Quality Services – Supervision and QA
Power Point Notes (not a transcript)

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Why are we here? This is the first in a series of webinars to help you address quality services in your program. It can be really difficult to define quality for your staff, especially since they have a variety of skills and abilities, and strengths and weaknesses. Each of the next four webinars will help you identify indicators of quality services related to the processes listed here: referral and evaluation, comprehensive needs assessment and outcome development, service planning, and service delivery.

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What else are we going to address? Supervision of staff. The supervision that you provide will enable you to address quality services in a way that will benefit families, support the ongoing professional growth and development of your staff, and reduce the risk to your agency that can occur without proper supervision. One of the things you will need to provide effective supervision is a list of the quality indicators for each process. You will also need tools to use to document what you see and hear to help you determine if staff are meeting those quality indicators. We will provide some tools today to get you started. We'll provide more tools with each of the upcoming webinars.

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What do we want you to learn today? Several things, starting with the purposes of quality assurance, so you have context for the supervision requirements. We will be looking at why we implement quality assurance activities throughout the webinar. We also want to show ways to integrate QA into your supervision processes, so that we're not adding yet another responsibility. We're going to be sharing some supervision tools that are already is use in programs, and give you access to others so you have choices in the tools you use. The **take away message** here is: providing and documenting quality services benefits families, reduces risk to your agency by ensuring medical necessity, and promotes the professional development of staff.

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In preparing for this webinar series, we wanted to gather some information about how programs are addressing quality services. We felt that it was important to know what you are already doing. The questions on the slide were submitted to program directors as part of the performance managers' quarterly survey, 2nd quarter. We used survey monkey for the questions, so program directors had opportunities to respond and add comments.

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1. Why did we ask about the BDI tools? We heard in the regional meetings that children are determined eligible due to a delay in one domain, but parents want to work on another domain. Some programs wanted help in how to address this issue. The BDI graphs provide a visual of the relationship between developmental domains, and can open the door to a discussion with families about how development in one domain impacts development in the others. We'll talk more in the referral and evaluation webinar about how to capture that information to inform outcome development in the IFSP.
2. The BDI-2 data manager is a new tool. We wanted to see if many folks are using it, and if so, how it's being used for quality assurance and supervision.

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And the survey said: **72.9% are not using the data manager.** That's really not a surprise since it's so new, and not everyone has it. Of those who are using it, some of the directors shared how they are using it. Those who would be willing to share your expertise with those others, please type your name in the box and we will share names.

When asked about the barriers to implementing the 7 Key Principles, **20% of directors responded that staff are not familiar with the 7 Key Principles or don't know how to implement them.** MIW has a module devoted to the 7 Key Principles, which could be used as a refresher training if needed. All the other MIW modules include the 7 Key Principles, as applicable to the topic addressed. They also include what the principle looks like when implemented.

Over 60% of directors indicated that staff would benefit from additional training on documentation. Correct documentation is a program efficiency that will result in better services for families, save time, and reduce financial risk to your agency. Documentation is addressed in MIW, the Reimbursement Guide, and FCCM, and will be included in each of the upcoming webinars in this series.

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We also sent out a numbered document in January to announce this webinar series. As part of that announcement, we asked program directors to send us samples of the supervisory and quality assurance tools used in your programs. Here's what we have found in reviewing the tools we received: **The majority of tools focused on compliance.**

Compliance is a foundational requirement of quality, but it's not enough. A concern that we identified in our review of the submitted tools is that many of the compliance tools contained inaccurate or outdated information. Some folks are using the DARS monitoring tools for QA. Those can be useful, but it's really important that you use the most current version that references the current TAC.

Here's an example of a tool containing inaccurate information: The form had a yes/no checkbox with the following statement: The family gave written consent for Part B notification or requested to opt-out, within appropriate time frames. By federal regulation, notification MUST be given for a potentially eligible child unless the family opts out. There is no consent for this requirement.

Many of the tools we reviewed that addressed case management, were limited to questions about TCM. That gives the message to your staff that the broader definition of case management and associated requirements are not important. A word of caution about TCM monitoring: You cannot require that each child with Medicaid receive a specific number of TCM billable hours per week or per month.

We also saw a variety to tracking tools for timelines. Timeline tracking is vital, but it's only a first step toward actual quality oversight. We're going to ask one of our programs to share a timeline tracking tool a little later. Now I'm going to turn it over to Chris to talk about quality assurance as a part of monitoring.

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In the last year DARS ECI implemented Quality Assurance review at the system level, through the participation of Quality Assurance Staff on monitoring teams. When a program is monitored, the QA staff on the team review child records and provide feedback regarding 1) compliance monitoring items that have quality components; 2) Quality indicators that we anticipate will be included in rule in the

future; 3) Quality indicators that are directly related to ECI assurances to Medicaid 4) Quality indicators that can result in more effective services to children and families, and 5) reviews of children who are referred, evaluated, but do not enroll.

Our overarching finding through these efforts is that teams are not documenting that IFSPs are developed based on all of the information about a child that is available. Remember that the IFSP provides the authorization for medically necessary services, and without complete documentation in the IFSP, the provision of services provided will not always reflect the medical necessity. This is critical because the Health and Human Services Commission contract with Managed Care Organizations requires that the MCOs contract with ECI and fund the medically necessary services in the IFSP.

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At the end of a monitoring review, this summary is provided to the program that was monitored. These screen shots will illustrate for you the lack of connection from referral to IFSP to services that we are finding. All of these areas will be reviewed in more detail in the upcoming webinars, presenting them today is intended to provide you with an overview.

This first section reviews compliance items with a quality component. You can see for this program there was a lack of identification of needs, and the family concerns and priorities were not documented. We could often see in the referral and initial contacts with families that concerns and needs were mentioned but then were not addressed in the IFSPs. Again, the IFSP provides the authorization for medically necessary services, and without complete documentation in the IFSP, the provision of services will not always reflect medical necessity.

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The items in Part 2 of the summary are items that are not compliance. Some of them are directly related to ECI Medicaid requirements. We anticipate that some of these will be finalized into rule in the future. Here again you can see the connection between the concerns expressed and the needs identified throughout the whole process, especially items C and D. In a quality assurance review of a record the QA staff attempts to follow the ECI progression of a child and family through the whole process, from referral through services. We find that this is often in direct contrast to how a program reviews child records, often reading sections in isolation and disconnected from each other.

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The final area of review is for children who are referred and evaluated, but do not enroll. A disconnect in the process can become even more apparent in this review. The pattern we see here is one that we have seen in numerous programs, in which the documentation of referral concerns is very weak, making it impossible to know if concerns and needs were addressed. We believe that this can present a liability to a program if a parent were to come back months later to challenge the eligibility determination for their child. Items EE and FF in this section relate specifically to documentation of evaluation and will be covered in detail in the webinar on April 11. I'll hand it back over to Fran now.

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Just to recap , in preparation for this webinar series we conducted a program director survey, requested and received supervision tools currently being used, and looked at what we've learned from our quality assurance monitoring. So now let's take a look at what we mean by quality assurance. **A program for the systematic monitoring and evaluation of the various aspects of a project, service, or facility to ensure that standards of quality are being met.** It's about having a quality assurance **system** in place.

We'll look at **Standards of Quality** soon. This definition, which could be applied to all ECI work, is also the medical definition of quality assurance. A QA system for medically necessary services will look for 3 things that must be documented: 1. the need for services, 2. a plan that addresses those needs, and 3. addressing the identified needs by providing services that meet quality standards. If you do those 3 things, the requirements of documenting medical necessity will be met. Remember, that's part of the takeaway message.

We're not going to provide you with a specific QA system, because one size does not fit all, but we do have a few suggestions. Two principles you will want to consider as part of your QA system are: "Fit for purpose." The product should be suitable for the intended purpose. An example of that is the forms that are used. The other principle is: "Right the first time." If you get it right the first time, mistakes should be eliminated.

Program QA system should also include a review of:
1. Staff competence, such as knowledge, skills, experience, qualifications
2. Soft elements, such as personnel integrity, confidence, organizational culture, motivation, team spirit and quality relationships, and
3. Infrastructure (as it enhances or limits functionality)

The Reimbursement Guide on the Extranet has a good explanation of a QA system from an operational standpoint. See Chapter 5.2, Quality Assurance

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Let's look at one more definition of quality assurance. This definition speaks to having a system, comparison with standards, and prevention of mistakes. This definition also addresses quality controls. Many of the QA tools submitted by programs address quality control, process outputs, such as timelines and IFSP components. Quality controls are an important part of a QA system for our services. To avoid confusion, I want to let you know that monitoring staff workloads and productivity is NOT a means of quality control, and is not a part of quality assurance. It is necessary as a management oversight function, but an individual staff person could have a huge caseload, or a tiny one, and not provide quality services.

At the regional meetings, many of you asked for a tool to help staff meet transition timeline requirements. Tina Hanks, at Spindletop, has developed a spreadsheet to track transition timelines and other process outputs. Tina's tool also includes other timeline requirements for each child. The spreadsheet can be used for direct service staff to enter information, and a program director or supervisor can use for monitoring purposes. It is currently being piloted. When the pilot is complete we will make it available to anyone who is interested. (Give control to Tina & Tonia for 10 minutes.) Thanks Tina. We look forward to the time when your pilot is finished. This looks like a great tool to use to track some of the quality control issues that have to be addressed.

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So now that we've talked about definitions of quality assurance, what will be the result of assuring quality? The federal child and family outcomes will be met. This is another **part of the take away message**: children and families will benefit from the services. Listed on the screen are the 3 federal child outcomes.

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Here are the federal family outcomes. Child and family outcomes can be some of our most powerful indicators of quality services. The fact that a service has been provided does not mean that a positive outcome has been achieved, which is why timelines alone aren't enough. Likewise, an outcome is not the same as satisfaction with the services received. The impact that services and supports have on the functioning of children and families constitutes the outcome, and our measures of the impact will tell us much about the quality of our program and services. The process of tracking these child and family outcomes is in its infancy, and DARS will be assisting you more in the future with the use of child and family outcomes as an indicator of quality.

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What is quality for early intervention? In addition to the federal child and family outcomes as indicators of quality, demonstration of the implementation of the 7 Key Principles is another place where you will find the indicators of quality. That demonstration may be found in child records, observations of service provision, and documentation of discussions in trainings and supervision consultations. Documentation of implementation of the 7 Key Principles supports your ability to bill your services as being medically necessary.

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Implementation of the 7 Key Principles is one of the things that makes ECI different from other early childhood therapy providers. The link on this slide is one of the QA tools you may want to consider for your program's QA system. It is a program self assessment tool based on a crosswalk of the 7 Key Principles and the federal child and family outcomes. Let's take a minute and look at this tool.

You will notice that this was developed by NECTAC and the ECO Center. Both of those are now under 1 umbrella called the ECTA Center (Early Childhood Technical Assistance Center). This document gives you quality indicators for the whole early intervention process, beginning with first contacts with the family, through IFSP development, service delivery, and concluding with transition. It allows you to determine if your program has not implemented the practices that are quality indicators, needs improvement, or has implemented the practices.

At first glance this document seems overwhelming. It's 16 pages long! But there is no requirement to use the whole document, nor do you have to use it all at once if you do decide to use all of it. Pick one or two areas to try and see how it works for you. That being said, QA and supervision take time, but the end result is that you will realize efficiencies in your system.

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WIIFM means, what's in it for me, and why should I care about quality? We talked earlier about benefits to children and families as a result of providing quality services. Here's a slightly different spin on that part of the takeaway message. Families need to know if their children are making progress toward outcomes or not. Documentation of good services (whether written, video, or audio) gives parents a record of the efforts made to help their child grow and develop, what worked and what didn't work, and how long it took for a child to make progress, or for the team to determine that they should try something else. Families will need good documentation of their child's experience in ECI as they address future needs of their child. Helping families learn how to use their child's record to access needed services, and communicate with medical personnel, could be a wonderful transition activity.

Supervision that promotes quality services supports the ongoing development of professional knowledge, skills, and abilities. The more your staff know, the greater the reduction in mistakes, which

results in greater efficiencies. This website has links to the Texas Early Childhood Career Lattice and Texas Core Competencies for Early Childhood Practitioners and Administrators.
I'm not going to open the career lattice link because it runs in a landscape format that would cause you to read sideways across the screen, but here's what the instructions say about the career lattice:

Practitioners can use the Career Lattice to examine their movement up the levels and consider what steps they can take to increase their value in the marketplace.

- Practitioners can also use the Career Lattice to help inform their decisions related to seeking increased compensation or increased levels of responsibility in their place of employment.
- Administrators can use the Career Lattice as a tool to guide compensation and promotion decisions in their programs.

Let's take a quick look at the core competencies. Increasing knowledge, skills, and abilities in these areas increases opportunities in terms of career options and compensation. For your program, and for families, it results in better services.

Lastly for this slide, let's talk about billing reasons. I know I'm going to repeat myself here, but I'm going to do it anyway. Providing and documenting quality services meets the requirement to provide and document medically necessary services. Staff who provide and document quality services reduce the risk of monitoring findings, audit "findings," sanctions, fines, recoupment of funds, contract termination, and civil and criminal charges.

As a side benefit, the provision of quality services promotes a good reputation in the community. Your staff are engaging in public outreach every day.

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Now let's get practical about how we do this. Key Principle # 5 states, IFSP outcomes must be functional and based on children's and families' needs and family-identified priorities. As Chris mentioned earlier, one of the reasons staff are having trouble with quality services is that they are not making, and then documenting, a connection between the information gathered before the IFSP, the development of the IFSP, and then the provision of services to address the outcomes and family priorities identified in the IFSP.

Information that is gathered at referral and the first contact with a family should help staff identify family concerns, and inform recommendations for evaluation team members. Information from referral and first contact, and then evaluation, should guide the conversation and questions in the comprehensive needs assessment.

The comprehensive needs assessment should specify the areas of the child's delay, how the child functions in the family's daily activities, what the family is already doing to address their child's needs and the resources they have available to help them do so, and then, what their priorities are in addressing their child's needs. Oversight of your staff's correct use of the first section of the IFSP (The Functional Abilities, Strengths and Needs Assessment/ Present Levels of Development) and attention to the prompts will ensure that all of these components of needs assessment are addressed.

The ongoing needs assessment should capture changes or lack of changes from one visit to the next within a discipline, and also across disciplines. Ongoing needs assessment information should be brought forward to inform the re-assessment process.

Connecting the medical necessity from one ECI process to the next process is a part of assuring quality services.

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How do we demonstrate quality? Demonstration of quality practices can be found in child records that document the connections throughout the early intervention processes, the provision of services according to quality practices, and documentation of medical necessity. Documentation of quality practices, and the connections between each of the processes, is documentation of medical necessity.

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Let's talk about documenting the connections. In trying to remember all of the requirements for each part of the process we can sometimes lose the continuity of the processes. Each of these, referral, first contacts, evaluation, and needs assessment are not individual tasks but required parts of the entire process that fit together.

One of the reasons the connections can get lost is that there are often different people participating in each of the parts of the process. The best way to make sure that all members of the team have access to all of the information gathered is to document it, either in writing or by some type of recording that everyone can access. (Reminder: recording and storing of recorded information must be done in a way that ensures confidentiality.) You may also collect a lot of information that will not be needed to develop a good IFSP. You may need that other information at some point in the child's enrollment, but you will need to sort out what is needed for the IFSP. Synthesize and summarize your information to develop IFSP outcomes. Using the prompts on the IFSP form will help you to both synthesize and ensure that you have included everything you need. Since we're talking specifically about documentation here, a good rule of thumb to apply throughout all of your work with families is, if it isn't documented, it didn't happen.

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The summary of information gathered before the IFSP meeting and as a part of the comprehensive needs assessment should inform the development of the IFSP. The outcomes, the COSF ratings, the family priorities, and the family resources should all be informed by the summary. The decision about the services that are planned should be determined by the outcomes that are to be met. The outcomes should also drive each of the service delivery visits. It looks like I've made a mistake here by saying service delivery drives service delivery, but I'm talking about the specifics of every visit should inform the next visit, both within a specific discipline, and across disciplines. (ongoing assessment). As the child makes progress, or does not, the plan will need to be reassessed to determine its appropriateness for meeting child and family needs, and changed as needed. In an upcoming webinars we will give specific child examples of each of these connections and documentation of the whole connected process for a child.

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The first item on our list of ways to demonstrate quality was to make the connections. The next item on the list of ways to demonstrate quality is about quality practices: implementing them and documenting them. ECI's requirement of documentation of parent involvement isn't separate from the 7 Key Principles. It's what Key Principle #1 looks like when implemented. As a reminder, principle #1 is: Infants and toddlers learn best through everyday experiences and interactions with familiar people in familiar contexts. Here's what it looks like: Helping **caregivers** engage the child in enjoyable learning

opportunities that allow for frequent practice and mastery of emerging skills in natural settings, AND focusing intervention on **caregivers'** ability to promote the child's participation in naturally occurring, developmentally appropriate activities with peers and family members.

That means your staff will need to know early childhood development, developmentally appropriate activities, and how to help families identify naturally occurring learning opportunities for their child in their daily lives. Implementing, embedding, and documenting implementation of the 7 Key Principles will meet both clinical and family requirements, support documentation of medical necessity, and actually help you meet the Medicaid, CHIP, insurance, and rule documentation requirements.

In addition to the 7 Key Principles, the Division for Early Childhood also has great information and tool kits to help you implement quality early intervention practices.

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The last of the three items on our list for demonstrating quality is documenting medical necessity. Experts in the reimbursement of health services indicate that the single most common, and therefore most costly, area of non-compliance is the service provider's failure to prove the need for the services provided. This is true for Medicaid, CHIP, TRICARE, private insurance, and Part C. So let's see what documenting medical necessity should look like.

Documenting medical necessity is much more than just including the medical information and prescription from the doctor. It begins with the referral and initial concerns identified. The next step is ensuring that the teams who evaluate the child for eligibility include a licensed professional of the healing arts, as specified in TAC. By IDEA law, the IFSP team determines the need for services, and the services to be provided to meet the child's needs. The IFSP serves as the authorization for Medicaid services. Documenting the connections between the identified needs, outcomes, and the ongoing services is documentation of medical necessity.

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That being said, how do we connect the dots, implement and document the 7 Key principles, and still document medical necessity? I'm glad you asked, because we're from the state and we're here to help! ☺humor☺

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We've developed a crosswalk of the 7 key principles and the components of a medically necessary service to help get you started. On the right are five components of a medically necessary service. On the left are the 7 Key Principles that correspond with each of the five components. For the next webinar, referral and evaluation, we will take each row, one color at a time, to elaborate on the contents. Just remember, there are no stand-alone pieces. Everything must be connected. This crosswalk is provided as a handout.

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So how do we improve quality? SUPERVISION. Yes, you have to provide the supervision in terms of workload and productivity issues. It's a part of management oversight. It's not a part of QA. You have to ensure compliance. Monitoring compliance is comparison of practice with compliance standards. It's a first step in QA. Now let's look at supervision in terms of quality assurance.

One of the components of a QA system is the feedback loop addressed in the definition of QA. The ability to provide feedback to staff in a supportive and helpful way is a leadership skill. It means that you have to risk not being liked. The leadership lesson here is simple: "Inspect what you expect." So at the risk of not being liked, you must have a QA system in place that includes inspecting what you expect to be done to make sure that it is done. Your supervision is more likely to have an effect of the quality of services if the focus of the supervision is informed by your quality assurance findings.

You are given three methods of supervision to choose from. Hopefully you will use all three at one time or another to get a complete picture, and to support your time and efforts for quality assurance. The three methods are record review, consultation, and observation. Let me remind you that any time you use technology for observation or consultation that you must ensure the confidentiality of child and family specific information. Skype and similar technology are not secured.

We've provided you with a handout that lists various supervision tools. The list is organized to correspond with each of the 3 methods of supervision. Let's take a look at record review.

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Review of records can be done one on one1, but it can also be a peer review of records. Wonderful learning takes place in the discussions of what is seen in a child's record. Project Ninos has given consent to share a sample of the progress note they use in their program. Let's look at it.

Top boxes include child's name, date, location, start time and length of service. You'll note that it includes updates since the last visit, including doctor appointments, changes in family routines, or other important events. The next section is a summary of the activities and routines addressed by the child and family that day (parent participation). It also asks that the provider enter any new information, instructions and recommendations (coaching). Then we have child progress since the last visit, and any new relevant information (this might include info about motivators that worked or didn't work, or new child interests). Then the IFSP outcomes addressed are identified. (By identifying a specific outcome addressed in the service, the connection is made between the identified need and the service provided to address that need.) Plans for the next visit might include new strategies, tweaks to existing routines, trying the strategies in other routines or locations. Joint planning for the next visit needs to include the caregiver. It provides another opportunity to document caregiver engagement in the service. Bottom has signatures with credentials. This sample progress note is also included in your handouts.

The parent's signature on the progress note and receipt of payment for the service are not considered proof that quality services were provided.

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For those of you who have had training in reflective supervision, it is one method that is often used for consultation. Central Counties Childteam shared with us the form they use for the consultation option for supervision. Let's look at it. It includes documentation of feedback to the staff member. The Discussion might include any of the indicators of quality services. It provides an opportunity for a discussion about a particular child or record. This could also address quality indicators, but could also provide an opportunity to support a staff person's professional growth in knowledge, and skills about child development. It addresses workload and productivity (remember that's part of supervision but not QA), and then concludes with feedback from families or other team members.

Another option for consultation is a review of scenarios addressed in various video clips. There are so many available to choose from. You might consider videos from the Early Childhood Learning & Knowledge Center or the Connect Modules. Some of the questions provided for the ECI self-assessment scenarios could be used with videos from other these other sites. Links are included in your handouts. Discussion of a training the staff person attended would also be an appropriate use of consultation time. One last suggestion for consultation, the QA chapter (5.2) in the ECI Reimbursement Guide.

Now let's look at observation options.

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Observing staff in the performance of their assigned duties is a great way to determine if they are providing quality services. You don't have to go onsite for the observation. If parent's give consent, a video of the service may also work. ECI has observation forms available for several types of services, IFSP, direct service, etc. For a service delivery visit QA tool, Robin McWilliam has a three page Support-Based Home Visiting Checklist. The checklist identifies practices that you would expect to see implemented from the 7 Key Principles of What It Looks Like. It addresses providing emotional supports to the family, engaging the family in the visit (parent participation part), child progress toward the outcomes, and coaching and joint planning. We've included a link for this tool in your handouts. There is also a link for a Robin McWilliam video on home visiting that has some excellent information.

So, now that you are aware of some of things you can address in quality assurance, and you have a few tools to get you started, what do you do if you don't have a QA system?

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Start with a narrow scope, because a QA system to address everything can be overwhelming. A good place to start would be with your agency QA staff person, if you have one. If you do have one, their focus may be on workload, productivity, and quality control issues. You may need to discuss with them some of the things we've talked about today. If your agency does not have a QA person, there are businesses that will help you develop a QA system, but a large fee is usually involved. So, if you're on your own, select one or two areas that you're concerned about. You can't do everything at once, so trust your instincts to guide you. You can also ask your staff. They will probably have lots of ideas. Implementing a QA system takes time up front, but will result in time efficiencies in the long run.

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One more thing about quality assurance. It applies to all children and all services regardless of the funding source. If you provide and document the provision of quality services, and you have to make the connections between the parts of the process to do that, you will satisfy all stakeholders and pay sources. You will also promote the successful completion of family out comes, and most children will make developmental progress.

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☺humor ☺ We would like to invite you to tune in for our next exciting Quality Assurance episode, Referral and Evaluation, April 11 at 9 AM. Future episodes are Comprehensive Needs Assessment and Outcome Development, Service planning, and the concluding episode, Service Delivery. Be the first in your ECI program to get the skinny on tips for evaluating infants and toddlers, questions to ask in needs assessment to find out what you REALLY need to know, developing an IFSP like no other, and providing a service that's the envy of other agencies. No need to set your DVR, all episodes of this dynamic series

will be available for replay at your discretion. This series is rated G for general audiences, but direct service providers and supervisors may enjoy it the most.