



Infant & Toddler Connection of Virginia October 2014 Update

October 2014

Note about This Update:

This Update is prepared by the Infant & Toddler Connection of Virginia State Team at the Department of Behavioral Health and Developmental Services as a means of sharing current information from the DBHDS/Part C Office.

Enrollment of Children in the Medicaid Data System (VAMMIS)

Please note the following contact information for questions about enrollment of children in the Medicaid Data System (VAMMIS).

Irene Scott 804-786-4868 irene.scott@dbhds.virginia.gov

Beth Tolley 804-371-6595 beth.tolley@dbhds.virginia.gov

Early Intervention Certification

For questions about certification of practitioners, contact Irene Scott 804-786-4868

irene.scott@dbhds.virginia.gov.

For questions related to completing the online application, contact David Mills 804-371-6593

david.mills@dbhds.virginia.gov

Monitoring and Supervision News

The final Local System Report on their indicator results for FFY13/SFY14 (July 2013- June 2014) will be sent to Local System Managers the end of this month, along with a memo from Commissioner Debra Ferguson concerning the results and requirements. Determinations and Enforcements are included with this report as well the information about requirements for local monitoring and improvement plans. The Public Report of FFY13/SFY14 indicator results will be sent to local systems and posted on the web in December. Thanks to all of you for your work to promote great results for infants, toddlers and their families while meeting compliance requirements.

Important Reminders about Service Coordination

From the Infant & Toddler Connection of Virginia Practice Manual (Chapter 7; page 28):

Frequency - For service coordination, record the projected **minimum** frequency of **direct contact time between the service coordinator and the family**, which includes activities such as home visits, phone calls and emails with the family, accompanying the family to an appointment, etc. For children receiving EI TCM, there must be at least one direct contact between the service coordinator and family every three (3) calendar months. Such contacts shall be person-centered with the choice of contact method determined by the family (face-to-face, phone, email, or text). The family's preferred method of communication (face to face, phone email, or text) for the family contacts that are required every three months can be documented in the contact note for the intake visit.

Length - For service coordination, record the projected **minimum** length of **direct contact time between the service coordinator and the family**, which includes activities such as home visits, phone calls and emails with the family, accompanying the family to an appointment, etc.

Monitoring and Supervision News Continued

Please note that the planned frequency and intensity listed on the IFSP is not synonymous with billable service coordination activities. Many of the billable service coordination activities do not involve direct contact time between the service coordinator and the family.

Further clarification is provided in the text box on page 28.

Frequency and Length for Service Coordination

The Infant & Toddler Connection of Virginia Office recognizes that the frequency and length of service coordination actually provided will fluctuate since service coordination is an active, ongoing process that is responsive to individual family needs and circumstances. When the frequency and length of service coordination delivered vary from that planned on isolated occasions, the service coordinator's contact notes must reflect the reason for increase/decrease in frequency/length. If the frequency and/or length of service coordination delivered vary greatly from that planned on a consistent basis, then it is time for an IFSP review. During State monitoring of service delivery, local systems will NOT be cited as out of compliance if there is not an exact match between the planned and delivered frequency and/or length for service coordination as long as there is documentation that service coordination was active and ongoing and based on meeting the family's needs and IFSP outcomes. Similarly, for children receiving EI TCM, a provider will not be cited as out of compliance with the requirement for direct contact with the family every three months as long as there have been repeated and documented attempts to make that contact within the required 3-calendar-month period.

Billing Tips

Providers must assure that electronic billing systems that generate claims based on scheduling do not inadvertently result in claims for more time than was provided or for services that are not billable. For example, if twins are each scheduled for an assessment for service planning during the same/shared time period with the same providers, some billing systems have generated claims for the full amount of time for each child effectively billing for double the amount of time the provider spent with the children (Sue spent a total of one hour assessing twins, Ben and Billy, but the system bills for 1 hour for each child). Other local systems have noticed that service coordination documentation automatically triggers a TCM claim in their billing system whether or not the activity was a billable activity and whether or not all of the criteria for billing for service coordination were met.



REMINDER:

PLEASE REMEMBER THAT ITOTS DATA ENTRY MUST OCCUR WITHIN 10 BUSINESS DAYS OF REFERRAL, INTAKE (FOR CHILDREN WITH MEDICAID/FAMIIS COVERAGE), IFSP DATE, OR EXIT. THIS IS ESPECIALLY IMPORTANT WITH THE DECEMBER 1ST CHILD COUNT DATE APPROACHING.

Monitoring and Supervision News Continued

Planning and Billing for Services for Twins and Triplets

Twins may be scheduled to be seen together for their intervention sessions (group/conjugate) or they may be scheduled for individual sessions. Either can be an acceptable way to plan for the intervention depending on the needs of the children and family. A group intervention session may be appropriate if the twins (or triplets) have similar needs and working with the caregiver during a group session can address the goals for both (all) of the children. In such situations, Group would be listed on the IFSP and the length listed would represent the total time that will be spent with both (all) of the children in each session. The claim for each child would be the group code for the discipline of the provider and would include the number of units to cover the entire session for each of the children (e.g., if the OT spent 45 minutes in a group session with twins, then the claim for each child would be for 3 units of group OT). Alternatively, the IFSP team may determine that each child should be scheduled for individual sessions. This is acceptable even if both (all) children are present throughout each child's session. In this situation, the focus is on the individual child and the twin/triplets are present as siblings for the session. The billing would be for the amount of time planned and spent focusing on the individual child. So, for example, twins Jo and Jane may have 30 minutes PT listed on their IFSP; the intervention may be scheduled for 60 minutes during which Jo will be the main focus for 30 minutes and Jane for the other thirty minutes. The billing code would be the individual PT code for 2 units for each child.

LIVE, INTERACTIVE, ONLINE SIGN LANGUAGE CLASS FOR FAMILIES

The Virginia Department of Education has given a grant to the Virginia School for the Deaf and the Blind (VSDB) to expand Outreach Services. The goal of these services is to help educators across the Commonwealth meet the needs of children who are deaf/hard of hearing, blind/visually impaired, and deaf-blind (ages birth to 22 years) and their families. In an effort to tailor the Outreach Services to your local infant and toddler system's needs, we will be disseminating a Needs Assessment via email. Your feedback will assist us in determining the services provided through this grant. One Outreach project that VSDB is planning to offer is distance sign language classes. Do you work with a child who is deaf or hard of hearing, and whose family has chosen to use sign language to communicate? Live, onsite sign classes are optimal for those learning to sign; however, if a family does not have access to a class or someone who can teach them, online lessons are the next best thing! A program will be piloted with four families. Each family will be paired with a professional who will meet virtually with them two to four times each month using Skype, Facetime, Gotomeeting, Adobe Connect or similar technology that will allow parties to interact in real time. Families will need a computer and high speed internet service. Vocabulary taught in each lesson will focus on a part of a child's normal daily routine. Signed vocabulary will then be posted so families can review it during the week. The family's early intervention provider is welcome to join the lesson. If a family with whom you work would like to participate in this pilot project, please have them contact Dr. Debbie Pfeiffer, Director of Outreach Services, at Debbie.pfeiffer@vsdb.k12.va.us or (540) 414- 5249.

Needs Assessment & Creating What You Need:

In an effort to tailor the Outreach Services to the needs of local systems, Debbie Pfeiffer, Director of Outreach Services, will be disseminating a Needs Assessment via email to LSMs. She would also like to attend regional meetings to talk with LSMs about the new program, to get feedback regarding the needs of their agencies and the families they serve. Feel free to invite her to an upcoming regional meeting or contact her directly to provide input. Thank you!

State Systemic Improvement Plan (SSIP)

As part of the new State Performance Plan /Annual Performance Report 6-year cycle that begins this year, each state is required to develop and submit to the U.S. Department of Education, Office of Special Education Programs, a State Systemic Improvement Plan (SSIP). The plan will be developed over the first 2 years and then implemented over the remaining four years. The SSIP's focus on evidence-based practices and improving results for children and families will fit perfectly with efforts already underway in Virginia.

The measurable result that will be the focus of Virginia's SSIP is increasing the percentage of children exiting early intervention at age level in the area of taking action to get their needs met (this includes functional skills like getting from place to place, feeding, dressing, and communicating wants and needs).

Here's what's new in the SSIP development process:

- Our efforts this month focused on identification of improvement strategies. The Virginia Interagency Coordinating Council (VICC) and local system managers had an opportunity to brainstorm possible improvement strategies in September. All stakeholders have been invited to review the ideas generated so far (<http://www.infantva.org/Sup-SSIP.htm>) and provide any additional suggestions or input to Kyla Patterson at k.patterson@dbhds.virginia.gov through October 24, 2014.
- On October 7, in conjunction with the Arc of Virginia, we held a webinar for families to explain the SSIP, summarize our data analysis findings and solicit their input on improvement strategies. We had great participation from families and received valuable suggestions for improvement activities. That webinar was recorded and will be posted to the Arc of Virginia website in the near future so that even more families can access the information.
- An updated list of improvement strategies suggested by stakeholders, including the families who participated in the October webinar, will be posted to the SSIP section of our website soon.
- In early November, state staff at the Infant & Toddler Connection of Virginia will be reviewing all suggested improvement strategies as well as criteria suggested by the VICC and local system managers for selecting the initial group of local systems that will implement the improvement strategies.



The Decision Tree

Child Indicator Seeds for Success

Writing an Honest, Balanced and Meaningful IFSP Narrative by: [Dana Childress, M.Ed.](#)

Does this sound familiar?

Devin is a happy little boy who enjoys playing with musical toys, splashing in the bathtub, and looking at books with his grandmother. During the assessment today, Devin was able to stack three blocks, scribble with a crayon, and point to four pictures in a book. He sat independently, pulled to stand at furniture, and crawled across the floor to get to his mom when she called his name. He is beginning to take a few steps but is not yet walking without his hands held. Devin uses approximately 12 words and signs to communicate and understands simple 1-step directions, such as give me, come here, and find your ball. He tantrums often throughout the day and can be difficult to calm down. He is a good eater and feeds himself using his fingers. He has begun to use a spoon with lots of spilling. He primarily drinks from a bottle but can use a sippy cup as well....

Sounds like Devin is doing quite well developmentally, doesn't it? From this IFSP narrative, you have no idea that Devin is actually 28 months old and is showing global developmental delays. What is missing from this narrative? What is needed so that any reader clearly understands Devin's developmental status?

Writing an Honest, Balanced IFSP Narrative

The IFSP narrative is intended to provide a summary of the child's developmental status based on information gathered from the child assessment. This summary should include the child strengths AND functional limitations and needs. It can be so easy to over-emphasize the child's strengths and the skills a child can do in an effort to present a positive perspective. When we do this, we are sharing only half of the story. Every child has areas of strength and limitations and understanding both is vital to developing individualized outcomes and intervention strategies.

The IFSP narrative should present an honest description of the assessment findings and do so in a balanced manner that helps others understand what the child can do and what he has not yet mastered. This helps the parents understand the child's development from a holistic and functional perspective and recognize what skills and abilities come next. It also provides background information for understanding family priorities related to what goes well for the child and where the struggles may be and why.

The OTHER Problem with this Narrative

Did you notice the other problem? This narrative reads like a list of test skills in paragraph format. When a narrative is written like this, it can be very difficult for families, child care providers, insurance reviewers, and others to understand the relationship between the skills the child demonstrated based on test items and the functional abilities and struggles that occur in everyday life. Many states are moving to crafting the IFSP narrative from the perspective of the three OSEP child outcome indicators (i.e., positive social-emotional skills, acquisition of skills and knowledge, and use of appropriate behaviors to meet needs). Framing the IFSP narrative using the child outcomes can help all team members understand and use assessment information to inform intervention decisions.

Check out the rest of this blog post on the [EI Strategies for Success Blog](#) for 7 tips from Dana and ideas from other providers to help you write an honest, balanced and meaningful IFSP narrative.

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