and abilities. "Equivalent knowledge, skills and abilities" would need to be defined. A suggestion was made to consider a

continuum of requirements such as a bachelor's degree or registered nurse or specific "equivalent knowledge, skills and abilities".

Local Lead Agencies may opt to require higher qualifications than those required by the state. This is currently the practice for a number of Local Lead Agencies where a bachelors (or masters) degree is required and in some cases, a specific number of years experience is required.

Deana will send a survey to Local System Managers to gather information about the number of service coordinators currently practicing in Virginia who do not have a bachelor's degree.

Documentation Subgroup

- The Part C requirements for service coordination capture all of the case management requirements found in 42 CFR 441.18 and 42 CFR 441.169
- Documentation Recommendations:
    - Strengthen guidance in the Infant & Toddler Connection of Virginia Practice Manual for service coordination goals
        - Documenting on Page 4 of the IFSP
        - Documentation in contact notes
        - Addressing progress
    - Add guidance for addressing the health indicator status questions
    - Delete guidance about ID TCM in the Practice Manual
- Forms
    - Consider adding a pre-printed Health Indicator Status Short term goal to Page 4 of the IFSP (this is not a new form, but a modification of page 4 of the existing IFSP form)
    - Create an optional combination Physician Certification/Health Indicator Status Form local systems could use to communicate with MDs about the Health indicator status at the same time they are sending the physician certification request.
    - Create an optional Health Indicator Status Form local systems could use to request the Health Indicator Status information for systems who are concerned that combining the forms might result in incomplete responses from physicians and for those times when the Health Indicator Status questions need to be asked, but Physician Certification is not necessary.
    - Discontinue current ID TCM IFSP form
- Training
    - Provide training for all service coordinators
        - Service coordination goals; documentation
        - Communication with families and with physicians about the health indicators; documentation of these communications
        - Communication, coordination, collaboration with other case managers, including MCO case managers (and documentation of the communication)

    - Incorporate the above training content into training of new service coordinators (Kaleidoscope)
    - Incorporate the above training into pre-service training (colleges and universities)
- Inform physicians of new practice of semiannual request for update on the Health Indicator Status questions

The Documentation presented the following questions to the full Task Force for discussion:

1. Will the requirement for addressing the health indicator status apply to all children or just to those with Medicaid/FAMIS?
    i. Should the Health Indicator Status Short Term goal be pre-printed on page 4 of the IFSP or should it be added just for those children who have Medicaid/FAMIS (if the decision is that the requirement applies just to Medicaid/FAMIS children)?
    ii. Will the communication with the physician about Health Indicator status be required for all children or just for those with Medicaid/FAMIS?
2. Shall we refer to the service coordination as case management or can we simply refer to the service as service coordination to be consistent with Part C regulations?

Jeff provided information about the expectations for communication with physicians and families about the health indicator status questions. The goal is for case managers/service coordinators to be proactive in reinforcing the importance of well baby/child checkups, immunizations, lead screening to help promote health. The CM/SC would be responsible for communicating with the child's physician every six months as well as discussing this with families. There is not an expectation that Part C CM/SC are responsible for assuring that the families follow through with appointments and immunizations, or that Part C follow up with physicians who do not return the completed Health Indicator Status Questions. Part C services are not contingent on family follow through with well baby appointments and immunizations.

The group discussed whether the quality measure and physician communication requirements should apply to all children in Part C or just to children with Medicaid. While there was general agreement that it would be good for this to apply to all children, concerns were raised about having sufficient time to provide high quality services to all children and families in Part C if this documentation/communication requirement is added. Caseloads vary across Virginia; the case load for one of the EI TCM TF participants is 80. Concern was also raised about "over-interpreting" since this documentation and communication is not required by regulations. On the other hand, some local systems indicated that they would apply the requirement for all Part C children in order to have a consistent process and/or because children often go on and off Medicaid/FAMIS. Others indicated that they would encourage CM/SC discussions with families about well child checkups, immunizations and lead screening, though they would not fax the six Health Indicator Quality questions to physicians every six months.

Several options were discussed about how documentation of communication with families about the health indicators could be streamlined. Suggestions included revisions to the IFSP to allow documentation of the discussions with the family. Concerns were raised about adding specific

information to the IFSP (such as referencing immunizations) because that could be an issue for some families who choose not to have their child immunized.

Task Force Recommendation: Require communication with physicians about the health status indicators only for children with Medicaid/FAMIS, but encourage local systems to have the conversations about well baby checkups and immunizations with all families; and consider ways to streamline documentation about these conversations.

The Task Force supported the addition of the following short term goal on page 4 of the IFSP: **Provide information and support your family, as needed, in accessing routine medical care for your child.** The draft forms were discussed briefly. The forms include a combination Physician Certification/Health Indicator Status Questions form and a stand-alone Health Indicator Status form that can be faxed to the child's physician. The forms are intended as optional templates to use for communication with physicians. The purpose of having a stand-alone form for the Health Indicator Status Questions is to allow separate documents if the local system is concerned that the physician may complete only one part of the combined form and for those situations where a physician certification is not needed at the 6 month review because services have not changed.

There was acknowledgment and appreciation that the Intellectual Disabilities TCM and Mental Health TCM documentation requirements that have been cumbersome because they don't fit for infants and toddlers will no longer be required when the EI TCM program is implemented.

Case Management vs. Service Coordination

Tammy indicated that the regulations must refer to case management to be in alignment with federal regulations. However, "service coordination" can be the terminology used for early intervention "case managers" to be in alignment with the Federal Part C regulations. Participants agreed that the preferred terminology for EI case management is service coordination. The DMAS Manual and the DBHDS Practice Manual must make the correlation between the case management terminology in regulations and the service coordination language in practice.

Billable services

The requirements for what is considered a billable service must be consistent with what is required for other case management programs. ID and MH TCM require that there be a service plan in place, quarterly face to face contacts and monthly collateral contacts with documentation that the activities and contacts are addressing the goals on the service plan. Collateral contacts include talking to another service provider, talking with the family, etc.

The group discussed minimum requirements for face to face contacts (in order to bill for case management); preliminary recommendations were face to face contacts at the initial IFSP and annual IFSP. There was discussion about whether intake should be included in the face to face requirement or whether it would be sufficient to have the requirement for face to face in the initial IFSP meeting. It was

emphasized that the actual face to face contacts should be dependent on family needs, but that the minimum requirement to be able to bill must be established.

Discussion follow about whether billing could be done for service coordination/CM provided prior to the determination of early intervention eligibility. It was determined that the program would include reimbursement for service coordination activities from the first intake visit up until the time the child is determined ineligible or the child is discharged (for those who are found eligible). This is in alignment with the 90 day case management that is available while programmatic eligibility is being determined for children who are suspected to be eligible for ID or MH TCM. The EI TCM regulations and the program manual will need to use the same type of language that is used for 90 day case management.

In order to allow for billing for service coordination/case management prior to the determination of EI eligibility, the DMAS and DBHDS policy/procedures will need to be changed to start the EI benefit the date of intake rather than the date EI eligibility is determined.

EI TCM Regulations

The budget language for DBHDS (which provided the statutory authority to promulgate regulations) did not make it into the package for the general assembly. DBHDS is communicating with the Office of the Attorney General (OAG) about whether DBHDS has the authority to modify the regulations we already have to add certification requirements for service coordinators.

- If yes, revisions to the existing EI personnel regulations will be fast tracked
- If no, the program can't operate until the regulations are promulgated.

Tammy is checking with DMAS leadership to see if we can we continue the current EI SC certification process in order to proceed with the July 1, 2011 target date. (DMAS leadership is about to change, so it may be 2-3 weeks before she receives a response). Mary Ann is checking with DBHDS leadership about this.

We are proceeding with the expectation that the target date remains July 1, 2011. DMAS does have the authority from budget perspective to develop the program. They will include that EI Certification is required.

There was a brief discussion about licensure versus certification. Certification will be pursued rather than licensure.

Agenda for 3/14/2011

- Training Committee Report
- Collateral Contacts/Billing Requirements