Conference ID: BCW3053
Host Name: Carolyn Welch

Speaker: Good morning. This is Cynthia Ikata with the Babies First! Program and welcome to the forms training webinar. We're glad you were able to join us. Hopefully last night you all received copies of the case studies we're **** as well as copies of the forms. It's okay if you don't have them. You should be able to get through the webinar without them, but if you did print them they would be handy to have nearby. I am joined today with our co, um, uh, what are we, co-trainer, co-creator, co-conspirators, cohorts, collaborators, Candace Artamenco and, and Sue Walmount so good morning.

[Hi, everybody.]

[Morning.]

So here's our friendly reminders about webinar etiquette. Really, really important to place to not place your call on hold but to do use your mute button. I believe Star 6 will mute your phone if you don't have a mute button on it. Great, thank you, and you can chat with us throughout the webinar by using your text box, and if you have a question or would like to add a comment, um, vocally you can raise your hand and we'll pause from time to time to call on folks to give you the floor.

So, I have the dubious honor of presenting to you some, some forms and charting is the least favorite part of any nurse's job. Um, it certainly wasn't a favorite part of my job when I was out in the field, but I want to talk with you a little bit about why are we doing this now. Um, as, as you know we've been working for the last couple of years towards standardized practice in Babies First and we've come a long way, but we still have some distance to go. Um, we still know that there is some variance in how Babies First is, is administered by county and there is a little bit of variance even in, um, the targeted case management component, so the point of the standardized forms is to help us all get on the same page and to be approaching this work in a similar manner.

Last year we released some, um, targeted case management forms that were, um, considered optional. Um, we've had those out for a little over a year. We've had lots of great feedback and, um, have tried to implement that feedback and make improvements. We listened and we really hope you like the improvements in the forms that we're about to go over today. We've also learned over the past year as we've been trying to provide, um, more technical assistance around targeted case management that it can be quite confusing, and we hope that these forms will provide a clarifying tool that you can have in your hand on a daily basis to help you, um, be within the rules and within your contract requirements.

Also another reason why now is that many of you have been asking for standardized forms for a long time and we've kind of resisted 'cause there's two camps. There's the group of counties that want standardized forms and the group of counties that doesn't so we, we finally decided that, um, we will move forward with standardized forms and we're starting here with targeted case management. It felt like the low-hanging fruit. It's probably one of the easier

things to standardize and it's essential to keep us in compliance during these tough economic times to make sure we are functioning within the rules and maximizing, um, the funding opportunities that we do have.

But most importantly, our goal was to provide you with a tool that could make your job smooth and easy, and if it doesn't feel that way and if we haven't reached that goal please let us know. We hope that some advantages of these forms are that you can feel assured that you're working within the contract requirements and the rules when you're using this process for your documentation, and if you were to be audited it would be easy for the auditor to find your documentation. Um, the forms have been standardized to reflect the most common targeted case management components so you're not having to write it each time and, and create individualized care plans. However, throughout the forms you'll see there's an opportunity for others so that each step along the way can be personalized to the individual client.

As you know from looking at the forms, they're in a check-list format so that was done to keep it, um, quick, um, and to assure that it could be complete. By using these forms, it'll help assure that we don't miss a requirement. Something as simple as, um, that we missed last year, was the timeline for goal completion is a requirement in the rule and, um, so now that's been added to the forms.

All right, so let's jump in and go over the forms a little bit. If you have them printed it'd be, this is a good time to pull 'em out. What you see on your screen is the top portion of the assessment form. The assessment form, um, is to be, is designed to be completed at intake. Um, it may take you one or two visits to complete the assessment and plan and that's okay, but the idea is that you start with this at the beginning of the case. You'll notice that the form is really set up to determine eligibility and for you to document that eligibility, as well as to get a quick overview of what the family's targeted case management needs are.

**** to show you the bottom of the form. Want to call attention to the case manager's signature. Um, you'll notice different signature lines across the three forms. On the assessment form, the case manager's signature is here because the rules do require that the RN case manager complete the assessment and plan.

As we go through the day today, what we're going to be doing is we're gonna, um, have some case studies that we apply and then we'll show you how the, how the forms have been used to support, um, the case studies, so we'll have an opportunity to dive into some of these individual items as we go through our, our talk together.

So, let's look at the plan. So, um, the assessment and plan have, have, um, been designed to be on a front and back page. Um, you'll notice right at the top the date, the next TCM plan review. Um, that's to be the date the next review is due, and, um, the OARs indicate that you need to review the plan at least annually or more often as it's indicated by changes in the client's situation.

The goal, um, section gives you an opportunity to solicit from the client. What are their priorities, and then below that we have the most ****, um, that are related to case management. And then, of course, there's other so you can also write individualized, um, provider goals.

A new feature is the targeted date for completion. Um, again that is required in the rule and it will help you evaluate your progress with the family, as well.

Below you'll see planned activities and it's really important to understand the, the different purposes of the three forms so the assessment form is truly just your assessment. The plan is truly what you plan to do, and in a minute we'll have the, the visit form which is documenting what you did do, what you did deliver in regards to targeted case management. So there's three separate forms with three separate **** purposes.

Okay, let's look at the bottom of the plan. This is the bottom of the page and you can see your planned referral, so this is to reflect for your goals above what referrals do you anticipate needing to make. It's not, this is not where you document the referrals that you did make. This is what you plan to do to support your goals.

The plan is a place where, um, individual nursing practice will come into play. For instance, um, some nurses based on the client's assessment may have a plan that will last an entire year. Other nurses may have shorter-term goals and their plan might last anywhere between a month and three months, and that's really up to your nursing assessment to determine that. Um, so you may with one family end up with multiple TCM plans depending upon the length of time that you're working with them and how quickly they progress towards their goals. You'll notice on the plan that we've added now a place for a home visitor sig, signature so this is an opportunity where you can document that the case manager, the nurse, and the home visitor have consulted and, and both agree and understand the plan through these signature lines.

Okay, um, let's go ahead and review the visit form and then we'll pause for some questions. So here's the top of the visit form. This is to be completed at each TCM visit where targeted case management interventions are completed. It's important to remember as we're talking about these targeted case management, um, chart forms that nurse, nurse documentation is also still required. And it is in, in addition to your nursing documentation we also want to remind you that the ORKIDS data is still essential and important to gave, gather so as you're completing the referrals we want to remind you that we still, um, are tracking those referrals in ORKIDS and that data is still important.

On the visit form, again, you see an opportunity for both a case manager signature and a home visitor signature, and this is really how you use these signature lines is really gonna be up to the discretion of the individual nurse case manager. We now through our consultation with the State Board of Nursing that to work under the direction of a nurse requires that the nurse assess and determine based on her professional assessment how to do that, and how to document that, um, and that really may vary by, by nurse and community health worker. Um, it may depend upon the, the home visitor's background skills and experience, and it may vary depending upon the client's individual service plan.

The frequency of sign off and oversight is truly up to the nursing professional judgment. We've included these signature lines here as a tool for you to you to use, um, as you see appropriate but what is essential is that you do demonstrate that the community health worker or home visitor is working under the direction of the nurse, and by having co-sign off that's one way to do that.

Oh, okay. What about, um, I thought, I thought our next slide was going to be the question slide but that's okay. We can talk about electronic health records now. Oh, I know why. Bear with me. Let's do come back to electronic health records. Hold on. Okay, let's pause for questions, um, but hold your questions about EHRs if you don't mind, please.

Do you have any ****. Any hands up? Are you guys awake? Great, we got a question. Okay, so we've had a question come through. When do we start using the new forms? We are encouraging you to start using the new forms right away. Um, we will be working through the contract negotiation process and we plan to have this become a mandatory component **** your Program Element 42, and we anticipate that will happen July 1, 2012. By starting the forms now, if there's any big things we've missed or problems that gives us an opportunity to implement some changes prior to July 1. In, in a way these forms have been out there and been piloted for about a year. This is the new and improved version but you know things can always be better, so if you start using the forms now and get us feedback, by the time they're mandatory we can make them even stronger.

So we have a question coming in about duplicate documentation and I, I'd like to maybe give the mic to Sharon Caputo, um, so that we can have a little bit of a conversation about this question. Sharon? You want to unmute your phone? What, what I see being typed is that if we use the TCM visit form we will then, um, be documenting the same information in three places in the chart. So, I'm curious about what the two other places are where you're documenting the TCM interventions. Maybe you can type in and we'll circle back to you.

Okay, yes, you're absolutely right that you'll be documenting your referrals in ORKIDS and in the chart, and right now that's the hard reality where we don't have the capacity to extract data from your chart records. Um, in regards to documenting them in a narrative, you don't need to do that. You can just cross-reference your different forms to one another so you certainly don't need to document referrals in your narrative.

Next Speaker: Correct.

Next Speaker: Period. I do not need to do one bit more.

Next Speaker: Okay. It looks like we've addressed all the questions at the moment. Um, so keep 'em coming in and we're gonna go ahead and jump into some case studies so that we can practice using these forms together. So, I'm gonna hand this over to Sue who will walk you through **** Scenario No. 1.

Next Speaker: All right. And, before I start, um, I wanna just say a, a couple of things. One is, um, in Washington County, my staff have been using standardized TCM care plans and

assessments for years. Um, we, we, after the last, um, webinar not, not a couple weeks ago, but the one a year or so ago, we went to standardized, um, TCM what we call activity, uh, forms, but they're the ones, the ones that you do on each home visit. And, most of you probably don't know much about my staff, but my staff are hardcore old public health nurses. I mean, my staff has been doing public health nursing from anywhere to, you know, 12 years at the 1east to 33 years at the most. So, they don't like new forms and they don't like a lot of charting and we've tried really hard over the years to keep everything to a minimum. But, introducing the, um, the home visit TCM form was not a problem. I expected angst, um, but there was none because it really only takes a couple of seconds. And, the value that you get from it is so great compared to the few seconds that it takes to do it that it's really a nonissue. So, for those of you that are, you know, saying oh my God, how am I gonna do one more thing, let me assure you that this is not as onerous as it looks. It's doing, it's thinking, maybe thinking about things in a different way, but it is not a lot of additional charting. It will really save you in the long haul. Um, and it will make a huge, huge difference if you're audited. So, okay. So, with that in mind, let me go through, um, my scenario and then we'll talk about how it would be charted on these forms and then if anybody has questions you can, we'll talk about 'em. Okay? All right. So, um, the, the first, uh, paragraph is just what you would get on a referral. So, if we got a referral let's say from the NICU, it would say something like this on our forms. So, this is scenario is, uh, 24-year-old prima gravida. She had her preterm infant at 32 weeks. The apgars were 1, 1 and 6. Um, the birth weight, length, head circumference is there. Uh, the baby was in the NICU for six weeks and discharged yesterday. Um, we'd get the referral the next day. Um, the discharge weight, length and head circumference are listed, and the baby was sent home on breast milk fortified with Enfacare to 24 calories. And, then the last piece, and this wouldn't be on the referral but it would be on the address, is that this family lives 30 miles outside of where we all are. Um, so about ten days later after the nurses contacted the family and the family's had their first doctor visit and so on, the nurse goes out to make her first home visit. And, on that visit she weighs and measures the baby. Um, she finds out that the baby saw the, uh, pediatrician yesterday. Uh, the baby was given its two-month immunizations and told to come back in two months. Um, the mother was told that the baby was doing well. And, Synagis was never mentioned. Um, the mom tells us on the visit that she's pumping her breast milk and that she's mixing five ounces of breast milk with 1 teaspoon of Enfacare. The baby's feeding 1½ ounces every three to four hours except at night, and at night the baby's sleeping from 10:00, uh, in the evening until 7:00 in the morning. Next slide. Okay, um, when we talk to the mom about what she's worried about, she says she's worried about constipation. She says the baby's fussy, gassy and spitty. Um, but she's very relieved that she gets her sleep at night, because the baby's sleeping all night. Um, the nurse notes that the baby's sleeping on its abdomen and when she mentions that to the mother, the mother says that the doctor told her it was okay because the baby was a preemie. Um, we also find out at that visit that the mom is working part time at Fred Meyer, that her husband was laid off when she was 20 weeks pregnant and he is not eligible for unemployment. Um, the mother went on OHP during her pregnancy and the baby is on OHP now. They're not on WIC or food stamps because they don't believe in government services. Um, the family has a car but doesn't have much money for gas. They live in a one-bedroom rental, but the rental is from their great, uh, grandfather who owns the house and lets them live there for a very low rent but the family has to pay utilities and they have oil heat. Um, the, the baby's mother mother, the maternal grandmother, um, is very supportive but lives 30 miles away and works full time. Um, the mother of the baby also has a sister that's very supportive but she has four kids of her own that

are under the age of 5 and she lives in town. Um, the mother tells us that this was a planned pregnancy, that she and her husband have been married for a year, that they're very excited about this baby, they're glad the baby's home, but they are a little bit overwhelmed by the needs of the baby. So, what does – oh, so first, the first thing that the nurse would do is go to the home I would hope with the, the birth weight, um, and the weight at discharge graph and then she would put, um, her weights from that visit on the graph. And, so I'm showing you the graph just so you can visually, uh, kinda see what's going on. This is a standard preemie, um, growth grid. The weight at the bottoms shows that the baby's weight seems to be kind of leveling off. Um, and actually at you look at that weight going down, um, the baby's head circumference seems to be going up and the baby's length seems to be kind of staying, uh, put a little bit. So, this is other data that the nurse would have when she would come back from her home visit and sit down and start sorting out what, what is she going to do and what else does she need to know. Okay? So, what, the way that we work in Washington County is to sort of separate the nursing needs from the case management needs, because it makes it cleaner. Now, that may not work for some of you, but that's how we have tended to operate. So that, um, so that it's really clear what we're doing with both. So, **** the things that have been identified by the nurse as the nursing issues that she's gonna work on in subsequent visits. First thing is the weight loss, the second thing is the inappropriate feeding schedule – and by that I mean that this mother's letting this preemie sleep all night, not waking the baby up to feed, which may be one reason for the weight loss – um, the mother is not appropriately mixing the breast milk with, um, the Enfacare. It should be, uh, 1 teaspoon to 3 ounces, not 5 and so the baby is not getting 24 cal, calories, which may be another reason for the weight loss. Um, the baby's head size seems to be increasing which is somewhat concerning. Um, the baby is sleeping on its stomach, uh, which is certainly, um, not, um, okay and is not part of the AAP guidelines, especially the new guidelines that just came out last week or two weeks ago which says that never under any circumstance should a baby be sleeping on its stomach. Um, that this baby meets the AAP criteria for Synagis but it's not been discussed with the family. This baby may have reflux and it's certainly a high risk for reflux because it's a preemie and, um, and then that there's gonna be no medical follow up for the next two months. So, these are the – and there's probably more – but this is the nursing stuff that you would be putting into your nursing care plan and say, okay, these are the things I need to take care of, I need to address, I need to plan my subsequent visits around to meet this baby's health and nursing needs. Okay, next slide. At the same time, this family has a number of issues around asking us and utilizing services, which is the definition for TCM. So, here are the issues that the nurse identifies as being, um, needed to be addressed in the targeted case management plan. First one is this is a low income family and they have a lot of expenses pending. Um, with winter coming and oil heat, that alone is pretty scary. Um, they have a major problem with transportation. No gas, very little gas money and they're gonna have to be coming to town, um, much more often than they maybe think they are. Um, they're eligible for WIC and food stamps, but they haven't applied because, um, they have some issues about that and so that means that there is going to need to be a conversation around this to help the family understand what the advantages and disadvantages might be for them to apply for WIC and food stamps. Um, Enfacare is pretty expensive. Um, the infant meets the criteria for Synagis, but the doctor hasn't ordered it and OHP hasn't approved it. And, for anyone who's worked on Synagis with a care plan, um, you know that that can be a real issue since Synagis can cost anywhere from a thousand to $2,000.00 a shot and this baby's gonna need them from, um, probably November to April. Um, this baby might be eligible for SSI. The nurse doesn't have enough information yet

to know, but that might be a possibility. They're probably gonna be eligible income wise, but the baby's condition may not make them eligible. But, that's certainly something that's gonna need to be pursued and this baby's probably gonna need more frequent medical follow up than once every two months. Um, so those are the things that the nurse would look at as being, um, necessary for her targeted case management plan. Okay? So, let's look at how this would be charted. The charting for the nursing pieces are gonna be done the way that you, you do your nursing charting. And, in Washington County, we have a, uh, we have a progress note. In the progress note, the nurse dates it and she says, see. And she would say, see TCM assessment and plan. If there was a home visit form, she would say see that. She would say see preemie growth grid and she would say see nursing assessment and plan. And, then the forms would be filled out and put in for that subsequent, for those visits. Um, so the nurse would first sit and do her nursing, um, charting, which we do by checklist it's really pretty quick. Um, and then she would sit down to do her TCM assessment and plan. So, for this particular baby, the first part, the eligibility, is this baby eligible. Well, yes. The baby's being enrolled in Babies First. Remember, this is a Babies First baby, not a Cocoon baby because it's a preemie. So, it's an A diagnosis. Um, the baby has not reached its fifth birthday and the baby is on OHP. The second part is, is this baby or family receiving services from another TCM program? Well, not yet. So, maybe at some point, this baby may be referred to EI and be receiving case management services. Maybe. Hope not, but maybe DD. Um, by right now, no. So, nothing is filled out in that part of the form. Um, under the family strengths, it says the family strengths that can be leveraged to support the plan. Well these parents are very concerned about the infant's health and development and so that's good that you've got a major strength to work from that you can talk to the family about how to meet the needs of their baby and they are interested in doing that. Um, and they have a support system. They, they do have the, the mother and the sister, although they're pretty far away. But, at least emotionally they're available to them via phone or whatever. Okay. In terms of the assessment. Remember, this is what is the family identifying as needing help with around accessing and utilizing services. So, the first thing is regular immunizations. It looks like the baby's on its regular schedule, 'cause it got its first, um, series of shots yesterday. But this baby is certainly by AAP criteria, um, needing Synagis and so that's gonna be something we're gonna have to pursue. Um, Social Security, again maybe if the baby is eligible and the nurse needs to pursue that to figure out if they do. Um, okay. Next one. So, those are the two things that were identified. Whoops.

Next Speaker: So, this is the bottom of the first form.

Next Speaker: Okay.

Next Speaker: So, this is the bottom of the assessment.

Next Speaker: Yeah. I'm just wondering why they aren't checked.

Next Speaker: They're gonna be now.

Next Speaker: Oh, they are. Okay. All this technology. All right. Moving on down the form. The, the block of, the block that says the child's family does not need assistance accessing and/or utilizing services. On this first visit, if you determine that they do not need assistance accessing

or utilizing services, you would mark Y and that would be the end of it. You would never do this again because you won't be billing TCM after this. If they don't need it, we can't bill it. Um, but this family does need assistance accessing and utilizing services and the reasons, and these are the reasons. Um, they're having trouble, um, securing the baby's basic needs and especially around food. Uh, because they're, they're struggling financially. Um, the, the mom does, and the father probably also, does not really have an awareness of the multiple resources that are available to them in the community, and this is something the nurse will work on helping them understand SSI, um, maybe EI at some point, maybe DD at some point and so on. Um, the, the, the inadequate caregiver health literacy – and what that means is the mom has some pretty basic misunderstandings just about, um, health in general – so putting the baby on its stomach to sleep, that's one issue. Um, not mixing the formula correctly, um, that's another issue. Letting the baby sleep all night when it's, well no newborn should be sleeping through the night, but, um, especially a preemie. So, there's a lot of things that the mother really doesn't understand or know. And, how would she? She's never had a baby before, let alone a preemie. So, these are things that you'd be working on. And, then the, the transportation difficulties that they have would be a critical piece that you'd wanna work on and the, the financial, um, instability. And, so that's it. So, you just go through, you mark it, mark it, mark it, you sign it, you date it, you put the baby's name on the form and the baby's birth date and that's it. Okay? So, that is the assessment. And, this is the plan. So, this visit was made, I think, October 28th. So, uh, February 1st of 2012 is about three months. So, it seems like that would be a really good time to sit down and sort of review your plan and decide do I need to update it. Because, by then, you may have made, I don't know, five, six, seven visits to this family, maybe more or maybe less, I don't know. But, you will have, um, gotten a lot more information and been working on the things that you have put in your plan. All right. The top two, uh, priorities, and this is the client priorities not your priorities, my priorities if I would making this visit would probably be a little different. But, the mother's priorities were to do something about the transportation because she knows she's gonna need to take the baby in, um, for visits and other things. And, sufficient income to cover the expenses that this baby is going to incur for this family. Um, the goal that is agreed upon between the nurse and the family is that the parents will be able to, um, identify and access the social services that they need and that would, that would be, um, completed by the time you do the review in, on February 1st of 2012. The activities and interventions that you're planning to initiate and that you'll carry out on your subsequent visits are you're going to continue to monitor whether there are, um, barriers that are keeping this family from getting the services that they need. You're gonna continue to identify strengths that the family may have that you will build on and work with as you see the family. You're going to help them, um, increase their knowledge of community resources by helping them understand what's available to them and how they can access those services. You're going to, um, help them work in getting those services, whether it's helping them make appointments or fill out the paperwork or whatever. Um, you're gonna help them, you're gonna help them do paperwork if needed for SSI and food stamps if, um, you can, um, help them, um, become more interested in accessing food stamps. Um, you're gonna problem solve with them around the transportation issues that they're faced with and try and come up with some things that might be available to them in, in the community that you're in. And, then last but not least, you're gonna work on this Synagis issue. And, the Synagis issue can, can be considered both a TCM issue because of all of the calls that may need to be made and the integration with the family doctor and with the insurance plan and, you know, all of those kind of things to get it in place and then it would also be a nursing issue

because this baby needs Synagis because of its high risk for RSV. So, but, but the TCM pieces are the collaboration with the doctor and the OHP plan around getting it approved and then getting it in place and then working out the transportation to get the family in for it, blah, blah, blah. Okay? So, those are, those, this is the two forms that you would fill out on the first visit. You would not do a TCM visit form unless you felt like you needed to. Um, oh I missed, I missed, what? The bottom of it?

Next Speaker: The bottom of the plan.

Next Speaker: I'm sorry.

Next Speaker: That's okay.

Next Speaker: These, when they come up. Okay, so you're only half done with your plan. The rest, the rest of your plan is who do you think you'll be referring to and, um, one of the, one of the things you're gonna be looking at is transportation and see if medical transportation is available for this family and if they will go 30 miles out and bring the baby in and that kind of thing. WIC, again if you can, um, help the family maybe change their views about WIC and decide that that would be helpful for them. Um, help them around the basic needs issue of food, which is the food stamps. And, probably although it's not listed here, the utility issue around the oil which is gonna be a big problem. And, then the, um, the Synagis, uh, question. As far as monitoring, what you're gonna monitor on subsequent home visits is whether or not the family is, um, able to access and utilize these services. Um, you're gonna monitor their commitment to the plan, which means are they following through, and the progress that they're making towards the goals. So, that, this, these are the things that you would fill out then on the TCM plan. Okay. And, again, you would not necessarily need to do a TCM visit form, because you've done the assessment and the plan and that makes you, you've got everything in place, this visit can be billed and on subsequent visits then, you would fill out the TCM visit form, um, to, um, document what you did in terms of activities that, uh, go along with your plan. Okay? That make sense to everybody? All right.

Next Speaker: But we do have some questions that we'd like, um, to address.

Next Speaker: So, one of the questions was what if the client goals and priorities change, um, throughout the life of the service plan?

Next Speaker: Well, if they change, you change the plan. Again, I know it sounds like oh my God another form. But, you know, this really, filling out and changing the plans is really a, a couple minute job. So, if things change, you change the plan, you re-date it and you, you know, decide again that you're gonna re, redo it in X number of months. So, the plan can be changing throughout the course of the time with the family. And, actually, it probably should.

Next Speaker: And, um, somebody asked what about maintaining a stable income? Would that be a potential goal or issue to address as well?

Next Speaker: It certainly could be. It certainly could be. I, I think that and, you know, everybody practices in a little different way, as I look at this family, it's very important that they learn to access and utilize services and that we're working on that. But, the nursing issues for this family are huge and we can't ignore those. And, the reality is, you know, you've gotta make a balance here so, you know, how much are you really gonna be able to do about their income and when there's all these other things going on? Maybe that, maybe it would be very simple, you know, maybe, but maybe it wouldn't. So, yes, you're right. You could certainly add that to your, um, plan, your assessment and your plan if you needed to do that.

Next Speaker: I mean, this is really the, the place where you see your independent professional nursing judgment. This is your practice. It's not gonna look like somebody else's practice. That's not right or wrong. That's how you implement your public health nursing skills.

Next Speaker: And, in this case, you know, maybe a question that you would ask is why did he, why did the husband not qualify for unemployment?

Next Speaker: Right.

Next Speaker: And maybe it was some fluke and maybe he should of. Maybe he just never went down and applied. And, that would be a very easy thing then that you could help the family do. Okay?

Next Speaker: Well, and I think you said that, Sue, that it's about priorities. The most important priority right now is that access related to child safety. You know, some of those other things. I don't, a question about whether if it takes you two visits to finish your TCM assessment, is both, are both visits TCMable?

Next Speaker: Yes.

Next Speaker: Did everybody hear that? So, as long as you're working on your assessment and your plan, you can still be billing the visits because you're, you're getting the information together to then carry out as a case manager for, uh, for TCM. Okay.

Next Speaker: Okay. We, we had one additional question about, um, skipping WIC on the assessment form but including it in the plan. And, when I, um, look at the assessment form, we did, we did check WIC as needing help here. Um, so.

Next Speaker: Where did we skip it?

Next Speaker: In the front.

Next Speaker: Yeah, I'm not sure that we did skip it. Um, so maybe we'll open up the phone lines for, uh, back and forth exchange about that. But, in addition, um, why do we have the no health needed column?

Next Speaker: So, you, you have the no help needed column. Oh, the no help needed column. I, I think that some people like to just document whether it's yes or no.

Next Speaker: Yeah, and the way that, um, that we're recommending you use the no help needed is if you establish in your family assessment that you know they're not gonna need help in that area, you can just take it off and not have to return to that. But, you're not gonna know for every single item at the first visit if they need help or not. So, you can complete that as you learn and date and initial it.

Next Speaker: Right. And, and so that point is you don't need to have a brand new form, right? You can update the form that you have, you put your date on it where you got that. And, then in your nursing progress notes, you would say see update to nurse, uh, TCM assessment form.

Next Speaker: Yeah.

Next Speaker: This date.

Next Speaker: Yeah.

Next Speaker: If you, I personally do not want to get bogged down in developing new forms if you don't need one.

Next Speaker: Mm hmm.

Next Speaker: Yep.

Next Speaker: Can I interject a question? This is Donna Kipp.

Next Speaker: Hi, Donna.

Next Speaker: Hi. Uh, I think I miswrote my, my previous question about the WIC. Um, on the planning activities and interventions and referrals, it seemed to me that that was the point where we didn't mark WIC. Um, and in another, there was a discrepancy in there. I can't remember exactly where it was 'cause I don't have, um, it's seemed like at one point we kind of skipped over WIC and then at another point we went back to it like it was gonna be something we would pursue. My question just really has to do with match. You know, how much do we have to be sure that we match up every point of the assessment, uh, and the plan so that it, that it's a straight crosswalk.

Next Speaker: Yeah, I really appreciate that question, 'cause it is important and we do see, um, in chart reviews a scatter where the, the interventions are, have never been part of the plan. And, that happens quite a bit. So, it is really important that your assessment plan and interventions do create a storyline that makes sense. And, um, so I'm not sure, uh, what happened, how we appeared to get away from WIC. Maybe we missed checking a box somewhere, but that certainly wasn't the intent.

Next Speaker: So, we also have a question about family advocate and this is a great question. So, what if the family advocate goes out, um, after the assessment and plan has been completed and it's noted by the family advocate that the family wants assistance with housing. Is this something that the family advocate can add to the plan per concerns of the parents? And, I would say yes and they need to consult with the case manager and make sure that the case manager and the advocate have consulted and that they co-create the plan together because then you're documenting that, um, the advocate continues to work under the direction of the nurse.

Next Speaker: Okay. Great questions. Looks like we're ready to dive into our next scenario.

Next Speaker: Cynthia?

Next Speaker: Yes.

Next Speaker: Hi, this is Diane, uh, from Multnomah County. I just had a quick question. I, maybe I misunderstood one of the comments. But, if it takes more than one visit to complete the TCM, um, planning and, uh, or assessment and plan, you only bill that once, once it's completed, correct?

Next Speaker: No, you can bill both. So, it's a, it's different from maternity case management where you have a special procedure code for your assessments. In targeted case management you just get paid for each visit and you can submit a TCM bill as long as you conducted TCM activities on the visit.

Next Speaker: Okay.

Next Speaker: Yeah.

Next Speaker: Thank you.

Next Speaker: Uh huh. Okay, so let's jump into our second scenario. This is Tracy and Alex and, um, what you learn about the family, um, well let's just walk through it together. So, Tracy's 18. She was on your maternity case management caseload. You know her from that experience, and you know that she dropped out of school before completing her senior year, um, when she found out she was pregnant. And, she had Oregon Health Plan to cover her pregnancy. She delivered her baby boy, Alex, at 39 weeks gestation and you receive a call from the hospital discharge planner who has some concerns about the family and wants to refer the family to Babies First. The discharge planner didn't know that they had been an MCM client. The reason for the referral from the family birth center is that they have concerns about breastfeeding, bonding and a big conflict that occurred during the, um, labor and delivery process. The conflict was exacerbated when dad returned to the birth center with a case of beer to celebrate and had to be escorted out, um, by security. You know from your MCM history that this client has a history of marijuana and alcohol abuse. So, um, hearing of the delivery you make several attempts to reach the client, um, that are unsuccessful. So you, you conduct a drive by home visit to try and track the client down. And, a neighbor comes out of the house who is known to you. This is a neighbor who had visited during one of your prenatal appointments and the neighbor tells you

that the client has moved to her mom's and gives you her new cell phone number. You call the new number and, um, reach the client and successfully schedule a visit. So, here's what happens on your first visit which occurs at about eight weeks postpartum. You, you confirm that the mother and child moved in the with the maternal grandmother. Um, the house smells of stale smoke. You did note on your approach to the house that there's a, um, a lot of coffee, uh, a lot of cigarette butts outside the front door. Um, the family moved in with the grandmother because the father was, um, arrested. And, this, the father of the baby was previously the sole financial income. The grandmother, um, does note and disclose that she does smoke and she's been working really hard to smoke outside since the, the client and the baby moved in. The client reports missing her six-week postpartum visit because the father refused to drive her. She's, um, still kinda been busy and hectic and hasn't found the time to establish a pediatrician. And, the baby has not seen any medical providers since discharge. The client states that now that, um, her boyfriend's in jail, um, she really doesn't need a postpartum visit 'cause she doesn't need any birth control since he's not around. The grandmother then comes home and demonstrates lots of positive care and concern for both her daughter and the infant and also chimes in as she overhears you talking about well child care, that the baby doesn't need a doctor he's perfectly healthy. So, you go through your postpartum, um, visit. You do a postpartum nursing assessment with Tracy, and you don't note any physical concerns. Um, she is exclusively breastfeeding and it's going really well. She has no concerns. Tracy talks to the infant, makes eye contact and makes lots of positive statements about the baby throughout the visit. You complete weights and measures and all of those are within normal limits. Much of your visit is spent listening to the mother and grandmother talk about their financial stresses and concerns about not having the father of baby's income support. And, um, again grandmother is very loving and concerned, but has some, um, inability to provide any additional financial assistance. The client has been enrolled in WIC throughout her pregnancy, but she's lost track of her appointments and can't remember and actually discloses having problems with her memory. Um, she, she is teary talking about the father of baby arrest, and discloses she's having trouble getting out of bed. And, um, uh, the grandmother, um, concedes that she has been pressuring Tracy to either get a job or go to school. She doesn't want Tracy just laying around the house. Um, and Tracy responds by saying she doesn't want her baby going to a dumpy daycare. Uh, Tracy also does disclose to you that she has had a few beers. She's been interested in reconnecting with her friends from treatment, but all of their phone numbers were in her old cell phone which has been lost. During your time in the home, you notice that the grandmother has, um, really bad breath, a swollen, and a swollen jaw and you ask her about the symptoms. The grandmother discloses that she's had some, um, dental problems for some time, that she knows she needs to have a teeth, a tooth pulled, it's been getting worse in the last couple of days but she doesn't feel like she has any options. You encourage her to take her temperature. You discover she does have a fever, and you help her connect with the FQHC for a next, next-day appointment. Pretty typical visit, ay? Okay. So, here, here's kind of a summary of the case of what you're gonna be noting in your nursing notes and nursing care plan. So, all of the nursing activities that you do will be documented according to your own processes. Um, but here's kind of a summary of separation of what goes in the, the maternal nursing record, um, versus what we're gonna end up discussing via the targeted case management plan which is our focus today. Okay. Now, here's nursing issues for the infant's record. We're glad to see that on the newborn assessment this, this does appear to be a really healthy infant and the weights and measures are great, the breastfeeding's great. So, we're really excited about that. That's a huge strength. Um,

the family does seem to need some intervention around health maintenance and the value of, of wellness care. The tobacco exposure, you know, it's great that there's some harm reduction going on, grandma's making efforts to smoke outside, but we're gonna wanna monitor that. The parent/child interaction. So, initially on the hospital referral, there was concern about bonding. And, it seems like, um, maybe some progress have been made there, 'cause you're noting actually a lot of positive attachment behaviors during your visit. And, in, at some point in the future, you may need to do some safety planning, um, related to the maternal substance use. Kind of need to get more information about that, but that's something that you may wanna include on your, um, infant nursing care plan. And then, what about this grandmother? How do we document, um, the interventions that you did for her? And, that's gonna be according to how your agency guides you on those types of interactions. And, here's our summary of our TCM activities and plan. So, this family has lots of barriers to accessing and utilizing services. Um, it is pre-contemplative about wellness care. Um, not up to date on immunizations at this point, has no primary care provider, needs assistance with reconnecting with WIC, um, huge issues around income, basic needs, um, sustenance and also transportation. So, here's what our charting's going to look like. Um, we determine eligibility pretty smoothly and easily. This baby has all kinds of A codes to qualify for Babies First. Um, the baby is definitely under 5 and is enrolled in Medicaid. We're not able to establish that the family has any other TCM service providers at this point, so we can skip right over that. Um, we document some strengths around breastfeeding, um, what we see overall about bonding as positive and both mom and baby are physically healthy. Um, maternal grandmother appears supportive and this old neighbor, Sarah, um, mom talks about her as being a support. So, we go into our assessment and, um, I mentioned earlier that no need, no help needed you're gonna complete as you're aware of the information and you can update that section, sign, you know, date and initial it as is appropriate as you go along. And, then here at the bottom of our plan, so again we're gonna skip over does not need, because we know this family needs some assistance. Um, and again, you know, you're gonna wanna triage and decide where's your initial focus gonna be. I, I went a little crazy here. I checked a lot of things. I could've checked one or two and just focused there and then came back on a later plan and checked more. So, again, it's up to your discretion how you use these. You can, you can be, um, all inclusive or you can just start with a couple and then return later to address other ones. Um, I checked quite a few. Okay, and then we have our service plan. Um, I know the plan needs to be reviewed at a minimum a year from now, so I just, you know, to make it easy on myself I go ahead and put that date there. Um, mom's primary needs on this visit were she was concerned about diapers and their income. And, then my concern was primarily related to health service access and social service access. So I, I make a couple goals, um, to start with around accessing and utilizing those services. The interventions that I have planned, um, I'm gonna keep an eye out on barriers and strengths. I'm gonna help the family expand their knowledge of resources and I'll help them work with those services moving forward and advocate on their behalf. We'll do some problem solving around transportation and, with this particular family, I anticipate a fair amount of motivational interviewing techniques and strategies are gonna be necessary because they're, they're pre-contemplative about well care. So, my planned referrals, um, I'm gonna help with scheduling of appointments, um, help them reconnect with WIC, um, again help refer them to transportation, assure that they get immunizations and that's where I'm gonna start for now with basic needs, uh, primary care provider and in this fantasy county called Mount Hood, we have a church closet that provides diapers, so I'm gonna refer her there. Um, and then my monitoring that I'm planning. Now, in this situation, the only intervention that I

delivered, um, got, that involved a referral was for the grandmother, so I actually didn't do any TCM interventions. I was entirely focused on my nursing care, my assessment, and then I did obviously complete my TCM assessment and plan. So, I don't have a follow up form on this initial visit. I just have my assessment and my plan and that is enough to submit my claim. Okay, so let's take questions about this case. So we have a question about when you're updating the plan, do you just state it or make a separate plan? What's the best way to update the original form? And, I think the answer to that is gonna vary a little bit depending upon how significant the update is. If you're just updating a small section, you can initial it and add a date. But, if the plan changes dramatically, it's probably gonna be easier just to pull out a new form and, and start a new plan. And, again, I know it's another piece of paper, but it's a process that goes pretty quickly. So, it will depend upon the, the extent of the update. Okay. Other questions? Um, okay. We'll handle it over to Candace for our Cocoon example.

Next Speaker: Good morning. I hope you're all awake out there and just excited as all get out about this wonderful way to, um, improve the speed of your charting. Let's see what we have. So, we have, uh, received a referral from, um, DHS self sufficiency and it states that we have 6-year-old boy who was expelled from kindergarten for aggressive behavior and that the mother reported that he bites and hits and screams at other children and his teachers. The mother told the DHS worker that she cannot control him, and she was at DHS for domestic violence housing and other supports and asked for help with her child. Um, the PHN received that referral and called and is invited, um, for the home visit. When she goes to the home, an elderly woman opens the door to her apartment, identifies herself as the great grandmother of Bobby, who's in the room dressed in a T-shirt, underwear, and one sock. PHN asks if Bobby is cold, because she's cold, and the great grandmother states that she cannot make him dress and that they don't have many clothes for him and if he was cold, he would find something to wear. The great grandmother herself is in several layers of clothing. The home is cluttered and cold, and she states that they cannot afford heat as she returns to her recliner. Bobby then hides behind the chair as the PHN begins to talk to grandmother. Grandmother states mother just got a job at McDonalds, um, so is not at that visit. She doesn't know if the child has a medical card, though she says mom's been working on something since her last fight with her boyfriend. The apartment is hers. She has a small disability check, but she can't afford to support, um, her granddaughter and son. And, when asked, uh, what the needs are related to Bobby, um, the PHN is told that he is just like every other male, um, she has known – wild, crazy and mean. Um, what she and the mother want for him is that he be back in school and for him to straighten out. They cannot discipline him because hitting him doesn't change his behavior. It even seems to make him worse. Mom doesn't have time to watch over him. Um, she has her own life, and grandmother's hands hurt too much from her arthritis to care for him. The PHN then asks about some specific things: Meals, and grandmother says he gets his own food. Um, but they're at the end of the month now, so there isn't much. And, she said she doesn't worry about his eating since he had food in his sleeping bag. Grandmother doesn't know if he has a doctor or whether he sees a dentist. When asked if she thinks he can hear or how he speaks, grandma says he must be able to hear because he yells. The PHN comments that he's not spoken since she came in, and grandma says that's a relief. The PHN asked to see the medical card. Grandma does not have it and cannot provide her mother's work number. At this point, um, the PHN makes an appointment to come back when she can see the child and the mom. At that point the nurse has made a home visit that she is going to open a chart on, but it is not TCMable. She's received a

referral, she's made an initial contact, she was allowed in the home by invitation, the, there was no reason not to leave that home, but it's not TCMable because the grandmother is not the, um, guardian of the child and at this point there's not permission. But, the mother does make an appointment and comes back to see the child and the mom the next week. And, at that visit, the mom shares many of the same things great grandmother shared, plus her desire to have her own home. She was evicted from her last apartment, she has not finished high school, she did attend special education until she left school at 15. She's now 18. Her No. 1 goal is to get Bobby back in school full time. Her second goal was for him to quit being mean. She has no car, she rides the bus to work or depends on others and at this spot, visit, Bobby is again dressed the same and again spends time behind his chair. She doesn't know if she has a medical card for him. He's not seen a doctor or dentist. She says he fears great grandmother and he mumbles a lot because he's a bad boy. So, can she TCM for that first visit? We talked about it. No, she cannot because she's not the guardian, the mother's not present, um, she's not been enrolled in Cocoon and, uh, but she will begin her initial nursing charting and open a chart. Can the PHN TCM for that, um, second visit, she wants to make sure – remember, mom didn't really remember if she got a card – even though you got the DHS referral and you know they were there, sometimes things happen. The truth is she goes back to the office, checks on these things and sure enough the child does have a medical card, so she can TCM this second visit. So, the PHN primary nursing goal is really to come back and complete a full assessment of child safety. There are lots of concerns about child safety and the nurse had shared with the mom her concerns that Bobby may have problems hearing or speaking or making himself understood. Um, she makes her appointment and this is now her second visit to come back and tells the mom she's gonna be looking at specific issues around child development. She also gives the mother, uh, the numbers for the food pantry, um, Salvation Army for clothing, transportation. Really does sort of a shotgun approach to giving maybe too many referrals, but because she's concerned about, um, Bobby's safety, whether he's really eating, um, probably does too much at one time. Uh, but mom says, um, she, uh - oh the nurse also asks about the domestic violence assistance money – and this is a typo, mom says she doesn't really know what happened to that money. So, you come back, we're gonna do, um, facts again or complete that initial assessment. The child has Cocoon risk factor, um, and is enrolled and, and she's gonna choose, um, uh, some concerns about behavior, um, B90. We don't really know exactly what's happened, but there are enough concerns from, um, that nurse's background to go ahead and choose Cocoon. She can always change it if it's not ****. Um, and she's checked so she knows they're in Medicaid and she can do the TCM visit. Um, she has assessed whether or not there are any other TCM partners involved and there aren't. Um, what's not written here is what she did find, which were the child's strengths and what the leverage they were highly motivated to have him in school and to have his behavior change. And, the support system, um, that would've been on here include that they have a great grandmother that has, as she said, put a roof over their heads. Um, we have some concerns about many things and, um, and this is my TCM form, this is gonna last me a year if it can. And, so I marked everything that I think I'm gonna be doing for the next year. And, I'm even gonna really be looking at the health insurance and maintaining coverage. Um, the child's too old for WIC and too old for the relief nursery. Those are the only ones I wouldn't have checked. Um, clearly the child needs assistance. Um, the only reason I didn't put inability to fill out paperwork is because I'm not positive about that yet. Um, it seems that mom at least went and filled out some, so we can come back to that if it truly comes out to being ****. I wasn't sure about the family health needs and passing the child's ability so I didn't check that one. And, I'm not sure about

culture. Um, but I had enough things to check. So, you can see I, I am addressing everything I know about after this first visit and we're gonna, of course, sign these and, and date. So, now I'm coming to the, my service plan, because I actually did do some things. I, um, did not write in what I should of which was the next date and it would be ****/11/12. Okay? Um, the agreed upon, you know, the client had identified goals. Everybody in the house has identified the goals for Bobby except Bobby. And, the agreed upon goals between me and the family are really related to, um, accessing health services, um, identifying and independently accessing learning services for quality child care and I think it's gonna be special education but, and then demonstrating the ability to identify and independently access other social services. And, if you'll note, the targeted dates for completion are slightly different. I'm gonna give myself a whole year to have them independently access services for, um, social services and health services, but I'm really gonna check and, and assess my plan and the family plan that we came up in about six months about, uh, accessing learning services or some kind of care for this child because I suspect that's gonna be part of the safety plan I think. And then, again, I used everything. I'm looking at this as a year and I'm gonna be utilizing not all of these in every visit, but within the next year I'm gonna be looking at, um, using all these things in my, in my tool bag. This is my public health nursing way of filling out this form. So, what I'm gonna do, these are the planned things that I'm looking at doing for this child. Um, I didn't initially check OHP health insurance because they're on it. But, if you remember, um, I have already checked that there's going, I'm gonna monitor whether they're staying on it. Okay? And then the planned monitoring, everything again. And, then I want you to go look at my nursing care plan and my nurse progress notes, because what you're gonna see there is, um, my concern about a developmental delay, a lack of health maintenance or even well child care and, um, did I say safety already? I'm really concerned about this child's safety. That the No. 1 thing on my mind, and I'm keeping it pretty simple and straightforward until I know a lot more about this family. So, I did some things in this visit. So, I'm gonna go ahead and use that, um, visit form. This was the initial visit, but I'm actually talking to her about, um, some of these specific things they wanted. I, I know this is probably too much, but again, it's related to my own anxiety a little bit, but I'm gonna closely monitor. I'm gonna come back in a, in a week and I'm, I, because of where I practice, I have time to do that. Some of you may not have, um, time in your schedules to just decide you're gonna go see somebody next week. Um, so I made those referrals and that, that's really what I did. I'm, I'm, the next visit is when I'm gonna monitor. Okay? Go back. Do you have any questions? And, I think the No. 1 thing that you can see is really the kinds of things that occurred for this client are TCM urgent. And, the nursing needs for doing that more thorough assessment, really I can see that Bobby's alive, I don't see any obvious injury, you don't get that from this TCM scenario, but I'm really concerned about his development and a lot of other things about feeding ade, adequacies. Many, many things. But, I needed to understand who the people are that were with him, um, not just grandmother but also mom. Now, we could have made a case for should I have left the home without trying to, um, doing an assessment on Bobby, but I had some real concerns based on my history that he would act out and that would become the full target of my home visit. I wanted to be able to have a targeted home visit that demonstrated some success to family before the child is out of control. Any questions or thoughts about that? Okay.

Next Speaker: Great. Okay. So, let's talk a little bit about electronic health records or electronic, um, medical records. Uh, okay, so what we know is we have five counties that use, um, EHRs or

EMRs. Um, some are using the same software, but there's several different softwares involved. So, what we'll be doing is I'll be working with our Informatic team here in maternal child health to gather information about how those EHRs that are currently in place are currently documented, documenting targeted case management charting. And, we'll do kind of an inventory of their current documentation process and we'll compare that to the features of these mandatory forms. Um, once we have all that information gathered and, um, evaluated then we'll determine some next steps. We may be, um, you know, moving towards a negotiation process where these forms are included in your EHRs or we may be able to accept and sign off on your current EHR processes. So, it will just depend upon what we find. Um, I wanna assure you that we know this an issue and that we, um, should have time between now and July 1 to address it. So, um, stay tuned but, um, please let us know if, um, you have concerns about this and our Informatic's team will be working with, um, the software vendors directly to gather some information about this.

Next Speaker: Okay. How does this boy qualify for Cocoon? Um, I know about his behavior because I read about it in the scenario, but how, how does it qualify? Um, you know, if we wanted to be, um, really technical on this, you might be able to say, okay, I'm not sure this child qualifies for Cocoon. But, the truth is, he doesn't qualify for Babies First and you wanna make a home visit. And, he's been expelled from school for something serious enough that the mother has mentioned it to the DHS workers. You can go in and see that this child's behavior and interactions are not within what you would consider normal. So, you're goin' for a Cocoon diagnosis, a Cocoon risk code, not diagnosis, because that's how you're gonna serve this child in the home. If you find that he does not qualify for Cocoon over time, that this is really a parenting issue or it's a child welfare case that there are really no, um, no delays, no developmental risks in this child, I would be very surprised. So, he qualifies because I want to serve him and I think that the program we have to do that in is Cocoon.

Next Speaker: And you have that other code.

Next Speaker: And we have a B90 code. So, that's why I talked about maybe tentatively if I felt strongly enough that I was concerned about his hearing, maybe, maybe I heard him mumble, or I couldn't discern any, any understandable language from this child. But, even by just the referral and the great grandmother's report and then the mother re-emphasizing the same thing, I can change my B code if I need, I can, I can, um, clarify by B code late, later if I need to. And, B90 is always one you can choose to say something's going on, I just don't know what yet.

Next Speaker: I, I also think that his behavior was enough to indicate that he, and, and, so he has bad behavior, a speech problem and there's a question about his hearing.

Next Speaker: Yep.

Next Speaker: You know, I think, as a nurse, you can pursue the hearing piece because maybe the child is hearing impaired –

Next Speaker: Right.

Next Speaker: – and he's never been diagnosed and his behaviors are a result of that. So, you know, you can't just automatically assume that he's, he's got behavior problems because of poor attachment –

Next Speaker: Right.

Next Speaker: – or poor parenting. You've gotta look at the medical issues also.

Next Speaker: Right.

Next Speaker: And so you're busy ruling those in or out.

Next Speaker: Right. So, for this child, there was an enormous amount of work that already had presented itself and when I was thinking about going into this home, one of the things I wanted to do was preserve the, the relationship with the historian so that I could sort those things out over time. Um, the question I kept asking myself is do I have time. When they said, oh, he feeds himself. You know, all those things that you experience when you go in. Um, but I didn't determine that I needed to call child welfare that first visit. You know, I didn't give you an exhaustive history of what I found, but I'd like to say if I didn't call child welfare the second visit, I was pretty confident the child was not at risk of, of, of severe harm until the next time I saw them. Is that helpful? B90 is your best friend. And, and how are you gonna, how are you gonna serve this child without it? I mean, maybe your health department lets you make random home visits, but if the child's not in Cocoon or Babies First, you don't get the TCM. Just a thought.

Next Speaker: And then you also have a code for developmental delay.

Next Speaker: Oh, we do.

Next Speaker: So, if the delay is documented, then they're gonna squarely qualify under that code.

Next Speaker: Right. Right, I mean, they squarely qualify under any of the codes you choose, including B90. But, what, when we come and look at how you're charting that, I wanna know why it's B90. So, if you have a B90 for the last five years of serving this child, I wanna know how come nobody's figured out what's going on. It does happen. It does. We all know that. Um, what was I gonna say about this? Sue said something. You, I want you, when you're coming in, as a public health nurse going in, getting these kind of referrals, I want you to feel confident about making this a Cocoon child. Use the B90. Something chronic is going on with this child. This isn't, you're not making this up. You're not bending the rules. You're not cheating in order to serve this high-risk child. This is what Cocoon is about. We want you to just boldly go in there and figure out how to help this child develop.

Next Speaker: Okay. Great. So, I want to just do a little, um, wrap up. I wanna especially think Angie Flock who, um, or my support extraordinaire. She was able to make this possible with very little, um, direction and she juggles a lot of projects on a daily basis. So, I really appreciate Angie's help. Um, a special thanks to all of you for the hard work that you do every day and for

bravely showing up today to hear about mandatory forms. Um, and, uh, just a couple review reminders, um, that you can see on your screen there. Um, and we have a few minutes left. So, we're happy to either open the phone line or, or have, take some additional questions, um, via the ****.

Next Speaker: You know, one of the things that I wanted to add, Nancy and I –

Next Speaker: Does somebody have a question?

Next Speaker: Oh, yeah. This is Jane **** from Marion County. Um, I just wondered, um, if it's mandatory to start using the TCM forms by July 1st, 2012. At that time, for the charts that are already open, do we need to, uh, start using a new plan to **** [dictation ends here].

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