

CIS Open Agenda Call Summary: April 15, 2009

Participants: CIS Representatives from the following regions: Bennington, Windham, Rutland, Addison, Springfield, Hartford, St Johnsbury, Washington, Lamoille, Chittenden, Franklin Grand Isle, Newport

Representatives from the CIS State Team: Sue Schmidt, Sue Shepard, Terri Edgerton, Helen Keith, Danielle Howes, Sue Harding, KC Whiteley, Christina Strobridge.

Next Open Agenda Call: Wednesday, May 21, 2009, 1:00-2:00 PM
Call in Number: 1-866-642-1665
 Participant code: 471230

<i>Topic</i>	<i>Discussion Points</i>
<i>Updates</i>	<p>CIS Listserv: The list is running smoothly. A few things to keep in mind:</p> <ol style="list-style-type: none"> 1) Only post CIS-specific messages. The list address is cis@list.uvm.edu 2) Stop and think before hitting reply to a list message: when you hit reply, it means your response goes to the entire list. If your response only needs to go to one or a few people, please send the message directly to their individual emails. 3) If you are not getting attachments, your internet service provider probably has an automatic block in place related to listserv mail. Talk with your IT support person. 4) If you or someone on your team is not getting CIS communications (like this summary), or you wish to be removed from the list, send name and email address to list manager Christina Strobridge: christina.strobridge@ahs.state.vt.us <p>CIS Brochure: Revisions based on feedback from the regions is underway. The goal for distribution is July 1, 2009.</p> <p>CIS Referral and Intake form: Revisions are underway based on feedback from regions. The goal is to have the final version ready for July 1, 2009.</p>
<i>Sue Schmidt: Vision and process for CIS Shared Intake and Referral Process</i>	<p>The vision for the CIS Program is for a holistic and comprehensive early childhood system of care for Vermont's children and families, prenatal to age six. This includes</p> <ul style="list-style-type: none"> • Easy access to services for families, no wrong door. • The means for accessing CIS services is through a shared intake team • Coordinated data collection about the families served via the many services offered by the CIS program • Improved outcomes for children <p>Process: All referrals to the CIS Program and its array of services will go through a small, multi-disciplinary CIS intake team led by a CIS Intake Coordinator. The CIS intake coordinator will manage the functions of intake, data collection, and preliminary clinical coordination. The only exception when a referral would not go through the CIS intake team would be when there is a need for urgent or immediate services. This means all referrals to early intervention services (formerly Part C/FIT Program), all referrals to maternal child health services, family support services, health promotion and nursing services (formerly HBKF Program), and all referrals for ECFMH services (formerly the CUPS Program) will cycle through the CIS intake team regardless of which door a family came through with the initial referral.</p>

	<p>Services within the CIS program will be delivered as they always have been. Billing for services will remain the same for now. The first change is in the shared referral and intake team process.</p> <p><u>Referrals for immediate or urgent services:</u> Are acted upon immediately. Referral information goes to CIS Intake Coordinator as soon as possible after the initial contact.</p> <p><u>Referrals for a specific service:</u> There are many referrals for service which are straightforward and do not need extensive team review. For example, a referral for lactation consultation goes directly to the home health agency. They provide the service and pass on the intake information to the CIS Intake Coordinator using the CIS Referral and Intake form. A referral for a speech and language evaluation may come directly to Early Intervention services. They accept and act on the referral and make sure that then the CIS coordinator gets the referral and intake information as well.</p> <p><u>More complex referrals:</u> The CIS Intake team reviews these together in more depth and determines the best service approach for the family. A primary service provider is assigned and, as needed, an individualized child and family team is identified.</p> <p><u>Membership of CIS Intake team:</u> At a minimum, a CIS intake team includes the CIS Intake Coordinator, a VDH MCH nurse, ECFMH professional and a Developmental educator. Regions may choose to add other relevant members to the team as they see fit.</p> <p><u>Consent:</u> AHS legal staff representing all CIS services is currently reviewing CIS consent at the point of referral to ensure for all involved that the form and associated process meets all necessary requirements. Will be ready for July 1, 2009.</p> <p><u>Rationale:</u> CIS intake coordination allows families to access services through whatever door they know. It ensures that each referral gets a multidisciplinary review. It ensures all partners in CIS are providing services in a coordinated fashion. It allows the state and the various service providers to receive, interpret and act on data for all children 0-6 in the CIS system of care.</p>
<p><i>CIS Intake Coordinators</i></p> <p><i>(Please refer to attached revised document)</i></p>	<p>CIS Intake Coordinator role: Discussion focused on the draft <i>CIS Coordinator Role and Responsibilities</i> document which was circulated after the March Open Agenda call. An updated version which includes minimum qualifications is attached with this month's summary.</p> <p><u>By July 1, 2009 regions will:</u></p> <ul style="list-style-type: none"> • Have identified their CIS Intake Coordinator • Have identified which agency will hold the Intake Coordinator contract • Have identified where CIS calls will come to for 211 • Have AHS Consent form for CIS referrals • Begin the shared intake process for CIS using the CIS Referral and Intake form • Begin outreach and referral partner education re: CIS. CIS brochure will be available.

Phased Roll-out: It is understood that not all regions will be ready to implement CIS program intake by July 1. It is important for regions to self-assess and communicate their level of readiness for implementation with their assigned CIS TA staff. **The CIS program with shared referral and intake team will be fully operationalized in all regions by January 1, 2010.**

Sue Schmidt reviewed the points made on the last call regarding the CIS Intake Coordinator:

- The State is not creating new classified positions for this role.
- There will not be an FTE for every AHS district. FTE's were figured by looking at the number of children served in each region through the combined programs for the past 3 years fiscal years (2006, 2007, 2008). The numbers and associated FTE's will be shared with each region soon if not already through a meeting or call with your CIS TA person and Sue Schmidt.
- It will be the community's decision as to who they hire into the CIS Intake Coordinator role. It cannot be the VDH Maternal Child Health coordinator. Communities will fill the role in the way that best meets the needs of their region, including details of the role, where that person sits, where families and referral partners call. The state will provide job description and minimum qualifications. I have some language around minimum qualifications that we had agreed on from a while ago.
- This is not a direct case management position. This is not a direct service position. The Intake Coordinator acts as the point person to assure the outcomes of the CIS referral and intake process, to make sure families get the needed services in an effective and efficient manner and to problem solve when they do not. The role requires administrative, medical billing, and clinical assessment skills.

Participant Questions

What is the exact name of the coordinator role?
CIS Intake Coordinator

What is meant by the term "region" within the context of CIS?
A region, for the CIS Program, refers to one of the 12 AHS districts.

Can we use our MCH coordinator to fill the CIS Intake Coordinator role?
No. Refer to VDH specifications for the MCH coordinator role and the attached VDH memo.

What role will the MCH coordinator play in CIS?
Like other members of the multidisciplinary intake team, the MCH coordinator offers a specific lens of professional expertise: MCH coordinators work with community systems and focus on population health, wellness and prevention, e.g., targeting approaches to improving outcomes such as decreasing smoking rates in pregnancy; increasing screening and referral for postpartum depression; or promoting EPSDT services. The MCH coordinator is a strong connection to the medical community and referring partners. MCH coordinators will be key in CIS outreach planning and coordination; will continue to be an important source of referrals into the CIS Intake team; and, as a member of the Intake team, will assist with triaging intakes and referrals.

Our region already does coordination at the level CIS asks. Can we use the intake coordinator money for something else?

No. The funds are specifically for an intake coordination position.

If we can assure CIS coordination tasks and functions, do we need to hire a new coordinator?

If a region can assure that there is one central point person responsible for coordinating CIS services, data collection, reporting, and problem-solving then they are welcome to make a proposal to CDD CIS as to how this will be structured. The region would not receive CIS Intake Coordination money.

The draft "CIS Intake Coordinator Responsibilities" document does not list criteria and background and qualifications. Does CDD plan to add these specifications?

No. Each region has different market rates and hiring availability. CDD will add minimum qualifications, as suggested on this call (See attached). In general, strong candidates will possess a clinical background and associated skills, will have Medicaid and medical billing knowledge, and possess strong organizational, facilitation, and administrative skills.

How much decision-making is up to the regions in hiring the CIS Intake Coordinator?

Hiring is up to the local region within the parameters described in the *CIS Intake Coordinator Responsibilities* document.

Specifics related to hiring:

- 1.0 FTE = \$60,000 (based on an estimate of \$45,000 salary, \$15,000 fringe and admin costs, but communities can decide not to pay benefits and put more to salary, etc.)
- The CIS Intake Coordinator will be the employee of whichever agency in the region takes on the AHS contract for the position
- Regions should consider which agency has the most suitable infrastructure (space, computer, phone access, supervision, admin costs) as part of the decision
- Liability is covered by AHS
- Training and support will be provided to the CIS Intake Coordinators by CDD CIS TA staff. CDD TA staff will go to regions to provide training and support to keep travel to a minimum.
- Supervision of the CIS Intake Coordinator will be provided by the agency holding the contract.
- AHS confidentiality rules apply to the CIS Intake Coordinator position as they do to all CIS staff.

Does the Fiscal Agent for a region have to be in that region or can the fiscal agent be in a different part of the state?

The CIS Intake Coordinator and the infrastructure supporting that person's work must be in the region where they work but if a region feels there is advantage to a fiscal agent located elsewhere, they can propose the arrangement to CDD CIS for consideration.

If each region has a different FTE amount for the intake coordinator position, the job description and work specs must be adjusted accordingly. A .60 FTE cannot produce the same amount of work as a 1.0 FTE.

The FTE amounts for each region are based on a three year average volume of

	<p>services so, proportionately, the FTE should relate directly to the amount of work. Training and TA will be offered on site and regionally to eliminate the need for extensive travel for statewide meetings</p> <p><i>We know that the “One Plan” will not be required for billing, but will it (in a revised version from what was piloted this past winter) be an expectation for documentation?</i></p> <p>No. Every family served by the CIS Program will have a single plan of care. The format and documentation of that plan of care will vary depending on the service (for example, for early intervention services, it is the ISFP).</p> <p><i>When we get a client signature on a referral form to CIS, can we use that signature as a release to bring the referral to the team or does the Intake coordinator need to obtain a separate consent to bring to the team?</i></p> <p>Yes, the CIS referral form serves as initial consent to bring the referral to the intake team and share <i>just the basic information</i> needed to determine service. Often the first level of consent will be verbal. There is a line on the referral and intake form which denotes obtaining verbal consent. The CIS Intake Coordinator will not need to obtain any further consents at this stage of referral and intake.</p> <p><i>Once thru the referral and intake, everyone would then proceed with their service specific consents, correct?</i> Correct. Once the referral goes to the specific service provider, all their usual paperwork and procedures, including more detailed consents for treatment and release of information, is completed.</p> <p><i>Will Prior Authorizations for the former HBKF services still be required after July 1, 2009?</i></p> <p>Yes, for now, Prior Authorizations will continue to be required for Medicaid oversight and will continue to sit with the VDH MCH coordinators until CIS has a more established and integrated method of oversight.</p> <p><i>Why is the CIS coordinator responsible for the Community Resource Directory and is there funding in the \$60,000 to produce that document?</i></p> <p>The responsibility for the Community Resource Directory has been eliminated in the current version of the <i>CIS Intake Coordinator Responsibilities</i> document. Also deleted: <i>review performance standards, clinical competencies and best practices</i></p> <p><i>Will the TAG document be updated to reflect the evolution of the CIS Program?</i></p> <p>Yes. Specifically, the outcomes for each element need to be refined.</p>
<p><i>Next Open Agenda Call</i></p>	<p>Next call is scheduled for Weds, May 21, 2009 from 1:00-2:00 PM. Call in Number: 1-866-642-1665 Participant code: 471230</p> <p>Open Agenda calls occur on the third Wednesday of each month from 1-2 PM. Agenda items may be requested at the start of the call or sent ahead of the call to your TA person or Christina Strobridge Reminders are sent out a few days ahead of each call. Summary notes are sent to CIS teams statewide via listserv.</p>