Virginia Interagency Coordinating Council (VICC) Meeting
March 9, 2011
Approved Minutes

VICC Members Present:
Rick Beaman, Jeannie Odachowski, Delly Greenburg, Allan Phillips, Lissa Power-deFur, Glen Slonneger, Tammy Whitlock, Ginny Heuple, Sonia Lopez, Mary Wilson, Sandra Woodward, Cathy Cook, Yolanda Tennyson, Pat Popp, Charlie House

Guests:
Debra Holloway, Bonnie Grifa, Beth Tolley, Tamara Wilder, Deana Buck, Beth Tolley, Mary Ann Discenza, Heidi Faustini, Mary Anne White, Cori Hill, Alison Standring

Minutes from the December 1, 2010 VICC meeting were approved with the following two changes:

- Minor corrections to documentation of Allan Phillip's data report
- The Grant recipient was the National Association Scholarship, not Project Hope

Agency Reports:

Pat Popp reported that the National Educational Conference for Children Experiencing Homelessness (Horizons Conference) will be held in June. For information, go to: http://www.horizonsforhomelesschildren.org/Programs-YCWH-National-Conference-2011.asp

Virginia Department of Social Services: Mary Wilson reported that the Annual Child Abuse and Neglect Conference will be held on April 11, 2011 in Richmond. Registration forms were provided. Information is on the web at http://www.dss.virginia.gov/news/2011/cps_conference.pdf.

Lissa Power deFur reported that Virginia LEND is currently recruiting trainees. Va-LEND is an advanced level interdisciplinary leadership training program for health professionals and related disciplines in the field of childhood neurodevelopmental disabilities. For more information see: http://www.vcu.edu/partnership/va_lend/ .

Virginia Department for the Blind and Vision Impaired: Glen Slonneger reported that work is in progress to fill vacant educational coordinator positions.

Early Intervention Targeted Case Management (EI TCM)

Mary Ann Discenza reported that DMAS convened a small group of stakeholders in October 2010 to consider the possibility of developing a case management program specifically for early intervention. Development of the early intervention targeted case management program will be required if early intervention services are to continue to be carved out of Managed Care. In order to proceed with development of early intervention targeted case management, budget language had to be prepared by DMAS and DBHDS in order to have the authority to promulgate regulations. The DBHDS language did not make it to the budget. Communication is in process with the OAG to see if it is acceptable to amend the current personnel regulations. If the Department of Behavioral Health and Developmental Services receives approval for this approach, regulations specific to early intervention case management will be developed and fast tracked. If the OAG doesn't allow this, the plan will have to be revised.

Currently, children must meet programmatic eligibility for Intellectual Disabilities (ID) TCM or Mental Health (MH) TCM in order to have TCM reimbursed through Medicaid. Many local systems have been reluctant to utilize ID or especially MH because the requirements don't exactly fit for infants and toddlers and there has been fear that payback will be required if mistakes are made.

A Medicaid Early Intervention Targeted Case Management Task force was convened in February 2011 to develop a case management program specific for early intervention and to be for all children with Medicaid who are receiving early intervention services. There are two subgroups: Documentation (led by Jeff Beard and Beth Tolley) and Knowledge/Skills/Abilities (KSA)/Training (led by Deana Buck and Cori Hill).

- The Documentation group reviewed the federal regulations for Case Management and determined that current Part C requirements capture these case management regulations. Training will be needed and some forms may need to be tweaked. When this is implemented, the ID TCM requirements will be removed from Part C forms (and the combined IFSP/TCM form will be eliminated).
- The KSA/Training Group will propose the educational, training and KSA requirements for people to be certified as Early Intervention Case Managers/Service Coordinators. A survey was sent this morning from the Partnership for People with Disabilities to learn if/how many service coordinators are in Virginia's system who do not have a bachelor's degree. Other options, besides certification were explored (ie, licensure), and the decision was to pursue certification rather than licensure.

TCM for MH and ID would still be available but must be used only if the mental health or intellectual disabilities services were greater than the early intervention services.

Debra Holloway asked that the face to face contact not be devalued. She has heard concerns from some families that they are not seeing their service coordinator, and that this lack of face to face meetings makes the early intervention experience very different.

The reimbursement rate for ID and MH TCM is $326.50/month. The rate for EI TCM is projected to be $120/month in order to be budget neutral. With this change in the reimbursement rate, it is projected that 14 systems will have decreased TCM revenue (totaling about $1,000,000), but the overall change for the entire system is projected to be an additional $300,000 when all children are receiving (and claims are submitted for) EI TCM. The Part C Office is looking at ways to decrease the impact to those 14 systems that will be negatively impacted.

A question was raised about whether caseloads are being discussed. Concern was expressed that caseloads may be raised in response to a reduction in the reimbursement rate.

All Local Lead Agencies (not just Community Service Boards) will be able to bill for EI TCM. A comment was made that taking on the responsibility of billing may be an issue for Lead Agencies who do not currently bill for this service.

Appreciation was expressed to the Department of Medical Assistance Services staff for all the work the agency is doing to develop this program. This EITCM program is important for meeting the Part C payor of last resort (POLR) requirement.

Professional Development

Deana Buck presented evaluation findings for 5 webinars presented September through February. There has been great participation and feedback for each of these webinars. See separate report. Debra asked if many parents participate in the webinars. Deana reported that to date, not many have participated. Deana will work with Debra to strategize ways to encourage more parent participation. The webinars are posted and are accessible to anyone, including parents (at www.eipd.vcu.edu). Since Feb. 1, 2011, there have been 550 separate visitors to EIPD website.

Lead Exposure in Children

Nancy Van Voorhis, Director of Lead-Safe Virginia Program at the Virginia Department of Health provided information about lead exposure in children.

Screening

- Virginia has a Screening Plan, "Guidelines for Testing Children for Elevated Blood Lead Levels", that was developed to assure the testing of children determined to be at-risk
    - This is considered "targeted screening" and saves resources.
- Once a child is identified with an elevated blood lead level, The "Care Coordination Manual for Public and Private Practitioners" provides the recommended protocol for follow up. Very rarely is treatment (chelation) considered an option.

Surveillance

- Lead is considered a "reportable disease" in Virginia.
- Children under 72 months of age (6 years) with an elevated blood lead level are targeted for education, medical, and environmental interventions.
- The number of children identified with a confirmed elevated blood lead level in 2010 was 324 and 202 of these were Medicaid enrolled (62%). It is not known how many of the 324 have developmental delays.

The Care Coordination Manual provides extensive details about the VDH Childhood Lead Poisoning Prevention Program and can be found at http://www.vahealth.org/leadsafe/documents/2009/pdf/Virginia%20Care%20Coordination%20Manual.pdf.

Discussion followed:

- VDH is focusing on prevention.
    - Poverty, diet, environmental exposure, etc are risk factors.
- CDC (Center for Disease Control) has recently published new guidance for testing women while they are pregnant (and at risk for lead exposure) because lead can cross the placenta. Pregnant women cannot be treated with chelation.
- The most critical time is birth to three because the brain blood barrier is not fully developed. The challenge is that consequences of lead exposure may not show up until later.
- There is no safe lead level. Chronic low dose exposure is a problem. A level of 10 triggers case management.
- There is not a direct correlation of lead exposure and specific consequences.
    - Visual motor abilities may be impacted by lead exposure. But some issues may not show up until school age. The Ages and Stages Questionnaires do not identify visual motor issues.
- Not all children with elevated lead levels have problems, but this is a high probability of developmental problems.
- Elevated lead levels must be reported the VDH. There is not a requirement to report risk factors.

- Recommendations for early intervention providers included being aware of the child's environment and encouraging lead testing if there is a concern.
    - Nancy suggested that home visitor look at risk factors such as the presence/absence of smoke detectors, rat droppings, open heaters. If there is something that can be addressed, then address it.
    - Nancy reported that the Center for Disease Control (CDC) has a risk assessment that can be done to identify risk factors. The problem with the CDC checklist is that to remedy all of the issues that might be identified is very expensive. Average cost to make family home healthy and safe is $2500.
    - If risk factors are identified, discuss these with the family. Direct families to the website or to the local Health Department if they have questions. Nancy encouraged people to be aware of families' feelings when providing education. Emphasize what the family is doing well (safety features they are using) and don't be critical.
    - Issues were discussed including costs of testing and modifying the environment when there are concerns.
    - Families' fears of losing their housing – but there are laws in place to protect families from being expelled from their housing if the housing is identified as needing treatment to remove lead.
- If there is a concern that a child may have elevated lead levels, they child should be seen at their Medicaid Home for testing.
- While lead is no longer used in paint for houses, it is used on roads and in marine (boat) paint.
- Refer to Http://www.vahealth.org/leadsafe/ for educational information and materials, including downloadable materials.
- The Childhood Lead program is ending on June 30, 2011. VDH is moving to a Healthy Homes Program.
- Education and Training opportunities were discussed.
    - A suggestion was made to have a webinar for Part C providers.
    - The Home Visiting Consortium has a "Safe Homes" training module. Nancy recommends that a Healthy Homes module be added.
    - A National Center for Healthy Homes training will be held in Richmond May 3.

Discussion about possible next steps:

- The Childhood Lead Poisoning Prevention Care Coordination Manual does not currently include information about Part C early intervention, but Nancy indicated that she would be happy to add Part C information to the Manual.
- Nancy will collaborate with the Part C Office to explore opportunities to provide links to the Infant & Toddler Connection Website on the VDH Lead-Safe Virginia Program website and vice versa.

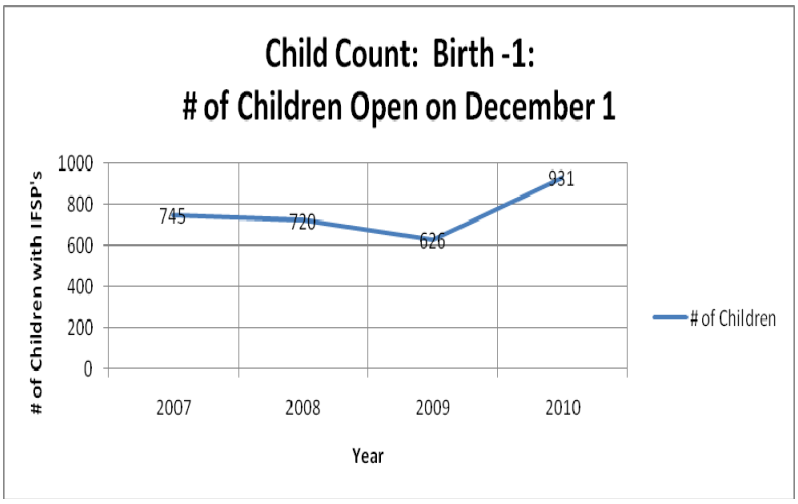
- Discussions will occur with Nancy and the Part C Office about the possibility of adding elevated lead levels to the list of conditions with a high probability of resulting in developmental delay.
- Consider participation of a couple EI trainers in the May 3 conference.

Contact information: Nancy Van Voorhis
Program Director, Lead-Safe Virginia Program
Virginia Department of Health
Toll free 877-668-7987
http://www.vahealth.org/leadsafe/

There were no public comments.

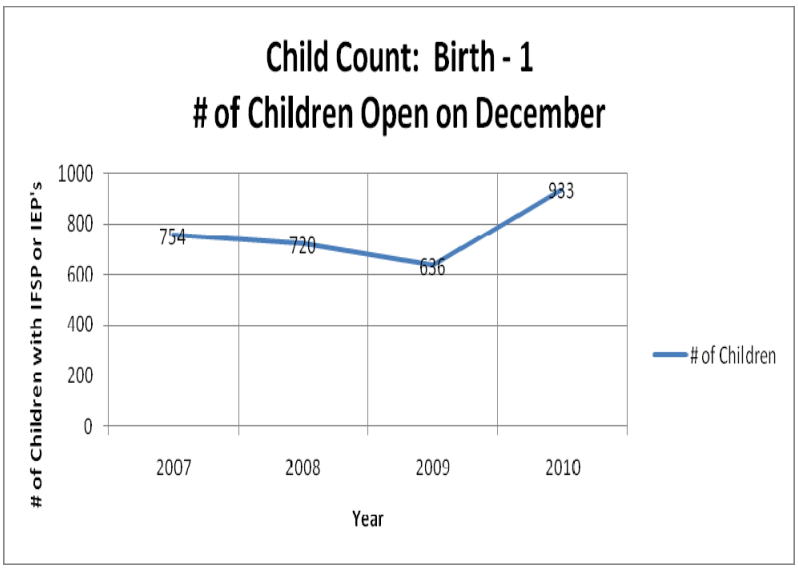
Child Count and Child Find

Mary Anne White reported that the Part C Staff has been in contact with a statistician within DBHDS who will be assisting the Office with analysis of Child Count data. She reminded the VICC that Virginia is the only state where children age two can be served by either Part C or Part B.



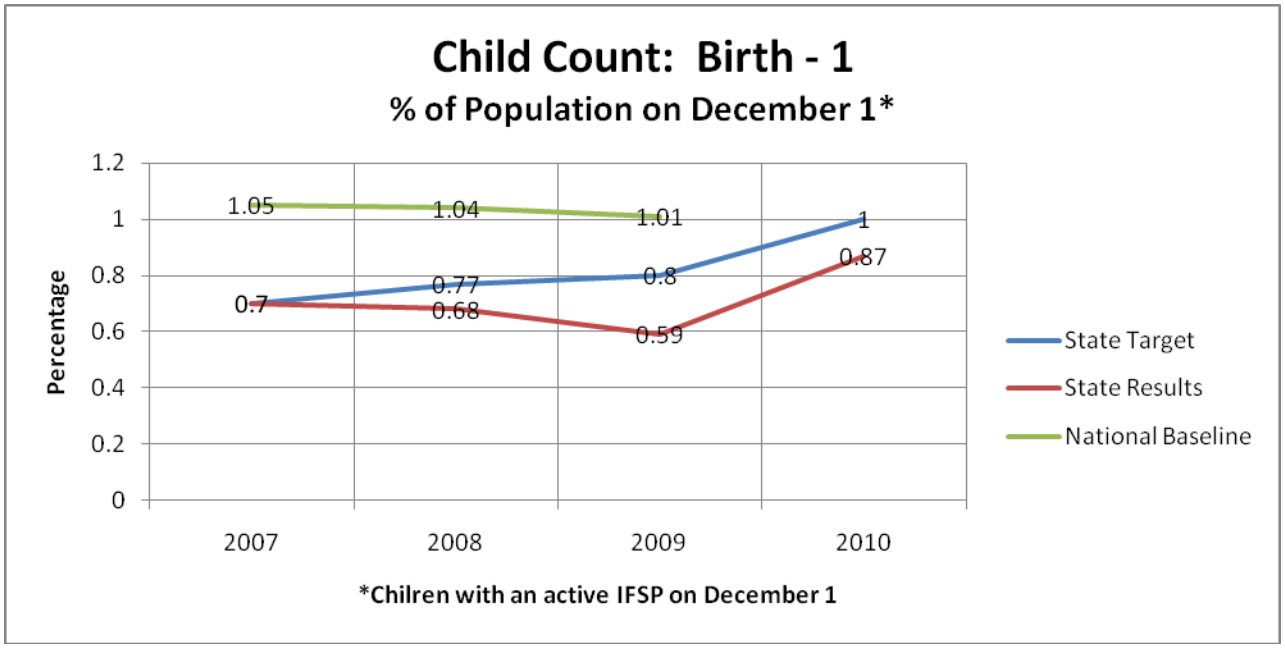
This chart represents the number of children who had an active IFSP on December 1. These children were served only by the Part C early intervention system.

This number is the "official" December 1 Child Count reported to OSEP annually in the State Performance Plan/Annual Performance Report (SPP/APR).



This chart represents the number of children who had an active IFSP or IEP on December 1. These children were served either through the Part C early intervention system or the local school division.

Part B served 9 children ages 0-1 in 2007, 0 children ages 0-1 in 2008, 10 children ages 0-1 in 2009 and 2 children ages 0-1 in 2010. These children are reported to OSEP in the annual SPP/APR but are reported as having an IEP in place on 12/1.

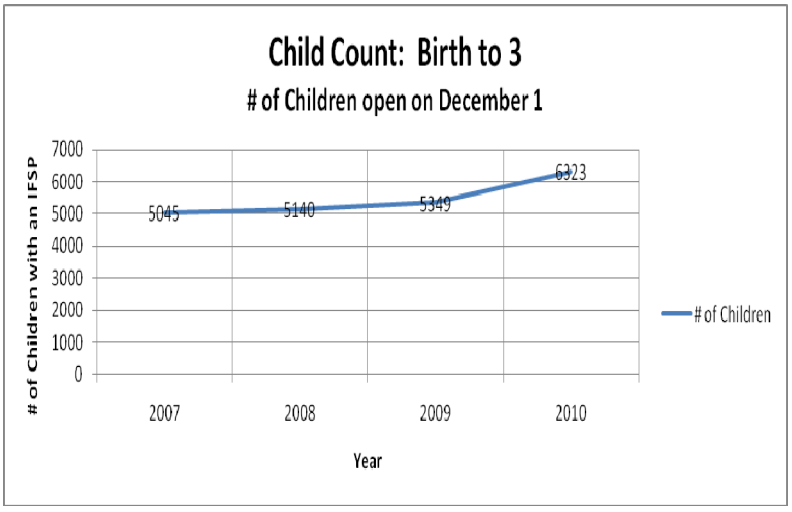


This chart represents the percentage of the birth to 1 population who had an <u>active IFSP</u> on December 1.

Addition of the Part B child count <u>did not change</u> the state results achieved.

- The blue line represents the State Target established by the VICC. This number represents the percentage of the birth to one population in Virginia targeted to have an active IFSP on 12/1.
- The red line represents the actual percentage of the birth to one population in Virginia that had an active IFSP on 12/1.
- The green line represents the National Baseline of all 50 states and 3 territories.

- The population figures used in the calculations are from the previous calendar year (e.g. the 12/1/07 child count is compared to the 2006 population, the 12/1/08 child count is compared to the 2007 population).
- The population data was accessed from "Easy Access to Juvenile Populations: 1990-2009 http://www.ojjdp.gov/ojstatbb/ezapop/.
    - Information from this website provides the following data sources:
        - National Center for Health Statistics (2010). *Estimates of the July 1, 2000-July 1, 2009, United States resident population from the Vintage 2009 postcensal series by year, county, age, sex, race, and Hispanic origin*. [Released 7/23/2010; Retrieved 8/23/2010]. Prepared under a collaborative arrangement with the U.S. Census Bureau. Available online from http://www.cdc.gov/nchs/nvss/bridged_race.htm.
- Users interested in how these data files were prepared should consult the *United States Census 2000 Population with Bridge Race Categories* report, available as a PDF file from http://www.cdc.gov/nchs/data/series/sr_02/sr02_135.pdf.



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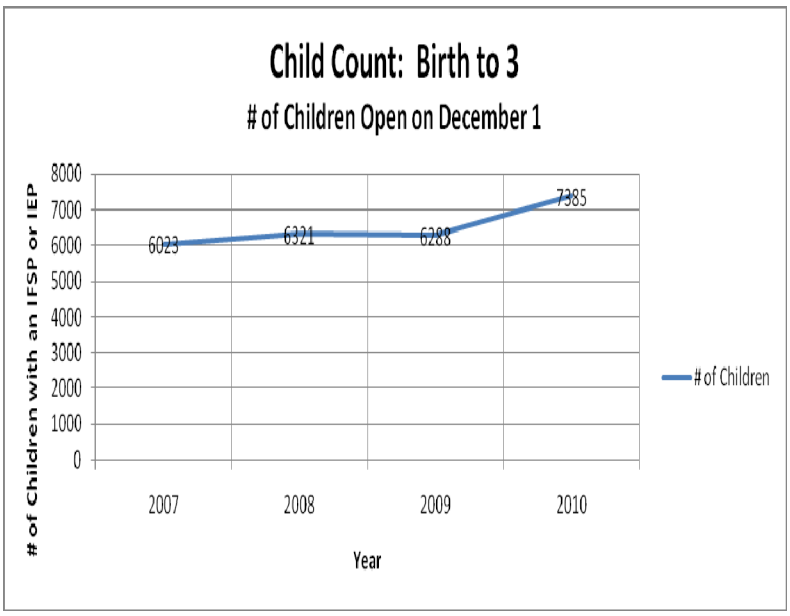
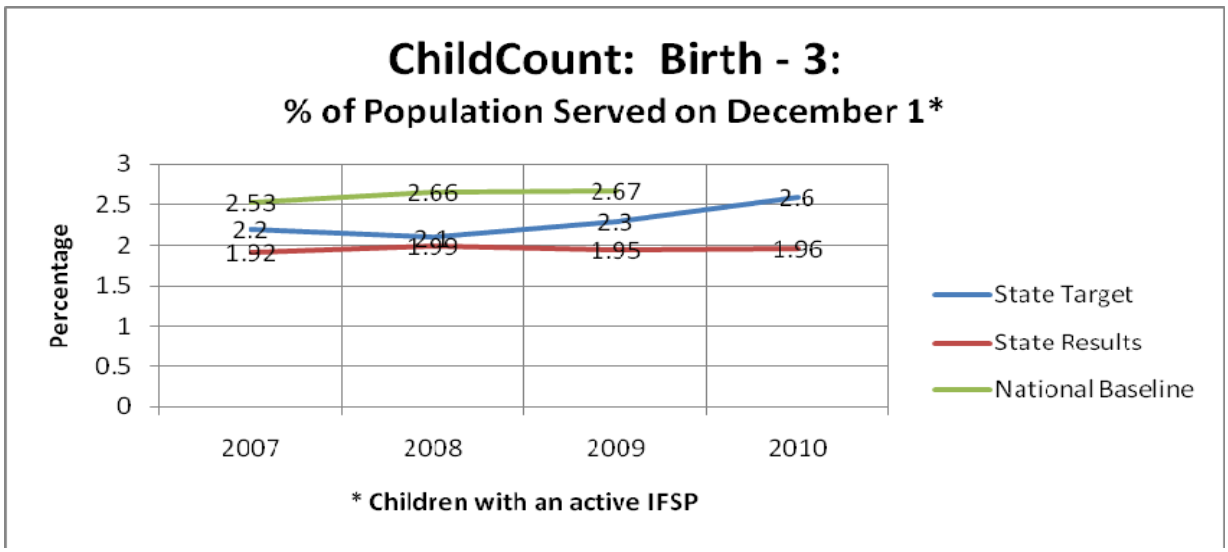
This chart represents the number of children who had an active IFSP or IEP on December 1. These children were served either through the Part C early intervention system **or** the local school division.

Part B served 78 children ages birth-3 in 2007, 1181children ages birth-3 in 2008, 939 children ages birth-3 in 2009 and 1062 children ages birth - 3 in 2010. These children are reported to OSEP in the annual SPP/APR but are reported as having an IEP in place on 12/1.





This chart represents the percentage of the birth to 3 population who had an <u>active IFSP</u> on December 1.

- The blue line represents the State Target established by the VICC. This number represents the percentage of the birth to one population targeted to have an active IFSP on 12/1.
- The red line represents the actual percentage of the birth to one population in Virginia that had an active IFSP on 12/1.
- The green line represents the National Baseline of all 50 states and 3 territories.
- The population figures used in the calculations are from the previous calendar year (e.g. the 12/1/07 child count is compared to the 2006 population, the 12/1/08 child count is compared to the 2007 population).

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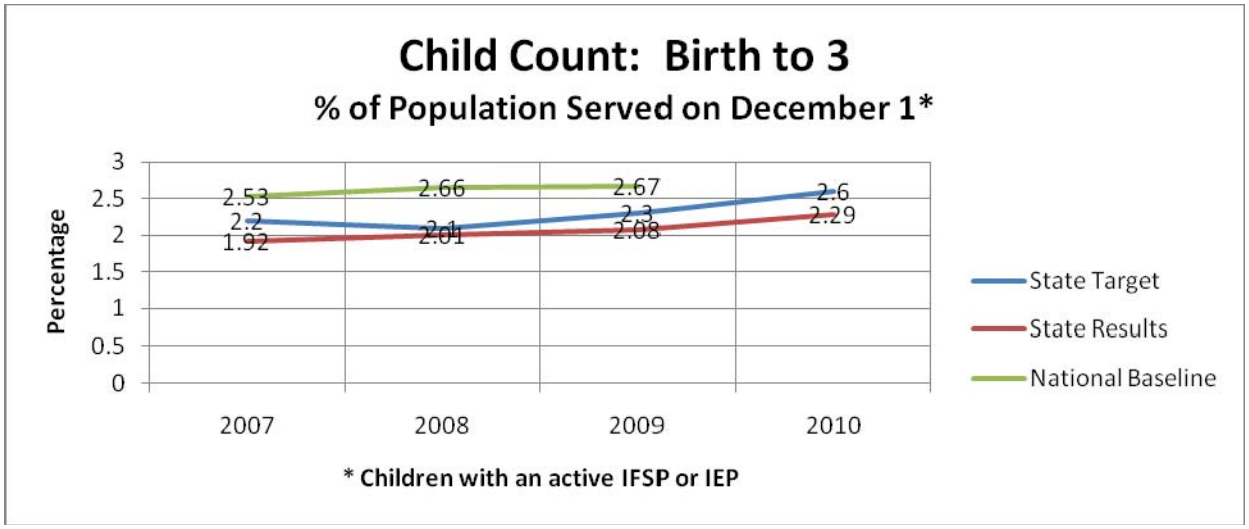

This chart represents the percentage of the birth to 3 population in Virginia who had an active IFSP or IEP on December 1

Discussion followed:

- We have made tremendous strides in serving more children (both birth to one and birth to three) and need to celebrate. On the other hand, Virginia's child count is below the state target and the national average, even for some of those localities that made significant increases.
- Virginia is compared to other states which do not have the option of serving children through Part B at age 2. Perhaps this should be noted on the charts posted on the Infant and Toddlers Association website: http://www.ideainfanttoddler.org/pdf/2009_Child_Count_Data_Charts.pdf
- The following were suggested as possible contributors to increases in child count:
    - Local system outreach efforts
    - Data analysis process with local systems
    - Medicaid early intervention initiative
    - Changes in how local systems looked at atypical development
    - Increasing local system staff or contracted providers
- When the Part C System looked at other states with higher child counts, the difference was related mostly to how those states considered premature babies eligible.
- The change in eligibility criteria for premature babies was implemented after the December 1, 2010 count, so that change would not impact 12/1/10 child count.
- The Part C data system (ITOTS) does not have the level of specificity to fully analyze referral sources and referral outcomes. Specific data is dependent on voluntary collection of data locally.

Beverly Crouse, Technical Assistance Consultant for local systems in the southwest part of Virginia reported that following:

- The impact of change in local lead agency has greatly impacted numbers. Example: Central Virginia.
- In the Infant and Toddler Connection of Blue Ridge, data analysis done to identify issues has resulted in development of a mechanism to collect and analyze specific information about referral sources and referral outcomes so that time can be spent where it is needed. They questioned why families were declining services, so the local system is now tracking the point at which families decline.
- A presentation to area physicians by Colleen Kraft, MD emphasizing the importance of early intervention, as well as the collaborative work with Kathy Kerkering, MD, has positively impacted referrals and child count in Roanoke.
- The Infant & Toddler Connection of Harrisonburg-Rockingham was part of an initiative aimed at encouraging physicians to do more developmental screening; there has been a subsequent increase in referrals from physicians.

Lissa Power deFur reported that stabilization of staff and the use of an intern to distribute early intervention materials to all physicians in the catchment area have contributed positively to the large increase in the Infant & Toddler Connection of the Heartlands.

Information was requested about the number and reasons for declining services. Since the reasons for declining are not captured in ITOTS, local systems must collect this information outside of ITOTS if it is to be available for analysis. Systems that have Service Enhancement Plans for not meeting the child find targets are collecting this information. Discussion followed about:

- The need to collect data to identify specific issues so that the appropriate actions can be taken; and
- Data collection burden.

The Part C Office was asked to provide the Referral Outcome by Referral Source Report (which lists outcomes for all referrals, including the number lost to follow up, number who declined services, etc.) for December 2, 2009 through December 1, 2010. The Part C Office was also asked to report whether children who have IFSPs, but who decline services are counted in the Annual Child Count report.

Public Awareness Committee Report

Charlie House reported that he has received the following input from Public Awareness Committee members:

- Face to face is most effective way to do public awareness.
- Public awareness approaches that could be considered include:

- Word of Mouth
- Brochure on how to conduct public awareness
- Kit to use for Marketing/presentations (table displays)
- Human Interest stories in newspapers
- Social Media – ex: Harrisonburg has a facebook account
- Ads
- Newspapers
- TV – public service announcements on PBS, through cable
- Radio
- Billboards
- Public transportation (ads on buses, etc.)
- Identify key stakeholders in communities who will support PA
- Local Parent Magazine
- Work with Local Interagency Coordinating Councils
- Financial or in-kind support

Current Part C public awareness materials accessible from the Infant & Toddler Connection of Virginia website (http://www.infantva.org/Pr-PublicAwareness.htm) include:

- Developmental Checklist Brochure
- Billboard/Bus Placard
- Logo and name
- Logo with Phone and URL
- Posters

Public awareness suggestions included:

- Development of a "How to" manual for public awareness
- Be sure materials are up to date, accurate, relevant, culturally sensitive
- Consider engaging public schools (community outreach projects) and places of worship
- Use word of mouth
- Public Venue Kits (displays)
- Newspaper Articles
- Social Media (Facebook)
    - ARC has Facebook page
- Consider other venues
    - Billboards
    - Magazine ads
    - Videos
    - Newspaper ads
    - TV commercial (cable)
    - Online commercial (cable)

- Public transportation

Charlie reported possible costs for the various public awareness options:

1. Billboards: $900/6 mo ($210,600)
2. Magazine Ads: $2,700/yr ($105,300)
3. Videos $1,000/min ($5,000)
4. Newspaper ads ($600)

Charlie recommended being creative in identifying funding and in-kind support for public awareness.

Public Awareness Committee Recommendations to the Part C Office:

- Create templates (Posters, billboards, etc…)
- Create Cable Video
- Sample News Release (PSAs)
- Create Generic Videos
- Provide Infant & Toddler Connection of Virginia Folders
- Develop "How To" booklet/brochure for PA

Public Awareness Committee Recommendations for Local Systems:

- Identify primary means of public awareness
- Recruit interns
- Find volunteers

Discussion followed:

- Partner with other community programs (include this idea in the "how to" booklet).
- Include information about how to recruit volunteers in the "How-to" booklet.
  - Students and family members are potential volunteers for public awareness. A comment was made that there are barriers for some local systems for using volunteers.
- Consider target audiences for specific PA efforts. Audiences include the general population, families, and pediatricians (and other referral sources).
- How can the recommendations of the PA committee be communicated to local systems in time for local PA efforts during EI Month (May)?
- Mary Ann Discenza stated that it is possible to use ARRA funding for development of products that could be used by local systems – things that can give us the most bang for our buck and have a long shelf life. She recommended considering sustainability; developing an approach that can be maintained over time.
- Glen Slonneger commented that there has been a pattern in Part C of using one-time money because the pressure continues to be on directing funds to direct services. There

are some approaches such as Facebook that don't involve a lot of money or a lot of staff time (either locally or at the state lead agency).

- Some counties don't allow access to Facebook.
- Mary Ann will take the suggestion about using Facebook to the Department of Behavioral Health and Developmental Services Administration.

- A suggestion was made that each locality look at their data and their public awareness approach; look at this individually and from a regional and state perspective to see what is working.
- Allan Phillips reported increased physician communication was a big contributor to their increase in child count. They hired a Pediatrician to consult with them a couple hours per week. This physician has met with the Northern Virginia Pediatric group. Infant & Toddler Connection of Fairfax/Falls Church also provides training for local child care organizations.
- Another suggestion was to add public awareness to the agenda for the next Local Interagency Coordinating Council Meeting.
- A collection of 15 and 30 second PSA (public service announcement) videos developed by the Smart Beginnings Coalition of the Valley were sent to all local systems in January 2011. These have a tagline about contacting early intervention if there are concerns. It was suggested that guidance be provided to local systems for using these PSAs.
- Discussion followed about advantages and disadvantages of a state versus local approach to contacting cable companies or local television stations to request the PSAs be aired.
  - It was suggested that the state make the contact with cable companies because since there are just 4 companies serving all of Virginia.
  - Cori Hill reported that the group that developed the PSAs indicated that localities need to negotiate with their stations about when and how often they would air the PSAs.
- A question was raised about whether some local systems do not implement public awareness plans because of concern about not having enough staff.
- It was suggested that options and opportunities for public awareness be provided to local systems without requiring specific approaches.

Plan:

1. The Part C Office will request that the Governor proclaim May as Early Intervention Month.
2. The Part C Office will determine how many PA materials are currently available and how much money is available for public awareness.
3. Mary Ann Discenza will talk with the DBHDS Communications and Media Relations Director about what approach should be taken for the PSAs (state, regional, local or combination)

Parent Involvement Project Report

Debra Holloway provided the following report: "Our staff continues to participate in committees and work groups as requested. Two Medicaid Waivers trainings have been hosted since our last meeting. The Arc of Virginia has been advocating for individuals with developmental and intellectual disabilities by assisting families with contacting their local representatives and hosting or supporting families such as the Coalition Rally and Public Hearings. The Arc of Virginia has launched our new branding, please take the opportunity to visit our website www.thearcofva.org and check it out! We will be hosting our annual Convention at the Virginia Beach Wyndham August 11-13, please save the date!"

VICC Membership Status

The Governor has appointed several new people to the VICC. The Part C Office will contact the new appointees.

Child Find: Part C Role in Serving Children Who are Homeless

IDEA 2004 specifically identified homeless children as a population to be served (if eligible) by Part C. The Project Hope website has contact information for Homelessness school liaisons.

- The majority of children in shelters are under age 5.
- There are 100s of shelters in Virginia.
- Project Hope has a database that lists all the shelter.
- Head Start and Project Hope are working together. Early Intervention needs to be a part of this work so that children who need early intervention are identified and served.
- Collaboration between Part C and the Homelessness school liaisons and the shelters needs to occur at the local level. Liaisons are listed on the Project Hope website: www.wm.edu/hope

Plan:

1. Pat Popp will provide information to be included in one of the Infant & Toddler Connection of Virginia Technical Assistance Updates.
2. Information about identifying and serving children who are homeless will be posted on the Early Intervention Professional Development Portal (website).

Summary of Action Items:

- The Part C Office will collaborate with Nancy Van Voorhis to explore opportunities to provide links to the Infant & Toddler Connection Website on the VDH Lead-Safe Virginia Program website and vice versa.

- Discussions will occur with Nancy and the Part C Office about the possibility of adding elevated lead levels to the list of conditions with a high probability of resulting in developmental delay.
- The Part C Office will provide the Referral Outcome by Referral Source Report (which lists the number who declined services) for December 2, 2009 through December 1, 2010.
- The Part C Office will request that the Governor proclaim May as Early Intervention Month.
- The Part C Office will determine how many PA materials are currently available and how much money is available for public awareness.
- Mary Ann Discenza will talk with the DBHDS Communications and Media Relations Director about what approach should be taken for the PSAs (state, regional, local or combination).
- Pat Popp will provide information to be included in one of the Infant & Toddler Connection of Virginia Technical Assistance Updates.
- Information about identifying and serving children who are homeless will be posted on the Early Intervention Professional Development Portal (website).

Next Meeting: June 8 at Hanover DSS

Agenda Items for June 8, 2011

- Homelessness Update
- Public Awareness
- Child Find – Referral Outcomes by Referral Source
- Comprehensive System of Personnel Development Update
- Early Intervention Targeted Case Management Update