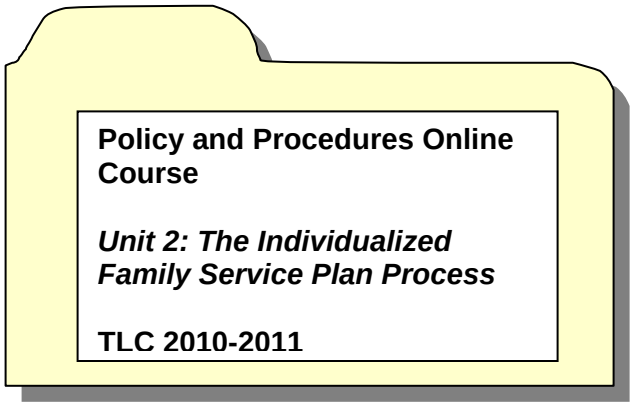

This file is available for use as an easy reference to the OCDEL bulletins, Philadelphia Policy Statements and other guides that are a part of the Unit. It does not include all of the content and learning activities that complete the Policies and Procedures online course. Go to the TLC Home page and click on "TLC Courses" to access "Polices and Procedures."

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Philadelphia County Early Intervention Exit Strategy for Children Prior to Age 3

City of Philadelphia
Mental Retardation Services
Infant/Toddler Early Intervention

Policy

Every child that is referred to infant/toddler early intervention in Philadelphia County (whose parents give consent) will receive a multidisciplinary evaluation (MDE). Children who receive early intervention services will receive an annual MDE. Parents who need or request the evaluation in another language will receive a translated version of the official document. The parent(s) will participate in the MDE as a member of the team, along with the Service Coordinator and the MDE evaluator(s). The parent is permitted to invite any additional persons to the MDE that they wish.

Procedures

These procedures will be applied to every evaluation completed in Philadelphia County

- The evaluation will be completed within 45 days of referral
- The written ER (Evaluation Report) will be given to the parent within 30 calendar days of the evaluation
- The information gathered from the child and family assessment (completed in the initial visit with the family) will be shared with the MDE team and will be considered along with the overall evaluation of the child and the identification of family needs

Purpose of the MDE

The Multidisciplinary Evaluation is the process through which children (0-3) are determined eligible for early intervention services. Children may be found eligible in one of the following ways.

- Delays of 25% or more in one or more developmental areas: cognition, motor, self-help, communication or social emotional.
- Established (presumptive) condition – A medical diagnosis that has a high probability of developmental delays.
- Informed Clinical Opinion- used when the team suspects that a child has a developmental delay and the delay is not captured or measured by a standardized tool, or team members have a significant concern that cannot be addressed by standardized assessments. Qualitative and quantitative data about the child's behavior must be collected and documented to support eligibility and the need for early intervention. Team members justify clinical opinion in the appropriate developmental domain section of the Evaluation Report.

MDE Sequence of Events

- The ChildLink Service Coordinator (SC) reviews the supervisors form, the ASQ or CLA and makes the initial call to family to schedule the initial home visit. The Service Coordinator introduces him or herself and states the purpose of the call. During this call and or the initial home visit the Service Coordinator completes the FAQ and the CAQ. The Service Coordinator should also review all information gathered at registration (ex. name, address, birth date of child). This information is used to complete pages 2-4 of the ER and to begin the service coordination plan.
- The initial home visit is scheduled at a time and place convenient for the family. At the initial home visit the Service Coordinator should review all intake information, complete the FAQ and the CAQ, and gather information that might have been missed at registration.
- The initial home visit packet information is discussed. The proper consents are signed. After the family consents, the Service Coordinator contacts the referral and compliance unit to have the MDE/scheduled.
- The Service Coordinator works with the family to complete pages 2-4 of the ER in preparation for the MDE meeting.
- Upon return to the office, the Service Coordinator submits all documentation to the referral and compliance unit, enters the FAQ, CAQ and consents into the electronic system, and sends a confirmation letter to the family stating the date, time and place for the MDE.
- The Service Coordinator refers to all information gathered from the initial home visit to complete pages 2-4 of the ER.
- The Service Coordinator should contact the family at least the day before the scheduled appointment to confirm that this date is still convenient and to make certain that all information remains the same.

The Meeting

- The Service Coordinator should arrive before the team.

- The Service Coordinator should explain purpose of the meeting and how the meeting will be conducted.

- The Service Coordinator should facilitate introductions between the MDE evaluators and the family with everyone's name, agency and role. The Service Coordinator should take the time to review all information gathered prior to the MDE before the evaluation begins.

Outcome of the meeting

- The team should have a thorough discussion of the outcomes of the meeting by discussing family priorities and concerns and the strengths and outcome for each developmental area.

- Team Recommendations and Parental Consent - a statement that the child is eligible or not eligible for services. The parent signs the appropriate consent.

- If the child is not eligible for services, the parent is informed that the child will be discharged from ChildLInk and will be provided with information about child development and community resources.

- The child (if eligible) may also be referred to the At-Risk program.

- If the child is eligible for services the team moves forward to write the IFSP.

Updated August 2008

Does the child have a condition that has a high probability of resulting in a developmental delay?

yes

Child is eligible

no

Does the child have a 25% or more developmental delay in at least one developmental area?

yes

no

Can the MDE assessments measure the areas of concern?

yes

no

Does a member of the team suspect that the child may be eligible by clinical opinion?

no

Child is Not Eligible

yes

Do data indicate the behaviors of concern are age appropriate in quality, type, frequency, and intensity?

yes

no

Is the issue significantly influencing his or her participation in routines?

no

yes

Use Problem Solving Strategies

no

Is the there team consensus that the child is eligible by clinical opinion?

yes

Child is eligible by clinical opinion

Decision Making for Eligibility by Clinical Opinion

Review qualitative and quantitative data with the team.

1. Record justification Child's Abilities and Strengths Sections of the IFSP. Justification must include the words that the "child is eligible by clinical opinion and standardized assessments are not appropriate to measure the issue of concern" (in any order). Additionally, record specific observable and measurable quantitative and qualitative data used for justification.
2. Check eligible by clinical opinion block on page 8 of the IFSP.
3. SC records justification on eligibility EIRS form

REASON FOR DELAY: ____ Family ____ System (Provider, ChildLink, Resource)
____ Act of Nature/weather ____ No Delay

EARLY INTERVENTION ELIGIBILITY DETERMINATION

Child's Name_____ CL#_____

Birth Date_____ CA_____ AA_____ Evaluation Date_____

TYPE OF EVALUATION TOOL(S)_____

_____ Initial MDE _____ Review/Annual MDE _____ Other MDE

MA Access#_____ _____ Not MA

MDE EVALUATION RESULT (circle 1, 2, 3, 4 or 5):

ELIGIBLE FOR EARLY INTERVENTION SERVICES:

1. Eligible for early intervention services based upon these developmental areas (record developmental age for areas with ≥25% delay, record WNL for all others):

Area	Developmental Age	Area	Developmental Age
Cognition	_____	Fine motor	_____
Language	_____	Gross motor	_____
Self-Help	_____	Social/Emotional	_____

2. Eligible for early intervention services based upon informed clinical opinion (record statement and rationale):

_____

3. Eligible for early intervention services due to high probability of developmental delay (record diagnosis, including vision and hearing):

_____

NOT ELIGIBLE FOR EALRY INTERVENTION SERVICES

4. Eligible for monitoring/tracking because_____

_____

5. Not eligible for early intervention services or tracking

Comments_____

_____

_____

Potential ITF waiver eligible _____ Yes _____ No

For office use only (PD)

C	L	SH	P	SE

Provider _____ Supervisor Initials _____

City of Philadelphia
Mental Retardation Services
Infant/Toddler Early Intervention

Individualized Family Service Plans (IFSP)

Policy

The development of an IFSP should be a team process and it should be completed according to the Commonwealth's guidelines on IFSP development. The IFSP should reflect the strengths, priorities and concerns that are identified by the family and professionals that make-up the early intervention team. The team should review the intake information, Child Assessment Questionnaire (CAQ), Family Assessment Questionnaire (FAQ), and MDE information to complete the IFSP. Additionally the IFSP should:

- Reflect child and family outcomes
- Use family friendly language
- Be translated into the family's primary language
- Reflect what is important to the family

It is required that there is a 6-month and annual review scheduled for each IFSP. In Philadelphia County there is a quarterly review process that encourages the review of the outcomes on the IFSP on a quarterly basis with the emphasis on identifying new strategies or affirming current strategies (if successful) towards the achievement of the IFSP outcomes.

Procedures

The SC should prepare for the initial and annual MDE/IFSP by working closely with the family to identify child and family strengths and needs prior to the MDE/IFSP meeting. In preparation for the MDE, the SC also completes the M-CHAT for all children 16 months or older. The team should identify child and family concerns, priorities and resources. *(the following sections of ER: III. History, IV. Family Information, V. Health, Vision and Hearing Summary and VI. Evaluation of Developmental Domains)*

- IFSP team will document findings on the EI eligibility determination page. *(ER Section VIII. Eligibility)*
- IFSP team will recommend both early intervention and non-EI community services and resources. *(ER Section IX. Recommendations)*

- IFSP team (team is defined as the family and all those participating in the development of the IFSP) will reflect the team's concerns, impact on daily

routines, and what makes learning easier. *(IFSP Section II. Child and Family Information)*
- IFSP team will identify and document the expected measurable outcomes for the child and family on the intervention plan. *(IFSP Section IV. Outcome/Goal)*
- IFSP team will identify and document teaching and other strategies for addressing the outcomes. *(IFSP Section IV. Outcome/Goal)*
- IFSP team will provide justification for services not provided in natural environments and identify a plan to move such services to the child's natural environment in the future.
- IFSP team will discuss with the family the best time and place for service delivery, as well as provider preference.
- SC facilitates transition discussion with team. *(IFSP Section III. Special Considerations or Section X. Transition Plan, depending on child's age)*
- SC ensures that all team members sign IFSP. *(Section I)*
- SC conducts summary of the team's findings, recommendations and clarifies as needed before adjourning the meeting.
- The Service Coordinator (within 24hrs) will make referrals for services with the compliance and referral unit. Comments, if any, in reference to provider preference, date and time of service delivery, language and service delivery address if other than family home should be included.

The Service Coordinator will monitor the start of service, ongoing service provision, and coordinate the quarterly review of the IFSP services by the team.

Individualized Family Service Planning and Plan Development

Policy

Per the requirements of the Individuals with Disability Education Act and the Pennsylvania Early Intervention Services Systems Act, it is the policy of the Department of Behavioral Health/Mental Retardation Services, that the IFSP must be completed within 45 days of referral to ChildLink. The IFSP is the outcome of a collaborative planning process among family members, professionals, and other significant persons of the family's choosing. As such, it is the cornerstone of family-centered early intervention services.

The EI professional responsible for ensuring that this critical plan is properly developed and implemented is the ChildLink Service Coordinator. In this pivotal role, germane to the present section, the Service Coordinator explains procedures to the family; arranges for the child's assessments, including the MDE; helps the family identify the various supports they may need; and organizes the team to write the IFSP and revise or/addend it as needed.

Beyond the IFSP, the Service Coordinator:

- ensures that the IFSP services are delivered in a smooth and timely manner
- informs the family of appropriate services and resources in their community
- assists the family in protecting their rights
- helps prepare the child and family for transition to the next set of services before the child turns three.

Intake and Service Coordinator Assignment

Guideline: Intake and assignment to a Service Coordinator is to be completed within 48 hours of referral to ChildLink. Referral may be initiated by anyone. Families and their children are self-referred, referred by other family members, or by medical personnel such as physicians or nurses in an office, hospital, or clinic.

Problem Resolution Process: If the intake and service coordination assignment has not taken place within 48 hours of referral to ChildLink, ChildLink management staff will take immediate action.

Service Coordinator Home Visits

Guideline: Home visits are to occur within 10 days of referral to ChildLink.

Problem Resolution Process: if the home visit has not taken place within 10 days of referral to ChildLink or no specific time/day for the visit has yet been scheduled, Service Coordination staff will take immediate action. Actions may include:

- Arrange evening and/or weekend visit.
- Assign a new Service Coordinator, if such a preference is indicated by family.
- Propose an alternative location for the initial visit.
- Document initiation of good faith efforts.

- Examine schedules, intensity of caseload, and other factors that may be affecting timeframes.
- Have another ChildLink staff person make contact with the family.
- Survey family about issues, problems, and recommendations.
- Confirm the initiation of good faith efforts, if indicated.
- Identify training needs.

Responsible Parties: ChildLink management staff, ChildLink supervisors, Service Coordinators

Multidisciplinary Evaluation Guideline

The MDE is to occur within 30 days of referral to ChildLink

Therefore, the MDE is to be scheduled within 10 days of the initial referral, which is consistent with the timeframe of the completion of the home visit by the Service Coordinator. Service coordinator calls the MDE provider from the family's home to schedule the MDE. They call the provider assigned to the zip code were the child lives.

Problem Resolution Process: If the MDE is not scheduled within 10 days of referral to ChildLink or does not take place within 30 days of the referral, service coordination staff will take immediate action. Actions may include:

- Pursue scheduling with another MDE team or locate another professional to assure appropriate composition
- Review times,/scheduling options with family.
- Determine if there are any MDE cancellations and maintain list of families to be contacted to “replace” original family. Similarly, efforts will be made to replace MDE staff with appropriate staff if cancellations are made by staff.
- Ensure master schedule is reflective of actual appointments made and confirmed by each MDE team.
- Contact MDE provider(s) to assess if change can be made to respond to individual’s needs (e.g., via scheduling modification, authorizing additional hours, approving overtime).

- Pursue local community resources to address family issues such as transportation and baby-sitting.

- Assure initiation of good faith efforts, as appropriate.

- Locate and authorize appropriate professional to conduct evaluation including staff from another MDE team, ChildLink Resource Fund, or service provider.

Responsible Parties: ChildLink and MDE providers/Philadelphia MR Services.

IFSP Guideline

The IFSP is to be completed within 45 days of referral to ChildLink. In general, the MDE and the IFSP are completed during the same scheduled period. However, if the team determines that the processes should be completed separately, the IFSP will be rescheduled at another time.

When it is clear that the MDE/IFSP will occur more than 45 days after referral to ChildLink, or is not scheduled within 45 days after referral to ChildLink, additional actions will be taken. These include:

- Review circumstances surrounding the delay to assess appropriate actions to be taken.

- Attempt to re-schedule to a date which occurs before the end of the 45 days.

- Review problem solving/ongoing monitoring of situations via EI management meeting.

- Review MDE/IFSP delays on systemic level via monthly Management Information Group meeting, to include activities such as continual assessment of MDE capacity/efficiency, expanding resource provider arrangements, and renegotiating/revising contracts where provider-specific barriers exist.

- Review Service Coordinator and provider contacts with families to determine strategies that are most effective.

Responsible Parties: ChildLink and MDE providers/Philadelphia MR Services and State OMR.

Updated August 2009

Philadelphia Infant//Toddler Early Intervention Services

MDE's and IFSP's in PELICAN

The implementation of PELICAN will require that Initial MDE providers eventually have lap tops available for their evaluators. It may also mean that every agency providing ongoing early intervention services also have lap tops available at the office for the ongoing service delivery staff to use to complete the Ounce on-line.

We believe that this is the most efficient way to complete ER's and IFSP's in PELICAN (and Ounce online) because the time spent can be billed by service providers if completed while in the home with the child and family. Even when lap tops and wireless air cards are available to staff, we suggest that providers supply word templates of the ER and IFSP for their providers should the PELICAN or wireless systems be temporarily inaccessible. Once in the office, the template documents can be cut and pasted into the PELICAN system when it is accessible again.

The process for how the Ounce on-line will be completed in Philadelphia County is outlined in a separate document for providers and service coordinators. The process below is to outline how the Initial and annual MDE and IFSP will be completed in PELICAN effective July 1, 2009.

1. SC calls assigned provider (ongoing service delivery team) to schedule annual MDE
2. SC returns to office and attaches provider to the child in PELICAN for evaluation,
3. SC and provider can begin to update the ER information in PELICAN that is gathered during quarterly review meetings, calls and service visits with the family
4. SC and provider(s) go to the home to conduct the Annual MDE using paper copies of the ER.
5. Eligibility is determined, team discusses ER findings with the family
6. If child is eligible* IFSP is discussed and outcomes developed using paper copies of the IFSP
7. SC takes MDE and IFSP notes to the office to enter ER and develop IFSP in PELICAN within 2 calendar days.
8. **No copies of the documents will be left in the family home, but will be distributed at a later point.** Provider agencies can print copies of the documents for themselves from PELICAN
9. **Provider may complete the Ounce on-line for the child
10. SC exits provider from child's file in PELICAN as an evaluator

*IF child is not eligible, follow step #7 (entering the ER results only) and #10 to complete the process. After the ER is entered and finalized in PELICAN, the case is then closed or transitioned to At-Risk tracking and monitoring if appropriate
**The Ounce may be completed within 60 days (before or after) of the Annual evaluation of the child. If the child is not eligible for early intervention the annual Ounce will serve as the exit Ounce.

Philadelphia Department of Behavioral Health/Mental Retardation Services
Infant/Toddler Early Intervention

Memorandum

To: All Early Intervention Provider Agency Directors
From: Denise Taylor Patterson, Children's Services Director
Date: August 10, 2009
Re Start Date Compliance
Copy Sharon Burke, Lisa Zeigler, Stephanie Bey, Deborah Groom, David Lara

Thank you for all of your hard work over the past four (4) months to monitor, improve and report your service start dates. Many of you continue to achieve a high percentage of timely service starts and while our overall County compliance is still a concern (because of the children waiting to be picked up for services) we appreciate all of your efforts to accept referrals of children in a timely way.

Our focus in the next 6 months will be to continue efforts to increase our service resources while making most efficient use of the resources that we currently have available. We believe that the full implementation of the Transdisciplinary model of service delivery this fall will help us do that. This model will allow us to assign a single primary service providers who will begin the child's services and gives the team access to other service disciplines (as consultants) who will work with them to develop and implement strategies to achieve the IFSP outcomes.

We will continue to increase the County's start date performance expectations in order to move closer to full compliance. Attached you will find the reporting form that you should use to report your start dates for the first 6 months (July-December 2009) of this fiscal year. As you review the attached reporting form, please pay special attention to the County Targets and timeframes indicated. **The July and August reports can be submitted together and both will be due on September 20th because of our delay in getting the form out to you.**

We want to remind you of the initiatives that we anticipate that providers will implement in order to continue the County's progress towards start date compliance.

A. Implement telephone/electronic start date reporting system to replace paper/contact note reporting by staff and contractors.

B. Designate (or recruit additional) staff from all service professions to service high volume zip codes identified by the county (or in your region).

C. Identify staff who can be available 7 days per/week, holidays and until 9:00 PM to accomplish 'brief first visits'. This can be done by allowing current staff to do additional 'shifts' or replacing staff that leave the agency with staff who have flexible schedules.

   Employment and Orientation materials should be changed to reflect the fact that a more flexible work schedule is required. Staff must be prepared to 'start' services on Sunday, Saturday, Holidays, and evenings in order to start the service within the '14 day from IFSP development' time frame.

It is our expectation that each provider adhere to the time frames and Start Date Guidelines and expectations outlined. We thank you for your continued compliance efforts and commitment to the children and families of Philadelphia.

I General Start Date Guidelines

The County has changed the start date expectations for providers as outlined below

1. When a provider accepts a referral they are to triage service starts based on the number of days that remain (in the initial 14 day from IFSP development time frame) in order to have a timely Start date.
2. The County will add to the provider referral authorization form, the number of days remaining in the 14 day (from IFSP development) start date time frame.
3. Any service that **can** begin within 14 days of IFSP development (services that were under 14 days when the provider was authorized) **should** begin within that time frame. Using any strategy necessary in order to make that happen.
4. When the provider accepts a referral, no automatic start dates should be submitted to the referral unit. Each start date given should be based on the child's IFSP development date and the 14 day timeframe within which all services should begin.
5. Providers should be aware of and remind their staff that regardless of interim targets, ultimately all start dates will be monitored towards full (100%) compliance. This includes annuals, initials and addendums.
6. Providers are expected to begin services within **10 calendar days** (or less) from service authorization (annual, initial and addendum), with the understanding that this number of days will be reduced to 7 and ultimately 5 as the County increases its efficiency.
7. Providers who do not meet the County targets will be **required** to implement the brief first visit and to set up a system for referral unit staff to schedule the first appointment within the 14 day period from IFSP development or addendum, once referral is accepted
8. Providers should be aware of and remind their staff that **Start dates (even brief starts) are services** and should be reported as such and billed to whatever funding source is paying for the child's services.
9. Careful consideration should be given when identifying the designated reason for delay, using the guidelines developed by the County.
10. All early intervention staff are to be trained to properly assign the delay reasons and to understand that **delay reasons are not an effort to assign blame or fault** for a service delay. The intent is only to categorize for OCDEL and OSEP reasons why services, may not start within the 14 day time line set in the regulations.

II County Targets

A. Service Start Targets: A provider delay is any service that begins more than 10 days from provider authorization

1. No more than 5% of referrals authorized can be delayed due to provider reasons. **This target must be reached by 12-31-09**

B. Reporting Start Dates Target: A start date is the first face-to-face visit with the family by an early intervention service provider after IFSP development (initial or annual), or after an IFSP addendum.

1. All service start dates (100%) must be reported to the County within 5 working days of the service start date. **This target must be reached by 12-31-09**

Philadelphia Infant/Toddler Early Intervention
Provider Start Date Target Form

Agency Name: _____

Reporting Month_____

Person Completing the Form_____ Telephone # _____

Directions:

1. **Complete this form at the close of each month and forward (fax or email) to your program analysts by the 20th of the month following the reporting month. For example, the report for March must be received by April 20th.**
2. **Fill in all of the percentage boxes and check the box next to the current reporting month.**
3. **Provider agency data detail (item B) must be compiled and reviewed by each provider agency, but does not need to be submitted unless the agency's start date percentage is below the County target. The data must be available for review by the County upon request.**

I Services Started in 10 days or less

County Start Date Target: 95 % by 12-31-09
(Percentage of on time start includes delays due to family reason-as reported to PEIRS)

☐Provider Start date % for July: _____, ☐Provider Start date % for August _____

☐Provider Start date % for September: _____, ☐Provider Start date % for October: _____

☐Provider Start date % for November: _____, ☐Provider Start date % for December: _____

A. Status of County Expectations: Complete if Start % is below the County target:

1. Inform all staff that new cases must be seen within 5 days of provider authorization
   □Implemented □ not implemented (if not implemented give status below)

   Status: _____
2. Person taking referral also schedules first appointment
   □Implemented □ not implemented (if not implemented give status below)

   Status: _____

3. All providers were informed to implement the brief first visit with all new cases to expedite the first contact.
   □ Implemented □ not implemented (if not implemented give status below)

   Status; _____

B. Provider Agency Data (complete if the percentage is below the County target)
Attach data that details the points below. Include your analysis of the data and the planned corrections to improve individual service provider or service profession performance.

1. Each service profession's start date percentage for each month covered by this period

2. Each staff person service start percentage for the months covered by this period

Provider Start Date Target Form

II Reporting Start Dates to County

County Start Date Reporting Target: 100 % in less than 5 days by 12-31-09

☐Reporting Start date % for July: _____, ☐Reporting Start date % for August____

☐Reporting Start date % for September: _____, ☐Reporting Start date % for October: _____

☐Reporting Start date % for November: _____, ☐Reporting Start date % for December: _____

A. Status of County Expectations (Complete if reporting start date % is below the County target)

1. All service providers submit start dates and updates on the day that they occur
   □Implemented □ Not implemented (if not implemented give status below)

   Status: _____

2. Implement telephone (electronic) start date and update reporting system
   □Implemented □ Not implemented (if not implemented give status below)

   Status: _____

B. Provider Agency Data (complete if the percentage is below the County target)
Attach data that details the points below. Include your analysis of the data and the planned corrections to improve individual service provider or service profession performance.

1. Each service profession's reporting start date percentage for the month covered by this period

2. Each staff person service reporting start percentage for the month covered by this period

Philadelphia Infant/Toddler Early Intervention
Start Date Delay Reasons

System Reason for Delay

- No provider available to pick up referral for service. Child on waiting list for 14 days.

Provider/System Delay Reasons

- Service provider assigned by agency can/does not start service as scheduled.
- Provider misses or cancels appointment for any provider related reason* and the appointment cannot be rescheduled within the 14 day time frame.

*provider related reasons: car broke down, illness, personal emergency, another appointment

Family Reason for Delay

- When provider attempts to arrange appointment (with 2 days notice), the family cannot schedule within the 14 day start date period.
- Family calls to cancel for any reason (vacation, illness, other appointment, etc.)
- Family reschedules visit (for any reason) outside of the 14 day period.
- Family not available at time of scheduled visit (e.g., no answer on telephone or at the door).
- Child not available (for any reason) at time of scheduled visit. For example: child not a day care, child is in hospital, child is ill.

Acts of Nature

- Weather related emergencies such as icy roads, snow or ice storm, flooding, torrential rains, active hurricane or tornado and/or hurricane/tornado watch.
- Safety related emergencies such as fires, terror attack or alert, active crime scene, etc.

Promoting the Language Development of Infants and Toddlers - Fact Sheet

Best Practice

To support young children in the development of language and successful communication:

- We partner with families and give families suggestions and activities to foster their child's language learning.
- We train, support and supervise special instructors and teachers with additional communications training to maximize the quality of their intervention with children and families.
- We train and support speech and language therapists to work with children, families, special instructors, teachers with additional communications training (T/ACT) and other members of the team as collaborators, consultants and direct interventionists.

I. Initial, Annual Evaluations

- All children receive a multidisciplinary evaluation (MDE) that determines a child's developmental needs including general language level.
- Children may receive a speech and language consultation to further assess the child's language level and needs.

II. Outcomes

- Based on the information gathered about the child's language development and the MDE, the team of parents and professionals will identify outcomes for the child as part of the child's Individual Family Service Plan (IFSP).

III. Intervention

- The approach to intervention that the team recommends is based on the information gathered as part of the child's MDE the child's stage of language development, the child's needs and suggested outcomes.
- Intervention approaches to address language stimulation and communication outcomes include:

    - A Speech and Language Pathologist (SLP) to work with the child and family to develop and implement a plan for recommended therapeutic techniques.
    - A Teacher with additional communications training (T/ACT) to facilitate and stimulate early language development with the child and family, with clinical collaboration by a Hanen Certified SLP. Both the (T/ACT)and SLP are from the same agency.
    - A Special Instructor (SI) trained to facilitate early language to work with the child and family with consultation by an SLP. The SI and SLP should be from the same agency.

IV. Individual Family Service Plan (IFSP)

A. **Teaming** (excerpted from the *Philadelphia County Best Practice Guidelines for Early Intervention*)

- Consider a variety of options to determine the duration and frequency of service, joint service delivery options, or number of services so that each child's IFSP will be truly individualized.
- Consider:
  - Brainstorming challenges, solutions and effective ways of addressing child and family outcomes
  - Ways to ensure that families understand their critical role on the team
  - Everybody's ideas are needed and helpful
  - Who can address a child's communication issues? (See *Philadelphia County EI Speech and Language Best Practice Guideline Descriptions*)
  - Consultation with an SLP to develop an intervention plan (consultative sessions can be billed to the county)
  - Use of non EI Resources
- Offer:
  - A variety of options such as:
    - Duration of service (e.g., 1.5 hours, 1.25 hours)
    - Frequency of service (e.g., 3 times per month, 5 times in 3 months)
    - Consultation model (e.g., joint service delivery options)
    - Number of services (e.g., service-relay: one service for 6 weeks, followed by another service for 3 months, etc.)

B. **How to Identify Services on the IFSP for T/ACT, SI and SLP**

- Teacher with additional communications training (T/ACT):
  - This model includes a Hanen Certified SLP from the same agency.
  - Team decides on frequency and duration for T/ACT <u>only.</u>
  - SLP is <u>always</u> on the IFSP once in a 3-month period; if the team recommends additional time (<u>not to exceed once per quarter</u>) for the SLP to visit the child with the T/ACT, an IFSP addendum must be written.
  - T/ACT and SLP must be from the same agency
  - Only pre-designated agencies have T/ACT's (See *Philadelphia County EI Speech and Language Best Practice Guideline Descriptions*)
  - The T/ACT will be designated as a Z8 on the IFSP.
- Special Instructor and Consulting SLP
  - Team decides on the frequency and duration of the SI and consulting SLP
  - SI and SLP should be from the same agency
  - An SI from any provider agency in Philadelphia County has training in facilitating communication with young children using Hanen techniques.

- SLP Only
    - Team decides on the frequency and duration of the SLP

V. Referrals to T/ACT Agencies

- There are trained Teacher with additional communications training (T/ACT) and Hanen certified Speech Language Pathologists at the following agencies:

COMHAR
Ken-Crest
Northeast Growth and Development Center
SPIN
Sunny Days
Sunshine Therapy Club
Therapy Solutions
Village Care

VI. Ongoing Service Delivery, Evaluation and Monitoring

- As part of each child's intervention the child's progress in communication and language is closely monitored, regularly discussed with the collaborating speech therapist and reviewed with the team every three months as part of the Quarterly Review.
- In cases where the T/ACT is working with a child, the Hanen Certified SLP also visits the child once in a three (3) month period to ensure that the child is progressing and to suggest other language stimulation strategies. If the service delivery team recommends additional visits by the SLP, an IFSP addendum must be written.
- The County has developed a pre and posttest of language development adapted from one in the Hanen "It Takes Two to Talk" curriculum manual. All SI's and T/ACT's should use this measure to monitor progress and provide a visual documentation to the team of the child's language acquisition.
- The team of parents and professionals from these (and all) agencies will develop a Service Support Plan to address the communication outcomes for the child on the IFSP and develop measurable objectives in order to monitor their progress.

VII. Ongoing Training and Resources

A. **Training**

- Training programs are offered on an ongoing basis. Service providers must show competency in the techniques taught through the following courses:
    - All Special Instructors are trained in "Facilitating Early Communication based on Hanen Principles" This is a specialized language course based on the Hanen curriculum "It Takes Two to

Talk". This curriculum teaches strategies to facilitate the communication skills of young children, and how to teach those strategies to parents.
In addition to the course listed above, all Teachers with additional communications training have successfully completed the following additional language topic areas as part of their additional training.

- ❖ "The Foundations of Language Development" provided the T/ACT with information about the basics of child development and how the young child develops language.
- ❖ "Oral Language Development" reviewed major theories of oral language acquisition and development as well as methods for addressing problems in oral language development in general and those that are associated with specific disabilities.
- ❖ Indirect language stimulation techniques using the "Oh Say Can You See" curriculum. This focused on indirect language stimulation techniques that teachers can show parents and use in their work with children.

- The Hanen Certified Speech and Language Pathologists at each of the participating T/ACT agencies listed above also receive certification through specialized training. Two levels of courses are offered as part of the Hanen program.
  - ❖ Level One certifies Speech and Language Pathologists in the "It Takes Two to Talk" program and trains therapists in how to work with Special Instructors and Parents as language facilitators.
  - ❖ Level Two certification is available for Speech and Language Pathologists that take additional training for their work with families of children with autism spectrum disorders, families with children who are late talkers and with teachers.

B. **Resources**

- In addition to training, all T/ACT agencies (listed above) are provided with supplies and materials that are a resource for the Teachers with additional communications training (T/ACT) as they plan and implement interventions with children. Currently, the following resource have been made available:
-
  - "Language Development: An Introduction", 7th edition. By Robert E. Owens (2007)
  - It Takes Two to Talk by Jan Pepper and Elaine Weitzman (2004), Canada: The Hanen Centre.

PHILADELPHIA COUNTY
INFANT TODDLER EARLY INTERVENTION
SPEECH LANGUAGE PATHOLOGY, TACT & COMMUNICATION PRACTICE GUIDELINES:

September 2010

Speech and Language Pathologists (SLP)	Teachers with Additional Communication Training (T/ACT)	Special Instructors (SI) (often with a SLP consult)
1. Child not developing a typical pathway to form speech sounds, language, grammar, vocabulary and functional use of language. **2.** Cleft palate, cleft lip and other or facial anomalies **3.** Augmentative and alternate means of communicating **4.** Aural rehabilitation (helping communication skills in children with temporary hearing deficits and mild hearing loss) ***see note 1** **5.** Voice- (hoarse, coarse, soft, high, or no voice) **6.** Children with breathing problems- that interfere with their ability to produce speech-physical therapists are also trained in this area **7.** Feeding (occupational therapist or other professional with specialized training may also be used in this area) ***see note 3** **8.** Fluency- stuttering **9.** Praxis- (motor planning for speech) **10.** Sound production (the silent child) ***** see note 2** **11.** Phonological and Articulation (child producing word- child can't be understood) **Notes:** **Note 1**: Teacher of the Deaf and Hard of Hearing or an SLP with specialized training with children who are deaf or have a severe hearing impairment, may need to be used with children who have sensorineural hearing loss, deafness or children with cochlear implant. **Note 2:** Children along the Autism Spectrum may need to be assessed for other risk factors for ASD.	**1.** Child developmentally behind but developing a typical path for language development **2.** Work with children whose communication development is behind that of other developmental skill areas. **3.** Work with infants and very young children to prevent developmental speech and language concerns by encouraging sound production and promoting a child's comprehension of language. **4.** If the communication concerns identified are found to be environmental in nature, T/ACT may work with the family to ameliorate these issues towards the achievement of the communications outcomes. A T/ACT will participate in clinical collaboration with a Hanen Certified SLP at their agency to determine the child and family's greatest need, strategies for intervention, etc. The team may want to consider the use of a social worker to assist the family to eliminate some of the identified environmental risk factors. **5.** Provide language stimulation for all children. Materials and methods used to capture a child's attention and support communication development may need to be reviewed by an SLP. **6.** If language is progressing at the same level (or slightly behind) as other skills (especially cognitive skills) and no specialized issues are present, the T/ACT could address communication concerns. ❖ The materials that a T/ACT uses to capture a child's attention and support communication development will be reviewed by a SLP through their clinical collaboration.	**1.** Work with infants and very young children to prevent developmental speech and language concerns by encouraging sound production and promoting a child's comprehension of language. **2.** If the communication concerns identified are found to be environmental in nature, any special instructor may work with the family to ameliorate these issues towards the achievement of the communications outcomes. A SLP may be consulted to determine the child and family's greatest need, strategies for intervention, etc. The team may want to consider the use of a social worker to assist the family to eliminate some of the identified environmental risk factors. **3.** Provide language stimulation for all children. Materials and methods used to capture a child's attention and support communication development may need to be reviewed by a SLP through consultation. **4.** If language is progressing at the same level (or slightly behind) as other skills (especially cognitive skills) and no specialized issues are present, the special instructor could address communication concerns, with consultation from a SLP, as needed.

Note 3: Certain types of feeding issues such as picky eaters, basic positioning, behavioral concerns for feeding may be assessed, implemented or monitored by other professionals such as OT, PT, Nutritionist or Nutrition Support. T/ACT or SI who has an educational background (a Bachelors' Degree) in Speech Therapy or Behavior Development can address these issues with ongoing consultation (SI) or Clinical Collaboration (T/ACT) with a SLP.

Writing it on the IFSP

SLP	T/ACT	SI (with SLP Consult)
Same	**1.** Team decides on frequency and duration for T/ACT only **2.** The 4 units of SLP are 1 x per 90 days based on discussion with family and documentation of delay as "family reason." **3.** Use designated Z8 coding. **4.** The T/ACT and SLP must be from the same agency **5.** The agencies that can receive this referral are *pre designated by the County. *The pre-designated T/ACT agencies as of 6/10 are FSS, KenCrest, NEGD, RHD, ResCare, SPIN, Sunny Days, Sunshine Therapy Club, Therapy Solutions, Village Care.	**1.** Team decides on the frequency and duration of the SI and consulting SLP **2.** A special Instructor from any provider agency in Philadelphia County has training in enhancing communication and can work with a child on the areas identified above **3.** SI and SLP should be from same agency

PHILADELPHIA COUNTY EARLY INTERVENTION SPECIFICATIONS FOR USE OF TACTs and SIs to Address Communication Outcomes on the IFSP

Agencies agree to:

- Adhere to the Philadelphia County "Specifications for use of TACTs" and the Philadelphia County Infant Toddler Speech Language Pathology and TACT Practice Guidelines."
- Provide Clinical collaboration by a Hanen Certified Speech/Language Pathologist (preferably one who is 'on staff' or as a contractor, works more that 50% of their time with your agency)
- Support teachers to attend other skills building conferences and training related to enhancing language and communication skills in young children.
- Reinforce 'family centered' practice, whereby the parent is actually doing the interventions that are modeled by the service provider.

Teachers must:

- Have a bachelor's degree (those without bachelor's degrees at the time this is implemented will be 'grand fathered' into the eligibility)
- Have a certificate of competency from MRS for the "Facilitating Early Communication using Hanen Principles" topical training session
- Complete and demonstrate competency in any subsequent language and communications related training developed/offered by the County.
- Complete the Philadelphia County Communication Assessment Tool pre and post tests as part of the annual IFSP and 6 month review for children that they are seeing.
- Reflect the strategies used to address communication (and other) outcomes in the written progress notes, session notes and in the service support plan for the child.

Frequency of Clinical Collaboration:

- Speech/language therapist providing clinical collaboration to the TACT and family will attend at least 1 child and family intervention for each 6 months of service. The clinical expectations are that the SLP will attend at least 1 child and family intervention within 6 months of service and that the SLP will make every effort to attend the visit with the teacher to see the child and family to confirm the direction of the planned strategies. Variations in the frequency of SLP service may be developed by the team based on individual child and family need.

- On-site visit by SLP: The SLP will be entered for 2 units per 90 days with an end date of 6 months, in order to meet the requirements of the PELICAN data system. The clinical expectation is that the SLP will attend at least 1 child and family intervention within 6 months of service. After six months, the TACT and SLP can decide on the schedule of collaboration based on the individual needs of the child and the family.
- TACT Support: 1 time per/month if the teacher has a BA in speech therapy. 2 times per/month if the teacher does not have a BA in speech. Agencies may use their discretion for frequency of SLP support based of TACTs with extensive experience.

Content of Clinical Collaboration: During on site visits and TACT support opportunities SLPs will assess, teach and verify to determine the appropriateness and success of recommended strategies for children and families. The SLP's activities include:

- Review IFSP outcomes for children and service support plan of teachers
- Review strategies and activities and planned measures for the children served
- Review progress of child and suggest new strategies or materials to use
- Reinforces 'family centered' interventions, so that caregivers are taught the intervention strategies (by the teachers) and the parent demonstrates them during interventions.
- Support the development of TACTs.

Writing the IFSP and making the referral

Teachers with Additional Communication Training (T/ACT)

In this model:

- Team decides on frequency and duration for T/ACT only
- The SLP is usually in at 2 units per 90 day period with an end date in 6 months. The clinical expectation is that the SLP will attend at least 1 child and family intervention within 6 months of service. Potential variations may be developed by the team based on individual child and family needs.
- The T/ACT and SLP must be from the same agency
- Team uses the special Z8 code in making the referral to identify the T/ACT
- The agencies that can receive this referral are *pre designated by the County.

***The pre-designated T/ACT agencies as of 6/10 are FSS, KenCrest, NEGD, RHD, ResCare, SPIN, Sunny Days, Sunshine Therapy Club, Therapy Solutions and Village Care.**

Special Instruction (SI) (with consultation from a Speech Language Pathologist)

In this consultation model:

- Team decides on the frequency and duration of the SI and consulting SLP
- A Special instructor from any provider agency in Philadelphia County who has training in enhancing communication and can work with a child (on the areas identified in the Speech Language Pathology, TACT and Communication Practice Guidelines) who has communications outcomes on their IFSP.
- SI and SLP should be from same agency

Note: Strategies that are used by any service provider (including those to address communication outcomes) should be written on the session note and the service support plan for the child.

Service Provider: _____ ChildLink #: _____ Child's Name: _____

DOB: _____

PHILADELPHIA INFANT/TODDLER EARLY INTERVENTION

WHAT YOUR CHILD COMMUNICATES ABOUT

ASSESSMENT TOOL

Directions: Ask Parents: Does your child communicate about these things? First, tell me if s/he communicates to you about these things (e.g., lets you know that s/he wants the television on). Then, tell me if s/he comprehends your language (e.g., responds to you when you say "we're going outside.")

Please remind parents that children may communicate with body language, sounds, gestures, sign language, a communication board or words. Note what/how the child communicates in the example section. Mark a (+) or (-) if child comprehends when parent communicates about topic.

Child Communicates to Parent/Other About	Initial Assess Pre-Test Date:				Quarterly Progress Date:				Quarterly Progress Date:				Re-Assess Post-Test Date:			
	Yes	No	Example	Comp +/-	Yes	No	Example	Comp +/-	Yes	No	Example	Comp +/-	Yes	No	Example	Comp +/-
1. Food or drink (eating)																
2. Toys (playing)																
3. Clothes																
4. Pets																
5. Brothers and Sisters																
6. Other Relatives																
7. Parents																
8. Neighbors/Friends																
9. Babysitter																
10. Toileting/Diapering																
11. Going for a ride (going out)																
12. Going outside																
13. Television																
14. Listening to music																
15. Illness or pain																
16. Bathing/washing																
17. Nap Time, Sleeping, Waking																
18. Other																
Verbal Language Sample (Note words child is using and tally):																

Comments:

WHO WILL PROVIDE THE DBA SERVICES?

The following organizations currently provide Developmental Behavioral Assessment Services:

Classic Rehabilitation, Ltd.
KenCrest
Kids and Family
NEGD
SG Issac's
SPIN, Inc.
Sunshine Therapy Club
Sunny Days

Each organization has staff who are experienced and trained to work with children who have behavioral/ communication concerns. They receive training annually to keep them abreast of the practices in this field that may be of benefit to you and your child. Training information is available at: http://jeffline.jefferson.edu/cfsrp/tlc/

Additionally, they are guided by the practices outlined in Philadelphia County's Position Statement on the Provision of Services to Children with Autism Spectrum Disorder (ASD) and those at Risk for ASD.

Philadelphia County Infant/Toddler Early Intervention Services

Denise Taylor Patterson, Early Intervention Coordinator
701 Market Street, 5th Floor, Suite 5200
Philadelphia, PA 19106
Phone: 215-685-5905

7/28/2010

DEVELOPMENTAL BEHAVIORAL ASSESSMENT SERVICES

(DBA)

Dear Parent/Guardian:

Developmental Behavioral Assessment (DBA) services have been recommended for your child based on concerns identified on the Modified Checklist for Autism in Toddlers (M-Chat Assessment) and observations of your child's behavior during the Multidisciplinary Evaluation (MDE). DBA services are being recommended to obtain more detailed information about your child in order to identify the appropriate ongoing supports and services to address your child's and family's needs.

A qualified early interventionist who has had extensive training and experience working with children who have challenging and/or atypical behavior will complete this assessment and begin service provision. These interventionists work for different organizations and represent a variety of disciplines. Depending on the organization providing the DBA service, the interventionist may be a teacher, occupational therapist, social worker, psychologist or other qualified professional.

We will not know which of our early interventionists will provide the DBA service for your child until a provider is assigned, therefore "Psychology" will be listed initially on your Individualized Family Service Plan (IFSP) as the discipline or service that will provide the DBA service. Once the provider is assigned, the IFSP will be changed to reflect the actual discipline of the early interventionist who will provide the DBA service. **We want you to know that when an Agency is obtained to provide your DBA service, ChildLink may change your child's IFSP from psychological to the discipline of the person who will provide the DBA service (if it is not a psychologist).** If you have any questions about the DBA service, your IFSP, or your service providers, you should contact your service coordinator.

We hope that you and your child will benefit from your involvement in Early Intervention Services.

Sincerely,

Denise Taylor Patterson, Director
Early Intervention Services

DTP:MRS;clw

WHAT WILL HAPPEN DURING THE DBA?

During the Developmental Behavioral Assessment (DBA) service, the early interventionist will meet several times with you and your child to get a full picture of your child's strengths and behavioral concerns. The DBA is not just another assessment, it is the beginning of service delivery. The early interventionist providing your child's DBA service is there to support your family and begin to work with you immediately to identify and implement interventions with you to help your child. In most cases the agency providing your child's DBA service will also provide ongoing services that are recommended after the DBA is complete. The purpose and content of the DBA is to understand/observe and document:

1. Your child's specific behaviors that are of concern for your family, and the strengths of your child and family.
2. Environmental factors affecting their behavior such as sleep habits, eating, and family dynamics.
3. Daily routines and to observe your child's typical day; the impact of any medications, special diets or health concerns.
4. Methods of communication: verbal, non-verbal and their ability to relate to others.
5. Play skills, play activities, appropriate use of toys, and play with siblings/others.
6. Sensory processing factors (observe/understand your child's sensory-based behaviors).
7. Current early intervention and other relevant services.
8. Appropriate strategies and interventions, and begin work with you immediately to identify and implement them.

If you have any questions about the DBA service, your IFSP or the service providers who are working with you and your child, we encourage you to contact your service coordinator immediately.

October, 2006

Philadelphia County Infant-Toddler Early Intervention

*Position Statement on Provision of Services to Children with ASD and Those At Risk for ASD

The Philadelphia Infant-Toddler Early Intervention System has developed this Position Statement on the provision of services to children with Autism Spectrum Disorder (ASD) and those at risk for ASD so that parents, families, and service providers may come to a shared understanding of the system's approach to supporting infants and toddlers with these development issues. This statement has been developed via a work-group of county and provider representatives and is based on the thorough review of the current best-practice literature within the field.

I. Early Intervention Values:

Our approach to service delivery will incorporate some basic early intervention principles that research has shown are also critical to work with children who have ASD. They are:

- **Inclusion:** When specified by individual outcomes, special instruction to children with ASD should occur with typically developing children.
- **Early Intervention:** early entry into services
- **Parental involvement:** Interactive guidance allows parents to be involved in the success of their child and to learn the interventions. (Family centered practice). This will maximize the child's time of active engagement to approximate the 25-hour minimum recommended by research.
- **Natural Environments:** The provision of services that are functional and embedded in the natural routines and activities of the child and family
- **An integrated model:** The delivery of service crosses disciplines and approximates how the child and family lives and functions in their home and community, and uses a variety of approaches.
- **Individualized services:** Given the heterogeneous nature of all children (including those children with ASD), service delivery must be individualized and use service approaches that are matched to the skills, outcomes and needs identified for the child and family

II. Identification of Children:

It is not necessary for a child to be diagnosed with an Autism Spectrum Disorder (ASD) in order to receive services form Infant/Toddler Early Intervention. Children who are considered ASD although not 'formally' diagnosed should exhibit symptoms that match the descriptions outlined in the DSM-IV and listed on the attached document. In addition to systems described in the DSM-IV, the child may also exhibit sensory processing concerns.

If it has been determined based on the M-CHAT that a child in early intervention is 'at risk' for ASD, the family will be counseled to obtain a full evaluation from a professional with training, expertise, and qualifications in both the identification and diagnosis of children with ASD. We recommend using the attached article **"Critical Information for Parents of Young Children with Social Communication Delays"** as a guide for your discussion with these parents. The family will then be referred to one of the early intervention agencies to obtain a developmental behavioral assessment (DBA) through which a determination will be made regarding the services that are indicated based on the assessment of the child, family and environment.

III. Principles of Service Delivery:

All service to children in Philadelphia County with ASD will be based on the following principles as of quality services that have emerged from a consensus of experts in the field of autism as presented by the National Early Childhood Technical Assistance Center (NECTAC)[1]. In recent years, there has been a significant increase in the number of research studies examining the relationship between different types of interventions for children with autism and the attainment of outcomes and the development of skill for these children. Research has failed to identify a significant relationship between any one single intervention method and the enhancement of skills and outcomes attainment. Rather, consensus as outlined by NECTAC indicates that there are increasing numbers of children receiving a **variety** of intervention approaches ranging from behavioral to developmental and that there **does not** appear to be a simple relationship between any particular type of *intervention and a decrease of characteristics commonly associated with ASD.* Therefore, all services must contain the 'elements of effective programming' for children with ASD as outlined by NECTAC (see attached) and utilize a variety of approaches that are:

- Delivered as an integrated model that approximates how the child and family lives and functions in their home and community
- Relationship based (skill building activities are introduced gradually within the context of the positive interaction)
- Child and family centered
- Grounded in sound developmental theory
- Activity based within the natural routines and activities of the child and family
- Developed and delivered 'within the context' of the child and family outcomes lifestyle and activities.

IV. Elements of Effective Intervention for Children with ASD:

- Services are matched with the child's identified strengths and weaknesses
- Services are delivered within a flexible service structure. It is not exclusively 'child lead' or exclusively 'adult directed'
- Approaches to problem behavior are integrated with communications outcomes/programming
- Services are Comprehensive and prioritize, functional and spontaneous communication, social interaction and play skills, positive approaches to problem

behavior and emotional regulation, and when present addresses sensory processing issues.

- Allows for a review and possible adjustments in programming every 3 months
- Intensive instruction in the range of 10-25 hours of services per week, 12 months per year including the active time of engagement with the parent/caregiver. This amount of service is to be inclusive of all interventions the child receives, whether they be funded through the behavioral health system or the infant-toddler early intervention system
- Includes a family component (*****one of the best predicators of a positive outcome for children diagnosed with ASD are family variables such as the degree of family support and involvement)
- Uses Developmentally appropriate activities
- Services are delivered in a Family Centered approach. This is best Operationalized using the principle drawn from the **Early Interaction Project Approach**.[2] Each home visit between the family and the early interventionist must include these three steps:
    - Gathering and Giving: Share information and resources, Enhance competence through conversations, and Establish supportive environment.
    - Observing and Guiding: Watch and suggest simple adaptations, Focus attention to salient features, and practice or model with feedback
    - Problem Solving and Planning: Collaborate on goal setting, Monitor child and caregiver progress and plan implementation
- Incorporating these principles mandates that services for each early intervention service provider developed on the IFSP be written in increments no less than 75 minutes.

V. SUMMARY:

As part of our ongoing commitment to continuous quality improvement, it is the County's intention to monitor the research and service delivery literature regarding best practices for serving children with ASD. As the literature base expands, and updated intervention information becomes available, the County will work with Elwyn, Inc., the Preschool Special Education provider for children ages 3-5 years, to coordinate and facilitate the transition of services for children as they approach their third birthday.

Citations

1. Research Source: Committee on educational intervention for children with autistic spectrum disorders-birth to 8 years (NRC 2001)
2. Early Social Interaction Project (Juliann Woods and Amy Wetherby)

Philadelphia County Infant/Toddler Early Intervention
Transdisciplinary Team Policy and Procedures

Background

Public Law 108-446, the Individuals with Disabilties Education Improvement Act of 2004 and PA Act 212 endorse the team approach for the provision of Early Intervention services to children and their families. As required by this legislation, Early Intervention must be coordinated, collaborative and effectively promote the capacity of families to support infant and toddler learning and development.

Policy

The transdisciplinary team approach is one of the primary approaches to service delivery that is used for children with Individual Family Service Plans (IFSP) in Philadelphia County (see Table 1). The family is central to the Early Intervention team. A primary service provider (PSP) is the primary Early Interventionist that is identified for each child with an IFSP. The PSP is the Early Interventionist that can best help the child and family/caregivers achieve the IFSP outcomes. The PSP supports and coaches the family to learn strategies and use adaptations and resources that will promote their child's learning and development. The other Early Interventionists on the transdisciplinary team are brought in for short-term periods as consultants to the family and PSP, and may suggest additional strategies, intervention, adaptations and resources to address the IFSP outcomes. The Service Coordinator will facilitate and participate in the development, implementation, review and evaluation of the IFSP, and will coordinate the team's services (OCDEL Announcement EI-07 #02).

All Early Intervention professionals working in Philadelphia County Infant/Toddler Early Intervention are knowledgeable about the transdisciplinary team approach, as well as other service delivery approaches used in Philadelphia and are able to function as a PSP or consultant on a transdisciplinary team.

Early Intervention Team Approaches

Multidisciplinary	Interdisciplinary	Transdisciplinary
• separate assessment	• separate assessment	• collaborative assessment
• integration of findings and recommendations typically is left to the family	• formal channels of communication to share findings and discuss individual results	• professionals teach others activities or intervention strategies that don't require the expertise of the therapist
• plan is carried out by professionals independently	• plan is carried out by professionals independently with collaboration of family	• plan is carried out by family and one team member designated as primary service provider

Table 1 Types of Team Approaches

Discussion
The transdisciplinary team approach emphasizes the joint responsibility and collaboration of the team of parent, service coordinator and professionals from a variety of disciplines, to assess and plan interventions for the child. Professional team members are interdependent and work together to support the family and the child's PSP (primary Early Interventionist) through collaboration, coaching, consulting and role expansion, exchange and release.

Although nearly 75% of children in Philadelphia Infant/Toddler Early Intervention receive a special instructor on their service delivery team, the initial team may determine that another service profession (e.g., Occupational Therapy) should be the child's PSP. This assignment will be decided based on the priorities of the family and by assessing the service profession that can best help the family and child accomplish the outcomes on the IFSP.

Philadelphia County Infant/Toddler Early Intervention has developed practice guidelines to help teams determine when a therapist or specially trained teacher (occupational therapist, physical therapist, speech language pathologist, teacher of the visually impaired, and teacher of the deaf and hard of hearing) should be used as a consultant or as the PSP (instead of a special instructor or other discipline). These guidelines (see Appendix A) were developed in conjunction with Early Intervention professionals from the respective disciplines. The guidelines will be used by the initial evaluation teams, as well as IFSP team members, to support their decision making about the assignment of the PSP and the potential need for consultation. These guidelines provide guidance to the team and do not supersede the team's determination of the individualized plan for the child based on assessment, observation and progress monitoring. There are practice guidelines in place for children with Autism Spectrum Disorder (ASD) and supplemental guidelines for children with low incidence concerns will be forthcoming.

Benefits
The transdisciplinary team approach is an evidence-based practice. This approach to service delivery has a variety of potential benefits and is an area of active research (King, Strachan, Tucker, Duwyn, Desserud, & Shillington, 2009). These benefits include:

1. Children benefit and progress when development is viewed as an integrated and interactive process.
2. Families have a more efficient yet comprehensive service and a consistent, single point of contact, as all interventions are coordinated through one service provider.
3. Transdisciplinary teamwork provides support in ways that empower families rather than focus on the 'experts' to control the interventions.
4. **The PSP (primary Early Interventionist) is able to build a strong relationship and to develop and nurture a partnership with the caregiver.**
5. The family benefits from focused intervention from a single service provider while accessing the knowledge and expertise of other service types, without

complicating their home schedule and having to accommodate multiple service providers on an ongoing basis. Additional services will be phased in and out as needed.

6. Intervention activities are designed to fit into a child and family's normal daily routines, to maximize the child's learning and participation and to address multiple developmental needs simultaneously.
7. **Family availability increases as service provision is focused around a single service provider and consultants whose contacts will be much less frequent.**
8. The team develops a shared core of knowledge and skills to address the IFSP outcomes.
9. **The transdisciplinary model encourages the parent and professionals to reflect on successful practices and areas in need of improvement.**
10. **The skills of existing team members are increased instead of adding fragmented services or providing a frequency or duration of service that doesn't effectively meet the needs of the child and family.**
11. **The team has access to a range of new strategies to learn and explore through consultation. The enhanced skill and knowledge remains with the service providers to integrate into their practice and informs their work with other children and families.**
12. **Role expansion, exchange and release occur when team members assume responsibility for implementing interventions and strategies suggested by consulting disciplines.**
13. **Professionals learn how to effectively coach and consult with family members and other service providers.**
14. **Professionals share their discipline based knowledge and expertise with families in a manner consistent with evidence-based practice in Early Intervention.**

Team Member Roles

Family: As a central member of the team, caregivers can participate in a variety of ways. The caregiver's level of participation does not affect whether Early Intervention services and supports are provided and continued. The parent/caregiver must be present and participate in each early intervention session.

1. Work directly with the child as PSP (primary Early Interventionist) observes and coaches caregiver to use strategies and adaptations to address the IFSP outcomes.
2. Work with the PSP to help the child learn and participate in the family's activities.
3. After each visit by the PSP, try the suggestions written in the Contact Note.
4. Update the PSP on successes and challenges with suggested strategies, adaptations and resources.
5. Be present with the PSP and the consultant when consultation is given and actively participate in the consultation.
6. Use the suggested strategies, adaptations and resources from the consults to promote the child's participation in the family's typical activities and routines.

Service Coordinator

1. Support the family/caregiver to work with the PSP (primary Early Interventionist) and consultants (when assigned).
2. Facilitate quarterly reviews and annual IFSP meetings with the caregiver and PSP and consultants (when assigned) to review the progress on outcomes and any additional concerns.
3. Assures the balance on the team of a PSP and consultants so that there is not more than one PSP on a child's team.
4. When the team makes a request for consultation or a change in PSP as part of the quarterly review or annual IFSP meeting, the SC will make the needed referrals according to all required procedures for timely starts.
5. When an Early Interventionist on the team makes a request for a team meeting to discuss a change in the IFSP, that does not occur during a quarterly review or annual IFSP meeting, the SC will receive a completed Request for Team Meeting to Consider Consultation (or other changes to the IFSP) form from the requesting early interventionist. The Request for Team Meeting to Consider Consultation form must be signed by the PSP's supervisor. The SC will follow the steps and timelines specified in the Request for Team Meeting Process in Appendix A.
6. Families may make a direct request for team meeting outside of the quarterly process, to the SC. In those instances, SC will follow the same time line specified in the Request for Team Meeting Process (Appendix A) to set up a team meeting and discuss any changes to the IFSP.

Primary Service Provider (PSP) as Primary Early Interventionist

1. Start services and visit the family with the greatest frequency.
2. Help the family to use strategies, adaptations and resources to achieve the child's IFSP outcomes.
3. Review interventions and progress data with the family and their supervisor when a child is not making progress or the PSP needs guidance about the use of additional strategies, adaptations and resources.
4. Coordinate with the parent, SC and other team members to assess the need and scheduling of consultations.
5. Be present and participate along with the family at the consult.
6. Be coached and trained by the consultant.
7. Prepare annotations on the IFSP Implementation Plan page to reflect the strategies and adaptations recommended by the consultant. Follow agency procedures for plan updates in PELICAN.
8. Collect and share the visual representation of progress at the quarterly review meeting and at consultations.
9. Document all sessions on session notes. For sessions that occur with the caregiver, PSP and consultant, document type of session as "Other: consultation." PSP and consultant can both sign and use the session note as documentation for both providers, if they choose.

Consultants

Consult with the caregiver and PSP (primary Early Interventionist) by using a three step process: assess, teach and verify. The consultant will complete a session note to document all aspects of the consultation (i.e., assess, teach, verify) and include the following information: individuals present at the consultation and the recommended interventions, adaptations and strategies for the child and family.

For sessions that occur with the caregiver, PSP and consultant, document type of session as "Other: consultation." PSP and consultant can both sign and use the session note as documentation for both providers, if they choose.

The consultant documents each step of this process:

1. Assess and Document:
    - Assess by collaborating with family and PSP to review Mulitidisciplinary Evaluation (MDE) information, determine child's progress, skills or behavior changes.
    - With family's agreement, discuss possible changes in the family's situation (i.e., environment, routines, activities) and give guidance to PSP and parent as to how to address outcomes within the context of these changes.
    - Document the findings from this collaborative assessment on the session note.
2. Teach and Document:
    - Suggest strategies and adaptations to address the IFSP outcomes(s)
    - Teach and coach the family/caregiver and PSP to use recommended strategies, interventions and adaptations
    - Give input into the development of the services and supports plan
    - Document the training of the family/caregiver and PSP on the recommended strategies and adaptations. Document on session note.
3. Verify and Document:
    - Determine whether the family/caregiver and the PSP are implementing the strategies and adaptations as recommended. Re-teach as needed.
    - Review and assess unsuccessful strategies and redirect the interventions using new strategies
    - Document that the strategies and adaptations are used as instructed, re-teaching that is required and changes to interventions. Document on session note.

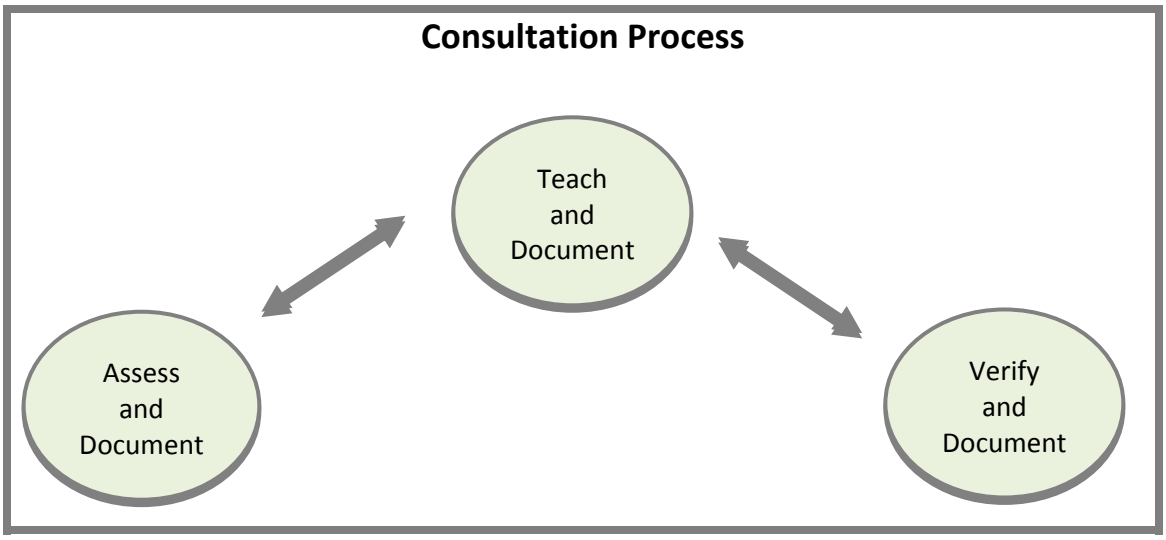

Figure 1

Procedures: <u>Transdisciplinary IFSP Development & Implementation</u>

<u>I. The Primary Service Provider (Primary Early Interventionist)</u>

A. During the initial and annual IFSP meeting, and whenever new outcomes are being formed (e.g., quarterly review), the team will discuss the priority needs of the family and the desired outcomes for the child. As a team, the family and the professionals choose a primary Early Interventionist who will be the primary service provider (PSP). **To select the PSP, the team asks: *Who is the best person to help the child and family achieve this outcome based on these priority needs?***
B. The team will use the practice guidelines developed by the discipline and low incidence groups to help them determine when a therapist or instructor (OT, PT, SLP, Teacher of the Visually Impaired, Teacher of the Deaf and Hard of Hearing) should be used as a consultant or as the PSP (instead of a special instructor or other discipline). These guidelines provide guidance to the team and do not supersede the team's determination of the individualized plan for the child based on evaluation, observation and progress monitoring.
C. The PSP will start services and may be the only service provider delivering ongoing services to the child and family.
D. **The PSP will coach the caregiver to use strategies, adaptations and resources to help their child learn and develop.**
E. In those instances when a child is not making progress or the PSP needs guidance to develop and implement strategies and adaptations to meet the needs of the child and family, the PSP will review the strategies and adaptations implemented to date as well as the progress on the IFSP outcomes with their supervisor. The supervisor may guide the PSP to consider additional resources and try other strategies and adaptations.

II. Transdisciplinary Team Collaboration

A. When an agency picks up a child for PSP, they provide support and opportunities for the team to collaborate through consultation, collateral contact and cross disciplinary training. Collaboration occurs when team members discuss and demonstrate strategies and adaptations that are generally used or specific to the needs of the family and child.

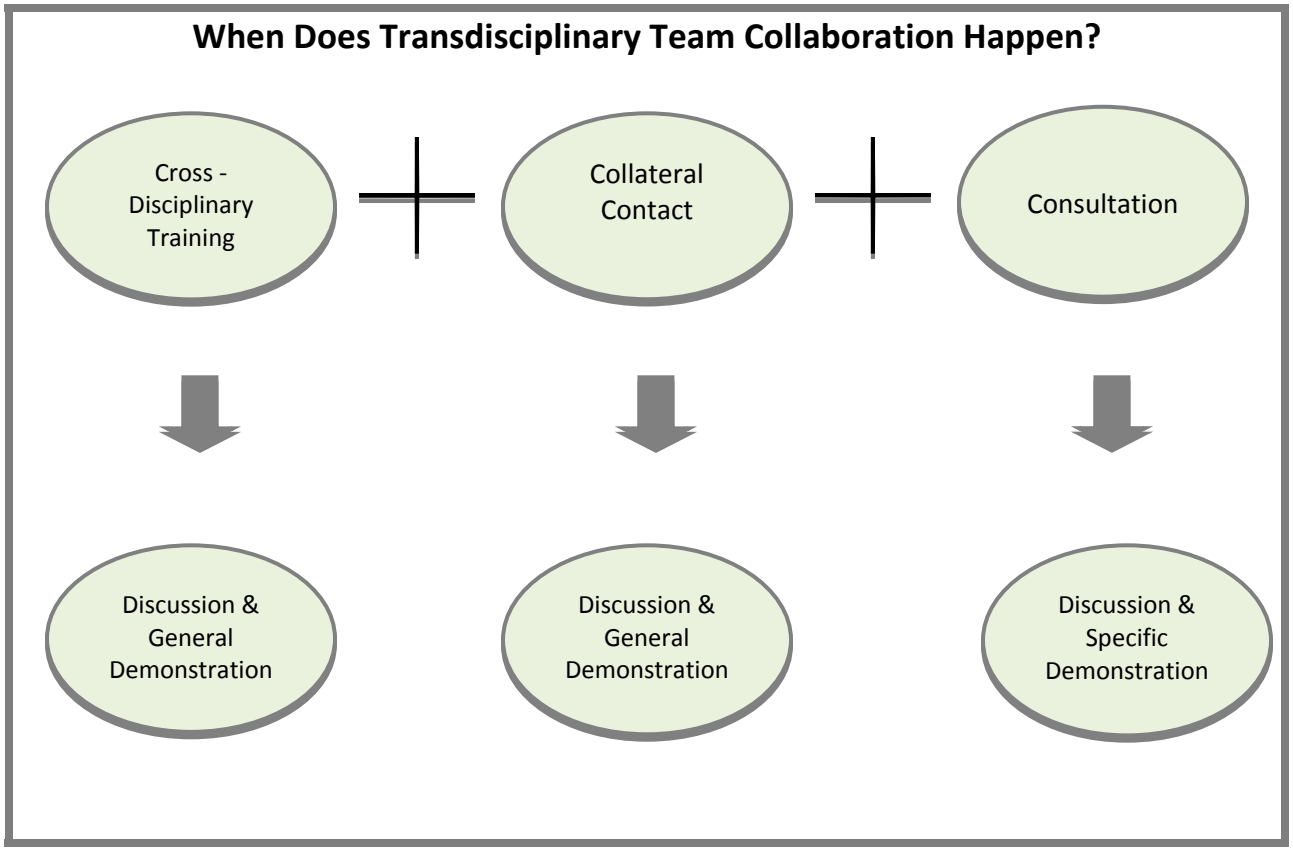

Figure 2

B. When an agency picks up a child as the PSP, they are agreeing to also provide consultation and collateral support, if it is requested, at a later point in the delivery of IFSP services. Agencies will establish relationships with other EI agencies to support access to service disciplines that they may not have available in their individual agencies.

C. Transdisciplinary Team Consultation

1. Other than the PSP, any other Early Interventionists who are on the team serve as consultants and function on the team to assist and support the parent and PSP to achieve the IFSP outcomes.
2. In general, consultants will provide periodic short-term or time limited consultation and the PSP will see the child with the greatest frequency.

3. The caregiver and PSP must be present when the consultation is given. Collaboration by phone (e.g., the consultant calls in while the parent and PSP are present with the child) may occur when necessary. (See Table 2)
4. **Caution must be taken by the consultant not to supplant the role of the caregiver and PSP. The consultant's primary interaction during the consultation will be with the caregiver and PSP to suggest strategies and adaptations to promote the child's participation in the family's typical activities.**
5. During the consultation sessions the consultant will assess the needs of the child and family, teach the caregiver and PSP strategies and adaptations, verify the use of recommended strategies and adaptations, and document the consultations. (See section on Role of Consultants above.)
6. To support team members' role expansion, role exchange and role release, as well as the consultant's participation in quarterly reviews, the team will generally plan consultations that use a three step process (assess, teach, verify) and will allow up to a total of 21 units of service in the quarter (3 months). **In general, the team will plan 15 or less units for consultation visits in the quarter and 6 units for the consultant's participation in the quarterly review.**
7. The consultant may complete the steps of assess, teach and verify in fewer than 15 units of service. After the initial round of consultations, there may be fewer or zero consultations in subsequent quarters, as determined by the team.

D. Team Process for Deciding About Consultation

1. Because a collaborative process is the foundation of the transdisciplinary team approach, the team process is the only context within which services can be added or changed on the IFSP. Team discussions about progress and changes in service will most often take place during the quarterly review meetings.
2. The first quarter of service is time for the family to become acclimated to Early Intervention, and for the PSP (primary Early Interventionist) to become acquainted with the family and child, and to try various strategies**. In many situations, the PSP will be the only service provider in the first quarter of services.**
3. For initial IFSP's, the first quarterly review meeting is typically the time to discuss any changes to the IFSP. Exceptions to this procedure may include:

    - Children whose IFSP's include DBA assessment services
    - When there is a change in service provider or funding.
    - A child has met their outcomes and no longer has a need for service.
    - The service frequency or duration is being changed.

4. The quarterly review meetings (3 month, 6month, 9 month or annual IFSP reviews) are typically when the team (e.g., family/caregiver, PSP, Service Coordinator, consultants, child care teacher) discusses the need to make

changes to the IFSP, change the PSP or potentially add or exit consultation. (See Philadelphia County Quarterly Review Process 2009)

5. The team must support their reasons to add or exit consultation with progress monitoring information. This progress monitoring information should include visual representation of progress (or lack of it) and documentation that other strategies have been tried.
6. The team can use the practice guidelines (see Appendix A) to help determine when a therapist or specially trained teacher (occupational therapist, physical therapist, speech language pathologist, teacher of the visually impaired, or teacher of the deaf and hard of hearing) can be used as a consultant or as the PSP. These guidelines provide guidance to the team and do not supersede the team's determination of the individualized plan for the child based on assessment, observation and progress monitoring.
7. No individual Early Interventionist can request consultation in isolation. The decision to request consultation services must be done within the team process and will typically occur as part of quarterly and annual reviews.
8. Every effort will be made to have all members of the child's IFSP team available at quarterly and annual review meetings to collaborate on a review of the child's progress and to discuss potential changes to the IFSP. Since this is a planned opportunity for the team to collaborate, **it is critical for all service providers to attend the quarterly, six month and annual meetings**.
9. During a quarterly review meeting, the child's service delivery team may decide that the PSP should change. If the focus of the child's IFSP outcomes or family priorities changes, the team may determine that the PSP should change. The initial PSP may be exited from the IFSP and/or their service delivery frequency decreased as they assume the role of a consultant.

   The new PSP may have been one of the consultants on the team, in which case their service delivery frequency will increase. Or a new service provider may be added (who had not been on the former team) because it has been determined that they are the best person to help the child and family/caregivers meet their IFSP outcomes.

E. <u>Request for Team Meeting to Consider Consultation Process and Form</u>

When an Early Interventionist requests a team meeting to consider consultation, add or increase service or when there is a change in an IFSP outcome outside of the quarterly, six month and annual review meetings, the team will use the form "**Request for IFSP Team Meeting Outside of QRM** (To consider Consultation, Adding or Increasing Service or Changing an Outcome)." The Request for IFSP Team Meeting Outside of QRM process and form are included as Appendix A to this policy.

Note: <u>If the team is considering a change to the IFSP at a quarterly or annual meeting with the team members, there is no need to use the Request for Team Meeting Form.</u>

F. Collateral Contact

1. Collateral contact is discussion and demonstration that pertains directly to a particular child and family's IFSP outcomes, progress, strategies, interventions, adaptations and potential resources. Discussion and demonstration outside of these topics does not constitute collateral contact.
2. As part of the County's pilot to track the use of consultation and collateral contact in the transdisciplinary approach, the collateral contact that the County will pay, (if we are given permission by OCDEL) will not exceed 12.5% of the child's direct units per month, per discipline on the IFSP, with a maximum of one hour per discipline per month.

This consultation and collateral contact may occur as follows:

IFSP Team Members	**IFSP Team Member and Early Interventionist not on IFSP**
PSP & Consultant together for on-site consultation with caregiver and child. **Direct Service**	Early Interventionist not on IFSP may give guidance to caregiver and Early Interventionist on IFSP team by phone. (e.g., PSP is present with caregiver) **Early Interventionist on IFSP = Direct**
One or more IFSP team members on phone while other IFSP members on-site with caregiver and child. **Team Member on phone = Collateral Team Member on site = Direct Service**	Early Interventionist not on IFSP may give guidance to Early Interventionist on IFSP team by phone or in office** (e.g., PSP not present with caregiver and child). **Early Interventionist on IFSP = Collateral**
Limited discussion among Early Interventionists on IFSP not in presence of caregiver and child. **Team Members = Collateral**	Supervisor of Early Interventionist on the IFSP may give guidance to Early Interventionist by phone or in office**. **Early Interventionist on IFSP = Collateral**

Table 2

**IFSP professional team members may have limited "office" (i.e., not present with caregiver and child) discussions to obtain guidance outside of direct service delivery. The limits of "office" collaboration are:

1) Inclusion of the caregiver is prioritized (caregiver can be on the phone).
2) No decisions are made without the knowledge and consent of the caregiver.
3) PSP or Consultant must **document the collateral contact on a session note,** and at the next visit with the caregiver, review the content of any discussion in which the caregiver did not directly participate.

3. Documentation of Collateral Contact:
    a. To document collateral sessions, designate type of session as “Other: collateral.”
    b. PSPs or Consultants must document who was present or participated in the collateral contact on the session note. PSP and consultant (i.e., IFSP Team Members) can both sign and use the same session note as documentation for both providers, if they choose.
    c. In the “Description of Activity” section of the session note, the PSP or Consultant must describe the content of the discussion regarding the child and family’s IFSP outcomes, progress, strategies, interventions, adaptations and potential resources.

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Appendix A

PHILADELPHIA INFANT/TODDLER EARLY INTERVENTION

Request for IFSP Team Meeting Outside of *QRM Schedule

(To consider Consultation, Adding or Increasing Service or Changing an Outcome)

Within 24 hours (end of day 1)

1. SC alerted by service provider that there may be a need for an IFSP meeting outside of the regularly scheduled Quarterly Review Meeting Schedule (for the purpose of considering consultation, adding or increasing service or a change in outcomes).
2. Service provider completes request form and discusses request with supervisor to review what has been tried and to discuss other alternatives (to changing the IFSP before the next quarterly meeting).

*Service Providers should not begin discussions with the family (before the full team is assembled) as to whether services should/could be added or increased/decreased. Observations/progress/concerns should be discussed with the family and the fact that you (the service provider) will be talking with you supervisor about your concerns/observations/progress. The service provider can also inform the family that there will likely be a team meeting to discuss the concerns/observations/progress further.

Within 48 hours (end of day 2)

1. Supervisor discusses issues with service provider and signs form (if warranted)
2. Agency should indicate on form if they will accommodate the change to the IFSP (increased service or adding a consultant). Where possible the agency should immediately (after the discussion and filling out the form) begin contacting their collaborating agencies for a resource, if they know that they cannot fill the need.
3. Service provider (or provider agency) contacts SC and lets them know whether a team meeting will be needed or if the issues can be addressed at the next quarterly review meeting.

   If this is the only service provider on the IFSP, while on the telephone, the SC should schedule the team meeting for the time of the next planned home visit by the service provider, or discuss another date/time for the meeting)

4. If a team meeting is needed, the service provider then sends a copy of signed request form to the SC. If after the meeting with the supervisor, no meeting is needed-the service provider (or provider agency) should call/email the SC to let them know that there will not be a need for a team meeting.

Within 36 Hours (end of day 3)

1. SC finalizes a date for the team meeting to discuss request and potential IFSP revision. <u>The meeting is to take place within 5 working days of request.</u>

2. SC sends a written notification of the date and time of the IFSP team meeting (can be a phone conference).

By End of Day 5

SC facilitates the meeting (can be a phone conference) to discuss request and potential IFSP revision

When IFSP revision is completed

• Agency of PSP (primary agency) has 24 hrs to assign/identify a consultant and alert ChildLink of the same. Agency of PSP will collaborate with other EI agencies to access services that they may not have available in their agency.
• Referral will go on the MRL on the same day that the IFSP revision is received, however the agency of the primary service provider (and their collaborating agency) gets priority so that the whole child can be served by a single agency and the teaming process can be supported.

PLEASE NOTE:
Families may make a direct request to the SC for an increase in services or to add consultation. In those instances, SC will follow same time line in setting up a team meeting and implementing any changes to the IFSP.

When/if the family makes this request to the service provider, the service provider should contact the SC immediately (without making a commitment as to whether this could be done or not). The SC will follow the same time line and process (outlined above) for setting up an IFSP team meeting outside of the QRM schedule.

PHILADELPHIA INFANT/TODDLER EARLY INTERVENTION

Request for IFSP Team Meeting Outside of *QRM Schedule

(To consider Consultation, Adding or Increasing Service or Changing an Outcome)

Please complete the following information. If an IFSP team meeting will be needed, fax the SIGNED form (signed by Supervisor) to the ChildLink Service Coordinator.

ChildLink FAX#: 215-731-2128 Date Faxed: ____/____/____

Attention Service Coordinator (Name): _____

This form must be completed by the SERVICE PROVIDER requesting the IFSP Team meeting.

Child's Name DOB / / ChildLink #
Parent's Name ChildLink Service Coordinator
IFSP Development Date / / / Month/Year of Next Quarterly Review
Service Provider completing the form: Supervisor's Name: Other Service providers on the IFSP team: **Change to IFSP being considered**: Why this team meeting cannot wait until the next Quarterly Review Meeting:
Concerns/Issues that prompted this request: (For example: child's progress/lack of progress, the outcome being addressed, team member's need for support around a particular skill/strategy…) Date the provider consulted with their supervisor: _____ List the suggested strategies, adaptations and resources that were suggested by the supervisor: _____ _____ _____

Does agency of requesting provider *believe they have the capacity to supply the requested consultation or increased service? Yes _____ No _____ **Note:** **Does collaborating agency (of requesting provider) *believe they can supply the requested consultation or increased service?** Yes _____ No _____ Name of Agency:_____ Note: Agency Contact Person: _____ ***Do not delay sending form while ascertaining resources. Form must be processed within time frames indicated in the policy. More information about provider's ability to fill potential service need can be shared at the team meeting.**
Agency Name:_____ **Supervisor approval (signature): _____** **Date: ____/____/____** **Telephone#:**

cc: IFSP Team Members
Provider Agencies of Team Members

***QRM=Quarterly Revie**

ANNOUNCEMENT: EI-09 #02
OFFICE OF CHILD DEVELOPMENT AND EARLY LEARNING
BUREAU OF EARLY INTERVENTION SERVICES

ISSUE DATE: January 15, 2009
EFFECTIVE DATE: January 15, 2009
SUNSET DATE: On-Going

SUBJECT:	**Behavior Supports for Young Children**
TO:	**Personnel Working To Provide Behavior Supports for Young Children**
FROM:	**Harriet Dichter** **Deputy Secretary, Office of Child Development and Early Learning** **Joan Erney,** **Deputy Secretary, Office of Mental Health and Substance Abuse Services** J.D.

PURPOSE:
The purpose of this announcement is to clarify and better define how the Early Intervention and Behavioral Health Service systems can work together in a cooperative, respectful and family responsive manner in order to provide services as needed for children from birth to five years of age.

BACKGROUND:
The Commonwealth is committed to supporting the behavioral health needs of young children and their families. In support of that commitment, joint efforts between the Office of Child Development and Early Learning (OCDEL) and the Office of Mental Health & Substance Abuse Services (OMHSAS) have been initiated to ensure that young children and their families have the tools to promote good mental health and access to an array of individualized services and supports for more complex behavioral health treatment. The term "behavioral health services" is used rather than "mental health services" to encompass a broader range of services. In young children, this may include services that address challenging behaviors in children with Autism Spectrum Disorder, as well as children with other delays or disabilities, who also have behavioral health needs.

Efforts to date, including mental health consultation for Keystone STARS programs and the Early Childhood Mental Health Advisory Committee have already demonstrated the need for ongoing collaboration and information about accessing behavioral health services. As an outgrowth of this work, OCDEL and OMHSAS are responding to the need to offer more information and resources to help families, counties, schools and providers understand how Early Intervention services and behavioral health services are available to support children with behavioral health needs.

OCDEL and OMHSAS and share core principles for supporting children. Services and supports should be individualized, strength-based, child-centered, family-focused, community-based, and culturally competent. A child with behavioral health needs may qualify and benefit from the same or similar services from both systems, but those services should be coordinated to avoid duplication. Although progress has been made, additional work is needed throughout the Commonwealth to continue to develop an appropriate response to the early childhood behavioral health needs of

children birth to five. This Announcement is part of the ongoing collaboration between OCDEL and OMHSAS to assure that all children are receiving the necessary supports and services.

DISCUSSION:

Early Intervention is administered in accordance with PA Act 212, The Early Intervention Services System Act; 55 PA Code Chapter 4226, Early Intervention Services; 22 PA Code Chapter 14, Special Education Services and Programs; and the Individuals with Disabilities Education Act (IDEA). In Pennsylvania, OCDEL administers both the Infant/Toddler Early Intervention program (birth-three) and the Preschool Early Intervention program (three-five.)

At the local level, the county Early Intervention programs implement services for infants and toddlers and their families. Early Intervention services for preschoolers are implemented by local Intermediate Units, local school districts or private providers.

Behavioral Health services for children with or at risk of developing severe emotional or behavioral disorders and their families are administered by OMHSAS primarily through county government utilizing the Medical Assistance program, including the HealthChoices behavioral health managed care program, the fee-for-service (FFS) delivery system and community- based funds. Services are implemented at the local level through the county Mental Health/Mental Retardation (MH/MR) programs or the Behavioral Health Managed Care Organizations or both.

A. Early Intervention Services Defined:

Early Intervention services and supports are designed to meet the needs of children with developmental delays or disabilities and the needs of the family related to enhancing the child's development in one or more of the following areas:

- Physical development, including vision and hearing
- Cognitive development
- Communication development
- Social and Emotional development
- Adaptive development

The first step in the Early Intervention process is to contact the local Infant/Toddler Early Intervention program or Preschool Early Intervention program. An evaluation will be completed to determine if a child is eligible for services. If a child is found eligible for services an Individualized Family Service Plan (IFSP) birth to three or an Individualized Education Program (IEP) three to five will be developed with the team.

Some of the services provided to children from birth to five may include, but are not limited to:

For both Infants/Toddlers and Preschoolers:

- Assistive technology devices and services: items or equipment used to increase, maintain, or improve functional capabilities of children with developmental delays or disabilities; services that directly assist children with developmental delays/disabilities in the selection, acquisition or use of an assistive technology device;

- Family training and counseling services: assist families of children with developmental delays or disabilities in understanding the special needs of and enhancing the development of the child;

- Social work services: counseling and home visits: identification, mobilization and coordination of community resources and services to enable children with developmental delays or disabilities and the family to receive the maximum benefit from Early Intervention services;

- Speech-language pathology services: address communicative or swallowing difficulties in the development of communication skills; provide the family with ideas and suggestions on how to improve the child's communicative, cognitive or swallowing ability;

- Audiology services: identify hearing loss, determine the range, nature and degree of hearing loss and communication function; make referrals to medical and other services necessary for the habilitation or rehabilitation of hearing loss;

- Occupational therapy services: address the functional needs of children with developmental delays or disabilities related to adaptive equipment and adaptive behavior which includes feeding and eating skills, self care tasks and self regulation. Sensory, motor and postural development skills are also addressed to provide the family with ideas and suggestions on how to improve their child's functional abilities;

- Physical therapy services: provide screening, evaluation and assessments to identify movement dysfunction, provide the family with ideas and suggestions on how to improve the child's physical ability and effective environmental adaptations; address the promotion of sensorimotor function of children with developmental delays or disabilities;

- Psychological services: administer psychological and developmental tests and interpret assessment results; psychological counseling for children with developmental delays or disabilities and their parents; family counseling; consultation on child development; parent training; and educational programs;

- Medical services only for diagnostic or evaluation purposes: services provided by a licensed physician to determine a child's developmental status and need for Early Intervention services;

- Health services: services necessary to enable the child to benefit from other Early Intervention services, consultation by physicians with other service providers concerning the special health care needs of a child with a developmental delay or disability that will need to be addressed in the course of providing other Early Intervention services.

For Infants and Toddlers Only:

- Special Instruction: provides the family with information, skills and supports to enhance the skill development of the infant or toddler with a developmental delay or disability and design the learning environments and activities that promote the acquisition of skills by an infant or toddler with a developmental delay or disability in a variety of developmental areas, including cognitive processes and social interaction, planned interaction of personnel,

materials and time and space, to achieve the outcomes on the infant's or toddler's Individual Family Service Plan (IFSP);

- Service Coordination-services to locate, coordinate, and monitor Early Intervention services.

For Preschoolers Only:

- Special Education: specially designed instruction to meet the unique needs of a child with a disability.

B. Behavioral Health Services Defined:

Behavioral health services for children with serious emotional or behavioral disorders and their families are designed to address a broad array of behavioral challenges, including Pervasive Developmental Disorder/Autism. The following behavioral health services are available to young children for whom they are medically necessary, from the Medical Assistance funded behavior health system;

- Targeted case management, including intensive case management and resource coordination-services designed to coordinate and link children and their families to the array of therapeutic services and supports needed by the child and family;
- Psychiatric outpatient clinic services – individual, group or family psychotherapy, psychiatric and psychological evaluations, and medication management provided in a clinic by a multi-disciplinary team of professionals;
- Psychiatric and psychologist office visits-individual, group or family psychotherapy, psychiatric and psychological evaluations, and/or medication management performed by licensed psychiatrist or psychologist;
- Family-based mental health services – family-focused therapy and support delivered by a team of a mental health professional and a mental health worker in the home and community to address the behavioral health needs of the child;
- Behavioral Health Rehabilitation Services, including
    - Behavioral specialist consultation – consultation by a master's or doctoral level clinician to a behavioral health treatment team for the purpose of developing a specialized behavioral health plan that is often based on a functional behavioral assessment performed by the behavioral specialist over a period of several weeks in a variety of settings;
    - Mobile therapy – individual and family therapy provided by a master's level clinician in the home, school or community;
    - Therapeutic staff support – one-to-one supportive interventions provided by a paraprofessional based on a treatment plan often developed from a functional behavioral assessment;
    - Summer therapeutic activities program – a five-week therapeutic group program of recreational and other therapies, often operating 5 days per week for up to 6 hours per

day, designed to meet the behavioral health needs of children who have been receiving other intensive behavioral health services during the school year;

- Other services that are not on the Medical Assistance Program Fee Schedule but may be authorized by submission of a service description based on the individualized needs of the child and family;

- Psychiatric partial hospitalization – individual, family and group therapy provided at least hours but no more than 6 hours per day up to 5 days per week, including psychiatric and psychological evaluations and medication management;
- Therapeutic Services provided in a Community Residential Rehabilitation Host Home – out of-home therapeutic services in a family setting often with additional treatment services provided in the community;
- Inpatient Psychiatric Hospital Services – individual, family and group therapy provided in a hospital setting, including psychiatric and psychological evaluations and medication management.

PROCEDURES:

A. Eligibility for Early Intervention Services:
The Early Intervention program meets with the child and family to complete an evaluation which determines the child's eligibility for Early Intervention services. Following an eligibility determination the team develops an IFSP/IEP and provides Early Intervention services and supports in the child's natural environment or least restrictive environment (LRE).

Infants and Toddlers are eligible for Early Intervention services when the infant/toddler has a:

1. 25% delay in one or more of the five developmental areas: 1) physical development, including vision and hearing; 2) cognitive development; 3) communication development; 4) social and emotional development and 5) adaptive development, or

2. 1.5 standard deviation below the mean on an accepted or recognized standardized test in one or more areas of development, or

3. Condition likely to result in a developmental delay, or

4. Clinical opinion determines eligibility when no standard evaluation tool adequately measures the child's delay.

Preschoolers are eligible for Early Intervention services when:

1. The child is diagnosed with one of the following:
   - Autism
   - Visual Impairments, including blindness
   - Hearing Impairments, including deafness
   - Mental Retardation
   - Traumatic Brain Injury
   - Orthopedic Impairment

- Other Health Impairment
- Serious Emotional Disturbance
- Specific Learning Disability
- Speech or Language Impairments, or

2. The child has a developmental delay evidenced by:
   - Delay of 25% in one or more areas of development or
   - 1.5 standard deviations below the mean on an accepted or recognized standardized test in one or more areas of development

3. The child meets the criteria in 1 or 2, above, and is in need of special education

B. Eligibility for Behavioral Health Services

Behavioral health services for children may be obtained by utilizing private medical insurance, Medical Assistance coverage, a combination of both, or in some cases, county funds. Families who have private insurance should follow the procedure of their own health plan. Since many private medical insurance plans do not cover all of the services that may be needed by children with special needs, or may have deductibles, co-pays, or service limits, Medical Assistance coverage may be needed to alleviate those costs. For those families who may need to access the public system, the first step is to contact the county MH/MR program for more information on what services are available to meet the child's needs and how to obtain services. Many of the services require a recommendation based on a psychological or psychiatric evaluation performed by a licensed psychologist or a physician, who is often a psychiatrist, but can be other physicians such as developmental pediatricians or pediatric neurologists.

If there is a need to enroll the child in Medical Assistance, a family may contact the County Assistance Office (CAO) in the county of residence or apply online using the Commonwealth of Pennsylvania ACCESS to Social Services (COMPASS) application: https://www.humanservices.state.pa.us/compass/PGM/ASP/SC001.asp. A child will be eligible for Medical Assistance if he or she meets the low-income guidelines of the program, or if he or she has a disability that meets the Social Security Administration's (SSA) disability standards.

The Department of Public Welfare has a special category of Medical Assistance for children who meet the SSA disability standards. The disability must be diagnosed by a physician or licensed psychologist and must be verified by the SSA or the Department Medical Review Team.

The SSA considers a child to be "disabled" if he or she has a medically determined physical or mental impairment which:

A. Results in marked and severe functional limitations that can be expected to result in death; or,
B. Has lasted or can be expected to last for a continuous period of not less than 12 months.

A child whose disability meets these standards will be eligible for Medical Assistance unless the child has substantial income in his or her own name (excluding child support or Social Security Benefits for minors).

The CAO will give the applicant a list of verification documents needed to process the application.
An eligibility decision will be made after the CAO receives all required documentation. If the child is determined to be eligible, eligibility will be retroactive to three months prior to the date of application to assist with any unpaid medical bills. If eligibility is denied, the family can appeal by requesting a Fair Hearing.

Once a child is eligible for Medical Assistance, the child will receive services either in the FFS delivery system or through a HealthChoices Behavioral Health Managed Care Organization in the county in which the parent(s) reside(s). Medical reviewers will determine whether the services that have been recommended for the child are medically necessary. If determined to be medically necessary, services will be authorized for specific periods of time and may be reauthorized for additional time based on documentation of continued need for the service. If authorization is denied, the family can appeal. Once authorized, if services are reduced or terminated and the family appeals within 10 days, the services will continue pending the appeal process.

C. Determining the Need for Behavioral Services and Supports for Young Children

Staff who work in the Early Intervention and behavioral health fields must determine how to provide services for children who may be eligible for both Early Intervention and behavioral health services. A child who primarily needs Early Intervention could also be eligible for significant behavioral supports from the behavioral health services system while a child who is receiving behavioral health services could display a developmental delay that warrants Early Intervention services. Regardless of how the child enters the service system, both programs at the local level should have interagency agreements that assure referrals to the other program when indicated. While decision-making should be individualized, children who have significant behavior support needs without having developmental delays should be referred for behavioral health services. Children who have developmental delays should be referred for Early Intervention services. Children with both developmental delays and significant need of behavioral supports should be referred for both Early Intervention services and behavioral health services. If a child is eligible for both Early Intervention and behavioral health supports, the Early Intervention Coordinator should take the lead role in organizing services and making the necessary referrals to other programs. Individual service plans should reflect how the Early Intervention and behavioral health services will be coordinated rather than duplicated.

NEXT STEPS:

1. Infant/Toddler Early Intervention programs and Preschool Early Intervention programs, MH/MR Administrators, and CASSP Coordinators should share this information with families, Early Intervention providers and behavioral health providers so that the team is aware of the Early Intervention and behavioral health services that are available to eligible children.

Comments and Questions Regarding this Announcement Should be Directed to the Office of Child Development and Early Learning, Bureau of Early Intervention Services at (717)-265-8901, ra-ocdintervention@state.pa.us or to the Office Mental Health and Substance Abuse Services at (717)-705-8289 or by emailing Sherry Peters at sherpeters@state.pa.us.

Philadelphia Infant/Toddler Early Intervention -- Behavior Support Plan

DIRECTIONS: Challenging behavior that interferes with interaction and learning is a priority as it influences the child's ability to participate in everyday activities and routines through which the child grows and develops. This plan is developed and implemented by the primary person (or by a team of individuals) working with the child. This plan includes strategies for the family/caregiver to embed within everyday situations. It must be implemented immediately and closely monitored by the provider together with the family/caregiver at each visit to determine if there is change in the challenging behavior. The strategies need to be revised or replaced if the targeted behavior that the child needs to learn (left column below) is not achieved within 30 days from the development of this plan.

Child's name: _____ IFSP Date: _____ Date Plan Developed: _____

General description of behavior:

Behavior hypothesis: (the meaning of the behavior):

	Behavior child needs to learn	Strategy/ies to support development	Person/s responsible	When to Implement
Example	*Carmen needs to participate during family mealtimes by interacting with parents and siblings without biting & hitting*	*Strategy 1) Praise Carmen for using words and gestures "That's good - you said no thank you to Maggie." Strategy 2) Use consistent words "No hitting", "Gentle touch" then show Carmen how to touch parent, brother or sister softly.*	*Parents or grandparents who are present during mealtime*	*Strategy 1) Praise as often as possible when behavior is positive Strategy 2) When biting or hitting is attempted as family prepares for dinner, while sitting at table or during clean-up*

Parent Name: _____ Parent Signature: _____

Provider Name: _____ Provider Signature: _____

Date reviewed	Results and next steps	Parent initials	Provider initials
Example	*Mother reports family consistently used strategies #1 and #2 this week. Progress monitoring ratings on their satisfaction with Carmen's participation during meals without hitting and biting moved up from 1(before plan) to 2 this week. Parents will continue to use same strategies and review next week.*		

Philadelphia Infant/Toddler Early Intervention -- Behavior Support Plan

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Parent Name: _____ Parent Signature: _____

Provider Name: _____ Provider Signature: _____

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Department of Behavioral Health/Mental Retardation Services
Philadelphia Infant/Toddler Early Intervention

Implementing Behavior Support Plans

Instructions: When "behavior" is checked on the IFSP (*Section III, **Special Considerations)** (Does the child have behaviors that impede the child's learning or that of others?),* services must begin with an assessment of the child's behavior and you should then develop a plan to promote positive behavior with strategies for the parent/caregiver to implement. In Philadelphia, this must be documented on Behavior Support Plan form that we have developed for your use in Philadelphia.

Additionally, providers should review and be familiar with the OCDEL publication titled "Early Intervention Program Guidance for Developing a Behavior Support Policy". Specific areas to review and make note of are:

1. *Examples of Positive Behavior Support Strategies*
2. *Steps involved in developing a functional behavior assessment and*
3. *Safety Net Procedures, specifically strategies that would prevent the use of restraint.*

Process:

1) During the first visit, the provider and family discuss the child's challenging behavior and develop a description of what the behavior currently looks like. This is documented on the Behavior Support Plan in the first section, **"General description of behavior".**

2) Through observation of the child's participation during the activity/routine in which the challenging behavior occurs, review of information from family and child's developmental strengths and needs, the provider collaborates with the family to identify the meaning of the behavior. A hypothesis as to why the behavior occurs is documented on the Behavior Support Plan in the section, "**Behavior hypothesis: (the meaning of the behavior):**" This would be considered a functional assessment of the behavior.
3) Provider and parent/caregiver identify the positive behavior to be developed along with the context in which it is needed, targeting a meaningful and realistic participation-based outcome that can be achieved within a 30-day period. This is documented in the main section on the Behavior Support Plan, together with strategies to be implemented, who will implement these strategies, and when they will be used.

4) The Behavior Support Plan is discussed and explained to the parent/caregiver. The provider completes any teaching/instruction that's needed so that the parent/caregiver knows how to implement the strategies. The provider ensures that the parent/caregiver will begin to implement the strategies that day.

At each subsequent visit, the parent/caregiver and provider review the child's behavior and determine:

1) if the child's behavior is changing in a positive way
2) whether or not there are questions about implementing the strategies in the plan
3) how often the strategies have been implemented
4) other questions or issues related to the child's behavior and/or use of the plan
5) need to revise the plan

The date of each review is noted on the bottom section of the Behavior Support Plan, with a brief summary of results and next steps. Both provider and parent should initial this summary on the form.

ChildLink

EARLY INTERVENTION SERVICE COORDINATION SUPPORT PLAN

Service Coordinators perform a variety of roles and responsibilities. I am your primary contact in Early Intervention. Below are just some of the activities I can help you with:

- Notify you of opportunities to participate in community activities and events with other children and families.
- Inform you of community resources that may benefit you and your family.
- Make sure you know about local support groups and parent networks.
- Screen and track children who are at-risk for developmental delays.
- Coordinate initial and ongoing evaluations and assessments of your child and family.
- Facilitate and participate in the development, implementation and reviews of your Individualized Family Service Plans (IFSP).
- Assist you in identifying and gaining access to early intervention services and other supports identified on your IFSP.
- Facilitate the timely delivery of early intervention services.
- Assist you in identifying available service providers and facilitate communication with and between you and your service provider.
- Coordinate and monitor the delivery of early intervention services.
- Monitor progress of your IFSP outcomes on a quarterly basis.
- Inform you of your rights and procedural safeguards in early intervention as well as availability of advocacy services.
- Assist you in dealing with medical and health services your child needs or is receiving.
- Facilitate the development of a transition plan as part of the IFSP.

I will review this plan with you at least every 90 days. In the meantime, if there is anything you have questions about, need information on or just need to talk, please contact me.

Service Coordinator's name:
Phone number:

Supervisor's name:
Phone number:

Philadelphia County Infant/Toddler Early Intervention

Services and Supports Plan Policy

Implementation Effective date: 6/1/2010

Discussion: The purpose of this memo is to transmit new directions regarding the completion of the services and supports plan (SSP) for children in early intervention.

The purpose of the SSP is to put in detail the specific strategies that are being implemented in order to reach the IFSP Outcomes, including the measures that will be used to note progress.

The information on the Outcomes page of the IFSP is what is needed for the services and supports plan. Because the initial MDE teams in Philadelphia County complete this page for the initial IFSP and the ongoing service providers are not present, the Outcomes page strategies are written generically. At the time of the initial MDE/IFSP meeting, the specific interventions that the assigned ongoing service providers will use are not known as the provider has not yet been identified.

The best way to streamline this process, is to have the ongoing service providers (once they begin working with a family) write a revised and updated Outcomes page, delineating the specific strategies they will use to address the outcomes, how progress will be noted and the measures that will be used to identify that progress is being made.

Procedures

Logistics: Within 1 month (30 days) of a service start, the ongoing service provider (*PSP) will revise the outcome page to reflect the specific strategies, progress monitoring tools and measures they will use to address the child's IFSP outcomes. After the initial revision of the outcomes page, service providers should revise and update the SSP as interventions and strategies are met and/or outcomes are achieved and other strategies are implemented or new outcomes become the focus for the period.

Tools: Plan to use NCR copies of the IFSP Outcomes page for this purpose, so that families can have a copy. Since IFSP's will be generated in PELICAN there should be an ample supply available. Copies can be made of a blank Outcomes page and used (in the absence of NCR copies), with the plan to make a copy for the family and other team members.

Teaming: The development of this SSP should be a team process. Because we are using the transdisciplinary service delivery approach, only the *Primary Service Provider needs to complete the revised Outcomes page in consultation with the rest of the team. Forms should be brought to the session when a consultant joins the team, so they can be completed as the consultant shares strategies and interventions with the PSP and family.

Documenting compliance: Document should be labeled Services and Supports Plan and dated. A copy should be placed in the child's file and copies distributed to the other team members. It is each team member's responsibility to make sure that they have a copy of the SSP in the agency file

***Note: If a child does not have a transdisciplinary IFSP, each of the (non-consulting) service providers should have a service and supports plan and updates to reflect their interventions.**

Services and Supports Plan:

- Effective June 1, 2010, we are no longer completing a separate Services and Supports Plan (SSP) form. Instead, the SSP information will be on the child's revised IFSP outcomes page.
- The updated policy will explain the process.
- Please do not tell your staff to stop doing SSP's. Instead you should let them know that the SSP will be done on the intervention plan (outcomes page) in the child's IFSP.
- We will still be looking for SSP's when we monitor, as will OCDEL. Therefore we advise you to train your staff about where the SSP will be, before you tell them to cease completing the SSP forms.

Philadelphia County Infant/Toddler Early Intervention

Service Support Plan

Child's Name: _____ ChildLink #

_____

Last IFSP Date: _____ Date of SS Plan: _____

I. Outcome (s)_____

- Objective: What does the child and family need to learn or work on to help achieve the outcomes?
- Method/Activity: What methods/activities will help the child and family achieve this objective?
- Measures: How will you know the child has made progress?

A. Objective:
Method/Activity
   a. _____
   _____
   b. _____
   _____
   c. _____
   _____

Measure:
How do these methods/activities help the child and family achieve the other outcomes?
_____
_____
_____

B. Objective:
Method/Activity
   a. _____
   _____
   b. _____
   _____
   c. _____
   _____

Measure:
How do these methods/activities help the child and family achieve the other outcomes?
_____
_____
_____

C. Objective:
Method/Activity
   a. _____
   _____
   b. _____
   _____
   c. _____
   _____

Measure:
How do these methods/activities help the child and family achieve the other outcomes?
_____
_____

Child's Name: _____ **ChildLink #:** _____

II. Signatures:
Service Provider: _____ Date: _____

Provider Agency: _____ Date: _____

Parent: _____ Date: _____

Supervisory Check Off: □ Name: _____ Date Reviewed: _____

III. Status of Objective(s) Date Assessed: _____

Check all that apply:
I-A. Objective 1: □ Achieved □ Not Achieved
□ Yes, The Chart/graph/video/other was available for review by the team
□ Maintain methods/activities □ Revise methods/activities (see revised SSP) Dated: _____

I-B. Objective 2: □ Achieved □ Not Achieved
□ Yes, The Chart/graph/video/other is attached to (included with) this document
□ Maintain methods/activities □ Revise methods/activities (see revised SSP) Dated: _____

I-C. Objective 3: □ Achieved □ Not Achieved
□ Yes, The Chart/graph/video/other is attached to (included with) this document
□ Maintain methods/activities □ Revise methods/activities (see revised SSP) Dated: _____

Copies: Bring copy for SC and other service providers on the team to the Quarterly Review (including 6 Month Review) Meeting.

Philadelphia County Infant/Toddler Early Intervention
Service Support Plan Addition/Revision Sheet

Child's Name: _____ **ChildLink #:** _____

Additional Objectives
Revisions of Objective _____ Date: _____ Initials: _____

A. Objective:
Method/Activity
a. _____
_____
b. _____
_____
c. _____
_____

Measure:
How do these methods/activities help the child and family achieve the other outcomes?
_____
_____

Additional Objectives
Revisions of Objective ____ Date: _____
Initials:_____

B. Objective:
Method/Activity
a. _____
_____
b. _____
_____
c. _____
_____

Measure:
How do these methods/activities help the child and family achieve the other outcomes?
_____
_____

Additional Objectives
Revisions of Objective ____ Date: _____ Initials: _____

C. Objective:
Method/Activity
a. _____
_____
b. _____
_____
c. _____
_____

Measure:
How do these methods/activities help the child and family achieve the other outcomes?
_____

Philadelphia County Infant/Toddler Early Intervention

Progress Monitoring Strategies

Monitoring Progress and IFSP Outcomes and Objectives

What is Progress Monitoring?

Progress Monitoring is an *ongoing* process involving:

1. Documenting a child's growth and development and family-identified outcomes, and
2. Planning for changes in outcomes and objectives by:
    - Collecting and analyzing objective information
    - Making decisions based on the review and analysis of the objective information

A system for progress monitoring includes:

- What to monitor
- How to monitor
- How to report information to families
- Who needs to be involved in progress monitoring

What are the Benefits of Progress Monitoring?

- Everyone involved with the child and family are partners and know what is expected
- Families and staff have a documented and organized record of performance
- Families and staff know what is working or not working based on data
- It provides an "easy to understand" way to communicate with families and other team members about progress
- IFSP teams have comprehensive performance information to use for decision making and can make objective decisions

Why is Progress Monitoring Required?

- Results-based/Outcomes-based accountability is here!!
- It is no longer sufficient to simply provide services; services must be linked to outcomes and make a meaningful difference for the people who receive the services
- All funders, private and public, including federal, state and local sources, want "concrete" proof that their dollars are being well spent
- It's the law: Part C requires progress monitoring

Title 55. Public Welfare Early Intervention Rules and Regulations
Section 4226.74. Content of the IFSP

(3) Outcomes. A statement of the major outcomes, expected to be achieved for the infant or toddler with a disability and the family, and the criteria, procedures, timelines used to determine:

(i) The degree to which progress toward achieving the outcomes is being made.

(ii) Whether modifications or revisions of the outcomes or services is necessary.

PROGRESS MONITORING: A 9-STEP APPROACH

3. Develop outcomes
4. Write meaningful and measurable objectives
5. Decide possible intervention methods
6. Determine what information should be collected and how this will be done
7. Decide ways of collecting this information and when it will be collected
8. Represent the information
9. Evaluate the information
10. Adjust intervention
11. Communicate progress

Progress Monitoring Cycle * Must be completed every 6 months or more frequently if desired by the parent or other team members.

Beginning with Outcomes

Outcomes – What are they?

- Outcomes are the changes a family wants to see for its child or itself in relation to promoting the child's development
- An outcome can focus on any area of family life – any activities or routines in which families and their children participate

Outcomes are NOT . . .

- long term goal statements
- statements that include measurement strategies as part of the outcome statement
- necessarily a statement about a skill that a child needs to learn
- necessarily related to children's skill deficits or delays

Outcomes can…

- Improve activities and routines
- Promote participation in activities and routines
- Build skills and abilities within typically occurring activities and routines

What makes a great outcome?

- Family identified the outcome
- Reflects something that is important to the family (desired by the family)
- Improves child participation in an activity or routine through adaptation or skill learning opportunities
- Is stated well enough to be broken into objectives

Objectives as a next step

- Describe meaningful and *measurable* ways of "bridging the gap" between the outcome and what is happening now
- Describe reflections about what activities may be necessary for the outcome to be achieved

Objectives Do NOT

- Necessarily describe the teaching methods used to address the objective

Objectives are the "What?" - Methods are the "How?"

Progress Monitoring: Decisions To Be Made

- What information will be collected?
  - As determined by IFSP outcomes
  - Which objectives will you collect information about at this time?
- How will the information be collected? What forms will be used to record the information?
  - Keep them simple
  - Keep them reasonable
- Where will the information be collected?
  - Settings (the child's home, play group, child care, etc.)
  - Situations – naturally occurring routines (during feeding, bath time, etc.)
- How often will the information be collected?

- Who will collect the information?
    - Early Intervention Staff (e.g., therapist, special instructor, etc.)
    - Other people:
        - Parent or caregiver
        - Child care worker
        - Other

Examples of ways to collect information for progress monitoring

- Structured Interviews or Surveys: For very young children, often the most valuable information is learned through interviews with family members. Caregiver-completed surveys can often help give information that can be "followed up" in an interview.

  EXAMPLE**:** *Nakisha's Sensory Profile showed over-responsiveness to sensory stimuli. During the interview, her mom reported about activities that were impacted, Nakisha's dislike for bath time and the limited range of foods that Nakisha is willing to eat.*

- Observation: Seeing the child in a variety of naturally occurring routines and multiple settings provides valuable insight into typical performance.

  EXAMPLE**:** *Dustin was observed both at home and at the child care center eating breakfast. At home he ate with verbal prompts, while at the child care center, he ate only when Miss Stacey helped him with hand over hand assistance.*

- Photographs, Videotapes or Audiotapes: Taken over time, showing the child engaged in activity that demonstrates the work toward the desired outcome.

  EXAMPLE**:** *Angel was videotaped in March as he was crawling to play with his dad, and in August, he was videotaped as he was taking his first steps toward his mom.*

- Rating Scales and Assessment Checklists: A list of behaviors to record presence/ absence or score on a scale.

  EXAMPLE: *Motor Checklist, Developmental Checklist*

- Anecdotal Records: A brief, factual account of unanticipated behavior used to record information about a single event involving a child (the event being selected because it focuses on certain skills or behaviors).

  EXAMPLE: *Billy asked his mother for "more" milk by signing "more" at lunch. (Billy at kitchen table in high chair, 11:30 a.m. 10/05/06)*

- Ongoing or Periodic Performance: Samples: Counting the number of times a particular behavior occurs, indicating the number of opportunities the child has to exhibit the skill and the number of times it occurs.

- Permanent Products: Saving and comparing observable, concrete results or products.

  EXAMPLE**:** *The number of scribbles made with a crayon on paper*
  EXAMPLE**:** *Still photographs of child doing various things or of adaptations*

Philadelphia Infant Toddler Early Intervention
Ounce Scale

In Pennsylvania, an authentic, observation based assessment tool called the Ounce is used with infants, toddlers ages birth to 3 years old. The Ounce is part of a systematic assessment effort across early childhood programs in Pennsylvania.

Click on the link below to learn more about using the Ounce.

http://www.pakeys.org/pages/get.aspx?page=Programs_Network

Ounce data is to be submitted online and according to the following timelines:

- **Entry**
  - Must be in Ounce Online within 60 days from child's determination of eligibility
- **Annual**
  - Must be in Ounce Online 60 days prior to the child's annual IFSP
- **Exit**
  - Must be in Ounce Online 60 days prior to the child's anticipated exit from the program
  - Special Notes on Exit Data
    - ❖ Child must have been in the program 6 months
    - ❖ Collect if it has been 6 months or more since the last data collection period
    - ❖ Serves as the entry data for children transitioning to Preschool Early Intervention

Philadelphia Mental Retardation Services
Early Intervention

Visit Contact Sheets (April, 2002

Guidelines for Completing Service Contact Forms

Demographic Information

The completion of the following demographic information is required:
(Please Print all of this Information)

Child's name as it appears on the IFSP
ChildLink #
Date and location of service
Start time
End time
Total minutes of visits
Location of service
Service provider's name with discipline
Agency name
Check off appropriate box to indicate initial visit, missed visit ongoing contact, authorized make up, rescheduled contact or other. (SEE NOTE)

What we did today that addressed the IFSP outcomes

This section might include comments about:

A. Who participated in the session and how they were involved; e.g. mom, siblings other relatives, daycare provider, playmates, family friend, etc.

B. The discussion with the family/caregiver regarding how the child has been doing since the last visit, including any concerns of the family/caregiver related to the child's progress as it relates to the IFSP outcomes.

C. How the environment influences the desired outcome.

D. How the activity relates to the daily routine of the child and family.

E. If changes are being suggested in the IFSP or service delivery staff, they should be indicated here.

F. If parents express concerns or make other requests (regarding services), they should be indicated here.

_____

**NOTE:*
Authorized make up visit: Is defined as authorized on IFSP
Missed visit: Is defined when service provider goes to site for intervention and the child/family is not available for services (list under 'other' on the service contact form).
Rescheduled Visit: A visit replacing a missed visit that does not require an addendum because it fits within the parameters outlined on page 6 of the IFSP.

Follow-up Activities/Suggestions

The following information might be included in this section:

1. Activities that are functionally and developmentally appropriate for the child
2. Activities that relate to the desired outcomes and goals documented in the Intervention Plan section of the IFSP.
3. Suggestions that provide opportunities for the practice of existing skills as they occur throughout the child's day, using existing items in the home.
4. Activities to build upon mastered skills to develop new skills.
5. Additional resources provided to family; e.g. Therapy Skill Builders Activity Sheets, Help At Home Activity Sheets, adaptive toys and equipment, etc.

Note: Suggestions should be written using family friendly language and reflect the culture and beliefs of the family.

Service Provider Follow-up

The following information may be included in this section:

1. Suggestions for additional assessment or evaluation (include reason)
2. Equipment needs
3. Parent/family resource needs
4. Requests for additional or updated information pertaining to the child; e.g., medical reports, external evaluations, etc.
5. Changes in family status that may have an impact on current service delivery.

6. Any plans to converse with other service providers regarding the child's outcomes and how they can be supported.

Bottom section of Contact Form

1. Next visit/Appointment

    1. Date including month, day and year
    2. Time of visit.
    3. Check AM or PM

Closing the Session

3. Discussion should take place with the parent/family member/caregiver regarding the content of this completed form.

4. When the discussion is completed a copy of the form is given to the parent/family member/caregiver for their review.

- Parent/family member/caregiver prints name followed by signature and telephone number.

- Service provider prints name followed by signature and telephone number.

- When the family member is not present, the caregiver is given the family copy to give to the family or the form is mailed to the family by the provider.

- The family member is encouraged to keep the contact forms for reference.

- A copy of the contact note should be placed in child's confidential file at the provider agency.

- The service provider may retain/obtain a copy of the contact note for themselves when necessary.

- Be sure to identify on contact note for parent the day, date and time of next appointment.

pennsylvania
EARLY INTERVENTION
Serving Children with Developmental Delays

Early Intervention Session Note

Date _____

Optional Local ID # | | | | | | | | | |

Name of Child	Date of Birth	Provider/ Agency	Type of Service	Type of Session	Location of Session
			OT ☐ PT ☐ ST ☐ SI/SE ☐ Other _____	Individual ☐ Group ☐ Other _____	

Update since last session: _____

Outcome(s)/Goals(s) from IFSP/IEP to be addressed:

_____

Routine-Based Activities/Strategies/ Recommendations			Progress Notes
Routines Used: ☐ Play with Objects ☐ Physical Play ☐ Pretend Play ☐ Play with Others ☐ Bath/Hygiene Related ☐ Medical/Comfort ☐ Dressing Related ☐ Eating Related ☐ Computer/TV/Video ☐ Reading with Books ☐ Songs and Rhymes ☐ Writing/Drawing ☐ Community/Family errands ☐ Family Activities ☐ Recreation/Socialization Other:		**Strategies Used:** ☐ Establish Predictable Routines ☐ Increase Opportunities for Child to Practice ☐ Turn Taking ☐ Talk About or Label What You Are doing ☐ Use Physical Gestures as Cues ☐ Wait or Pause for Response ☐ Model or Demonstrate for child ☐ Encourage Child to Imitate ☐ Provide directions for What To Do ☐ Use Visual Supports or Other AT	**Progress (see codes)** **Plans for next session:** **How to collect progress information between sessions:**

Codes for Progress: I-Improvement M-Maintaining Skills SI-Slight Improvement SL: Slight Loss of Skills
Codes for missed session: CA-Child Absent PA-EI Professional Absent NS-No Show S-Act of Nature
BEIS/OCDEL 1/2010

		Other:	

Early Intervention Professional Name/Title: _____ **Parent/Caregiver Signature:** _____

Early Intervention Professional Signature: _____ **Supervisor Signature (if needed):**

Time in: _____ **Time out:** _____ **Units:** _____

Next Session:

Codes for Progress: I-Improvement M-Maintaining Skills SI-Slight Improvement SL: Slight Loss of Skills
Codes for missed session: CA-Child Absent PA-EI Professional Absent NS-No Show S-Act of Nature

Annotated Guidance for Writing Early Intervention Session Notes

Early Intervention Session Notes are to be completed for each session as well as when planned service delivery does not occur. A copy of the session note must be given to the parent/guardian/caregiver at the end of the session. Notes should be written legibly so that they can serve as a resource to the family/caregiver or other team members and service providers.

Each session note will include the following:

Date the service was delivered
Name of the Child receiving the service
Date of Birth of the child
Provider/Agency that delivered the service
Type of Service:

SI/SE – Special Instruction/Special Education
OT – Occupational Therapy
PT – Physical Therapy
ST – Speech Therapy
Other – Please specify (ex. Nursing, Social Work, Audiology, Vision, etc.)

Type of Session:

Individual – Service provided to just one child
Group – Service provided to a child in a group setting
Other – Please specify

Location of Session:

Indicate the location where the service was provided, ex. Home; Early Childhood Classroom, Community setting, Ex. Park, library, store, etc.

Update since last session:

Update information about the child/family related to any changes in medical, educational, social, developmental or other services. Discuss how the activities, strategies and recommendations from previous sessions are actually working. If something isn't effective, discuss adaptations or different routines/strategies for that activity.

Routine-Based Activities/Strategies/Recommendations

Outcome(s)/Goal(s) to be addressed:

Clearly identify which Outcome(s)/Goal(s) is being worked on. Include the Outcome/Goal # number as well as enough text to unmistakably identify the Outcome/Goal.

Routine Used:

Session notes need to contain documentation that services are being delivered within the context of the family's/preschool's routines and in a manner that is functional for the child. Put a check in the box next to each of the routines that may apply.

Play with Objects	Computer/TV/Video
Physical Play	Reading with Books
Pretend Play	Songs and Rhymes
Play with Others	Writing/Drawing
Bath/Hygiene Related	Community/Family errands
Medical/Comfort	Family Activities
Dressing Related	Recreation/Socialization
Eating Related	Other: (please specify)

Description of Activity and Recommendations:

Include how the family member/caregiver was involved in the visit. The note needs to give a clear, unique and detailed description of the visit. Include what was discussed with the

family/caregiver regarding suggested activities/strategies and how to use the particular activity during daily routines. Include specially designed instruction, supplementary aids and program personnel supports, home or program modifications and training and materials used/needed by the family or therapist.

Provide recommendations of activities the parent/caregiver can do between visits to enhance the child's progress and learning. Include information to enhance the family's/caregiver's capacity to assist their child's development and enhance the child's participation in everyday activities. Each recommendation should include a description of the appropriate natural environments or least restrictive environment, including community settings, and family activities and routines.

Strategies Used:

Early Intervention services need to be provided in a manner that will positively impact the family/caregiver's ability to successfully support the child's participation in daily activities. The Early Interventionist should choose a strategy that best matches the learning style of the family/adult caregiver as well as the child. Put a check in the box next to each of the strategies that were used.

Establish Predictable Routines
Increase Opportunities for Child to Practice
Turn Taking
Talk About or Label What You Are Doing
Use Physical Gestures as Cues
Wait or Pause for Response
Model or Demonstrate for Child
Encourage Child to Imitate
Provide Directions for What To Do
Use Visual Supports or Other Assistive Technology (AT)
Other: (please specify)

Progress Notes

Progress:

Codes for Progress: ***I****-Improvement* ***M****-Maintaining Skills* ***SI****-Slight Improvement* ***SL****-Slight loss of Skills*

Information needs to directly reflect the measurement strategy identified under **"**How will we as a team measure progress and collect data for this outcome/goal?" Include what was measured and how it was measured. The note may also contain documentation of progress with the use of suggested activities or strategies during the daily routines. Include information regarding the child's rate of attainment or the child's current skill level, as it relates to the outcome/goal. A review and analysis of this section over time will provide the basis for documentation of progress to support the requirement of ongoing progress monitoring of the outcomes/goals. Data should be presented in a manner that is understandable to parents/caregivers and describe progress in specific, functional terms.

Plans for next session:

This section is to be used to capture the Early Interventionist and the family/caregiver's plans for the next session. This may include activities/routines as well as revisions or modifications to strategies as needed or plans for addressing any lack of progress.

Data collection between sessions:

Where the team determines it necessary, indicate the data/information that will be collected between sessions. This may be data collected for progress monitoring as identified on the Outcome/Goal, as well as, any additional informal data that may be collected by the family or caregiver to help instruct or support service delivery.

Name/Signatures:

Each note should include the name and signature of the Early Intervention Professional who provided the service and the signature of a supervisor if needed. The note must also include a Parent/Caregiver signature.

Times/Units:

The note needs to include the begin time of the session as well as the end time, ex. 9:10 am to 10:13 am. The number of units is calculated by taking the number of minutes and dividing by 15, then rounding down to the nearest whole number, ex. 63÷15=4.2 which would equate to 4 units of service.

Next Session:

The date/time of the next scheduled visit/session.

Missed Session:

When a planned service delivery does not occur (i.e. child or Early Intervention Professional is absent; cancellation without notice or an act of nature) the Early Intervention Professional should document this occurrence, including the reason, in the child's record but should not utilize the NCR version of the session note format.

Additional Guidance

- **Write Objectively**
  Remember that the session note is not about you or your feelings. Make sure that your session notes do not reflect any negative feelings or reactions that you have toward the child, other people or events. Try to avoid terms and descriptions that seem judgmental.
- **Write Clearly**
  Be objectively descriptive. It helps you be precise about what you are describing. Try to avoid vague or general terms. Use proper grammar, and be sure that each sentence has proper sentence structure and sequencing of words so others can understand what you are documenting.
- **Write What You Observe**
  Documenting the following can be useful information: the child's appearance, mannerisms, dress, response to situations or events or to the interaction with you or others, intensity of mood, etc.
- **Write So Others Can Understand**
  Your primary purpose is to explain things so others can understand what you are documenting.
- **Write Using People First Language**
  When describing a child and referencing their disability, identify the child first, then the disability. The disability represents only one of many characteristics of the person.

Some of the suggestions included above are adapted from the following text:
Summers, Nancy (2001). *Fundamentals of Case Management Practice*. Brooks/Cole Thomson Learning, United States

Service Coordinator Notes

What should be included in service coordination case notes?

- A brief summary of the focus of the activity by date
- Tie the statement to the MDE/IFSP
- Clearly state exactly what occurred so that other interested people who were not present (other team members and compliance officials) can understand the activity
    - Answer the *Who*, *What*, *Where*, *Why* and *How long* questions
    - Answer *"how does this activity relate to the IFSP?"*
- Most effective when done with the parent present and with parent input

Sample Service Coordinator Case Note:

Activity: The Service Coordinator met with the family to discuss the parent's concern about a child's future placement at age 3.

Case Note: *02/06/02 Met with Karen **(WHO)** at her home **(WHERE)** for two hours **(HOW LONG)** to discuss her questions **(WHAT)** about where Maria might go to preschool **(WHY).** We talked about Head Start; St. Agnes preschool; Young Children's Day Care Center and the resources available through the All Kids project. Arranged for her to visit each of the programs in the next three weeks. During her visits, she will ask if there is any financial aid available. We will meet again in March to discuss what she felt about the different programs. She will then have more information prior to the transition meeting so that she can make informed decisions. **(HOW)***

Philadelphia County Infant/Toddler Early Intervention

Quarterly Review Process

(Revised April 2009)

Purpose

1. Review/update/discuss the family assessment

2. Facilitate a discussion among the child's early intervention service delivery team about the child's progress over the previous three-month period. Specifically, the team should:
    a) Discuss their satisfaction with the progress and interventions that the child has received,
    b) Strategize various alternatives to reaching the child's IFSP outcomes or identify new outcomes. (*A purposeful focus away from a discussion of services should be emphasized).
    c) Share each service provider's visual representations of the child's progress should with the rest of the team.
    d) ***Discuss and document the locations in the community that were used for early intervention services in the last quarter, so this information can be entered by the service coordinator in EIRS/PELICAN***

3. To discuss the child's continued eligibility for early intervention services and begin planning for the child to exit early intervention if their outcomes have been met and/or they are no longer eligible.

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*Note: An outcome of the Quarterly Review process is that recommendations for changes/additions to services on the IFSP's will grow out of (and be confined to) the Quarterly Review Meeting.

The quarterly review process is:

- A review of what is happening and what has happened (review not just a report).
- A common practice in most professions that has been established to assure quality services
- An opportunity for the team to come together routinely on behalf of the child to review outcomes and progress
- An opportunity to update the family's assessment
- A time to review the child's continued eligibility and/or need for early intervention services

Meeting Logistics

1. The quarterly team meetings will be held in 3, 6, and 9-month intervals and Annually (11 month review) from the date of the initial/annual IFSP. The annual MDE and IFSP will be completed at the 11-month meeting and before the 365th day of service.

2. The Quarterly review process should be discussed with the family at the first visit by the service coordinator and all service providers to prepare them for the fact that they will be noting the progress of their child over this period and giving feedback as to the same.

3. The Early Intervention Plan (IFSP page 10) attached, is now part of the Quarterly Review Form and should be completed at each Quarterly Review Meeting. Each intervention plan page accommodates 2 Outcomes, so the team should plan to use as many pages as necessary to cover all outcomes.

4. Under Reason for Update on the "Intervention Plan Update" form indicate one of the following: 6 month review, annual review, 3 month quarterly, and 9 month quarterly.

5. Any changes to the services will result in an addendum and a new intervention plan, and any changes in the outcomes will result in a change in the intervention plan. The service coordinator should bring a copy of the current IFSP to the quarterly review meeting.

6. If new outcomes are identified or old ones changed the team should then brainstorm methods to reach the new/changed outcome.

7. At the end of the quarterly review meeting, the date of the next meeting should be confirmed/set.

8. Annual MDE and IFSP development will serve as the quarterly review meeting and will occur on the 11th month of the service year to insure that a new IFSP is in place by the 12th month of the service year (or 365th day).

9. Appointment cancellations may result in some of the quarterly assessments being rescheduled in consecutive months (one month after the other) particularly the 9th and 11th month meetings. Every attempt should be made to have a minimum of 3 separate Quarterly Review Meetings as opposed to combining them.
   If the scheduling of the 9th and 11th month meetings become too difficult the 11th month meeting (annual MDE & IFSP) should be prioritized with the expectation that it is completed before the end of the 12th month (365th day).

10. When a child will transition to the 3-5 systems and they have had their transition meeting, the service coordinator from the 3-5 EI program will be invited (by the 0-3 Service Coordinator) to any Quarterly Review Meetings that occur subsequent to the transition meeting.

Meeting Content

Role of the Service Coordinator

1. Although the service coordinator may not facilitate every quarterly review discussion, they should guide the Quarterly Review Process. The responsibilities of the service coordinator are to:
   a. Assure that at every meeting introductions are made and roles are defined
   b. Assure that all members of the team are heard, and
   c. Assure that families are treated as the primary service provider and therefore a member of the team,
   d. (Most likely) assume one of the roles of facilitator or scribe
   e. Bring current IFSP
   f. Insure that the family assessment information is updated.
   g. Insure that the team discuss/reviews the child's ***progress and*** continued eligibility for early intervention services
   h. Request that service providers share the visual representation of the child's progress with the family and the rest of the team
   i. Document the locations in the community that were used for early intervention services in the last quarter, so this information can be entered in EIRS/PELICAN
   j. Confirm the date of the next Quarterly Review Meeting scheduled.

2. The parent and service coordinator will always have a complete and clear/legible copy of the quarterly summary and any individual reviews.

3. The service coordinator will make copies of the complete Quarterly Review Form and mail it to the other service providers after the meeting.

4. The service coordinator will schedule quarterly review meeting in advance (month and week) at the initial IFSP or the annual reviews. In this way, all team members (once assigned) would know the meeting schedule ahead of time, (even if they are only tentative) and could plan their schedules accordingly.

5. The Quarterly Review Meetings will be planned around the service coordinator's quarterly monitoring meetings with the family. The service coordinators will arrange their quarterly monitoring visits to coincide with the family's IFSP dates so that they coincide with the 6-month and annual reviews (and therefore the quarterly reviews).

6. The service coordinators will schedule the meetings during the time that one of the child's early intervention service provider visit are being provided in the home, to insure that at least 3 members of the service delivery team (parent, service coordinator, scheduled service provider) will be present for the review.

7. The service coordinator will notify the other members of the team in advance as to the exact date of the meeting. They should already be aware of the month and week of all of the review meetings.

8. The Service Coordinator will invite the MAWA Service Coordinator to Quarterly review Meetings, as appropriate.

9. The Quarterly Review Meeting should not go forward without the 0-3 Service Coordinator present.
   ChildLink will make every effort to:
   a. Arrange for the supervisor to fill in on a planned Quarterly Review Meeting if the Service Coordinator is absent.
   b. Give advance notice if the meeting must be cancelled.

10. If the service provider is at the home and the meeting is cancelled by the service coordination they should proceed to conduct an individual review using the Quarterly Review Single Service Contact Form. If the Service Coordinator calls/leaves a message to say that they cannot attend the meeting their supervisor should be notified and/or Sara Molina Robinson (215-731-2139).

11. It is the County's expectation that all quarterly review meetings will be scheduled, held and documented. The quarterly review meeting can occur via a telephone meeting if one or more of the team members cannot be present for the face-to-face meeting. Conference calling should be used to enable the parent, a service provider and the service coordinator to discuss the child's progress and continued need for early intervention services.

12. When a quarterly review meeting will take the form of a planned conference call, the service coordinator should insure that all members of the team who will be participating should have a copy of the following documentation so each member can be fully included in the discussion.

Documentation needs by the team during the Quarterly review Meeting

- Needed Documentation for the teams:
- Blank quarterly review forms
- Completed single service provider QR from (for service providers not at meeting)
- Service Provider progress monitoring charts/graphs
- The child's IFSP
- Copies of the services and supports plans being used for the child

Role of the Service Provider

1. It is everyone's responsibility to redirect the discussion when it focuses on services prematurely.

2. The quarterly review from has been reproduced on 3-part NCR paper with a copy each for the Service Coordinator and the parent. Other therapists should complete a contact note for the meeting and indicate that it was a Quarterly Review.

3. At the review meeting, team members present will jointly conduct the Quarterly review discussion and complete the Quarterly Review Form. The discussion should not be conducted as though filling out a questionnaire.

4. In discussing progress this is the time for service providers to share the visual representations of the child's progress with the remainder of the team.

5. When progress has been discussed and the child has met their outcomes and/or service providers suspect that the child may no longer be eligible, a new evaluation can be done by the team with specific focus on the developmental areas where there were concerns.

6. If a team member (service provider) cannot come to the Quarterly Review Meeting, they will conduct an individual service review with the family and send the service coordinator a clear copy of the Quarterly Review Form/Single Service Provider and the visual representation of the Progress Monitoring being done (charts, graphs, etc.) before the scheduled meeting so that it can be taken to the quarterly review meeting. The Quarterly Review Form will be reproduced on 3-part NCR paper (one for family and service provider). The Service Coordinator should receive the top copy so that it is legible once reproduced for other providers.

7. The Quarterly Review Form will serve as the contact note for the service provider for this meeting.

8. The service providers should be sure to ***document the locations in the community that were used for early intervention services in the last quarter, so this information can be entered by the service coordinator in EIRS/PELICAN***

Meeting Order

1. Introductions
2. Define who will facilitate and who will be the scribe
3. Review/Update the Family Assessment and needs.
4. The discussion starts with the outcomes identified.
5. Team members are then asked to describe the child's progress on outcomes with visual representation of the progress shared with the team.
6. If changes are recommended, methods to achieve new (or changed) outcomes are brainstormed by the group.
7. A review of who is the most appropriate service provider to address the outcome/strategy is at the very end and follows the brainstorming of all ways to reach the outcomes.
8. If outcomes have been met and/or the team suspects that the child is no longer eligible, a new evaluation can be done by the team with specific focus on the developmental areas where there were concerns.
9. Preparation should be made by the team to connect the family with other (non-EI) supports if there are continued concerns and begin the process with the family (transition process) for exiting the system. If parents are not in agreement with the decision, they should be informed of the parent's rights, which include the right to receive an independent evaluation.

Supervision & Monitoring of Quarterly Review Process

1. It will be critical for agency supervisors and administrators to review and understand the supervisory aspects of the quarterly review process and what will need to be done at the agency level to reinforce the guidelines and process.

2. Agency supervisors are also expected to review the evaluation and notes for any child who is found eligible by informed clinical opinion. The review should focus on:
    a. If the child is no longer eligible by developmental scores, is there non-early intervention service that should/can address concerns that the team may have?
    b. Are the concerns being expressed developmentally typical for the child's chronological age?
    c. Has the team considered using the at-risk-tracking to monitor a child who is not longer eligible but for whom there are residual concerns expressed?
    d. Is the documentation of ICO appropriate and complete?

3. Copies of all forms used for quarterly reviews, and progress-monitoring tools for every child should be in their file or correspondence to the ChildLink Service Coordinator requesting the same.

4. The county will expect agencies to write/revise and submit agency policies and procedures by July 1, 2007 regarding the use of the new forms with their staff and contractors. The policy should be included in the orientation, supervision and ongoing agency training to support these practices.

Billing Quarterly Review Activities

1. Quarterly Review Billing Instructions: IFSP Quarterly Review Activities are progress monitoring and are therefore considered service. Additionally, the QR meetings usually take place within the context of a service visit.

    a. All direct time participating in IFSP Quarterly Reviews eligible for Infant Toddler Family (ITF) Waiver funding can be billed to the ITF Waiver
    b. All direct time participating in IFSP Quarterly Reviews eligible for Medical Assistance funding can be billed to MA.
    c. If more than one service provider attends the IFSP Quarterly Review meeting (excluding the service coordinator) only one provider should bill MA. The other providers attending the IFSP Quarterly Review meeting should bill MRS for the service visit. If the child is in the ITF waiver both service providers can put the time in for payment by the waiver.
    d. Direct time spent with the child and family during a routine service visit, reviewing the child's progress is considered service. This includes the time spent by a single service provider reviewing progress in preparation for a scheduled quarterly review meeting that they may not be attending. This activity should be billed and coded as service delivery to the appropriate funding source
    e. Any indirect time, including participating in a Quarterly Review by telephone conference, is not billable.

County Logistics

1. The implementation date for using the revised forms is May 1, 2007. This means that the new Quarterly Review Form should be in use starting May 1, 2007, for children who have a QRM (3rd, 6th, 9th or 11th month meeting). After May 1, 2007
2. The IFSP intervention plan page being used by Philadelphia County for QR (in conjunction with our QR cover/signature page) includes boxes to indicate which quarter of service is being reviewed..
3. The County will monitor the implementation of this process through State and County compliance monitoring.

Revised April 2009

Philadelphia County Infant/Toddler Early Intervention
Quarterly Review Meeting Summary Cover Page
(used during the Quarterly Review Team Meeting)

Child's Name_____ **ChildLink#**_____

Today's Date_____ **Location of Service**_____

Start Time:_____ **End Time:** _____ **Date of IFSP**_____

Total Number of Pages in this Review_____ **Quarter (✓one)__3 mo _____6 mo ___9 mo**

___annual

DIRECTIONS: Also complete the attached State Commonwealth's Intervention Plan Update Form (IFSP page 10) at each quarterly review meeting.

.....

Are There Challenges To Address Outcomes in Natural Environment? ☐ Yes, ☐ No: If yes indicate why and list suggested strategies: _____

_____

_____

Identify Community Service Location used in previous quarter. _____

Change In Service Needed? ☐ Yes, ☐ No: If yes indicate why (also complete addendum for IFSP):

_____

_____

_____

We are satisfied that we have completed all outcomes ☐ yes ☐ no (If yes identify exit plan below):

Exit Plan: _____

_____

Comments: _____

.....

☐ Service Coordinator Support Plan Reviewed and Discussed

Signatures	**Role/Agency (if personnel)**	**Telephone#**
	Parent	
	Service Coordinator/ChildLink	

Date of Next Quarterly Review Meeting: _____

Philadelphia County Infant Toddler Early Intervention

Quarterly Review Form Single Service Provider Contact Form

(for Single Service Provider Quarterly Review)

Child's Name_____ ChildLink#_____

Today's Date_____ Location of Service_____

Start Time: ___End Time: ____ Date of IFSP_____

Discipline_____ Quarter (check one) __3 mo ___6 mo___9 mo__annual

Total Number of Pages in this Review ____

OUTCOME: _____

Status:

- ❑ We still need to work on Outcome. We will continue what we have been doing **(Continued)**
- ❑ We still need to work on Outcome. We will discuss new ways to get there (identify below) **(Changed)**
- ❑ The situation has changed, we no longer need to work on this outcome **(Cancelled)**
- ❑ We are satisfied that we have reached this outcome **(Finished)**
- ❑ Other: _____

Progress that family and service provider have identified (include visual representation of progress monitoring):

_____

_____

New Strategies to Work on this Outcome:_____

_____

_____

Changes/Strategies Recommended to others on the team (regarding new issues)_____

_____

_____

We are satisfied that this outcome has been meet ☐Yes ☐No (if yes identify exit plan)

Comments:_____

_____

Community Locations used in the previous Quarter of Services: _____

_____

Signature of Parent/Family Member	Relationship	Telephone #
Signature of Person Providing Service	Agency	Telephone #

Quarterly Service Review Continued

Discipline _____	Child's Name _____ Page __ of ___
ChildLink#_____	Today's Date _____

OUTCOME: _____

Status:

- ❑ We still need to work on Outcome. We will continue what we have been doing **(Continued)**
- ❑ We still need to work on Outcome. We will discuss new ways to get there (identify below) **(Changed)**
- ❑ The situation has changed, we no longer need to work on this outcome **(Cancelled)**
- ❑ We are satisfied that we have reached this outcome **(Finished)**
- ❑ Other: _____

Progress that family and service provider have identified (include visual representation of progress monitoring):_____

_____

New Strategies to Work on this Outcome:_____

_____

Changes/Strategies Recommended to others on the team (regarding new issues)_____

_____

We are satisfied that this outcome has been meet ☐Yes ☐No (if yes identify exit plan)
Comments: _____

_____

.....

OUTCOME: _____

Status:

- ❑ We still need to work on Outcome. We will continue what we have been doing **(Continued)**
- ❑ We still need to work on Outcome. We will discuss new ways to get there (identify below) **(Changed)**
- ❑ The situation has changed, we no longer need to work on this outcome **(Cancelled)**
- ❑ We are satisfied that we have reached this outcome **(Finished)**
- ❑ Other: _____

Progress that family and service provider have identified (include visual representation of progress monitoring):_____

_____

New Strategies to Work on this Outcome:_____

_____

_____

Changes/Strategies Recommended to others on the team (regarding new issues)_____

_____

_____

We are satisfied that this outcome has been meet ☐Yes ☐No (if yes identify exit plan)
Comments: _____

EARLY INTERVENTION REPORTABLE INCIDENT FORM

DATE OF REPORT:	TIME: AM/PM

Office of Child Development and Early Learning:
Fax Number: 717-346-9330

NAME OF INFANT OR TODDLER (LAST, FIRST, M.I.)			PROVIDER NAME:
ADDRESS:			ADDRESS:
CITY	STATE	ZIP CODE	CITY STATE ZIP CODE
PHONE:	COUNTY OF REGISTRATION:		PHONE:
INFANT OR TODDLER EIRS NUMBER:			BASE SERVICE UNIT NUMBER
DATE OF BIRTH: **M M D D Y Y Y Y** _ _	SEX: ☐ MALE ☐ FEMALE		DATE THE INCIDENT OCCURRED OR WAS RECOGNIZED/DISCOVERED: **M M D D Y Y Y Y** _ _
CLASSIFICATION OF INCIDENT:			TIME THE INCIDENT OCCURRED OR WAS RECOGNIZED/DISCOVERED: AM/PM

DESCRIBE THE TYPE OF INCIDENT AND THE ACTION(S) TAKEN TO ADDRESS THE INFANT/TODDLER'S HEALTH AND SAFETY AND THE RESPONSE TO THE INCIDENT, WHAT HAPPENED, IF A MEDICAL REFERRAL WAS NECESSARY (PLEASE LIST), DOCUMENT ALL OTHER REPORTS OR NOTIFICATIONS AND ANY CIRCUMSTANCES WHICH MAY HAVE PRECIPITATED THE INCIDENT: (INCLUDE ACTION TAKEN RELATED TO DISPOSITION OF EMPLOYEE.) ATTACH ADDITIONAL SHEETS IF NECESSARY.

NAME OF PERSON RECEIVING REPORT:	TITLE:	PHONE:

ANNOUNCEMENT: EI-08 #02
OFFICE OF CHILD DEVELOPMENT AND EARLY LEARNING
BUREAU OF EARLY INTERVENTION SERVICES

ISSUE DATE: March 7, 2008
EFFECTIVE DATE: March 7, 2008

SUBJECT:	**Reportable Incidents**
TO:	**County MH/MR Administrators, MR Coordinators and Early Intervention Coordinators**
FROM:	**Harriet Dichter** **Deputy Secretary, Office of Child Development and Early Learning**

PURPOSE:

The purpose of this announcement is to specify the guidelines for mandated reporters and to establish uniform procedures for reporting incidences involving children receiving Early Intervention (EI) to the Office of Child Development and Early Learning (OCDEL).

BACKGROUND:

All EI providers and subcontracted providers, County EI Programs and the OCDEL are partners in the effort to ensure the health and safety of infants and toddlers receiving EI services.

DISCUSSION:

Mandated reporters are defined as persons who, in the course of their employment, occupation, or practice of a profession, come into contact with children and are required to report when they suspect child abuse. This includes when a person has reasonable cause to suspect on the basis of medical, professional, or other training and experience that a child is a victim of child abuse.

Reports of suspected child abuse must be made to **ChildLine**, which is the **Pennsylvania Statewide Child Abuse Hotline, at (800) 932-0313.** Reports meeting criteria of suspected child abuse are then forwarded to the appropriate county children and youth agency for investigation. The county children and youth agency has sole responsibility for investigating reports of suspected child abuse.

Reports are to be made regardless of the relationship between the alleged perpetrator and the child. The requirement of reporting regardless of the relationship between the child and the alleged perpetrator was a change in 2007. Previously, mandated reporters were only required to report when the alleged perpetrator met the criteria within the Child Protective Services Law (CPSL). If the alleged perpetrator does not meet the definition of a CPSL perpetrator, the report will be forwarded by ChildLine to the appropriate law enforcement agency for investigation.

The term child abuse is defined as any of the following when committed upon a child less than 18 years of age:

1. Any recent act or failure to act which causes non-accidental serious physical injury.
2. An act or failure to act which causes non-accidental serious mental injury, sexual abuse or sexual exploitation.
3. Any recent act, series of such acts or failures to act which creates an imminent risk of serious physical injury, sexual abuse or sexual exploitation.

4. Serious physical neglect which endangers a child's life or development or impairs the child's functioning.

For purposes of the definitions above, recent act is defined as an act committed within the preceding two years. Further explanations of these terms can be found in the Child Protective Services Law (Title 23 Pa. C. S., Chapter 63) at § 6303.

A mandated reporter who makes a report of suspected child abuse is entitled to the final status of the child abuse report following the investigation, whether it be indicated, founded or unfounded, and any services provided, arranged for or to be provided by the county children and youth agency to protect the child.

In addition to reporting to ChildLine, the County EI Program shall be notified within 24 hours of observation or knowledge of *suspected abuse alleged to have been committed by an EI service provider*. The attached EI Reportable Incident form shall be used to notify the County EI Program. County EI Programs shall forward a copy of EI Reportable Incident form to the OCDEL via facsimile at **717-346-9330** within 24 hours of receipt of the form. The sender of the incident report shall call the County EI Program or OCDEL at the number listed in this announcement prior to faxing the report to assure confidentially of the information.

Effective with the date of this announcement:

1. For infants and toddlers that receive **both** EI services and mental retardation services, a report should be submitted to the OCDEL, using the attached EI Reportable Incident form, **and** to the Office of Developmental Programs through the Home and Community Services Information System (HCSIS) according to instructions contained in Incident Management Bulletin #6000-04-01.

2. OMR Bulletin #6000-04-01, titled Incident Management, no longer applies to infants and toddlers enrolled **only** in EI.

Reportable Incident Investigation

EI provider agencies have a responsibility for investigating reportable incidents alleged to involve staff employed or under contract with the provider agency. County EI Programs are responsible for investigating reportable incidents alleged to involve independent providers who are not affliated with an agency. Reportable incident report investigations will be conducted in a manner so as not to interfere with the local children and couth services agency and/or law enforcement agency investigation activities. Investigation training is the responsibility of the provider and/or County EI Program. The timelines and procedures are the same regardless whether the investigation is completed by the EI provider agency or the County EI Program.

County EI Programs and provider agencies shall have policies and procedures in place that ensure the safety of infants and toddlers receiving EI services during an incident investigation of an EI service provider. These policies and procedures must include disciplinary action or removal of the service provider when warranted.

Incident Report investigations shall be initiated by the EI provider agency or County EI Program within 24 hours of the receipt of the EI Reportable Incident form. Incident Report investigations shall be concluded within 10 business days of initiation of the investigation unless mitigating circumstances exist, such as a police investigation or county children and youth agency investigation, that prevent the completion of the incident investigation within this time frame. Extensions of the timeframes for conclusion of an incident investigation can be requested if the investigation cannot be completed within 10 days of the report of the incident. County EI Programs shall contact the OCDEL to request an extension of the timeframes for conclusion of an investigation.

An investigation report shall include:

- a copy of the EI Reportable Incident form,
- the date on which the investigation began,
- evidence:
  - list of all persons interviewed, including date and time
  - list of statements taken from persons interviewed
  - analysis
  - conclusion
  - recommendations
- the status of the alleged perpetrator,
- a description of the steps taken by the provider or the County EI Program in response to the incident as well as the conclusion reached as a result of the investigation, [The alleged perpetrator should not be permitted to work with the infant/toddler that he/she is alleged to have abused (or any child, when the allegation warrants such action) pending the outcome of the investigation]
- the date the investigation was concluded.

Provider agencies shall forward the investigation report to the County EI Programs via fascimile within 5 business days of completion of the report. County EI Programs are responsible for reviewing the provider agency's investigation report and approving the report or requesting additional information within 5 business days of receipt of the provider's report. County EI Program shall also forward a copy of the incident report and provider's investigation to the OCDEL upon the county's approval of the invesigation report.

An investigation report completed by the County EI Program for *independent providers not affliated with an agency*, shall be forwarded to OCDEL via fascimile within 5 business days of completion of the report. The OCDEL will review the county's investigation report, approve the report and notify the county in writing within 5 business days of that approval. If the OCDEL determines that additional information is needed, a request for additional information will be forwarded to the County EI Program within 5 business days of receipt of the report. If the additional information is satisfactory, the OCDEL will notify the county within 5 business days of approval of the additional information.

CONTACT INFORMATION

Office of Child Development and Early Learning:
Fax Number: 717-346-9330
Phone Number: 717-265-8901

NEXT STEPS:

1. Infant/Toddler Early Intervention Program administration should distribute this announcement to all Early Intervention staff for immediate implementation.
2. This announcement replaces EI-07 #11, titled Reporting and Investigating Alleged Child Abuse.

Attachment

Philadelphia County Infant/Toddler Early Intervention
Exit Strategy for Children Prior to Age 3

Policy

There are a number of children and families who have benefited from Part C early intervention services and have either reached developmental milestones, have successfully completed their IFSP outcomes, are no longer eligible and/or are no longer in need of services prior to age three. This will primarily be determined through quarterly review, an annual evaluation or through progress monitoring which requires the ongoing collection of data, ongoing assessment of services, interventions and progress and (at minimum) the quarterly reporting and examination of progress by the team. Determination or re-determination for early intervention services does not only need to occur during a 6-month or annual review. Using the processes identified above, it is an ongoing activity conducted in conjunction with the ongoing monitoring of progress towards achieving IFSP outcomes.

Process

1. The team should examine progress monitoring data to determine if the current outcomes have been accomplished, the outcomes are developmentally appropriate, and if the child has made progress.

2. When it appears that the child has reached the IFSP outcomes and may no longer need early intervention services, the child can be exited from early intervention, if there is agreement among the full team which includes the child's parents.

3. The team can also administer an assessment (at any point during the service delivery period) to determine if the child continues to have delays in the developmental domains initially identified or in other areas of development. If there are no delays that meet the criteria for eligibility, the child should be exited.

4. This comprehensive review of outcomes, progress, observation, parent feedback and updated assessment will give the team adequate information to determine if the child remains eligible and/or whether the child is ready to exit Part C early intervention.

5. If the child no longer meets eligibility criteria for EI service, the transition planning process begins to exit EI services. This includes the option to track and monitor the child and/or or transition (connect) the family to other community supports or services they may need once they are no longer receiving early intervention.

Procedures

A. Determination: All teams will follow requirements related to eligibility determination as outlined in PA early intervention regulations (4226.22, 4226.61). If the family disagrees with the determination, the team should review, discuss and make available to the family all appropriate procedural safeguards. If the family requests a due process hearing, and requests it, the team will conduct an independent evaluation at no cost to the family to assist in the resolution of the disagreement. The service coordination will document this discussion and the completion of the Parents Rights Agreement. If the teams determine eligibility based on informed clinical opinion, the team should pay special attention to early intervention regulation 4226.22 (b) and follow all of the requirements for documenting the qualitative and quantitative information that was the basis for the decision.

Exit Strategy for Children Prior to Age 3

In determining eligibility, the following four areas are the primary categories for consideration in exiting children from the early intervention system:

1. IFSP outcomes are met and the child is no longer eligible (by developmental scores). If the child also does not meet eligibility criteria for informed clinical opinion or pre-existing medical condition, transition planning should begin to **exit the child from early intervention services**.

   For example: Child has met their outcomes and is currently age appropriate in all developmental areas.

2. IFSP outcomes are not met, however the child is no longer eligible (according to developmental scores). If the child also does not meet eligibility criteria for informed clinical opinion or pre-existing medical condition, transition planning should begin to **exit the child from EI services**. This transition plan may need to be more detailed and the team should discuss the following during the transition planning:

   a. **Identify Non-EI Services**: Team discusses other 'non-EI' resources, activities and/or services in the community that families can be connected to (before/in anticipation of closure) for support. Who can best help the family accomplish this outcome?
   b. **Discussion with Parents**: Are the parents/caregivers comfortable that they know enough strategies to continue working on this outcome once the child has exited the program? Are the parents comfortable continuing to work on this outcome without consultation from the EI team and let the child be followed in at-risk tracking (if eligible for tracking)? If yes, discontinue the outcome.

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3. IFSP outcomes are not met and the child continues to be eligible (based on developmental scores, informed clinical opinion, or pre-existing medical condition): Child **remains in early intervention service.**

4. IFSP outcomes are met and the child continues to be eligible: One of the reasons that this may occur is because the child has a disability or pre-existing condition that carries with it a high probability for developmental delay in the future, or the child is determined eligible by informed clinical opinion. **Child may remain in early intervention services**. However, if team cannot identify new IFSP outcomes (that should be addressed in the early intervention system), **exit the child from early intervention services**. In this instance, we must keep in mind that the parents are a part of the team and are in agreement with the plan to exit. Before exiting the following items should be considered:

    a. **Discuss if there is a need for additional outcomes**: EI service(s) are based on IFSP outcomes; therefore, there needs to be at least one outcome in order to receive any level of EI service(s). Team should discuss if there are other functional (participatory) outcomes that can/should be added. If not, exit the child (Also see B below). Teams should

    b. Make sure in identifying additional outcomes that the early intervention system is the appropriate resource to address these concerns. Care should be taken not to form goals around issues that may be of concern but is more appropriately addressed thru other service systems (i.e. behavioral health, or medical)

Review Services Continuation: If the team can not identifying new IFSP outcomes, they may want to explore if the family would like to discontinue EI services with the understanding that they may re-enter the early intervention system (receive a MDE) in the future, if they have concerns. (See D, E and transition planning process below)

    c. **Identify Non-EI Services**: Team discusses other 'non-EI' resources, activities and/or services in the community that families can connect with (before/in anticipation of closure) for support or to address the non-early intervention concerns that the team may have.

    At-Risk Tracking: Explore at-risk tracking with the family (early intervention regulations 4226.25). Team should explain to the family that they might re-enter the early intervention system (be re-evaluated) if they wish in the future.

B. Transition Planning: The team should begin transition planning as soon as possible for any child who will be exiting early intervention prior to age 3. The transition planning process should be similar to planning for a child who is transitioning at age 3.There are 15 days to pull together a transition meeting and 30 days (from the time it was determined that the child was no longer eligible) to exit them from Early Intervention.

1. Teams should complete the transition plan form to document this process.

2. The team will make every effort to ensure that the parent understands the reasons for exiting EI service(s). This is best done by recounting the reasons for exiting at the time the parent's rights agreement form is reviewed and signed by the family and the IFSP addendum is prepared to exit the EI service(s) from the IFSP. Notification to the parent must be in their native language.

3. The service coordinator shall facilitate a planning meeting with the team, including the family, as soon as possible, but no later than 15 days after the determination has been made that the child is no longer eligible or in need of Early Intervention services.

4. The planning meeting should address concerns and issues the family may have related to child development or other supports for which the child and family may need assistance.

5. In addition to those children whose initial reason for referral to the Early Intervention program was related to the five at-risk categories outlined in 4226.25, families may be referred for tracking services. Teams should complete the transition plan form for these children as well.

6. The team should document the following on the transition plan form: discussions from this meeting, follow-up activities, and dates for completion of such activities. The transition plan form and signed by the parent and the service coordinator.

7. All activities discussed at the planning meeting will be completed within 30 days from the determination that the child was no longer in need of/or eligible for Early Intervention services.

8. A discharge letter will be sent to each family that includes the following information:

    a. The reason for exiting.

    b. The list of resources that the family has been connected with and contact information for those supports.

    c. An assurance that the family can re-enter the system (receive a multi-disciplinary evaluation) if at any time the child's development is of concern.

    d. The at-risk tracking process will also be documented in the letter, if the team will recommend at-risk tracking for this child.