ECM Question & Answers by Criteria

Criteria A-Training Center Discharges

Criteria B-Provisional/ Conditional License

1. The DBHDS Office of Licensing (OL) posts information on the DBHDS website listing each provider that is operating under a conditional or provisional license. Updates can be found at https://dbhds.virginia.gov/quality-management/Licensed-Provider-Location-Search. We will provide feedback to the OL regarding an addition to WaMS.

2. **If the family is under the sponsored provider and it's not conditional/provisional but the person has 2s on their SIS but was stable prior to the family becoming a provider, and now that they are in a sponsor placement (even though it's family) does that mean they need to be ECM for a year?** If a person is not receiving services under a provider with a conditional/provisional license ECM is not required. If 2s are the only reason and the person has been stable for 12 months then ECM is not required.

Criteria C- Service Interruption

1. **What do you do when an ECM person is in the hospital for over 30 days and you cannot conduct a face to face visit?** If the support coordinator cannot complete the required face to face contact, he/she must document the reason(s) and all attempts.

2. **If there is a voluntary interruption, let's say a person receiving Supported Employment, quits their job, are they then ECM for a year?** If a person is choosing to pause or end services, ECM is not required.

3. **Some CSBs consider starting ECM for someone not getting any waiver service for 30 days (tie it to the Retain Slot form). Are we supposed to be tracking each service? This is difficult because they come in and out of services. Some CSBs initiate ECM when any scheduled waiver service is interrupted more than 30 days.** If an interruption occurs for the services listed below, there is a requirement that ECM commence. If a CSB has made a decision to apply the criteria to additional services that is acceptable. It is important to recognize that an inability to access therapeutic, adaptive or environmental modifications is included under this criteria.

    - Congregate residential (including supervised and sponsored residential)
    - In-home residential
    - Personal Assistance (agency-directed or consumer-directed)
    - Supported Employment (Change in SE job site but not provider does not constitute interruption in service)
    - Day Services
    - Ongoing or inability to access therapeutic services, assistive technology, environmental modification, behavioral consultation.

If the individual requests to stop a service, it is not considered an interruption.

4. **For an interruption in services, are the listed services the ONLY ones that count in this area?** Yes, this would include congregate residential (including supervised and sponsored residential), in-home residential, personal assistance (agency-directed or consumer-directed), supported employment (change in SE job site but not provider does not constitute an interruption in services), and Day services.

5. **For any service, including these, if the person VOLUNTARILY declines a service, is this considered an interruption?** If the individual requests to stop a service, it is not considered an interruption.

6. **If someone is out of a program due to it not being reopened because of COVID issues and staffing, would this make someone ECM? We have several day programs that haven't reopened since the pandemic and the individual is on the wait list. We have some folks in group homes that don't have day programs to return to yet.** If the individual is requesting to stop services or otherwise choosing to wait for the program to reopen, no ECM is required. If the person is dissatisfied with the delay and alternate services cannot be located within a timeframe acceptable to the individual, ECM should commence until a new program is selected.

7. **Is there a need for ECM for individuals that are no longer receiving services due to COVID related issues?** ECM would not be required in this instance, however any face to face visit that does not occur based on individual and family choice while flexibilities are in place should be documented.

8. **If there is only one program in the area, or limited providers and individuals have been out of services for approximately 2 years due to COVID and staffing related issues, should they be on ECM?** ECM is appropriate when services are interrupted for this reason when the individual wants to continue the service and is not okay with waiting for services to resume. Please contact your Provider Team CRC to discuss service options and explore ways that additional services can be developed.

9. **We only have one provider in the area and need to determine how long before closing the individual out the service? Or continue ECM?** ECM is appropriate when services are interrupted for this reason when the individual wants to continue the service. Please contact your Provider Team CRC to discuss service options and explore ways that additional services can be developed.

Criteria D-Inability to access EM, AE or TS

1. **For individuals who request AT/EM but the Service Auth is denied – i.e. they want new carpeting in the home, do they become ECM? When would it end?** This criteria is needed services as identified by a qualified professional, not an individual "wanting". So if AT or EM services have been identified and unable to access the individual would stay on ECM until needed and requested services have been obtained. Also please note 12VAC30-122-370 C.6. – "Excluded from coverage under the EM service shall be those adaptations or improvements to

the home that are of general utility and that are not of direct medical or remedial benefit to the individual enrolled in the waiver, including carpeting, roof repairs, and central air conditioning."

2. **If someone needs a ceiling lift and waiting for denial from DME- do they then go through AT/EM- when does the person become ECM, when DME denies them? And how long would they be ECM?** Once the need has been identified the individual would start ECM and it will stop once the ceiling lift is complete, if that is the only criteria.

Criteria E-Crisis Admission

1. Admission (or assessment for admission) to a hospital is included with the criteria related to encountering the crisis system. Crisis includes admission or an assessment for admission to a hospital (other than for routine or elective procedures) and emergency room visits. Any crisis event includes the need for the SC to document the issue, convene relevant team members, revise the ISP, report suspected abuse, neglect, and/or exploitation to APS/CPS/OHR and to OL as defined in licensing regulations, and document the resolution. ECM visits continue for 90 days after the person is stable (not 90 days after the crisis event).

2. **If someone was admitted to the hospital for an outpatient procedure and ended up staying overnight, does that mean they need to be ECM?** If the overnight stay is related to the provision of the planned care, ECM is not required. If the stay is due to a complication beyond what was planned, ECM should be provided for 90 days following the person being determined stable.

3. The 2017 Case Management Operational Guidelines Update defines crisis as including behavioral/psychiatric and medical events and serious incidents to include admissions or assessments at emergency facilities or programs, emergency medical risks, APS/CPS involvement, and incarceration.

4. One encounter with the crisis system would qualify the person for ECM. An encounter would be an admission or assessment for admission to a Crisis Stabilization Unit, Emergency Services, Children's Crisis or REACH services, hospital and ER visits (other than routine or elective procedures), hospitalization followed by an admission to a Long Term Rehab or skilled nursing facility), as well as risk triggers to include a diagnosis of aspiration pneumonia, bowel obstruction, seizures, decubitus ulcer (pressure sore), UTI, seizure, falls, sepsis.

5. **If we make a referral to REACH for consultation services does that make them ECM?** No

6. **If Mobile Crisis comes out once and doesn't refer to consultation or other REACH services, does this make them ECM?** No

7. **If someone is open to REACH consult services and has a REACH Coordinator do they stay open until REACH closes them?** Until they are stable for 90 days.

Criteria F-5+ Bed home

1. **If a person is in a five bed home, does that make them ECM even if they do not have any 2's on the SIS?** If a person lives in a 5 bed or more group home and this is the only reason they meet criteria, they would only require ECM if they have not been determined stable as defined in Q5 for the past 12 months with no new risks identified.

2. **What if someone lives in a 5 bedroom or more licensed house and they are ECM and then two or three people move out? Does your person drop down to TCM if they also don't have any 2's on the SIS?** ECM would be based on the home's license rather than the number of people currently living there.

3. **Problem with the 5 bedroom or more - Why break this out if there has to be another criteria met, why have it as a reason?** ECM is required by the Settlement Agreement and was modified over time to incorporate exceptions, which have impacted the process. There does not have to be another criteria met to quality for ECM in addition to living in a congregate setting licensed for five or more individuals. If an individual lives in a 5-bed licensed home and is unstable, he should receive ECM until stable for one year.

4. **If someone moves from a 5 bed home to another 5 bed home and they were stable before, do they become ECM for a year due to being in the new home?** As long as the individual has been stable and remains stable for 12 months and no new risks are identified then no.

5. **If someone is in a 5 bed home and meets 2s on the SIS – on the worksheet they are meeting more than one category to meet ECM but if someone is stable for a year, would they still meet ECM because they meet two criteria for ECM?** Because they live in a 5 bed home and that is not the only criteria met (2s on the SIS) then ECM is required. Once person is medically/behaviorally stable for 12 months for this particular criteria, and no new risks are identified, then the person would be able to be removed from ECM, even if they have a 2(baseline) on SIS due to support needs needing to stay stable. Regardless of living situation.

Criteria G-a/1b SIS score 2

1. **When there are intensive medical or behavioral needs on the SIS, if in sponsored home and they have an identified need on the SIS, should they stay ECM even if they are stable in the home (this happens a lot with children - but no encounters with crisis system).** Enhanced case management/support coordination visits are not required for individuals who have more intensive behavioral or medical needs as defined by the SIS© 1A/1B or the annual risk assessment (regardless of residential setting) if no other ECM criteria is met and their medical/behavioral condition has been well-controlled and well managed for the past year. This applies to sponsored residential settings as well.

2. **What do you do when an ECM person is in the hospital for over 30 days and you cannot conduct a face to face visit?** If the support coordinator cannot complete the required face to face contact, he/she must document the reason(s) and all attempts.

3. **How does the new Risk Awareness Tool (RAT) play into identifying someone as enhanced CM?** The RAT assesses for risk in 11 key health and safety areas. If an increased risk is confirmed during the completion of the RAT, ECM is required if the person's condition is not yet addressed in the ISP or involves an increased need for health monitoring or intervention. Once the person has been stable for 12 months ECM may cease. If a person has ECM due to a "2" under medical and behavioral needs in the SIS ©, and their condition has improved, the SC can document team discussions and any related healthcare information that supports that needs have decreased. Once this is documented, and support needs do not increase over 12 months, ECM can cease.

4. **Regarding the SIS, the person at the time of the SIS had a medical issue that they were recovering from and had intensive support needs, but within a year, they were stable and recovered, please clarify how long they then should stay on ECM.** If this is the only reason they have ECM and they have been stable for a year, ECM services may end. Stability can be confirmed (and documented) when the individual is reported to have entered a phase of routine, non-emergency healthcare related to his or her condition or the condition is resolved. See Q1 above.

5. **When there are intensive medical or behavioral needs on the SIS, if in sponsored home and they have an identified need on the SIS, should they stay ECM even if they are stable in the home (this happens a lot with children - but no encounters with crisis system).** Enhanced case management/support coordination visits are not required for individuals who have more intensive behavioral or medical needs as defined by the SIS© 1A/1B or the annual risk assessment (regardless of residential setting) if no other ECM criteria is met and their medical/behavioral condition has been well-controlled and well managed for the past year. This applies to sponsored residential settings as well.

6. **For people with medical needs, let's say a G-tube, J-tube, and will need them for the rest of their lives, is ECM necessary for them if they have been stable for years with no changes in health, medical, falls, lifting, etc.? We recognize these are serious medical issues but it is ongoing and the person is stable.** Enhanced case management/support coordination visits are not required for individuals who have more intensive behavioral or medical needs as defined by the SIS© 1A/1B or the annual risk assessment (regardless of residential setting) if no other ECM criteria is met and their medical/behavioral condition has been well-controlled and well managed for the past year.

7. **With the SIS, if somebody has the SIS completed and they had a seizure in the past but are stable, and remained stable until it is time to do the second SIS, could this same issue qualify them for ECM again?** If this intensive medical need is the only criteria met for ECM, visits are not required for individuals who have been stable for the past year.

8. **If you have a child that has behavioral issues but they do not require any crisis stabilization or BSP, would this still require ECM?** If the child lives in a 5+ bed group home, and has either been unstable behaviorally or had new behavioral risks identified in the last 12 months, they would

qualify for ECM. If the child is living elsewhere, perhaps at home, and are behaviorally stable without new behavioral risks identified in the last 12 months, they would not qualify for ECM based on their behavior.

9. **If the SIS is the only reason someone is ECM, when is the appropriate time to end ECM?** When the SIS© is the only criteria, ECM can stop if the person has been stable for the past year. If the only identified risk is related to falls, ECM can stop after 90 days without a related incident. If the only item scored a 2 is related to receiving therapy services (1a #15), ECM is not required.

Stability-

1. **There are many situations when the person is stable - when do we discharge them from ECM?** Stable is defined as pre-injury/illness condition/functioning or the individual has reached post injury/illness, condition or optimum functioning as determined by a licensed medical professional (Primary Care Provider (PCM), Nurse Practitioner (NP), Registered Nurse (RN), Physician Assistant (PA)). This can be confirmed (and documented) when the individual is reported to have entered a phase of routine, non-emergency healthcare related to his or her condition or the condition is resolved.

2. **When someone changed from ECM to TCM, if you look at the DD SC manual, some of the timelines listed as 90-days stable and then some people say one year - clarification needed.**

ECM Stability Determinations: Stopping ECM

When →	Immediate	90 days	12 months
	• Interrupted services have resumed • Needed therapeutic, adaptive, or modifications have been secured	• Provider no longer has a conditional or provisional license • Only met for fall risk and has been without injury • Has been stable following medical or behavioral crisis • APS/CPS involvement resolved • Incarceration ended	• Only criteria is related to the SIS and has been stable without new needs being identified • Person has been in the community following a move from a Training Center • Only criteria is living in a 5 bed home and has been stable

3. **If a person is stable for a year and change back to TCM, but 6 months later they have a crisis related to something on the SIS, how long do they receive ECM before they go back to TCM?** ECM visits will be initiated and continue for 90 days after the individual is stable (not 90 days after the crisis event).

4. **For the healthcare letter regarding stability, do we have to get this in writing before removing them from ECM?** While in writing would be preferable, documentation in the record by the Support Coordinator would be sufficient.

OTHER

1. **Is there any flexibility with the settings (i.e., seeing the person every other time in their home)? Sometimes there are issues in Day Support, strategies are implemented after a meeting and the next month, we are more effective to go back to Day Support for follow-up. Some scenarios when we are going every month would be helpful.** Alternating home visits are required by the Settlement Agreement, so it is not negotiable. See **V.F.3**: "Within 12 months of the effective date of this Agreement, the individual's case manager shall meet with the individual face-to-face at least every 30 days, and at least one such visit every two months must be in the individual's place of residence, for any individuals who:
   a. Receive services from providers having conditional or provisional licenses;
   b. Have more intensive behavioral or medical needs as defined by the Supports Intensity Scale ("SIS") category representing the highest level of risk to individuals;
   c. Have an interruption of service greater than 30 days;
   d. Encounter the crisis system for a serious crisis or for multiple less serious crises within a three-month period;
   e. Have transitioned from a Training Center within the previous 12 months; or
   f. Reside in congregate settings of 5 or more individuals."

   2. Some clarity is needed when dealing with insurance vs. waiver and sponsor services. Several situations have occurred when Waiver will not cover items due to Sponsor situation but then insurance will not cover either. Does this make the person ECM if this cannot be resolved between the two? If there is an inability to access needed therapeutic services, adaptive equipment, or modifications, and those services have been identified, ECM is not required (if this is the only criteria).

3. **When there is a transfer from one CSB to another, does the transfer make them ECM? Or just check criteria upon arrival to the new CSB?** The CSB responsible for the person would determine once transferred if they meet criteria for ECM. A transfer alone does not qualify the person for ECM.

4. **With unplanned hospitalizations that become long-term, perhaps a Rehab stay also, do we start ECM when they enter the hospital or when they are discharged? Would a stay in Central State be different than a hospitalization?** With an unplanned and long-term hospitalization, or a stay in a Rehabilitation facility, ECM is initiated upon entry. A stay in a state facility such as Central State is different and ECM would not be provided during this stay.

5. **Would someone be ECM if we can't bill?** Not being able to bill within itself is not a reason to stop ECM; however ECM is required for crisis admission (including the criminal justice system) and hospitalization. If you are unable to make required face to face visits for whatever reason, you would document in record attempts and reasons why.

6. **If someone has been incarcerated in the past, when would they become ECM? When they became incarcerated? How far back to we need to go to make someone ECM now? Would they come off of ECM once released?** We are not backtracking ECM based on history of incarceration. This could be current incarceration or within 90 days. ECM is removed once the charges are resolved and no new issues for 90 days.

7. **How often should we complete the worksheet? Only when there are changes or annually?** As needed. The worksheet is an optional tool to assist with determining when to start and stop ECM.

SCENARIOS

1. **Person meets the 1A/1B due to medical support needs. They have a J-tube, and seizure disorder but have been medically stable for the past 6 months. They reside in a sponsored residential home. They have been approved by a therapist for a ceiling lift but cannot get it approved under waiver due to sponsored status. Insurance will not cover the device because it is a covered item under the individual's waiver (even though I have shown them the regulations about EM and certain AT not allowed for congregate/sponsor settings). Would this be considered ECM with the lift being in limbo? And would they remain this way until resolved.** If the person meets the 1A/1B due to medical support needs and has only been stable for 6 months, they would qualify for ECM until stable for 12 months. The lift being in limbo would not be a factor in deciding if they qualify for ECM.

2. **Person is receiving SE and sponsored residential services. SE has not been able to reopen due to COVID limitations and restructuring issues the agency is going through. Does this individual need to be ECM for the continued interruption of services?** An interruption in Supported Employment services for this reason does qualify the person to receive ECM. The choice of another SE agency may be warranted.

3. **Does a person automatically become ECM if an AT/EM need is being requested or has been recommended by a therapist? Does ECM end once the person has received the item? What if person's family wanted a device but the therapist didn't recommend it; does this constitute ECM?** If this were the only factor in determining if the person qualifies for ECM, the person would not require ECM as a result of unattained AT/EM equipment.

4. **We have an individual in a 5 bed home, she has 2s on her SIS for medical and behavioral issues and has been stable until she went into the hospital last December with COVID 19- but she's been stable medically for several months since coming out of the hospital in December. She was only in the hospital a couple of days. Would she be ECM now until December (12 months) or is she not ECM since she's been stable over 90 days.** Because she lives in a 5 bed home and that is not the only criteria met (2s on her SIS for medical and behavioral issues) then ECM is

required. Once person is medically/behaviorally stable for 12 months for this particular criteria, and no new risks are identified, then the person would be able to be removed from ECM. .

5. **For EM there isn't a need for medical necessity and there isn't a need for a physician's letter, someone wants a fence- does this mean they are ECM or not since there's no medical need? For someone who only needs EM for something and you don't have a qualified professional making the recommendation (the family feels they want it such as a fence or new railing) does it make this situation ECM?** I would think a family cannot just declare they need a fence and they get one? For the purposes of caring for someone who elopes, seems they would have a Behaviorist or OT involved and if needed, the make the recommendation?