

Virginia Service Pathway: Questions and Answers

Referral

1. If we receive a referral by phone and have talked directly with the referral source, do we still go ahead and send the acknowledgement letter?
Answer: Sending the *Acknowledgement Letter to Referral Source* to the referral source is always an optional step in the process but is strongly encouraged since it conveys a professional response that promotes further referrals from this referral source. The acknowledgement letter is electronically generated by ITOTS.
2. Clarify the PS at the bottom of the first column. Is this indicating that a procedural safeguards form needs to be sent in advance of the intake visit (for either screening or eligibility determination). If a screening tool is sent to the family after the intake call, in preparation for the intake visit, then the consent form needs to be sent with the tool, correct?
Answer: The procedural safeguards moment symbolized by the triangle at the bottom of the referral column on the service pathway indicates that the family may decide not to proceed to an intake visit at all, instead deciding at the time of initial phone contact to decline to proceed. The local system may mail written prior notice and consent forms associated with screening and/or eligibility determination after the phone contact and before the intake visit. It is correct that if you are mailing a screening tool to the family in advance of the intake visit, it is appropriate to mail the prior notice and consent for screening form at that time as well.

Intake

3. Does the first visit with the service coordinator have to be face-to-face? We have many working parents, and we are sending out a big packet and the parent at leisure fills out information and brings it to the evaluation.
Answer: Because of the amount of information that needs to be shared with and gathered from the family, it is expected that a face-to-face visit will occur with most families prior to eligibility determination. There may be some exceptions based on an individual child and family situation.
4. If the physician identifies a condition or a delay, is that sufficient to not do screening? What will we need from the physician to meet the criteria of a documented delay or atypical developmental?
Answer: If the physician has documented a diagnosed condition that meets Virginia's eligibility criteria or has documented a developmental delay or atypical development, then it is not necessary to conduct a developmental screening. In documenting a developmental delay or atypical development it will be important that the information provided by the physician include how that delay or atypical development was identified (e.g., through use of a screening tool, through observation, etc.).
5. Is parent report that their 2-year-old is not walking enough to say that a screening is not needed?

Answer: A developmental screening is conducted using a tool unless there is (1) a diagnosed physical or mental condition with a high probability of resulting in developmental delay, (2) documented developmental delay or atypical development, or (3) the child has already received a developmental assessment or screening prior to referral. Parent report of a delay is not sufficient to meet the criteria for a documented delay or atypical development. However, for those children who must receive a developmental screening using a tool, it is acceptable to first screen in the area of the suspected delay. If screening in that area(s) indicates the child will be eligible for Part C, then it is not necessary to screen in the remaining areas of development. In the question posed here, it would make sense to begin by screening in the area of gross motor development.

6. How is screening being defined? Does clinical observation count as screening?

Answer: If there is not a diagnosed condition, or documentation of a developmental delay or atypical development, and a screening or assessment has not been conducted prior to referral, then a screening must be conducted using a tool. The Part C office will be identifying some recommended screening tools to use and providing training and support on their use. Some screening tools, like the Ages and Stages Questionnaire (ASQ), are very quick and easy to administer. In identifying recommended screening tools, the Part C Office will review and consider inclusion of homemade tools (such as intake interview forms) currently used by some local systems. For those children who must receive a developmental screening using a tool, it is acceptable to first screen in the area of the suspected delay. If screening in that area(s) indicates the child will be eligible for Part C, then it is not necessary to screen in the remaining areas of development.

7. If I have received an OT report and a developmental pediatrician report, do I meet the family for intake, and tell them their child is eligible?

Answer: Eligibility must be determined by the multidisciplinary eligibility determination team. The family needs to receive written prior notice and give written consent before proceeding to eligibility determination, and the family needs to understand what they are giving consent for. That said, if the information described in the question is available at referral and the family provides written consent on the *Notice and Consent for Eligibility Determination* form by mail/fax, then it would be possible for the multidisciplinary team to determine eligibility prior to the intake visit.

8. If during the intake visit (or on the phone for a child who has a diagnosed condition) it is clear that the child is eligible, how can the Part C person frame the need to have two disciplines confirm the eligibility?

Answer: Explain that federal regulations require that 2 or more disciplines review health and developmental information in order to determine eligibility for Part C. Mention that since there is already documentation of a diagnosed condition or delay or atypical development, this will be a quick process. Use the Intake visit to begin establishing rapport with the family, sharing information about the Infant & Toddler Connection of Virginia and the family's role in the process as you begin to gather information about the child and family that will contribute to the assessment for service planning. If the child has a diagnosed condition, explain to the family that they may want to combine the eligibility determination and

assessment for service planning steps since eligibility can be quickly confirmed by the review of existing documentation at the same time assessment is conducted. Be sure to explain the purpose of both steps in the process and obtain parent consent for both eligibility determination and assessment for service planning.

9. If the service coordinator goes out on intake and sees that the child would clearly fail a screening, does the service coordinator have to screen?

Answer: For those children who must receive a developmental screening using a tool (those who do not fall into one of the three exceptions listed in the answer to question #5), it is acceptable to first screen in the area of the suspected delay. If screening in that area(s) indicates the child will be eligible for Part C, then it is not necessary to screen in the remaining areas of development.

10. Is a highest standard required for a service coordinator to screen?

Answer: The service coordinator may conduct screening activities as long as she/he has received training to conduct screening.

11. Do the hearing and vision screenings have to be completed during Intake since they are in the Intake column of the pathway?

Answer: Although hearing and vision screening appear in the Intake column, it does not mean that the hearing and vision screening must be fully completed prior to eligibility determination for all children. If the child has a diagnosed condition or an obvious delay or atypical development that will make the child eligible, then it is not necessary to complete the hearing and vision screening prior to eligibility determination. Under these circumstances, the hearing and vision screening may be completed as part of the assessment for service planning instead. However, no child may be found ineligible for Part C without having the hearing and vision screening completed

12. If we have done a Denver and observation and parent input, what more do we need to do for vision and hearing?

Answer: Please see the answer to the question directly above. The Virginia Part C Hearing and Vision Screening forms must be completed to document the hearing and vision screening.

13. Can we do vision and hearing screens without the child?

Answer: No.

Eligibility Determination

14. How do we determine who is on the multidisciplinary team for eligibility determination? In the past there was language that the disciplines for the multidisciplinary team were selected to correspond with child/family needs and referral information.

Answer: Federal Part C regulations make no requirement about how the multidisciplinary team is selected.

15. When two disciplines determine eligibility, do they not have to meet face to face? Can they meet at different times?

Answer: There is no requirement for a face to face meeting. Team members may review the available information at different times.

16. Can service coordinators determine eligibility?

Answer: A service coordinator would only count as a member of the multidisciplinary team for eligibility determination if she/he also met the practitioner qualifications for another discipline (e.g., the service coordinator is also an occupational therapist).

17. Does the parent have to be part of the eligibility determination process? Can the system choose to have parents be a part of eligibility determination?

Answer: Part C federal regulations do not require that the parent is part of an eligibility determination meeting. That does not mean that the parent is not part of the eligibility determination process. Information provided by the parent will always be considered in determining eligibility. Local systems have the option to invite the family to participate further in the eligibility determination process by phone, in writing or through a meeting, depending on how the eligibility process works in the local system and what makes sense for this specific child and family.

18. If there are two disciplines and one says the child is eligible and the other says the child is not eligible, then what?

Answer: Ensuring that appropriately trained team members are reviewing multiple sources of information (e.g., health and medical information, observation summaries, parent report and screening results) facilitates consensus decision-making. In those instances when there is disagreement, local systems may employ a number of strategies to reach consensus on the eligibility decision. It may be necessary to carry out targeted assessment to gather more information about an area of development where there is disagreement or it may be appropriate to ask a third practitioner to review the available information and offer an opinion for team consideration. If needed, other problem-solving strategies, like those used in resolving differences that arise in IFSP team decision-making, may be effective in this situation.

19. If we have reports from two disciplines such as a PT and SLP in Oklahoma, do we still need a multidisciplinary team to review the reports and say the child is eligible in Virginia? Do we now have to assemble a team to look at existing results?

Answer: Yes, two disciplines are needed to determine whether the child meets Virginia's eligibility criteria. This is a federal Part C requirement (see 303.320(a) of proposed Part C regulations based on IDEA 2004 or 303.322(a)(1) of current Part C regulations).

20. Are we doing away with the process of using results less than six months old or can we still use reports less than six months old?

Answer: You will still use reports less than 6 months old in the process of determining eligibility.

21. What can the doctor send us that would qualify as informed clinical opinion (ICO) to use to determine eligibility?

Answer: There are a number of ways that a doctor could be involved in the process of determining eligibility:

- Any information sent by the physician will be considered by the multidisciplinary team in determining eligibility.
- A written report by the physician is enough to count towards the requirement for 2 disciplines to participate if (1) the report or cover letter states that this individual believes the child is eligible for Part C based on _____ (developmental delay, atypical development or diagnosed condition as evidenced by ____); or (2) the report states the child's level of development or percent of delay, gives the diagnosed condition, or states the presence of atypical development; or (3) the report gives enough specific data about the child's skills that the other team member can determine that the child has at least a 25% delay in one or more areas of development or atypical development. If the written report meets one of these criteria, then only one other discipline is needed for the multidisciplinary determination of eligibility.
- The physician could also count as one of the disciplines for eligibility determination if he/she sends just general health and developmental information but also participates in a phone call or meeting with another discipline to discuss and review the available information for the purpose of determining eligibility.

22. Can the physician be used as the 2nd discipline if she/he completes and sends in a form that includes checks for child's developmental skills based on age skill expectations?

Answer: A written report by the physician is enough to count towards the requirement for 2 disciplines to participate if (1) the report or cover letter states that this individual believes the child is eligible for Part C based on _____ (developmental delay, atypical development or diagnosed condition as evidenced by ____); or (2) the report states the child's level of development or percent of delay, gives the diagnosed condition, or states the presence of atypical development; or (3) the report gives enough specific data about the child's skills that the other team member can determine that the child has at least a 25% delay in one or more areas of development or atypical development. If the written report meets one of these criteria, then only one other discipline is needed for the multidisciplinary determination of eligibility.

23. Right now, during evaluations, we are looking at records from the hospital with a discharge summary and using the doctor as the second discipline. We take one other evaluator out to evaluate the child. But in the future, will we need to use the doctor's report differently?

Answer: In current practice, evaluation (for eligibility determination) and assessment (for service planning) are combined in one step. Although those two steps in the service pathway, or parts of those steps, may be combined in certain circumstances, it will be helpful to think of them as separate in understanding the physician's role and use of the report. For eligibility determination, there need to be 2 people from 2 different disciplines reviewing the available health and developmental information to determine eligibility. The answers to questions #21 – 22 discuss when the physician can be considered the second discipline for eligibility determination. For purposes of determining eligibility, you will not need to be sending another person out to assess the child unless the multidisciplinary team finds that there is not enough information from medical records and the intake visit (observation, parent report, and sometimes screening tool results) to determine eligibility. If the child is found eligible, then you move to assessment

for service planning. Again, two or more disciplines must be involved in the assessment for service planning. If the discharge summary from the physician includes information that can be used for service planning, then the physician may be considered one of the disciplines for the assessment for service planning step.

24. Can we use an audiologist report of a hearing loss to determine eligibility? Do two disciplines still have to meet?

Answer: There must always be 2 or more disciplines involved in determining eligibility. The audiologist's report of hearing loss will document a diagnosed condition that makes the child eligible under Part C. The same guidelines apply to counting the audiologist as the second discipline as apply to the physician. See the responses to questions #21 - 22. Remember that a face-to-face meeting is not required in order to determine eligibility.

25. If the speech-language pathologist goes out to screen, can that screen be the basis for eligibility determination if combined with parent observation, etc.? We would need no further information and could just base eligibility determination on screening and other information gathered?

Answer: The multidisciplinary team would review the screening results and parent report information to determine eligibility. If that information is not enough to determine that the child has a developmental delay or atypical development, then targeted assessment may be needed to determine eligibility.

26. Doesn't the screening just tell you whether or not you need to do further assessment?

Answer: Screening results will not be the only piece of information available for determination of eligibility. Studies indicate that informed clinical opinion based on screening results, health and medical information, observation and parent report can be just as accurate as using an assessment tool for determining eligibility. The Mott and Dunst article and the Bagnato et.al. article listed on the *Virginia Service Pathway: Recommended Reading* handout from the November 3, 2008 statewide call are helpful for those who would like to know more about this issue. Keep in mind that the Virginia Service Pathway specifies that if eligibility is uncertain based on existing information, targeted assessment will be conducted to provide more information about the child's level of functioning in an area(s) of development where the eligibility determination team needs more information.

27. Are the eligibility criteria in Virginia changing? How are we going away from having age levels but still using 25% delay as an eligibility criteria?

Answer: There has been no change in Virginia's Part C eligibility criteria. Federal Part C regulations do not require age levels on the IFSP so Virginia is not requiring them either. Please note that since the November 3, 2008 statewide call on the service pathway, the Part C Office has confirmed that the Department of Medical Assistance Services (DMAS) does not require age levels on the IFSP either.

Age levels may still be considered in determining eligibility, and documentation of age levels is still allowed (just not required). In order to determine that a child is eligible based on developmental delay, the eligibility determination team needs to

be able to say that the child has at least a 25% delay in one or more areas of development. If the child is 10 months old, it does not matter for purposes of eligibility determination whether that child is at a 7 month level in communication development or a 5 month level. He is still eligible because he meets the criteria for a 25% or greater delay. On the new *Eligibility Determination* form, the team will document what sources of information they used and what conclusions they reached about the child's development and eligibility. The team may document age levels on this form, but this is not required. If the child's level of functioning is borderline and eligibility is uncertain based on existing information, targeted assessment will be conducted to provide more information about the child's level of functioning in an area(s) of development where the eligibility determination team needs more information. This assures that the team can make an accurate determination about whether there is a 25% delay.

For local systems that wish to document age levels, there are a number of places where that documentation can occur: in the assessment summary narrative on the IFSP, on the new *Eligibility Determination* form, in contact notes, and/or on screening or assessment instruments that are maintained in the child's record.

28. If you're basing eligibility on 25% delay without age levels, then you're also using a lot of informed clinical opinion. Are we not opening ourselves up to due process concerns? If we say to the family that their child is ineligible and can't show the parent age levels and we're not involving the parent in the eligibility process, then it is seems like a due process concern.

Answer: This question raises a number of issues: use of informed clinical opinion, documentation of age levels, parent rights and due process issues, and involvement of the parent in eligibility determination.

- You are correct when you talk about broader use of informed clinical opinion. The proposed Part C regulations open the door to use informed clinical opinion more widely than before, including using informed clinical opinion to establish eligibility even when screening or assessment does not establish eligibility. As emphasized in the Bagnato article (referenced on the *Virginia Service Pathway: Recommended Reading* handout from the November 3, 2008 statewide call) we know we are not finding the percentage of children nationally who should be eligible for Part C. The proposed federal Part C regulations are broadening use of informed clinical opinion to ensure accurate identification of all eligible children.
- Using informed clinical opinion in eligibility determination does not imply less documentation is needed or that age levels cannot be stated. There will be an eligibility determination form to be completed by the eligibility team, and the team will document sources of information used and what the team determined about the child's development and eligibility based on those sources of information. Please see the answer to the question directly above for more information about documentation of age levels.
- If the child is found ineligible and the family did not participate directly in eligibility team discussions then the service coordinator should facilitate an opportunity for the family to talk with the eligibility determination team if the family has questions or disagrees with the eligibility finding and if desired by the family. Just like now, if a child is found ineligible and the family disagrees with that determination, the family has the right to request mediation and/or a due process hearing or to file an administrative complaint.

- While Part C federal regulations do not require that the parent is part of an eligibility determination meeting, this does not mean that the parent is not part of the eligibility determination process. Information provided by the parent will always be considered in determining eligibility. Local systems have the option to invite the family to participate further in the eligibility determination process by phone, in writing or through a meeting, depending on how the eligibility process works in the local system and what makes sense for this specific child and family.

29. So it is safer to back up determination of a 25% delay with numbers (age levels)?
Answer: Please see responses to the 2 questions immediately above.

30. Doesn't Medicaid require evaluation?

Answer: Medicaid will require that there is documentation of the child's functional strengths and needs to establish medical necessity for services. This information will be gathered during the assessment for service planning and will be reflected in the Assessment Narrative on page 3 of the IFSP. The Part C Office has confirmed that the Department of Medical Assistance Services (DMAS) does not require age levels on the IFSP

31. We are only about 1/3 Medicaid. How will documentation for children with private insurance be used for payment if evaluation and age levels are not going to be part of the process?

Answer: Assessment in all areas of development using a tool will still occur for all eligible children. This occurs during the assessment for service planning. If age levels are required by a third party payor, they can be documented on page 3 of the IFSP.

32. I am concerned that we will not have funds to pay for the eligibility determination team meeting.

Answer: A meeting is not required in order to complete the eligibility determination step in the process. This is expected to take only a short period of time and may be combined with assessment for service planning when that makes sense for a given child and family and with parent consent. Given the high percentage of referred children who are found ineligible statewide, the new process for eligibility determination is expected to save money overall by reducing the number of ineligible children who receive a full assessment.

33. Do you have to have medical reports in hand before you can determine eligibility?

Answer: Service coordinators are expected to make every effort to obtain physician and other appropriate records prior to eligibility determination, following up on initial requests with actions such as phone calls to request a fax of the needed records, going to the physician's office to pick up copies, or collecting the information via a telephone call with a hard copy received later for inclusion in the child's record. Efforts to obtain the records must be documented in the child's record, and eligibility determination can proceed without those records if necessary.

34. Do you still have to evaluate all areas of development and, if so, at what point in the process?

Answer: Evaluation is not a term we will be using as we implement the service pathway. No child may be found ineligible for Part C without having a developmental screening completed in all areas of development. Children who are found eligible will be assessed in all areas of development using a tool during the assessment for service planning.

35. With this new process, will the eligibility determination process serve as the “evaluation” that some families insist be provided “free” to their child? (This is in relation to the families who insist on a free developmental evaluation, having been told by their physician that these are available free through the early intervention system).

Answer: A referral to Part C is considered a referral for evaluation (using federal Part C terms) to determine eligibility. Therefore, the eligibility determination process is what all referred children and families may receive. This process may include some assessment, if the multidisciplinary team is unable to determine eligibility based on available health and medical information and information gathered through intake (observation, parent report, and sometimes screening tool results).

36. Currently, some local systems sometimes determine during an initial phone call that the child does not need to proceed to evaluation based on parents' response to questions about the child's development. Will this be permitted when the service pathway is implemented, or will all children who are referred require a screening in order to be determined not eligible?

Answer: All children referred will proceed to screening (if needed) and then to eligibility determination unless the family declines to do so.

Assessment for Service Planning

37. If two or more persons are looking at information on a child, then are two or more people to do an assessment? If the speech-language pathologist goes out to screen and uses that information from screening, then does only one other person need to be involved in the assessment for service planning?

Answer: If the information that the speech-language pathologist gathered through screening and observation can be used for service planning, then, yes, the speech-language pathologist would be considered one of the two disciplines involved in the assessment for service planning.

38. Where do prior notices come in at the point of having gone through screening, and then having a second discipline assess?

Answer: There will be separate Notice and Consent forms for Screening, Eligibility Determination and Assessment for Service Planning. The timing for completion of these forms depends on individual child and family circumstances and preferences. The Infant & Toddler Connection of Virginia Practice Manual provides specific instructions on use of these forms and options for timing.

39. If we have a letter from Chattering Children that a child has a diagnosed hearing loss, is a full assessment still required by someone else?

Answer: It is still necessary to have one other discipline involved in the assessment for service planning, and there is a requirement that there is an assessment in all areas of development using a comprehensive assessment tool.

40. How many disciplines are needed for the assessment for service planning?
Answer: Two disciplines must be involved in the assessment for service planning.
41. Can a written report from an agency or neurodevelopmental clinic be used as one of the disciplines for the assessment (after eligibility is determined)? We often get reports from Carilion that include scores from at least one therapist and sometimes 2 therapists (speech and OT, for example) and we use those and then complete the rest of the assessment to write the IFSP. Can that report count as a discipline?
Answer: Yes, as long as there is a written report.
42. Do we have to use a foundation tool as part of the assessment for service planning?
Answer: Yes.
43. Can the tool that is used for screening serve as the tool that is used as the foundational tool for assessment for the OSEP child indicators?
Answer: We are researching this question.
44. At what point in the process do you determine the child's status in all areas of development?
Answer: The assessment for service planning includes reviewing available pertinent records that relate to the child's current health status and medical history and conducting personal observation and assessment of the child in order to identify the child's unique strengths and needs, including an identification of the child's level of functioning in each area of development (cognitive development; physical development, including vision and hearing; communication development; social or emotional development; and adaptive development) based on objective criteria, which must include informed clinical opinion.
45. Does OSEP require that all 5 areas of development be assessed separately?
Answer: Federal Part C regulations do require identification of the child's level of functioning in each area of development. This does not mean that each area of development has to be assessed by a different person or using different tools.
46. If you are combining additional assessment activities to determine eligibility with assessment for service planning (if the child is eligible), how do you prepare the family for this (i.e., procedural safeguards) and how do you proceed with the assessment for service planning if only one individual is doing the assessment and two disciplines are required to determine eligibility?
Answer: If existing information is insufficient to determine the child's eligibility under Part C, then the team will determine the appropriate provider(s) to carry out any assessment activities necessary for eligibility determination. In this situation, it is recommended that any assessment needed to determine eligibility be combined with assessment for service planning, with parent consent on the *Notice and Consent for Assessment for Service Planning* form. It is not necessary for the multidisciplinary team to meet again, as a separate activity, to determine eligibility before proceeding to assessment for service planning. In combining the assessment for eligibility determination and assessment for service planning, the multidisciplinary team is expected to consider how the

assessment can proceed in such a way that, if it becomes clear that the child does not meet eligibility criteria, then a full assessment for service planning is not completed. For example, if the area of concern (based on referral information, screening, observation and parent report) is language then begin the assessment by focusing on that area of development.

47. Can the assessment for service planning be done by the service coordinator and the family using written information from the other disciplines?

Answer: If 2 disciplines have completed the assessment, then the assessment for service planning step is done. The assessment information then will be used by the service coordinator, the family and other IFSP team members in planning outcomes, supports and services during the IFSP meeting.

IFSP Development

48. At IFSP development, does the temporary service coordinator do the whole piece before transferring to the ongoing service coordinator? Or would the ongoing service coordinator do the IFSP development?

Answer: Participants at the initial IFSP meeting must include the service coordinator who has been working with the family since referral and/or the ongoing service coordinator. Ideally, both will participate. The temporary service coordinator knows the family best and is in the best position to provide support to them during the meeting. At the same time, the IFSP meeting provides the ongoing service coordinator with a great opportunity to begin to get to know the family and their concerns and priorities.

49. Can the IFSP be written by anyone with the highest standard at the IFSP meeting?

Answer: The IFSP can be written by any qualified practitioner.

50. I didn't hear any mention of timelines. Does the 45-day timeline still apply for development of the initial IFSP?

Answer: Yes.

51. If we're not requiring age levels, then what about the boxes on page 4 of the IFSP?

Answer: Page 4 will be taken out of the IFSP form.

52. How will targeted case management be billed when scores are needed on the actual service plan?

Answer: While age levels are not required (under Part C) on the IFSP, you are not prohibited from including them. Age levels may be incorporated in the Team Assessment Narrative on page 3 of the IFSP form.

53. Are there changes to Part B regulations that would affect transition to Part B? Many of our school divisions accept age levels from Part C on the IFSP in the eligibility determination for Part B.

Answer: While age levels are not required on the IFSP, you are not prohibited from including them. Age levels may be incorporated in the Team Assessment Narrative on page 3 of the IFSP form. Age levels also could be recorded on the new *Eligibility Determination* form, in contact notes, and/or on screening or assessment instruments that are maintained in the child's record.

54. How will we assist families in applying for benefits for their child without having age levels: ex: SSI, MR case management, school referral? Will this now require more travel and time for the family and the Part C system to enable the child to receive other supports, services, and benefits?

Answer: While age levels are not required on the IFSP, you are not prohibited from including them. Age levels may be incorporated in the Team Assessment Narrative on page 3 of the IFSP form. Age levels also could be recorded on the new *Eligibility Determination* form, in contact notes, and/or on screening or assessment instruments that are maintained in the child's record.

55. We usually do the IFSP the same day as assessment. Will we follow the same procedure now?

Answer: While development of the IFSP is a separate step in the process, the IFSP meeting may occur on the same day as the assessment for service planning if that is the family's preference. Families may need time to review and consider the assessment information, do research or ask questions in understanding and preparing for the IFSP development process. Parents may want to talk with other family members or individuals who offer guidance and support to them before participating in the IFSP meeting. A decision to combine the assessment and IFSP meeting activities on the same date must be made by a fully informed family and cannot be required by the local system.

56. If we go through all of these steps and the family chooses to delay IFSP development, and that takes us over 45 days, is that considered family scheduling preference?

Answer: Yes

57. At annual IFSP, will we pull two disciplines together?

Answer: A multidisciplinary team is required for confirmation of ongoing eligibility. Confirmation of ongoing eligibility may occur prior to or during the annual IFSP meeting.

58. Why are we requiring two disciplines to confirm eligibility at annual IFSP?

Answer: Part C regulations require that initial and ongoing eligibility are determined by a multidisciplinary team.

59. Is it correct that the annual IFSP does not require age levels, and you can use progress notes to determine continued eligibility?

Answer: Age levels will not be required on initial or annual IFSPs. The documentation of eligibility will be on a separate form and, at the time of the annual IFSP, will be based on progress reports (written or verbal, based on contact notes) of team members.

60. Are there expectations or requirements about which providers confirm the eligibility? For example, can providers who are not on the child's IFSP team make the determination (based on review of the child's record)?

Answer: Generally, those individuals who are providing supports and services to the child will participate in the confirmation of ongoing eligibility since they know the child. If, for example, the child is receiving only service coordination and occupational therapy or the child is only receiving service coordination, then it will

be necessary to pull in a second discipline to participate with the occupational therapist and the service coordinator or to pull in 2 disciplines to participate with the service coordinator in the determination of ongoing eligibility.

61. Will age levels be in the background information for the OSEP child indicators? We were under the impression that there had to be an age level within six months of exiting to complete exit indicators.

Answer: There is no requirement to report a child's scores in each area of development in conjunction with determining the child's status on the indicators.

62. Allowing families to pick the service provider does not seem practical, i.e. mileage coverage for provider who has families all over the county, increased time for travel. Also, most families do not know members of the team and what advantage does this provide the family when they do not know the staff? What is wrong with assigning a service provider?

Answer: Free choice of providers is already a requirement for children who have Medicaid. Citations for this requirement are found in the Centers for Medicaid and Medicare Services (CMS) state Medicaid manual and in the Code of Virginia: 12VAC30-10-490: Free choice of providers. The Part C System provides supports and services in a manner that is consistent for all children and families, regardless of payor source. Thus the requirement applies for all children/families.

63. Am I correct that the family has a choice of providers, not of disciplines?

Answer: That's correct. The IFSP team still will determine what disciplines are needed in order to meet the outcomes.

64. Does family choice of providers mean a choice of individual providers or provider agencies?

Answer: Families must have the opportunity to select from among the provider agencies (which can include solo practitioners) who are qualified to provide the service and who are in their payor network and who practice in the area where the child/family lives.

65. The rectangular box (on the service pathway chart) about completing the development of the IFSP mentions individual practitioner plans. How will this work?

Answer: The Department of Medical Assistance Services (DMAS) has recommended that the IFSP, with minor revisions, be used as the plan of care for Medicaid without the need for separate provider treatment plans. Therefore, reference to individual practitioner plans has been removed from the service pathway box cited in the question. The Part C Office will not prohibit providers from developing individual treatment plans in addition to the IFSP, though that will not be necessary to meet Medicaid requirements.

Other

66. Will there be a highest standard for service coordinators?

Answer: Service coordinators will have to be certified as Early Intervention Service Coordinators.

67. Which of the steps in the process will Medicaid reimburse?

Answer: The following services will be reimbursed by Medicaid through Early Periodic Screening, Diagnosis and Treatment (EPSDT):

- Assessment to define developmental service needs for the IFSP;
- The design of activities and environments that promote the child's acquisition of skills in a variety of developmental areas, including cognitive processes, social emotional development, language acquisition, movement and adaptive skills;
- Intervention planning, including the planned interaction of personnel, materials, and time and space that leads to achieving the identified outcomes in the IFSP for the child with a disability; and
- Consultation with the child's family and other service providers to assess service needs, plan, coordinate, and evaluate services to ensure that services reflect the unique needs of the child and family within the context of the child's development in all domains.
- Providing families with information, training, and support related to enhancing the skill development of the child; and
- Working with the child with a disability to enhance the child's development in one or more developmental domains.
- Fabricating, customizing, fitting assistive devices designed to promote the child's development, and instructing families and other caregivers in use, care and maintenance of assistive devices. Assistive technology devices will continue to be reimbursed as Durable Medical Equipment.

68. Will private insurance be different?

Answer: It is recognized that most private insurance companies do not reimburse providers at the early intervention rates established under Medicaid Fee for Service. Guidance will be forthcoming regarding mechanisms for "charging" the Part C system to cover the costs of those components of early intervention services that are not currently reimbursed by private payors.

69. Will there not be a required number of visits to accomplish the tasks in the service pathway?

Answer: There is no required or expected number of visits between referral and the start of services. The number of visits will depend on individual family needs and preference.

70. This is such a departure from what we are doing now. Is there any talk about a pilot?

Answer: There will be no formal pilot process. However, several local systems have started to implement the new service pathway practices related to eligibility determination and assessment for service planning now, rather than waiting until July 1. Feedback from these local systems will be used to inform further revisions to the Infant & Toddler Connection of Virginia Practice Manual, as needed.

71. How do we combine steps in the pathway when prior notice and consent are needed for each step (ie – will it be necessary to "waive" notice at times)?

Answer: Families do not "waive" prior notice. However, a fully informed parent may give consent to proceed with a proposed activity in less than the 5-day prior notice timeline by initialing the Optional statement in the lower right corner of the notice and consent form. The Infant & Toddler Connection of Virginia Practice

Manual details the requirements associated with prior notice and consent for each step in the service pathway and explains use of the Prior Notice and Consent forms when steps in the pathway will be combined.

72. You stated that parental understanding had to be granted at several points during the process, and we would like clarification of how that would be achieved in an objective way.

Answer: During the call we emphasized the need for parents to be fully informed before opting to begin an activity before the 5-day prior notice period had elapsed or opting to combine steps in the service pathway. The Infant & Toddler Connection of Virginia Practice Manual details the requirements associated with prior notice and consent for each step in the service pathway and explains use of the Prior Notice and Consent forms when steps in the pathway will be combined. Sample scripts are provided to assist service coordinators in talking with families about their options in these situations to ensure the parent's consent is fully informed.

73. Could you clarify use of children's names on e-mail communication?

Answer: Personally identifiable information like the child's name can only be shared via email if the email message is encrypted. HIPAA compliance officers within your agency can assist in further clarifying agency requirements associated with emailing personally identifiable information.

74. During the call you indicated that where things look very different from what we're doing now that's because clarification in the proposed Part C regs (based on IDEA 2004) gives us the opportunity to (1) better align our practices with federal intent, and (2) do things in ways that use personnel and existing information in the most effective and efficient way. Could you cite which regulations this is specifically addressing?

Answer: Citations of relevant regulations were provided as handouts for the November 3, 2008 technical assistance call and are available on our website, www.infantva.org, under Administration and System Transformation.

75. I remember a memo in which it sounded like the service pathway was guidance. Now it sounds like a requirement. Could you clarify if this is in fact a requirement and, if so, what will be the measurement of compliance?

Answer: The service pathway provides a consistent framework within which family-centered, individualized planning occurs for each child and family. The Infant & Toddler Connection of Virginia Practice Manual identifies the requirements associated with implementing the service pathway. Compliance will continue to be monitored through our system of general supervision and monitoring, which includes mechanisms such as record reviews, review of ITOTS data, family surveys, data verification, etc.