

Missouri Part C Service System Structure Stakeholder Meeting
April 25, 2007
9:45 – 3:30
Truman State Office Building, Room 750
Jefferson City, MO

This stakeholder group was convened at the request of the SICC to begin statewide discussions regarding the challenges Missouri faces related to availability of providers. DESE contacted NECTAC, the National Early Childhood Technical Assistance Center, to assist the state with information on various models used by other states in the provision of early intervention services and to facilitate a meeting of stakeholders to look for possible improvements to Missouri's current system. This group consisted of SICC members, SPOE directors, RICC chairs or co-chairs, lead agency staff and providers from urban, rural and all geographic regions in the state. The provider group represented large and small agencies, independent providers, hospital providers, and one agency that no longer provides services in the First Steps program.

Anne Lucas, TA Specialist, and Joicey Hurth, Associate Director for NECTAC facilitated the meeting.

NECTAC reviewed the day's agenda and addressed the general intent of the group's work. The agenda was developed to review current challenges in Missouri and recognize that programs run differently among the states with no one method being problem-free. Missouri's challenge will be to decide on which set of problems the program wants to address. The group was charged to consider how we should work as a state on the program's structure and infrastructure and how we have dealt with the challenges so far?

During the meeting the group discussed the various program structures used across the country and identified pros and cons for each structure. The theme for the day was a balance in comprehensive discussion and thinking and recognition that there is no perfect solution. After hearing about the various models, the group considered how each would fit within Missouri. While final decisions were not an expectation, the group was charged to arrive at some conclusions that would lead to recommendations for future consideration. Presentation of the groups work will be made at the next SICC meeting in May.

To begin the discussions the group was asked to write down several words that describe the challenges currently faced by the program and individual providers. Listed below are some of the challenges that were identified:

- ◆ Evaluation procedures often redundant for the family
- ◆ Turnover of service coordinators
- ◆ Inconsistent IFSP development
- ◆ IFSP Team Coordination
- ◆ DMH Initial Case Management not being included in initial IFSP coordination to start services. Provider therapists not at IFSP to be a part of the plan
- ◆ Ongoing provider not always getting information prior to first visit
- ◆ Providers not getting necessary background information including medical, evaluation and family assessment.
- ◆ Providers should be able to access medical and other background information on the webspoe
- ◆ No information prior to beginning services

- ◆ Poor teaming between providers
- ◆ Lack of teaming (multidisciplinary)
- ◆ Scattered providers make it hard to do transdisciplinary/multi approach
- ◆ Need more teaming upfront for service determination/outcomes
- ◆ Difficulty in teaming amongst providers regarding specific child
- ◆ Little interaction time for providers – especially when thinking about moving to a primary service provider model.
- ◆ Consistent teaming and communication on implementing IFSPs
- ◆ Limited interaction among providers

- ◆ Higher Education – incentive to attract providers to rural areas

- ◆ Low provider rates
- ◆ No provider rate increase for years
- ◆ Low provider rates limit provider recruitment
- ◆ Ability to recruit therapists at a rate manageable with First Steps rates
- ◆ Reimbursement rates are not competitive resulting in 1) limited travel and 2) inability to maintain some disciplines

- ◆ Low number of providers in homes to compete with hospital and school district reimbursement rates
- ◆ Requirements that are not billable
- ◆ Evaluations – can't get paid for write ups
- ◆ Provider cost to enter notes, mileage logs, etc., - those are lengthy data collection processes – evaluation write-ups
- ◆ Provider consult not easily billable
- ◆ First Steps evaluation/assessment process does not necessarily/often coincide with some professional discipline requirements (ex. P.T., others?) of evaluation to be implemented for providing therapy visits
- ◆ Travel incentive for providers
- ◆ Reluctance to travel more than 15 minutes to families
- ◆ Travel reimbursement will help costs, but few therapists in rural areas resulting in long travel days
- ◆ Travel 80 miles round trip and you get reimbursed per mile but travel 120 miles round trip and you get mileage and \$45.00
- ◆ Some travel distances are 20-30 miles away, but may take an hour to get there
- ◆ Quality/quantity of services depends on where family lives

- ◆ Provider shortages
- ◆ Providers not willing to travel – can see more children at the center
- ◆ Few OT's in our area (no degree programs) losing those we do have to areas that pay more
- ◆ Shortage of OT, PT and ST in region, especially rural areas
- ◆ Not enough providers. Some children/families need more support and it is not available.
- ◆ Provider caseloads get really full after April through August

- ◆ Scheduling is a significant issue with Matrix system – have therapists who see children very far apart creating more time on “the road” instead of providing therapy
- ◆ Matrix not working

- ◆ Expensive/time consuming to become a provider – over 20 forms and costs more than \$115.00
- ◆ Fingerprints are only good for 6 months unless you commit a crime
- ◆ Not cost effective to see a few children – in rural areas

- ◆ Web-based system is slow
- ◆ Should be able to save work on notes and be able to go back to finish
- ◆ Providers can't enter progress notes on webspoe system after 3rd birthday
- ◆ Not all enrolled providers post notes on the web

- ◆ Under use of current providers
- ◆ Can't eliminate providers due to poor "quality" practices
- ◆ First Steps philosophy inconsistent approach by provider base
- ◆ Unacceptable practices
- ◆ Providers without pediatric experience
- ◆ Not all providers understand First Steps philosophy
- ◆ Limited training for providers in how to develop functional outcomes

- ◆ Provider oversight family center practice
- ◆ Ongoing oversight of providers and ongoing training
- ◆ Limited oversight of "independent" providers

- ◆ Lack of systematic communication system with providers
- ◆ Consistent training and information given across program statewide
- ◆ Sharing information with other similar SPOE's in the state regarding RICC committees which might have similar issues/goals.

- ◆ Childfind inadequate referrals to Medical community (urban issue)
- ◆ Lack of awareness among pediatricians of First Steps
- ◆ Kids that are being missed in Part C that are showing up in Part B with significant challenges

- ◆ Inability to do co-treatment "safety"

- ◆ Transition to part B not always positive processing.
- ◆ Paid First Steps provider participation at IEP transition.

- ◆ Provider training in Early Intervention in Natural Environment/Part C

- ◆ No support for providers regarding their specific discipline (i.e. discipline specific consultants)

- ◆ Flexibility of system 1) location of service 2) need for change in service frequency 3) need to change or add consult fee that sometimes need more or less consult time
- ◆ Independent providers system encourages the pick and choose model of service and delivery. Not equitable re: location socioeconomic, etc
- ◆ No provider available not always used at team determines

Provider shortages and difficulty in recruitment issues: What has everyone been working on?

- ◆ Collaboration with University based communication group – donate assessment and bill for specialist and student interventions
- ◆ Note billing for providers is adding burdens
- ◆ Try giving perks/incentives for enrollment e.g. lots of information, emergency support, e-mail lists, drawing for with contract information
- ◆ Desperately seeking provider e-mail
- ◆ Rural – Did billing for providers to CFO and must have ability to get provider notes on web (use billing form) – pay providers with evaluation/case notes
- ◆ Approached SP 40 Boards where no providers – enter into agreement with SPOE – providers SVS in community program which is NE
- ◆ Provider agency supports providers in the enrollment process (paperwork and expense)
- ◆ Independent providers assume responsibilities but agencies provide supports/incentives to providers who are employed by agency
- ◆ Could there be a centralized job posting (e.g. like school district does)
- ◆ Recruit through colleges and universities (not EI component in pre-services have been teaching some classes)

Provider Support

- ◆ Important to support independents in Northeast

Teaming

- ◆ Get consult time on IFSP “paid for time”
- ◆ Overlap visits; co-treatment
- ◆ Empower family as key team member to share info
- ◆ Build family confidence/competence to implement learning opportunities all day

- ◆ 1 or 2 people from organization on IFSP team (mentoring) – (when only 1 person harder)
- ◆ Evening provider meeting to talk about children/families
- ◆ Bring provider to SPOE meeting/lunch (building positive relationships) when traveling to area close to SPOE

A PowerPoint Presentation was given entitled State Structures for Part C Service Provision which went over the various states structures.

Listed below are the Pro and Cons that were identified by the group for each state structure:

Individual Provider

PROS

- ◆ Allows independence agencies/individuals
- ◆ Flexibility
- ◆ Family choice
- ◆ Allow creativity in service delivery (agencies)

CONS

- ◆ Provider training
- ◆ Inconsistency in services/coverage
- ◆ Oversight
- ◆ Underutilized providers
- ◆ Inefficiency of use (time and money)
- ◆ Confuses families and difficulty teaming.

Provider Agency Approach:

PROS

- ◆ Supervisor and oversight of all providers
- ◆ Consistency
- ◆ Transdisciplinary teaming approach
- ◆ Easier to have colleague participate in home visits if necessary
- ◆ Community familiarity
- ◆ More access to pool of providers
- ◆ Mentoring opportunities
- ◆ Agency incentives

- ◆ Scheduling efficiency
- ◆ Less confusion in families with smaller choice of providers
- ◆ Services and more equitable to families
- ◆ Grievances handled at agency level
- ◆ Maximizes funding sources
- ◆ Cohesiveness equals less turnover equals better communication equals more quality control over providers
- ◆ Improved child find

CONS

- ◆ Less parent choice of providers
- ◆ More of a closed system for obtaining providers may decrease provider availability
- ◆ No provider is agencies responsibility
- ◆ Money

Combination Approach:

PROS

- ◆ Local agency knows area
- ◆ Versatility (adapt for region)
- ◆ Total oversight S.C., E/A, provision,
- ◆ More accountability
- ◆ Could be a more efficient use of resources (provider areas),
- ◆ Professional development.

CONS

- ◆ Less family choice
- ◆ Greater power base on local agency could be misused
- ◆ Local policies and procedures would need to be developed to allow change if significant issues/needs possible
- ◆ Confusion from one area to another.

Combination-Implications for Missouri

PROS

- ◆ Tapping into local resources that have buy-in in their community
- ◆ Development of administrative oversight of contracts/subcontracts (all agreements contracts pass on requirements)
- ◆ Using a modified approach similar to Northeast SPOE some providers may not be on the Matrix

CONS

- ◆ Figuring out overhead costs and CFO
- ◆ SPOE would need to maintain provider Matrix which would be a change (plus and minus)

State Contracts with SPOE – Provider agency provides services to children and families

PROS

- ◆ Maintains relationship with CFO
- ◆ Teaming
- ◆ State would have fewer to “directly” oversee

CONS

- ◆ No provider /no agency to enroll
- ◆ State still is responsible
- ◆ Lack of communication
- ◆ Compliance
- ◆ Reducing local management
- ◆ SPOE has no oversight

Stay the same

PROS

- ◆ Could change provider agreement to a contract for oversight (increase accountability)
- ◆ Tied payment system based on mileage

CONS

- ◆ Does not give SPOE provider oversight
- ◆ Hard to address service availability in regions
- ◆ Not as many incentives available for independent providers to go in “rural” areas

Program/Agency Approach – Implications

Oversight changes **BUT** the state retains ultimate oversight

Some longstanding agencies and independent providers would no longer work in First Steps using an RPF process e.g. program may hire or contract with individuals

Urban – benefit 1) oversight re: practices 2) efficiency 3) minimize competition

4) teaming – start with family needs 5) limiting choice may increase 45 day timelines (intent of family choice gone way out of line)

PROS

- ◆ Plan for needs
- ◆ Children would receive some services

CONS

- ◆ Would there be one entity that would assume this responsibility
- ◆ In certain areas choice by family's may be limited
- ◆ Not competition to improve quality
- ◆ Some rural areas still have same issues as current Missouri model

A poll was taken of the participants as to which structure they would like to see Missouri move toward and the results were as follow:

1. Stay the same - 3 people voted to stay the same with 7 people voting it as their second choice.
2. Provider Agency – No one voted for Provider Agency for their first choice with 2 people voting it as their second choice
3. Combo Approach - 18 people voted Combo Approach as their first choice and 3 people voted it as their second choice
4. State SPOE/State Agency model – No one voted for State SPOE/State Agency model as their first choice and 3 people voted it as their second choice.

Our next step will be to plan out some activities that will occur regionally. We would like more providers to come and tell us what problems they face. Joyce Jackman thanked everyone for attending the meeting and for their excellent ideals.