

## **PowerPoint Notes from Quality Services - Service Planning Webinar**

The following are presenter notes. The following is not a transcript of the webinar.

### **Slide 1**

Hello everyone, welcome to Webinar # 4 in the Quality Assurance series. This webinar is about service planning

### **Slide 2**

Let's begin with a recap of the ECI processes.

You begin collecting information about a child and family at referral. There are several different ways you may go about increasing your understanding of a child and family. You may call the family, do a face-to-face visit, complete an eco map, review medical information. Any or all of these methods can help you determine who should be on the evaluation team.

Then you complete the evaluation to determine eligibility. Or the child may be referred with a qualifying diagnosis. Regardless of the way eligibility is determined, the next step in the process is critical.

**You have to determine that there is a need for services, including case management.** This step in the process is the comprehensive needs assessment. If you missed Webinar 3, you will want to watch the archive as it has very valuable information about this process. It includes information about conducting the comprehensive needs assessment, and using that information to develop outcomes. The outcomes developed must connect back to the needs of the child and family, and the priorities of the family in meeting those needs, established as a result of the evaluation and assessment processes.

A brief reminder here, the assessment process must be conducted using a tool such as the IFSP form or a Routine's Based Interview. The assessment must also include an interview with family members if they give their consent.

### **Slide 3**

We've talked about making the connections between the referral, evaluation and assessment to identify needs, and the development of outcomes. The next connection we need to make is between the evaluation and assessment processes and the services we plan on the IFSP. Here is the rule that supports this requirement. There is another step in the process that must occur before you specify the services that will be needed to meet the outcomes. You will need to develop specific procedures. On the next slide let's take a look at a sample of two outcomes that were submitted to us, and then some procedures.

### **Slide 4**

Here are two outcomes for a child, both on the same IFSP. Outcome 1: *Child* to imitate consonant and vowel sounds, at least 4 times a day. Outcome 2: *Child* to

identify one familiar object during play and daily routines. On the next slide we will show you two procedures. If you were going to apply the procedures to one of these outcomes, which one would it be?

### **Slide 5**

Here are the procedures that were provided:

1. ECI staff to provide activities and strategies to increase language development, and
2. Parents will follow through with the strategies

Let's go back and look at the 2 outcomes so you can determine where to apply the procedures. (Go back one slide briefly) In the actual IFSP these procedures were applied to both outcomes. Unfortunately, they are so broad that there is no helpful information here, and there is no individualization of planning.

The IFSP is intended to be a working document, a plan for achieving the outcomes. The outcomes are also broad, but we believe that more specific procedures could be developed. The IFSP form has cues to help you. Those cues are to help you remember the Instructions for developing Procedures. Let's take a look at those Instructions

### **Slide 6**

Here is the information on the IFSP required elements form. The left column cites the required element with prompts to guide you as you develop the procedures. The prompts are to help you remember the information included in the right column, the instructions for completing this section of the IFSP.

Following these detailed instructions will help you create an IFSP that is a functional, working document. This is **really important** for the initial IFSP because it can help parents understand what the services will look like and what to expect. Many parents come to us without really understanding what ECI services look like and can feel overwhelmed.

In the following slides we will be expanding on the instructions in the required elements.

### **Slide 7**

The bullets on this slide come from information from the ECTA Center and national experts in Part C early intervention. They are things to consider when you develop your procedures. You may not need to include all of them, but select ones that will make the procedures specific to the outcome to be achieved. That's how you make them meaningful and useful for the individual needs of that child and family.

As we go through the next slides we'll look at each of these individually. First on the list: Identify what the family is already doing to help their child. In completing your comprehensive needs assessment you probably identified routines involving the child that are difficult or stressful for the family, and how they are trying to resolve the stress. Documenting what the family is already doing for their child validates the participation of

the family in supporting their child's developmental progress. It also identifies them as the ones who know their child best. I want to be clear, though, that it is not a requirement to identify what the parent will do in the procedures. The family may not have realized that their child needed help in certain areas, or what they are trying isn't working.

### **Slide 8**

The next consideration on the list is break down the outcome - To build something sometimes you have to break it down. The bulleted item on the slide identifies the outcome we are going to break down. John will sit on the floor without support to play with toys for 10 minutes on three days in a week. The criteria for success is clear enough to pass the "grandma" test. Anyone reading this outcome will have a clear understanding of what is expected. What are the skills that John will need to master to achieve this outcome? Here are three suggestions:

1. John will sit balanced on the floor using his hands
2. John will regain balance after leaning over, and
3. John will regain balance after reaching to get a toy.

### **Slide 9**

The next consideration is for you to identify activities, routines, or settings for learning activities. The first line is an abbreviated outcome to remind us what we are working toward: John will have the ability to sit without support to play with toys. The outcome developed did not specify a routine but if it did, our procedures might identify other routines for practice. In this instance we identified three routines: playtime, snack time, and diaper changing time. Playtime could occur both indoors and out, giving John an opportunity to practice balance sitting on a variety of surfaces, such as a hard floor, carpet, grass, or a blanket on the ground. We've identified more than one setting where the playtime routine might take place.

### **Slide 10**

The next consideration is how to use the strengths John has to support his learning. We know from our comprehensive needs assessment that John is interested in a variety of toys, and we know that he can indicate his choices by holding his hand out for the toys he wants.

### **Slide 11**

For some outcomes, resources, supports, or equipment may be needed. We need to preserve John's natural environment, so talk with the family about what is already in the home.

For John, to achieve his outcome of sitting without support, he will first need to be able to sit with support, so items such as pillows, rolled towels, or an inflated beach ball might be used. As John builds his trunk strength and those supports are withdrawn, John may topple over some times, so mats or blankets for soft landings may be needed.

Our outcome is for John to play with toys while sitting, so using John's toys ensures that those toys are always available. Families can also make toys for their children using everyday household items such as paper towel rolls, various size fruit and vegetable cans with smooth edges, or spoons and pots and pans. Day care centers often offer "Make it and Take it" workshops, or ideas for homemade toys are available online.

### **Slide 12**

The last consideration for helping John achieve his outcome: motivators. John is an individual, so you will need to explore with the family the things that he likes, the things that will motivate him. We've listed some possibilities here for you such as people and things that are favorites, but again, you need to find what is unique for John. Remember that the motivators may change frequently, so be prepared to try something new when needed.

### **Slide 13**

This table cross walking the 7 Key Principles to the components of medical necessity has been applied to each of the four webinars in this series; here it is for IFSP outcomes and procedures. In the center column are the five components of medically necessary services. The left column notes one or more of the 7 principles that corresponds, and to the right is the application to IFSP outcomes and procedures.

### **Slide 14**

Here's a recap of what you need to consider to develop procedures: Follow the instructions included in the IFSP Required Elements Form instructions. Identify what the family is already doing if that will be helpful, break down the outcome into smaller steps, identify learning opportunities within existing family activities, routine, or settings, identify strengths to build on, identify resources and supports that are already available or may be needed, and identify child motivators. Keep the crosswalk handy to guide you. Now let's take a look at another federal regulation we need to remember.

### **Slide 15**

If you have established and documented eligibility, needs, and priorities, and developed outcomes and procedures to address the needs, you're ready for the next step, determining the early intervention services to be provided. Let's begin with the federal requirement for the IFSP. The IFSP must include a statement of the specific early intervention services that are necessary to meet the unique needs of the child and family. It requires that we document on the IFSP the services that are needed to meet the needs of the child. It also requires that we document services that will meet the needs of the family to support their child's development. And it requires that the plan be individualized, because all children and families are unique. If you made the connections between the referral information, evaluation and assessment information, and development of IFSP outcomes and procedures, you're well on the way to developing a truly unique IFSP that will also support documentation of medical necessity.

## **Slide 16**

Since the IFSP must also document that the services to be provided are medically necessary let's see what Medicaid has to say about the IFSP. The information on this slide is taken from the State Plan Amendment and the Provider Checklist in the Uniform Managed Care Manual. What does this mean for your work? It means that the IFSP team has been given both the privilege and responsibility of determining that the services listed on the IFSP:

1. have been selected to help the parent support their child in meeting appropriate developmental outcomes, and
2. are medically necessary for the child.

The really great news here is that for most services your program does not have to seek prior authorization from Medicaid before providing services. The IFSP serves as that authorization. For most providers of and types of services, the state requires providers to obtain prior authorization. So we're pretty fortunate to have our Medicaid managed care companies allowing our IFSP to serve as service authorization.

**This is another critical piece of the process:** Because if you haven't made the connections between the evaluation and assessment processes, the development of specific outcomes, and the services planned on the IFSP, your program may be at risk of losing funding because you have **authorized** services without establishing that they are needed. Medical necessity is demonstrated through clear identification of needs in the IFSP, outcomes that clearly address needs, and services that focus on assisting the family in meeting outcomes.

Remember, too that State Medicaid auditors will be using the DARS ECI rules in combination with HHSC's requirements to audit your records.

## **Slide 17**

Let's take a look at how the connection is made between assessment, outcome development, and planned services. Our thanks to Martha Aki at Katy ISD for allowing us to share this example from her program. The child in this example is eligible due to a medical diagnosis. He is 2 months old. This section of the IFSP that documents part of the needs assessment indicates two areas of concern: lack of eye contact, and motor development. The check boxes on the right identify these as areas of need, and the form also indicates the family priorities in addressing these concerns.

## **Slide 18**

This IFSP contains 2 outcomes. The first one addresses the Mom's concern about eye contact. **Child** will participate in his daily routine by engaging with Mom. We will know that he can do this when he can smile back at Mom and she knows that he is making eye contact and tracking 6 times a day in a month. This outcome is specific, measurable, achievable, relevant, and tied to a priority. It's a smart outcome.

### **Slide 19**

The second one is: **Child will** participate in the play routine by rolling. We will know he can do this when he rolls back to tummy three times a day at home for two weeks. This outcome is also specific, measurable, achievable, relevant, and tied to a priority. Both outcomes identify clearly the child's engagement in the activity, and the criteria for achievement is clear. We have not included procedures for these outcomes here because what is listed is generally more about strategies than procedures, but they still provided the parent with useful information about how to help the child.

It's important to re-state that, even for a child with a medical diagnosis, needs must be identified, and outcomes and procedures written to address the needs. When an outcome is written for a child to (and I'm quoting, here, **other** IFSPs that we have seen) "learn and develop like his peers" or "have age appropriate skills," it will be difficult or impossible to justify services as medically necessary.

### **Slide 20**

How did the team decide the services to be listed on the IFSP? We didn't attend the IFSP meeting, nor have we provided the entire IFSP for you to see, but in our review of this IFSP, it appears that the team feels the EIS has the skills and knowledge to support this family to help their child achieve these two outcomes. These outcomes may be addressed as SST at this point, with support to the EIS and parent provided by the OT once every three months. This IFSP makes the connections from needs assessment to outcomes to services planned.

### **Slide 21**

Sometimes it's hard to make the connections. Here's a real life scenario: Parent refers due to concerns in a specific developmental area, in this case, speech. Evaluation team is comprised of staff knowledgeable in that area. Child qualifies due to delays in another area. What do you do?

### **Slide 22**

In the example provided on the previous slide of the child referred due to concerns in speech, determine if the child has a delay in the communication area, even if it is not enough of a delay for a child to qualify. Needs in this area may be identified in the comprehensive needs assessment. Use the results of the BDI to help the team (including the parent) see the connections between developmental areas. Development in one area may have impacts in development in other areas.

When conducting the comprehensive needs assessment, use knowledge of child development to determine if there are functional needs the child has due to the motor delays. (Motor delays were identified in the BDI.) Schedule an assessment by a motor therapist. (Remember to give notice and get consent before assessing.) The motor therapist should review the completed comprehensive needs assessment in addition to BDI evaluation results before conducting the motor assessment. The motor therapist should then use clinical knowledge to assess any other functional needs that may have been missed by the team. As needed, revise IFSP.

Reminder: Determining a qualifying developmental delay or medical diagnosis is only one part of determining eligibility. **There must also be an identified need for services.**

### **Slide 23**

The services listed on the IFSP must be the services (including frequency and intensity) identified by the team as needed by the child and family to meet the needs addressed by the outcomes on the IFSP. They cannot be based on availability of staff. Services cannot be deleted, or another service substituted, if a service provider of a specific discipline is no longer available for some reason.

Here's another requirement: When planning services it is important to remember that the service identified on the services page must match what the staff person will in fact be doing. For example, if the IFSP team determines that basic parenting education is needed, the services page should indicate "Family Education and Training." The team should then determine the best person to provide this service. The IFSP team should **not** identify the service as "Counseling," and then assign it to the LCSW so the service can be billed. Providing one service and labeling it as something else for billing purposes places the agency and the licensed professional at financial and legal risk.

### **Slide 24**

We've had a lot of questions about when to determine SST as the service to be provided, and when therapy should be provided. This is an issue that is being addressed on the national level, and here at the state office as well. For the purpose of this webinar there are some suggestions we have for guidance:

1. Since the team decides the services, the planning should include a discussion of which members of the team have the knowledge and skills needed to support the family in helping their child achieve the outcomes. Because you need to develop child and family outcomes, not discipline specific outcomes, look at all of the outcomes, the child's strengths and family priorities. That will help you see the child, not just the delays. The scope of practice for the discipline of the person best suited to address the outcomes will determine the service to be listed. The team should also determine how much support will be needed from other members of the team, and if providing those supports will require meeting with the child and family. If so, other services may need to be added.
2. All early intervention providers should have some knowledge skills and abilities across all domains. The EIS should have expertise in child development, and may be the best intervention provider to address the child's cognitive development. Cognitive development includes executive function, which develops most quickly after age three. But the building blocks of executive function, which include memory, inhibitory control, and cognitive flexibility develop before age three. The EIS can also help the team and family understand how the child's cognitive development impacts other areas of development. For instance, turn taking, which is a cognitive skill, impacts a child's communication skills and social/emotional skills.

3. Be flexible. The IFSP is a working document. It may be that initially the best provider for the family is a therapist. As the family's confidence and competence in their abilities to generalize skills grow, the clinical expertise of the therapist may no longer be needed at the same intensity and frequency. The IFSP may be changed to identify someone else as the best provider for the family. Remember: Document the reasons for the change. A change in providers should be made to address the differing needs of the child and family.
4. The service definitions and continuums (found on the extranet) provide guidance for determining which services to put on the IFSP, and when changes may be needed. Two words of caution here: 1. EISs are not therapy assistants, so they don't provide "watered-down" therapy, nor is SST a service provided when the therapist can't come. 2. Therapists do not provide supervision of EISs.

### **Slide 25**

How much service (frequency and intensity) should be provided? The IFSP team decides, but cookie cutter services, a pattern of every child getting the same amount of service, are prohibited. The very concept of medical necessity requires that services be tailored to the individual child's needs. Both the Federal Regulation shown earlier and Early Intervention Key Principle number four require that services be individualized.

Some examples of applying a cookie cutter instead of need to service planning would include every child receiving two hours of case management every month, regardless of variability in families' need for case management or needs assessments that indicate, "the family has no needs in this area at this time." Yes, that means that case management must be provided to address identified needs, just like all other services.

Another example of cookie cutter services is the application of the same ratio of SST to therapy. Always having three SST and one PT every month, or two SST to two OT every month, throughout the child's entire ECI experience, and across most children convey that the team did not apply their knowledge of child development in an effort to tailor services according to the child's needs and strengths.

The same could be true if every child with the same diagnosis got exactly the same services. Two children with exactly the same diagnosis, or even the exact same scores on the BDI will have differing family circumstances, differing strengths and needs, differing family priorities: The list of differences is endless. Bottom line, the services must fit the child and family, not the other way around.

### **Slide 26**

Now let's look at SST a little more as it relates to case management. During our regional meetings some participants requested that we clarify the difference between SST and case management. We've already provided some information about what SST is and who can provide it. So what is case management?

Case management is assisting the family to get what they need to support their child's development. The need can be specific to the services provided by ECI or totally

unrelated to ECI services. Case management means being an active participant in problem solving with the family. This includes helping them collect needed information, complete applications, arrange transportation, scheduling appointments, going with them to appointments, helping them decipher governmental, educational, and medical correspondence, identify options and next steps, on and on and on.

Like SST and all ECI services, there is a component of educating families to case management. The service coordinator is expected to use their efforts as an opportunity to teach the family how they can do it, whatever it is, for themselves next time. So while the service coordinator can return to the office to make phone calls, and complete paperwork, and in some circumstances this approach may be the most effective, the service coordinator should try to involve the family in the efforts so the parent can see how to do it for themselves. And perhaps the next time the parent can take a more active role with the service coordinator in attendance to lend assistance if needed.

Case management, like SST and all ECI services, must be based on need and tailored to the child and family's needs and strengths. If your definition of case management is limited to handing out phone numbers, web links, and local city parks' schedules, you will probably have great difficulty tailoring case management to the child and family's needs and strengths. If, however, your definition of case management includes being an active participant in problem solving with the family, then the idea of tailoring case management probably already clicks for you.

Some of our families have resourceful parents who understand how to operate within the system. These families will have very little need for a service coordinator. All that may be needed is a brief phone call during the month to make sure things are proceeding as expected. And this is good because we have other families who need our time a whole lot more. And this is good too. Case management exists as a service so we can help these families, not those already connected families, but families who need help to access the resources they need. There should be lots of variability in how much service is provided to each family each month. And it is for this reason, that case management needs for any one family vary from month to month, that you are not required to, nor should you, designate a frequency and intensity for case management on the IFSP.

### **Slide 27**

Funding for all needed case management services is available to your program. For TCM the funding source is Medicaid. For other case management services, the funding source is your DARS contract. Regardless of the funding source, the services provided must address identified needs.

### **Slide 28**

As we get to the end of the planning section of IFSP development, let's look at signatures. For ECI, the parent signature on the IFSP provides consent for the listed services to be provided. It does **not** mean that the parent agrees with the plan as

written. This is different from the IEP for local education agencies or other contracts where the signature may signify agreement.

For you as ECI providers, your signature on the IFSP identifies you as a member of the team who helped develop the IFSP, or will be a service provider. You must include your credentials with your signature. The credentials you list must be specific to the service you will provide. For instance, an EIS who is also the service coordinator for the family must designate SC for the case management services and EIS for SST services. The IFSP services pages and signature pages are **NOT** documentation of medical necessity. Medical necessity comes from the identification of need through evaluation and assessment, the development of outcomes to address the identified needs, and the selection of services appropriate to address the stated outcomes.

Now that we've signed the IFSP, let's look at a few more resources to help you.

### **Slide 29**

Once again, here is the table cross walking the 7 Key Principles to the components of medical necessity. This time it is for service planning. In the center column are the five components of medically necessary services. The left column notes one or more of the 7 Key Principles that corresponds, and to the right is the application to service planning.

### **Slide 30**

In this webinar, and the three preceding ones, we have provided you with information and resources to help you use every part of the ECI processes to identify developmental and medical needs of the child, the family's concerns, priorities, and resources for addressing their child's needs, developing a plan that addresses those specific needs, and how to make and document the connections between the identification of needs, and the development of a plan to address those needs. We've also provided you with resources to help you through each of these processes, and tools to evaluate your work in each of the processes. Here are a few more.

The first one is a link to the Infant Toddler Connection of Virginia, the Virginia Part C program. This link takes you to a blog that they have developed for direct service providers to exchange ideas on strategies for helping families address different developmental needs.

The second one is a link to the ECTA Center, the topics page which deals with the IFSP processes and providing services in natural environments.

The last one is a link that will be of more benefit to program directors and supervisors. This link is for a community of practice workspace, and has been developed for individuals to collaborate as they learn about and prepare new technological resources to advance online learning opportunities for early intervention and early childhood professionals. It has topic specific training materials that other states have developed. Once you register as a member, the training materials are available to you for free.

Now I'm going to turn the mic over to Gina.

### **Slide 31**

We're also going to address re-assessment and ongoing assessment in this webinar because it also impacts planning. In the current Texas Administrative Code (TAC), re-assessment is described as both assessment and ongoing assessment. (1) Assessment is defined as the ongoing procedures used by appropriate qualified personnel throughout the period of a child's eligibility for early childhood intervention services; and (2) Ongoing assessment is defined as the continuous monitoring of a child's functional progress. Currently, if a regularly recurring service by an LPHA is planned, the re-assessment can occur as part of that on-going service. At a minimum, one time every six months, the LPHA should address the requirements of the monitoring in a progress note.

In the proposed rules for 2014, which will be effective on September 1, 2013, re-assessment will be defined as a specific type of assessment service, planned on the IFSP, in which a team member gathers and documents information regarding the child's functional progress on IFSP outcomes, and considers whether any modifications to the IFSP should be recommended.

### **Slide 32**

Ongoing assessment is a component of every ECI service delivery visit. We are constantly adjusting our interactions and strategies based on what we learn and observe in a visit.

As mentioned in the previous slide, the assessment that will address the SST requirement can also be provided when the LPHA is providing an ongoing service to the child in addition to SST. The LPHA may document and bring various recommendations to the team as a result of assessment: That the child has reached developmental proficiency, that another service should be considered, or that frequency or intensity of a service should be considered. The LPHA would document in progress notes the assessment observations and conclusions, and the recommendations that will be proposed to the team.

### **Slide 33**

When SST is the only on-going service planned, the requirement for monitoring is best met by planning re-assessment on the IFSP services page at a minimum of one time every six months. This should not be an automatic default plan; a re-assessment visit should be planned according to the needs of the child and family. Also, if SST is the only service planned on the services page, the LPHA should be chosen based on the child's needs.

For example, for a child who seems to have a straightforward delay in walking (no apparent tone, neurological or other apparent causative factors), the team might plan SST one time a week to help the mother arrange the environment, learn facilitation skills, etc. The re-assessment might then be planned to occur every other month (one

time every two months) by a physical therapist in order to closely monitor his progress and make needed adjustments to strategies or services. Effective, needs driven services requires that the re-assessment be meaningful to the child and family.

Additionally, in order to bill for the re-assessment there must be a needs based reason for the service. For the child with the identified motor concerns and motor delay, it would not be difficult to justify a periodic motor assessment. It would be harder to justify assessment by a SLP or LPC. Billing of evaluations and assessments was covered in detail in webinar two. All the guidance regarding initial evaluations also applies to periodic re-assessments.

### **Slide 34**

Now back to some of the specifics of ECI record keeping.

Planning re-assessment on the IFSP is one way to meet the requirement in this rule regarding SST that the service be monitored by the interdisciplinary team at least once every 6 months. At this time there is not a specific requirement that re-assessment be a planned service on the IFSP but it is the best way for a program to ensure that the requirement for monitoring of the services is met. Additionally, if re-assessment is not put on the services page, a notice and consent will have to be completed prior to any re-assessment that takes place.

We do want to point out that a requirement has been added to the 2014 draft rule that is posted on the ECI website until June 25. That requirement will be that either a re-assessment by the LPHA at least every six months be planned on the IFSP or re-assessment be a part of the regularly occurring service by an LPHA.

It is important to note that the once every six months monitoring requirement is only a **minimum** requirement. Re-assessment may be planned more often by the IFSP team when SST is the only service offered, and as discussed in the previous slide, should be planned to address the needs of the child and family. As part of the re-assessment, the LPHA would document informed clinical judgment tied to the outcomes. The LPHA would note what progress is being made towards the outcomes, recommend modifications to the outcomes, or to the plan when needed.

As part of the re-assessment, the LPHA would also look at whether the planned services are reducing the child's functional limitations, promoting age appropriate growth and development, and are responsive to the family's identified goals for the child. During the re-assessment, the LPHA may also identify a need to visit the family more often or provide more support to the Early Intervention Specialist.

### **Slide 35**

As stated earlier, a lot of us tend to think of the six month reassessment as synonymous with the six month IFSP review, which it is not. However, information from the re-assessment should inform the periodic review. Similarly, a lot of us tend to think that the reason for the six month reassessment is to provide supervision of the SST or of the

EIS who is providing the SST. But this is not actually the case. An EIS is not a therapy assistant and therefore does not require “supervision by a therapist” (quote-on-quote).

In the Medicaid State Plan we see the state’s promise to the federal government that all of the specialized rehabilitative services provided by ECI providers will be recommended, developed, documented, and monitored by the IFSP team and that the LPHA is but one member of that team. To keep the clothesline of medical necessity intact, the IFSP team needs to document the team’s rationale for changing or not changing services. The IFSP team must document what progress they have seen, what needs have emerged, and modify the IFSP to address those needs.

To reiterate, it is very important to plan the monitoring of the service so it’s real and meaningful. Don’t always plan it once every six months. This goes back to medical necessity: What is **medically necessary** for this child and this family? Although planning the reassessment on the IFSP is not required at this moment, in the near future it will be. It is a good idea to begin planning the re-assessment at the IFSP now so that your teams will be prepared for this change. The team, which includes the LPHA, can then make a preliminary determination of how often re-assessment needs to be done. The take home note in all of this is to **plan according to medical necessity**.

I am going to describe two examples of how re-assessment may be planned differently for each child.

In the first example, the team consists of a Speech Language Pathologist (as the LPHA) and an EIS. The EIS has lots of competence in the area of language and the team feels confident that he or she can support the family and the child with the planned language outcomes. In this case, the team feels comfortable planning SST services with the SLP coming out one time every six months to reassess. If, however, the team determines that the EIS and the family need more support, they would plan for the SLP to come out more often.

In the second example, the team consists of an Occupational Therapist (as the LPHA) and an EIS. A six-month old child displays momentary independent sitting but displays poor balance and protective reactions in prone, supine and sitting. In this case, the team feels comfortable planning SST services to work on independent sitting with the OT coming out one time every two months to ensure that other transitional movements, such as side sitting, kneeling, core strength and stability, are also developing.

### **Slide 36**

On the next few slides, we have included some sections from the ECI Medicaid Evaluation Crosswalk. Each item on the crosswalk describes an evaluation or assessment scenario, and explains the billing, TKIDS data entry and other information about the specific assessment. This section of the crosswalk describes assessments that are provided as part of ongoing services that an LPHA is providing.

### **Slide 37**

The section in blue on the crosswalk describes the various scenarios of specific reassessment visits by the LPHA. The crosswalk was developed at the time when the reassessment was required, as you see in line 17. We've already discussed the changes in rule regarding this. We recommend that you refer to the crosswalk to assist in planning, documenting, billing, and entering data in to TKIDS.

### **Slide 38**

No notes

### **Slide 39**

Before we end our discussion on re-assessment, it is important to discuss how re-assessments are closely related to periodic reviews. The information gained through re-assessment should be shared with the IFSP team to assist with planning at periodic reviews.

In the proposed rules that will become effective on September 1, 2013, if the team member who conducts the re-assessment is an LPHA who is not providing ongoing services to the child, he or she must have assessed the child within the previous 30 days of the periodic review. The LPHA's input from his or her re-assessment can then be used to assist in reviewing the IFSP outcomes, providing a description of the child's current functional abilities and progress towards goals, and developing or modifying outcomes.

Just in case you want it...

#### **§303.342 Procedures for IFSP development, review, and evaluation.**

(b) *Periodic review.* (1) A review of the IFSP for a child and the child's family must be conducted every six months, or more frequently if conditions warrant, or if the family requests such a review. The purpose of the periodic review is to determine—

- (i) The degree to which progress toward achieving the results or outcomes identified in the IFSP is being made; and
- (ii) Whether modification or revision of the results, outcomes, or early intervention services identified in the IFSP is necessary.

### **Slide 40**

Regardless of the service, be it SST, PT, counseling, nutrition, whatever, regardless of the funding source, be it Medicaid or Part C, the IFSP team must document the rationale for changing or not changing services. Failure to document the team's decision making takes a sharp pair of scissors to your clothesline of developmental need.

### **Slide 41**

We would like to invite you to tune in for the exciting finale to the Quality Assurance series, Service Delivery, on June 27 at 3pm. Learn the necessary rights and rituals to keep recouperment at bay. Provide services like no other and become the envy of every other agency as you dazzle families and auditors with your progress notes. No need to set your DVR, all episodes of this dynamic series will be available for replay at your

discretion. This series is rated G for general audiences, but direct service providers and supervisors may enjoy it the most.