Natural Environments & Individualized Family Service Plans Questions and Answers

September 17, 2001

I: Location of Services – Natural Environments Requirements

Question: Since “natural environments” is not a place, what does the line of the IFSP “justification of why early intervention outcomes can’t be achieved satisfactorily in a natural environment” refer to? The asterisk references the LOCATION of services.

Answer: The federal Part C regulations require that location of services be specified in the IFSP for each early intervention service. In accordance with guidance received from the Office of Special Education Programs on the natural environments requirements during the 1998 Natural Environment teleconferences, the location must be a natural setting where children without disabilities participate and be consistent with those settings where daily activities and routines of each child and family normally occur. We have learned from families and from research that intervention is most effective when integrated into the daily activities and routines of children and families. This broader perspective on natural environments was evident in the notes that accompanied the September 2000 proposed changes to the Part C regulations. Virginia has adopted the information provided in the Infant and Toddler Coordinator's Association "Position Paper on the Provision of Early Intervention Services in Accordance with Federal Requirements on Natural Environments, April 2000" (ITCA Position Paper). Specifically, Virginia uses the terminology “natural environments” when referring to the federal regulations, and refers to the process of providing early intervention services in the context of natural environments requirements as "family-centered intervention or family-centered intervention in the context of daily activities and routines of children and families."

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Question: How is treatment at a daycare without parents present different from treatment at a center? What is required for parent contact?

Answer: The daycare is considered a "natural" setting if the child would attend daycare even if he were not receiving early intervention services. In other words, the day care setting is a location where the child normally goes as part of his or her daily activities and routines. Providing early intervention in a daycare setting is critical for ensuring integration of learning opportunities to meet intervention goals and outcomes into the daily activities and routines that occur at the daycare center. The therapist is able to observe the activities and the environment and to provide suggestions and instructions directly to the caregivers who take care of the child on a daily basis, thus providing greater carryover. The frequency and means by which the therapist communicates with the parents when early intervention services are provided at the day care center is determined by the IFSP team, including the family, and is based upon the individual family's daily activities and routines.

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Question: If the parent is unwilling to have services in her home because it doesn't fit into her work constraints, is it possible to schedule therapy at a center since her employer will allow her the time to travel there and back within an hour?

Answer: In accordance with the ITCA Position Paper, Virginia provides early intervention services as part of the routines and daily activities of children and families in order to meet the natural environments requirements of Part C. If the issue is truly a scheduling issue, the service provider should consider alternative scheduling (very early morning, early evening, weekends) so that services "fit the family" instead of making the family "fit the services." (ITCA position paper). Convenience is not an acceptable justification for not providing services consistent with federal natural environments requirements.

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Question: What if a family says "my home is my private life where my child is my child. Having you come to my home just makes me realize that within my home my child is different. I want services at your center and I will take the responsibility of working on the therapy in my home."

Answer: Research indicates that providing early intervention services within activities that occur in natural settings and as part of the child's and family's daily routine offers opportunities for the child to learn and practice new skills. Carry-over of activities learned and practiced in a clinic is not as effective as carry-over of activities learned and practiced in natural, real-life situations.

Home is only one natural setting for families. If the family does not want services in their home, an alternative natural setting should be selected where the child's needs can be met. The IFSP team makes the decision about where early intervention services within the daily activities and routines of the child and family are provided. Every effort is made to select a setting that the entire IFSP team, including the parents, supports. Federal regulations do not support family choice or preference as an acceptable justification for providing services outside of a natural setting. As noted in the OSEP response to a 1998 letter from Texas regarding this issue, "… if the parents do not consent to a particular location for a service specified in the IFSP, the State may not use Part C funds to provide that service in a location different from that identified on the IFSP. The parents are free to reject any service(s) on the IFSP by not providing written consent for the service(s) …. If the parents do not provide consent for a particular early intervention service, which also includes the location, that service may not be provided [under Part C]…."

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Question: Is it okay for a child to receive Part C services at a center that is funded with non-Part C funds (Part C funding is not used to support the center – overhead, teachers, equipment)? Is it okay for parents to participate in a parent group at a center?

Answer: Part C services must be provided according to Part C regulations. If services for a child are provided in a center (without appropriate justification as to why the services cannot be provided for that child in a natural setting), those services are not Part C services and cannot be supported with Part C dollars. OSEP's response to a 1998 inquiry from Texas further clarifies that " … All funds used to implement the early intervention system under Part C must be used consistent with Part C. Thus, the State cannot circumvent the requirement to provide early intervention services in natural environments by using state funds that are budgeted for early intervention services under Part C and used to satisfy the non-supplanting requirement. State and local funds used in a way inconsistent with the requirements of Part C may not be considered in determining whether a State has met the standard regarding supplanting in 34 CFR 303.124(b)."

In accordance with OSEP's response to Texas in 1998, the natural environments requirements do not apply to services directed solely at the parent, such as parent classes and support groups.

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Question: What if sessions are scheduled at a clinic near the child's father's work in order to allow both parents to be present during the session. Moving the sessions to community settings would exclude the father because, being further away from his work, they would require more time off work than he can take.

Answer: There are other options for including a father who works, such as scheduling services at times when the father is not working or providing some or all services at a natural setting near the father's work. Children and families participate in a variety of community activities that are natural for them and most likely there is some option available near the father's work (e.g. a playground; a picnic area; a swimming pool, etc.) The IFSP team can learn about possibilities by identifying and understanding the family's routines and daily activities prior to determining intervention strategies to be used to meet IFSP outcomes. Taking into consideration the IFSP outcomes and what learning opportunities will help the child achieve those outcomes, the IFSP team, including the family, can determine which early intervention services are most important for the father's participation. If it is impossible for the father to be present during the therapy or other service sessions, the team may consider other ways that the father can be involved (e.g. sessions could be videotaped for the father to view at a later time, a written two-way communication notebook could be used, or a routine phone contact between the service provider and the father might be established).

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Question: Our local council contracts with hospital therapists to provide therapy for our early intervention system. The hospital therapists cannot treat outside of the hospital because of hospital restrictions. Can those therapists still be a part of our early intervention system? Can they continue to treat children at the hospital outpatient center? If not, how can the council coordinator recruit therapists who can treat in natural environments?

Answer: Hospital restrictions on therapists are not acceptable justification for not providing services in accordance with natural environments regulations. Early intervention services can only be provided in such a clinic setting if there is justification in the IFSP to support the IFSP

teams' decision that a particular child's outcome(s) could not be met in a natural setting even with supplementary supports. If the hospital services are used and services are provided in the clinic without valid justification for an individual child, then those services would be considered non-Part C services and would be listed as "Other Services" on the IFSP. Part C services would need to be declined and the parents must be informed that for these services, they are foregoing their rights under Part C. In addition, neither Part C funds nor state or local funds used to satisfy the non-supplanting requirement could be used to pay for these other services.

To determine what barriers are preventing therapists from providing services outside the clinic, a meeting with the hospital administrator should occur. Perhaps the barriers can be overcome. Therapists may be willing to contract privately with the local Part C system to provide services outside their regular clinic hours. The local council coordinator might also check with neighboring Part C council coordinators about therapists who are available to provide services in accordance with Part C natural environments requirements.

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Question: Please provide an example of a place that would not be a natural learning environment.

Answer: A natural learning environment is any place that children with and without disabilities and their families spend their time as part of their daily activities and routines. As characterized in the ITCA position paper on natural environments, natural groups of children are groups that would continue to exist with or without children with disabilities. However, even the most "natural" of groups is not a natural setting for a particular child if it is not part of that child's and family's routine or community.

Any place that is contrived or set up specifically to work on therapy or learning is not "natural." In its position paper on natural environments, the Infant and Toddler Coordinator's Association notes that groups that are not "natural groups" include playgroups, toddler groups or child care settings that include only children with disabilities. Service settings that are not "natural settings" include clinics, hospitals, therapists' offices, rehabilitation centers, and segregated group settings. This includes settings designed to serve children based on categories of disabilities or selected for the convenience of service providers.

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Question: Would an appropriate justification of why early intervention outcomes can't be achieved satisfactorily in a natural environment be the child's behavior/non-compliance necessitates a more structured environment (i.e. center-based) initially?

Answer: A child's behavior/non-compliance could be an appropriate justification for an individual child if an outcome(s) for that child could not be met in a natural setting even with supplementary supports and providing that the goal of the center-based, structured therapy is to help the child develop the behavioral control needed to return to a natural setting. Supplementary supports that might allow a child to succeed in achieving desired outcomes in a natural setting include adaptive equipment, early intervention provider consultation, training other adults in the natural setting, use of a "coach" to assist the child, and modification of the environment. Any justification for providing services outside of a natural setting must also include a plan with a time-frame and supports necessary for discontinuing the center-based therapy and returning to services within daily activities and routines and within natural settings. In this example, the IFSP team and/or service provider may also need to re-consider the developmental appropriateness of what is being asked of the child and re-consider ways to

base the intervention strategies on the strengths and interests of the child rather than viewing the child as "non-compliant."

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Question: Please provide some examples of justifications of why early intervention outcomes can't be met in natural environments.

Answer: Because any justification for providing services in a setting outside of natural environments must be based on an individual child's needs, there are no examples that will ***always*** meet the exception criteria. One example that might meet the justification requirement is the need to try a variety of mobility and positioning devices that are available at the clinic and which cannot be transported to the child's home (or other natural setting). Early intervention services might also be provided in a hospital setting during a child's inpatient stay following major illness, surgery, or premature birth.

It is important to remember the justification must document the IFSP team's decision that the child's outcome(s) could not be met in a natural setting even with supplementary support. Supplementary supports that might allow a child to succeed in achieving desired outcomes in a natural setting include adaptive equipment, early intervention provider consultation, training other adults in the natural setting, use of a "coach" to assist the child, and modification of the environment. The justification must include ways that services provided in specialized settings will be generalized into the child's daily activities and routines and a plan with timelines and supports necessary to return early intervention services to natural settings within the child's and family's daily activities and routines.

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Question: What are the penalties for not providing services in natural environments?

Answer: If a local early intervention system is determined, through the Monitoring Improvement Measurement System (MIMS) or complaint procedures, to be out of compliance with natural environment provisions of Part C, then a local plan of improvement would be developed and would indicate the steps to be taken and technical assistance needed in order to ensure compliance with Part C natural environment regulations. Sanctions for continued non-compliance would be determined through the additional steps available at the state level. The state has the ultimate authority to withhold funds, if necessary.

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Question: Do the natural environments rules apply to children who transition into the school system (Part B) but are still eligible under Part C? Do center-based programs in Part B need to be integrated?

Answer: A child cannot be served by both Part C and Part B simultaneously. If the child is age-eligible for Part B (2 years old by September 30th), is found eligible through Part B evaluation, and his or her parent's consent to placement under Part B, then the child is served by Part B and Part B regulations apply. Federal Part B regulations do contain language requiring children with disabilities to be with typically developing peers (e.g. least restrictive environment provision).

If the school is providing a Part C early intervention service (such as special instruction) identified on a child's IFSP, then Part C regulations, including those related to natural environments, apply.

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Question: How can an early intervention system that has been forced to move to a center get the funding needed to begin providing services in natural settings?

Answer: In order to meet the payor of last resort requirement, the local early intervention system must explore all available sources of funding in order to meet the needs of all eligible children and families in accordance with Part C regulations. This includes such funding sources as Targeted Mental Retardation Case Management, Mental Health SPO Case Management and Title IV-E. Your regional technical assistance broker can provide guidance regarding potential funding sources. Also, in 2001, additional Part C funds were made available for councils that demonstrated the need for additional funding and were accessing (or moving towards accessing) all potential funding sources. The reasons for being forced to move to a center-based model should also be discussed with the Regional Technical Assistance Broker. It is important to remember that services in natural settings differ from services in centers in more ways than merely the location of the services. Specifically, natural learning opportunities are identified and expanded upon when services are provided in natural settings and incorporated into the daily activities and routines of families. While direct hands-on therapy is not eliminated, it is utilized less; and consultation, coaching and teaching are used more.

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Question: What if the child's natural setting is in a drug-infested and crime-ridden area that the provider does not feel safe visiting?

Answer: The overriding concern in a situation where the natural setting is in a drug-infested and crime-ridden area is the safety of the child and family. The service coordinator should address safety; and if necessary, the situation should be reported to the Department of Social Services. Refer to Appendix G of Family-Centered Early Intervention within the Context of Daily Activities and Routines of Children and Families: Development of the IFSP for suggestions related to safety for therapists and service coordinators in natural environments.

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Question: Can the center be a location for learning opportunities?

Answer: The term "center" can refer to many things within a community, including a recreation center, a daycare center, etc. A center can be an appropriate location if it is a natural setting for a particular child and family (i.e. it is part of the child's and family's community and routine) and if the learning opportunities that occur there are part of an activity that would continue to occur even if no children with disabilities participated.

II. Eligibility

Question: Clarify atypical development and behavior and who determines it.

Answer: As indicated in Virginia's policies and procedures for Part C, children may be eligible for early intervention services in Virginia if they demonstrate atypical behavior (even when evaluation does not document a 25% developmental delay). Atypical development is demonstrated by one or more of the following criteria: (1) abnormal or questionable sensory-motor responses (such as muscle tone abnormalities, limitations in joint range of motion, abnormal reflex or postural reactions, oral-motor dysfunction, poor quality of movement or other skill performance or extraneous movements that interfere with function) or (2) identified affective

disorders (such as delay or abnormality in reaching emotional milestones, lack of eye contact, avoidance of physical contact and/or social interaction, frequent or continuous screaming for no apparent reason). The persons performing the multidisciplinary/interdisciplinary/ transdisciplinary team evaluation and assessment (including the family) determine eligibility. In the case of atypical development, Virginia's policies and procedures state qualified professionals determine the existence of atypical development by observing one or more of the atypical behaviors in the course of administering their evaluation and assessment procedures. Information from the pediatrician or other specialists may also be considered by the team when determining the presence of atypical development.

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Question: Clarify discharge requirements for children who are no longer 25% delayed. What if a family wants to continue with Part C special instruction even though the child no longer meets the eligibility criteria?

Answer: Discharge from Part C services because the child is no longer eligible requires collaborative "transition" planning involving the family, the service coordinator, and the rest of the team. Sufficient time should be built into the process to facilitate a smooth transition. Since determination that a child is no longer eligible for early intervention services under Part C would result in a change in provision of services, the parents must be given written prior notice at least 10 days before any change occurs, in accordance with Virginia policies and procedures.

Continuation of the special instruction outside of the Part C system, following discharge, would depend on the criteria for services for the program/agency to which the child transitions. The service would not, however be a Part C service and could not be paid for with Part C funds or with state or local funds used to satisfy the non-supplanting requirement.

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Question: For public schools serving children throughout the year as they turn two years old, does the eligibility criteria for Part C (25% delay) meet the criteria for eligibility for Part B?

Answer: Each local school division determines its own definition of eligibility for Part B services. Part C service coordinators and other Part C providers within a local council should be familiar with each school division's eligibility requirements.

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Question: Where is parent disagreement with the eligibility decision documented?

Answer: An additional page can be added to the IFSP form to document the disagreement as part of the Evaluation and Assessment record. The statewide IFSP form includes an "IFSP-cont" page that could be used. The Parental Prior Notice form (VBCW-PS-3(R) 8-00), which parents must be given if their child is determined through evaluation and assessment to be not eligible for Part C services, reminds parents that they have the right to request mediation and/or an impartial due process hearing if they disagree with the eligibility decision.

III. IFSP Process

A. Intake

Question: Should a service coordinator do the initial intake or can anyone else do this.

Answer: Any person assigned and trained by the council can obtain the initial referral information (including getting basic directory and similar information from the family when they first contact the local central point of entry). Once a referral is received by the local central point of entry, a temporary service coordinator must be assigned. The temporary service coordinator is responsible for the initial Part C intake including informing the family of their rights and responsibilities and available procedural safeguards under Part C, obtaining parent permission for the initial evaluation, and coordinating scheduling of the initial evaluation and assessment with the appropriate agency/individual. The role and responsibilities of the service coordinator are further detailed in Virginia Part C Policies and Procedures.

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Question: Are there any specific educational requirements for the person doing an initial intake which might include a screening for the child?

Answer: The person taking the initial referral information (taking the phone call from a family at the central point of entry) may be anyone assigned and trained by the council to do this. However, the temporary service coordinator assigned to the family (who is responsible for the Part C initial intake) must meet the requirements for a service coordinator as specified in Virginia Part C Policies and Procedures.

Individual child screening is not a mandatory procedure prior to evaluation and assessment. It is expected that most children referred to the local central point of entry will have had a screening as part of child find or will have a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. In those rare instances when a child and family reach the point of entry without a screening and a screening is needed in order to determine the need for multidisciplinary/interdisciplinary/transdisciplinary team evaluation and assessment, that screening may occur through multiple agencies and providers within the Part C system (as specified in local policies and procedures). Persons who provide screenings must be trained to administer whatever screening tool is used.

B. Interim IFSP

Question: How should an interim IFSP be documented? Can localities use their own form or will the state be developing an interim IFSP form?

Answer: In order to meet federal Part C requirements and in accordance with Virginia Part C policies and procedures, the following pages of the state IFSP form can be used as an interim IFSP:

- Page 1 - Document that this is an interim IFSP
- Page 3 - Document identification of a diagnosed condition likely to result in delay
- Page 6 - Document the early intervention services that are to begin immediately
- Page 8 - Document parent consent (parent signature) and team participation

Please note that the use of an interim IFSP does not affect the requirement that the evaluation and assessment and the development of the IFSP must be completed within 45 calendar days of referral to the local Part system. The rationale for the interim IFSP must be clearly documented on the prior notice form. Federal regulations related to interim IFSPs are listed on page 30 of the October 2000 Family-Centered Early Intervention In The Context Of Daily Activities And Routines Technical Assistance Guide.

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Question: Since an interim IFSP is permissible so necessary services can begin, why can't the interim IFSPs be included as part of the December 1 count?

Answer: The interim IFSP is used to allow children (and their families) with a diagnosed condition likely to result in developmental delay and with obvious immediate needs at the time of referral to begin receiving those needed services prior to the completion of the evaluation and assessment. The interim IFSP requirements do not allow for the slowing of the IFSP process. The evaluation and assessment and the development of the complete IFSP must still be accomplished within 45 calendar days of the referral to the local Part C system.

Because the December 1 child count must reflect only those children who have a completed IFSP (documenting complete evaluation/assessment information and the full range of desired outcomes and needed services), an interim IFSP cannot be counted. However, an interagency task force is currently addressing integrated data collection and will look into the possibility of including interim IFSPs in Part C data collection.

C. Evaluation and Assessment

Question: When is page 2 of the IFSP (which includes child and family activities and routines, as well as family resources, concerns and priorities) supposed to be completed and by whom?

Answer: Information about child and family daily activities and routines, and family resources, concerns and priorities can be gathered over time beginning at intake and continuing during subsequent communication with families as they prepare for the evaluation/assessment and IFSP meeting. The information can be added to the form itself prior to the IFSP meeting (as long as families then review for accuracy), during the IFSP meeting, or some families may choose to complete the form on their own. Temporary service coordinators, service coordinators, and other evaluation/assessment or IFSP team members may also participate in completing this portion of the IFSP form. As with other sections of the IFSP, it is expected that information on this page will be written using the family's own words and language whenever possible.

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Question: Is it okay for evaluators to fill in the evaluation and assessment table (developmental evaluation results and methods/instruments used) and initial this ahead of the IFSP meeting since they often don't participate in the IFSP meeting?

Answer: Ideally, the evaluators would participate in the meeting. However, if they do not participate in person, they can fill in the developmental evaluation results and methods/instruments used on page 3 ahead of time (and likely will do this before the IFSP meeting whether or not they attend).

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Question: If the evaluation/assessment team, along with the family, recommends Occupational Therapy, but an Occupational Therapist did not participate in the evaluation, is the "treating" occupational therapist required to use the evaluation/assessment that has already been done as the basis for their treatment planning.

Answer: Before answering the question about evaluation and assessment, the caution to be noted here is that team members do not recommend services, but determine services based on the outcomes identified by the team. Services are only provided if they are necessary to achieve an outcome. Ideally, the evaluation/assessment team will be composed of persons representing those disciplines most likely to be involved in provision of services. When this has not occurred, an evaluation/assessment by the discipline that is needed to address one of the outcomes should be listed as one of the IFSP services, e.g. OT evaluation/assessment. The evaluation/assessment would be at no charge to the family and would not be billed to commercial insurance payors. (Medicaid would be billed, if the child is covered by Medicaid).

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Question: Is "no family concerns" sufficient if vision and hearing have not been officially tested? Is specific screening or testing required for evaluation of vision and hearing? If yes, what tools or methods are recommended and who can perform the evaluation? If no, then what is sufficient?

Answer: "No family concerns" is not sufficient for evaluation and assessment of vision and hearing. For children born after 7/1/2000, hearing will have been screened as part of the newborn hearing screening mandate. Pediatricians also screen for vision and hearing. If no records are available, or if records are greater than 6 months old, or if there is a question about whether the prior results reflect the child's current function, an objective hearing and vision screening tool must be used as part of the Part C evaluation and assessment. Additional guidance is forthcoming.

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Question: I understand the evaluation/assessment reports that have been completed within the past 6 months are to be used rather than repeating the evaluation/assessment? How do we deal with our agency policy/procedure that we complete our own evaluation/assessment?

Answer: Many agencies required "their own" evaluations in the past. However, this practice is changing. Discuss the issue and the Part C regulations with your agency's policymakers. (In order to be a Part C provider, an agency/provider must comply with all Part C regulations.) Unnecessarily repeating evaluations adds to the cost of medical care, decreases the time available for providers to treat and places an unneeded burden on the family and child. Consult your technical assistance broker if further assistance is needed.

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Question: Where do we include information about sensory testing results?

Answer: Sensory testing might be done in conjunction with evaluation of fine, gross motor and adaptive skills and can be documented in those categories and also included as part of the team summary.

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Question: How do we fill in the team summary if the evaluations were done separately by different disciplines?

Answer: The team summary should be an integrated summary using the findings of the individual evaluations. Information from individual evaluations should be included in the written integrated summary and the source of the information should be referenced. The original individual evaluation reports should be a part of the child's early intervention record.

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Question: Do the individual evaluations have to be attached to the IFSP or can they be retained as a separated part of the child's record?

Answer: As noted above, the information from individual evaluations should be incorporated into the integrated summary and the individual evaluation reports should be referenced and filed in the child's early intervention record.

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Question: Must evaluations/assessments be completed in the child's home or can they be done in a clinic.

Answer: Federal regulations do not require that evaluations/assessments be completed in natural environments. However, Virginia Part C Policies and Procedures state that the service coordinator is responsible for arranging IFSP meetings in settings that are comfortable and convenient for families and that facilitate the family's ability to participate. Possible setting options include, but are not limited to, a family's home, the home of a neighbor or of a family child care provider, childcare centers, churches, family resource centers, and other community buildings where children and their families normally spend time. Evaluations/assessments done in settings that are natural/familiar for the child provide specific information about functional, "real-life" abilities and difficulties, and provide a basis upon which meaningful, relevant intervention can be planned based on the outcomes determined by the IFSP team.

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Question: Can "informed clinical opinion" be the sole method/tool used by one member of the multidisciplinary team (physician, for example) for the entire evaluation/assessment or for one component? Must an assessment tool (test, scale, etc.) be used for each of the five components and for the sub-components (gross and fine motor; expressive and receptive language, hearing and vision)?

Answer: "Informed clinical opinion" is used in conjunction with other objective evaluation and assessment measures. Informed clinical opinion makes use of qualitative and quantitative information to assist in forming an eligibility determination regarding difficult-to-measure aspects of current developmental status and the potential need for early intervention. Use of informed clinical opinion as a separate basis for establishing eligibility helps assure that children needing early intervention services will be appropriately identified at the earliest possible age. Evaluators may use any or all of the following to reach an informed clinical opinion about the development of a particular child: clinical interviews with the parent(s), evaluation of the child at play, observation of parent-child interaction, information from teachers or child care providers, and neurodevelopmental or other physical examinations. As indicated in Virginia's Part C policies and procedures, there are a variety of appropriate methods, procedures and approaches that may be used in evaluation and assessment, among them: use of standardized measures; interviews and discussions with families; observations of the child in natural settings;

play-based assessment; arena assessment; etc. The evaluation, or review of existing evaluation data less than 6 months old, must determine the child's level of functioning in each of the 5 areas of development, including the "sub-components."

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Question: Can a service coordinator be considered a discipline on the IFSP Evaluation/Assessment team and, with one other discipline, meet the requirement for at least two disciplines participating in the evaluation/assessment?

Answer: The service coordinator can only be one of the two disciplines necessary to meet the requirement for a minimum of two disciplines participating in the evaluation and assessment if

1. The service coordinator meets the criteria for one of the other disciplines listed in Virginia's Part C Policies and Procedures, **and**
2. The service coordinator is functioning as that other discipline during that evaluation and assessment, e.g., special instructor, speech-language pathologist, nutritionist, nurse, etc.

D. Outcomes

Question: How can you develop family-driven goals if families choose not to identify their concerns?

Answer: Early intervention providers can learn what is important to the family including goals for their child through conversations with families about their daily activities and routines rather than through the use of questions and forms/checklists. Listening to families and restating what is heard to ensure understanding is the best way to hear the concerns of the family. Even if they do not wish to identify needs they may have as a family, most families will articulate what they want for their child as a result of their involvement in early intervention. The service coordinator is responsible for offering the family multiple and **continuing** opportunities to identify its own resources, priorities and concerns since the family's choice about their level of participation may change over time.

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Question: Please give a clear definition of "measurable" including when a time frame is sufficient for making the outcome measurable and when a time frame alone is not enough.

Answer: In accordance with Virginia Part C Policies and Procedures, the IFSP must include a statement of the major outcomes to be achieved for the child and family, and the criteria, procedures, and timelines used to determine the degree to which progress toward achieving the outcomes is being made and whether modifications or revisions of the outcomes or services are necessary. IFSP outcomes are statements of the changes that families want to see for their children or themselves as a result of their participation in early intervention and are measurable. It is expected that outcomes will be functionally stated. The term "timelines," as used in the federal policy refers to the time frame for when an outcome is expected to be achieved (such as 3 months).

Measurable means that an objective or standard measure can be used to determine the status of the child's performance or ability in relation to the desired outcome. Measures can include numbers of times something is done in a given time span (such as number of times a day a

child indicates what he wants by saying a word), distance (such as “the child will crawl from the family room to the kitchen [15 feet] to be with his mom”), or duration (such as “ the child will stand at the sofa and play using both hands [stand without holding on to support] for 15 minutes”). A time frame can be used to make a specific action measurable as suggested in the example above of the number of times a day the child indicates what he wants by saying a word. A time frame can also be used as a measure for undesirable actions, such as the number of times a child spontaneously screams in 15 minutes or an hour or day. A time frame for when an outcome is expected to be achieved (such as 3 months) is required in addition to the measurable component of the outcome.

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Question: Who completes the outcome page if the evaluating therapist is different from the treating therapist?

Answer: The IFSP team develops the outcomes and completes the outcome page. Ideally, both the therapist who conducted the evaluation and assessment and the therapist who will be providing services participate in the IFSP meeting. If the evaluating therapist is unable to attend the meeting, that therapist may participate by telephone, have a knowledgeable representative attend (could be the treating therapist), or make pertinent records available for the meeting.

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Question: What dates should be used for the outcome (long term goals) and the short-term goals?

Answer: The timeframe is determined by when it can be reasonably expected that the child will achieve the outcome identified by the family. Families may identify outcomes that take several months or much longer than a year to achieve. In the latter case, it is helpful to break the outcome into components that can be achieved in a year. The parent’s desired outcome and time frame can be recorded followed by a long-term goal for the next 12 months. (This can be developed together with the family by discussing what interim achievements can be expected as the child works toward the outcome desired by the family). It is also helpful to coordinate the time frame of the goals with the third party payor authorization periods and with required IFSP reviews and evaluations. The IFSP must be reviewed anytime the goals or outcomes are changed.

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Question: Who should sign the outcome page if a therapy is recommended by a transdisciplinary evaluation team that did not include a representative of the recommended therapy?

Answer: Signatures are not required on the outcome pages of the revised IFSP form (9-12-01). However, the situation may arise when the IFSP team determines that a specific Part C service may be necessary to meet an outcome identified by the family, but the discipline representing that Part C service was not one of the participating disciplines in the evaluation. In such a case, then the IFSP team may identify on page 6 of the IFSP (services) that an evaluation by that discipline will be provided to determine the appropriateness of that discipline in meeting that specific outcome. For example, a physical therapist cannot determine specific goals, strategies and interventions for an occupational or speech therapist. The team may determine that based on the family driven outcome(s), OT or Speech may be a needed Part C service to meet that outcome(s). In this case, a Part C OT or Part C Speech evaluation should be listed as one of the Part C services on page 6.

E. Determining Services

Question: How can we best include/integrate intervention aimed at addressing impairments that have a high likelihood of resulting in development of a disabling condition if not treated with an asset-based, functional approach to early intervention?

Answer: Treatment of impairments in order to promote or retain functional abilities is consistent with an asset-based, functional approach to early intervention. The key is to keep the primary focus of the therapy and of each session on functional activities that occur within the child's and family's daily activities and routines.

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Question: Is it possible to refer to home program activities for learning opportunities instead of listing specifics? Therapists often incorporate new ways of doing things from week to week for generalization of skills.

Answer: Learning opportunities occur as part of daily living, child and family routines, family rituals, family and community celebrations and traditions, and as part of many other aspects of everyday family and community life. Home programs are generally thought of as a list of instructions about exercises or activities to be done outside of a treatment session. However, the term home program could also be used to refer to verbal or written information provided to assist families with integrating suggestions from therapists into daily life. Reference to home programs should be listed in the intervention, treatment procedures and modalities section of the Outcomes page of the IFSP. Broad, general information should be listed on the IFSP, but the specifics (which will change – just as daily lesson plans change) should not be recorded. Please note that the use of home programs in conjunction with services provided in a clinic setting does not meet the federal natural environments requirements.

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Question: If a child is receiving Part C early intervention, but the family chooses to receive therapy services by a non-Part C provider, how are these services recorded on the IFSP?

Answer: If a family chooses to receive the therapy services by a non-Part C provider, these services are recorded in the “Other Services” section on page 6. With the service being identified under "other services", the Part C rights and procedural safeguards do not apply nor can Part C funds be used to assist the family to pay for the services in cases of financial hardship. The families must be provided a copy of their rights and they must sign the "Declining Part C Services" procedural safeguard form.

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Question: Is it alright to use a range such as 2-3 times per month for the frequency of therapy on the IFSP. Is it okay to use a range for the intensity of treatment sessions such as 45-60 minutes/session? (This allows for flexibility based on the child's response to individual sessions).

Answer: Families need to know what to expect and what they are consenting to when they sign the IFSP. Therefore, frequency and intensity of services must be specific; ranges are not acceptable.

F. Intervention

Question: Are parents required to be available during early intervention visits? (Since emphasis is on teaching parents to be better or more effective teachers of their children)

Answer: The ITCA "Position Paper on the Provision of Early Intervention Services in Accordance with Federal Requirements on Natural Environments" emphasizes that determination of intervention strategies begins with identifying and understanding the family's routines and daily activities. Services and supports are provided within these activities to maximize the child's opportunities for learning and practicing new skills. Part C service providers serve as consultants and identify key individuals (i.e. parents, care providers, teachers) across environments, and use their knowledge and expertise to help others who are part of the child's daily environments facilitate learning opportunities in natural settings that assist children in achieving IFSP outcomes. The learning opportunities that are important to the child and family are identified by the family in the course of developing IFSP outcomes and intervention strategies. Depending on the daily activities and routines of the child and family and the natural settings determined appropriate for the provision of early intervention services, parents may or may not be present. The focus with Part C is not to teach parents to be better or more effective teachers of their children, but rather to help families and other persons important in the child's daily life identify and capitalize on learning opportunities that will allow the child to practice existing functional skills and learn new skills.

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Question: What obligations are put on day care provider to work towards a child's outcomes?

Answer: If the family identifies day care as part of the child's daily routines and activities, then the day care center or day care home may be a natural setting determined as the location for a Part C service(s). Part C service providers may use their knowledge and expertise to help the day care provider(s) facilitate learning opportunities as part of the child's normal daily activities and routines at day care that will assist the child in learning new functional skills and achieving IFSP outcomes. However, the day care provider(s) is not a Part C service provider and Part C does not place any obligations on that individual(s).

G. IFSP Reviews

Question: If services change at an IFSP review, should this be recorded on the page 6 of the IFSP as well as on page 9?

Answer: Yes, the original IFSP should be kept up to date by noting when there are changes in services, when outcomes and short-term goals are met, and when outcomes are changed or added. In addition to completing the IFSP review page (page 9), the changes should be noted on the appropriate page of the IFSP with the date of the change, the change and initials of person recording the information. E.g. new family contact information or service coordinator information should be recorded on page 1. Additional concerns, resources and priorities or changes in daily activities and routines are recorded on page 2. Progress on outcomes and changes or additions to goals, learning opportunities and interventions are recorded on page 5 (and a new page 5 is completed when new outcomes are added at an IFSP review). Additions or changes in services are recorded on page 6. Page 7 serves both as a planning page for

transition as well as a documentation page for transition activities and should be kept current. Remember, old information should not be crossed out when a change is made.

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Question: Page 6 of the IFSP form says, “Services will be discontinued if child is no longer eligible or if all of the goals are met." Are these the only reasons for discharge? And what if all the goals are met, but therapy is still needed?

Answer: The discharge statement on Page 6 of the IFSP form is included to satisfy Medicaid requirements. Specific “discharge” planning activities should be listed on the Transition page (Page 7). It is expected that goals will be met and new ones will be developed as the child progresses. Also, outcomes can be discontinued if the parent decides that the outcome is no longer a priority.

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Question: What is required at the 6 month IFSP review?

Answer: Federal regulations require that a periodic "*review of the IFSP for a child and family* is *conducted every six months or more frequently if conditions warrant, or if the family requests such a review. The IFSP review may be carried out by a meeting or by another means that is acceptable to the parents and other participants"* as long as all members have the opportunity to provide input about all contents of the IFSP. The purpose of the periodic review is to determine the degree to which progress toward achieving the outcomes is being made, and whether modification or revision of the outcomes or services is necessary. Routine re-evaluations and assessments in preparation for the 6 month IFSP review are neither required nor funded by Part C. Ongoing assessments should be occurring and should provide the information necessary for the IFSP review, including whether the child continues to be eligible for Part C.

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Question: Is it alright to fill in information under “Progress on Outcomes” (page 5) and on the transition page (page 7) as plans are made between IFSP meetings?

Answer: Yes, the IFSP is a fluid document; it is logical and appropriate to record progress (on the outcome page) when a short-term goal is met rather than waiting until the IFSP review or evaluation meeting. Likewise, if general transition plans are made at the IFSP meeting, it is acceptable to fill in details of the plans and to document the carrying out of the plans when those occur rather than waiting until the IFSP review or evaluation. Please note, however, that an IFSP review is required if the child’s progress results in the need for revision of any of the following components of the IFSP: outcomes, short-term goals, services (including frequency), or service provider.

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Question: How do you complete the 3rd page of the IFSP for the new IFSP that is completed as part of the annual review of the IFSP? What formal evaluations/assessments should be done, if any?

Answer: The IFSP must be evaluated annually using results of any written evaluations and ongoing assessment and revised as appropriate. Formal evaluations and assessments specifically for this annual evaluation of the IFSP are not required. Ongoing assessments should be occurring during provision of ongoing services and should provide the necessary information to determine if the child remains eligible for Part C. Statements of the child’s

abilities in each area can be documented and/or developmental scales can be used to record the information required on page 3 of the IFSP form. Depending on individual child circumstances, it is possible that certain evaluation procedures may need to be repeated before conducting periodic reviews or annual evaluation meetings for the IFSP. (Such circumstances can include illness or hospitalization of the child).

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Question: Can the IFSP meeting take the place of a therapy session for a therapist who is seeing the child once a week and who has no other time to participate in an IFSP meeting?

Answer: If the child is to receive therapy once a week, a therapy session cannot be omitted one week to allow the therapist time to participate in the IFSP meeting. The federal regulations state that "*if a person is unable to attend a meeting, arrangements* are *made for the person's involvement through other means, including*: *participating in a telephone conference call; having a knowledgeable authorized representative attend the meeting; or making pertinent records available at the meeting."*

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Question: Does an IFSP review (Page 9 of the IFSP form) require participation of the full IFSP team or at least 3 members?

Answer: An IFSP review must include the family and service coordinator. In addition, if the review includes discussion of outcomes or services provided by a part C provider, then that Part C provider should also participate.

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Question: On page 9 of the IFSP form, should we document whether the team members participated in person or by phone?

Answer: In addition to the space for signatures of IFSP team members who attended the meeting in person, there is a designated space on the form to list those persons who participated electronically (e.g. by phone), or in writing.

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Question: If an IFSP is reviewed and/or changed at 4 months, is the 6 month IFSP review due in 2 months (6 months from the original IFSP) or in 6 months?

Answer: Part C regulations require that IFSP reviews occur at least every 6 months. If a review is done before 6 months, the 6-month timeline is restarted at that point. However, this is not the case for the annual IFSP evaluation. The service coordinator is responsible for scheduling an annual IFSP meeting (at least by the anniversary date of the initial or previous annual IFSP meeting) to evaluate the IFSP, using results of any written evaluations and ongoing assessment, and, as appropriate, to revise its provisions. Because the annual IFSP meeting incorporates a periodic review, "*it is necessary to have only one separate periodic review each year (i.e., six months after the initial and subsequent annual IFSP* reviews*), unless conditions warrant otherwise*."

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Question: Can you write an addendum to the IFSP? Is there a state form for this?

Answer: Page 9 of the new IFSP form serves as the addendum where additions and/or changes to the IFSP are documented.

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Question: Can we add to the IFSP a grid that shows test scores over time?

Answer: The amount of information that must be included on page 3 precludes inclusion of such a grid. However, a grid could be developed and included in the IFSP as page 3b.

H. Team Process - Handling Differences

Question: If a physician has told the family that their child is "developmentally age-appropriate", but the family is concerned and has requested an evaluation by Part C, how do we approach the physician with this information and how do we obtain the required therapy evaluation orders? How do you proceed when a physician declines or refuses to provide or sign an order for therapy?

Answer: If the physician is not familiar with Part C, this is an opportunity to provide him/her with information about the early intervention system in Virginia. He/she should be informed that all children have a right to an evaluation and assessment at no cost to the family, that results of the evaluation and assessment would be shared with him/her and that if the child is eligible for services, he/she would be a part of the IFSP team. If the physician still refuses to provide needed orders for the child's evaluation, the family can be informed of other physicians who are more receptive to family concerns. If a physical therapist is part of the evaluation and assessment team, a physician referral is required. In addition, if Medicaid reimbursement is expected for the evaluation and assessment, a physician referral is required for occupational therapy and speech and language pathology as well as for physical therapy.

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Question: How can a professional refuse a level of service requested by the family, but felt by the professional to be inappropriate in light of the child's readiness or neurological development?

Answer: The Part C regulations require that services necessary to enhance the child's development be made available. The Part C IFSP team determines the frequency and intensity of the services that are identified by the team as necessary to meet the outcomes. Determination of these services is a team decision, not a family's choice. If a family wishes to have a greater frequency and intensity, the family may obtain those services outside the Part C system and those services would be listed on the IFSP as other services. (Neither Part C funds nor state or local funds used to meet the non-supplanting requirement can be used to support provision of these other services.) Families have a right to request mediation and/or impartial hearing if they disagree with other team members.

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Question: Where and how do we document professional recommendations that the team or family decline to follow?

Answer: Professional recommendations that the team or family decline to follow can be documented in your daily/progress note. Remember that families have the right to access their

child's early intervention record, and that information recorded in daily/progress notes should be written in an objective and non-judgmental way that reflects respect for the family's values and decisions.

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Question: What if a family requests a re-evaluation that the team believes is unnecessary?

Answer: Part C regulations do not require a re-evaluation on a regular basis. It is the IFSP team, not the family alone, who determines if a re-evaluation of a particular developmental domain is necessary. A family can choose to receive a re-evaluation outside of the Part C system. This would be listed on the IFSP as "Other Services" and could not be covered by Part C funds or state or local funds used to meet the Part C non-supplanting provision.

I. The IFSP Form/Records

Question: Does the new IFSP form meet Medicaid requirements?

Answer: The new IFSP form meets Medicaid requirements. The Department of Medical Assistance Services representatives participated in development of the form. The initial statewide IFSP form was reviewed and approved by the DMAS representative to the Early Intervention Interagency Management Team. The revised form (September 2001) was reviewed and approved by DMAS officials prior to implementation. The physician certification form (or documentation that includes the components listed on the physician certification form) along with pages 4,5, 6 and 8 (and page 3 if requested) serve as the approved Plan of Care.

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Question: Who keeps the original IFSP form?

Answer: The service coordinator is responsible for retaining a signed copy of the IFSP and for providing a copy to the family. The Virginia Interagency Coordinating Council Local Regional Direct Services Committee plans to review the documentation practices across the state and make recommendations for consistency including location of the one early intervention record/file.

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Question: When do we use the physician certification form?

Answer: The physician certification form is sent to the referring physician along with a copy of the completed IFSP so that the physician can review the plan and write the orders for therapy (when therapy is an identified service on the IFSP). The physician is to return the completed form. The IFSP and the completed physician certification form serve as the Plan of Care. Please note that the Department of Medical Assistance Services requires that only pages 4, 5, 6, 8, and the physician certification form be submitted (when requested) as the plan of care. (They may occasionally also request page 3).

IV. Service Coordination and Targeted MR Case Management

Question: What is SPO Case Management?

Answer: Case Management is a service that is available through the Home and Community Based Mental Retardation Medicaid Waiver and also for Mental Health through the state plan options for Medicaid. The current terminology for what was formerly called MR SPO Case Management is **Targeted Mental Retardation Case Management**. Both Targeted MR Case Management and Mental Health SPO Case Management can be used to provide service coordination for Part C children who are eligible for those programs. There are specific assessment, contact and documentation requirements associated with Targeted MR Case Management and MH SPO Case Management. The documentation requirements for Targeted MR Case Management have been incorporated into the IFSP. The documentation requirements for Mental Health SPO Case Management are more complex and have not been fully integrated into the IFSP at this time.

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Question: Does there have to be a service coordination outcome?

Answer: A service coordination outcome must be documented if the child is receiving Targeted MR Case Management. If the child is not receiving Targeted MR Case Management, it is not (federally) required, but it is recommended.

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Question: Does the state recommend a certain amount of contact with the family for service monitoring (service coordination) or is that up to the family and the service coordinator?

Answer: A specific amount of contact between the service coordinator and the family has not been established by the state. The amount and duration of contacts will be highly dependent on individual needs. The Targeted Mental Retardation Case Management and Mental Health SPO Case Management requirements provide minimum guidelines for service coordination for those children eligible for those case management services.

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Question: What is a realistic caseload for service coordinators?

Answer: Caseload standards for Part C service coordinators have not been established in Virginia. Many variables, including the service coordinator model being used and the individual needs of the families being served impact the determination of appropriate caseloads. Determining standards for caseloads would have significant impact on localities; considerable time would be required with broad input from the field in order to establish caseload standards.

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Question: Does an Individualized Service Plan have to be developed for children receiving Targeted MR Case Management, or will completion of page 5a suffice?

Answer: An Individualized Service Plan (ISP) is required for Targeted MR Case Management. However a separate ISP does not need to be developed in addition to the IFSP because the required elements for the ISP have been incorporated into the IFSP. For children receiving Targeted MR Case Management, the IFSP must include the service coordination/case

management outcome (page 5) and documentation of the following elements: physical/mental health; financial/insurance/transportation; home/daily living; education/vocation; leisure/recreational; relationships/social support; legal issues/guardianship; consumer empowerment/advocacy; additional information (which can be incorporated into the assessment and evaluation). *The Individualized Family Service Plan Guidelines* contain the specific information that must be included in the IFSP in order to satisfy Targeted MR Case Management Requirements. Quarterly reviews required for MR SPO Case Management can be documented in progress/case notes.

Question: Do federal or state regulations require a face-to-face meeting between the service coordinators and family every 90 days or is this a best practice recommendation?

Answer: The 90 day face-to-face meeting is a state requirement for Targeted MR Case Management. Part C service coordination may require that face-to-face meetings occur more frequently based on individual needs of the child and family.

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Question: Can someone who is not a Part C provider be a service coordinator for a Part C child?

Answer: No. Anyone providing Part C services must be a Part C provider (meaning that through contract, interagency agreement, or memorandum of understanding that agency/provider has agreed to comply with all Part C requirements in the provision of Part C services to eligible infants and toddlers and their families).

V. Research

Question: Please cite the valid research that supports therapy in natural settings as more effective than therapy in clinic settings, particularly when clinic settings include parent training and participation. Are there references that support therapy integrated into the daily activities and routines of the child and family is more effective that individual therapies (2-3 times per week) recommended by physicians?

Answer: The evidence concerning the effectiveness of family-centered intervention that is based on family identified outcomes and incorporated into the activities and routines of children and families continues to grow. Resources, including reports of literature, are listed in Appendix M of Family-Centered Early Intervention within the Context of Daily Activities and Routines of Children and Families: Development of the IFSP. This manual is posted on the Virginia Part C website (www.dmhmrsas.state.va.us/vababiescantwait/)

Additional articles and other resources include:

Bruder MB, Dunst CJ. Expanding Learning Opportunities for Infants and Toddlers in Natural Environments: A Chance to Reconceptualize Early Intervention. In *Zero to Three*. 2000; 20(2); 34-36.

Darrah J, Law M, Pollock N. Family-Centered Functional Therapy - A Choice for Children with Motor Dysfunction. In *Infants and Young Children* 2001; 13(4): 79-87.

Dunst CJ, Herter S, Shields H. Interest-Based Natural Learning Opportunities. *Young Exceptional Children* Monograph Series No.2.

Hanft BE, Pilkington KO. Therapy in Natural Environments: The Means or End Goal for Early Intervention? In *Infants and Young Children* 2000; 12(4): 1-13.

Hanft B. Perspectives on Becoming a consulting Therapist. *Pennsylvania Early Intervention*. 1999; 10(3) 1-6.

Shelden M, Rush, D. The Ten Myths about Providing Early Intervention Services in Natural Environments. In *Infants and Young Children* 2001; 14(1): 1-13

VI. Resources

Question: Where can we get a copy of the Colorado videotape (Being a Kid)?

Answer: This videotape has been phased out and a new videotape, Just Being Kids, which includes 6 stories and a Facilitator's Guide, can be ordered from Western Media Products.

Phone number: 800-232-8902
Fax: 303-455-5302
website: www.media-products.com

VII. Government Regulations:

Question: How, when and why did the government become involved in a child's health care needs. In other settings, the physician identifies a need or a parent expresses a particular concern to the physician and the appropriate referral is made; i.e., to a PT, OT and/or SLP. The parent then calls the clinician and an appointment is set up accordingly. What does government have to do with this? Are we saying the physician and health care professionals are not competent and therefore need government intervention? It appears that if a practitioner wanted to specialize in treating infants and babies that they could only do so where and how the government says it is appropriate. It makes it difficult for the private practitioner to "hang out their shingle" and treat children 0 – 3 independent of the government.

Answer: Federal and state requirements govern hospitals, home care, and other health services as well as schools and other human service organizations. Requirements established by the federal government were based on input from families and research evidence about best practices for promoting positive outcomes for children and families. Families have a choice to participate in Part C of IDEA, just as they do with Part B in the public schools. They may opt out of Part C services, including the Part C evaluation process that is at no cost to the family, and choose their own provider just as parents can opt out of Part B Special Education services and choose their own services or private school. Participating in Part C has specific requirements for providers beyond professional licensure/certification. More importantly, it provides additional benefits and protections to children and families, including procedural safeguards and rights and a family-centered, team oriented approach to intervention.