Army EDIS Early Intervention
Policy and Practice Questions & Answers
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IFSP-PD	
On the front page of the IFSP, should the dates for all processes that are completed be entered?	It is required to enter the date of the final process completed (e.g., If the plan goes to full IFSP enter the date the full IFSP was developed; if the paperwork only goes to evaluation then enter the date of the evaluation completion. It is possible to enter the dates of all three processes (screening, evaluation, and IFSP). What is required is the date of the final process documented on the IFSP-PD paperwork. Including all is acceptable.
On the first page of the IFSP, is it necessary to put something in each of the boxes "initial referral" and "annual review?"	No, enter the date in the appropriate box and leave the other box blank (i.e., if it is an initial referral enter the date of referral in that box and if it is an annual review enter the date of the annual review in that box).
What exactly is required for "date and results" under IFSP section 4 –Health Information "Child's Current Health?" Does the exact date have to be listed? What suffices as results? What if the family does not know the date or results?	If the exact date is not known, it is fine to indicate the month and year. This is needed to identify if the child had a recent (within 6 months) physical. If a well baby exam or physical has not been done within the past six months, refer the family to the child's PCM for a physical. However, it is not necessary to hold up the process by waiting for the physical. - With regard to documenting results, it is important to note if the child is essentially well or if there are any health concerns. Provided the results of the physical indicate that the child is basically healthy it is appropriate to state that. If the family does not know the date or results check AHLTA (if you have access to AHLTA). If the physical was not conducted in an MTF then ask the family to locate the results if they believe it was recent or refer the family to the child's PCM for a physical. A sick child appointment is not sufficient as a recent physical. The bottom line is that the child has to have a physical in the last 6 months or a referral is needed.
Do you need a recent physical for an annual IFSP? What if the child is nearing 3 and has not had a well baby exam in the past 6 months?	Recent physical is part of every IFSP developed, even if the child is nearing 3 years of age. If a recent physical (within 6 months) was not completed, refer the family to their child's PCM for a physical. However, do not delay the process while waiting on the physical. Also note that a sick child appointment is not sufficient as a recent physical.
Do we have to use the pain scale?	Pain is addressed by asking the question included in the IFSP. With that said, EDIS programs must follow the procedures laid out in their MTF policies, as this is a Joint Commission standard. It is known that some MTFs require use of the pain scale while others do not.
When screening, is it most important to write a full explanation on the IFSP paperwork or in the SNPMIS note?	Screening information is captured on the IFS-PD, with a synthesis in SNPMIS. If additional information is needed, providers can use a separate page or document it in SNPMIS and ensure that the family receives a copy.

It is hard to write the screening note right there with the family – how can this be done so that the family signs the paperwork at the screening? This is mostly needed when there are no plans for evaluation	One way is to use a general template. That is, have a skeleton format that provides the organizational structure and fills in the detail following the screening.
What are other ways to ask the family about their cultural or spiritual beliefs?	One option is to begin before you make the first home visit, such as saying *"We will be coming into your home and want to respect your family's cultural and spiritual beliefs, would you like to share anything we should know before coming into your home, such as removing our shoes or other routines?"* During the first home visit, you could reinforce that EDIS considers cultural and spiritual issues important by saying *"What will be important for us to know about your family's culture and spiritual beliefs as we begin to work together?" (e.g., celebration of traditional holidays, time in religious activities…)*
What is meant by major recommendations and next steps in the summary section of the evaluation on the IFSP-PD?	*The IFSP summary calls for "next steps in the process and any major recommendations."* The next steps are what will happen next in the process. As the Rubric addresses, the next steps for an eligible child would include the RBI. If the child is not eligible, the next step might be to provide information and resources to the family and discharge – or track for possible delays later on, as appropriate. Major recommendations are the suggestions or agreed upon follow-up activities that should happen. A major recommendation might also be a use of (or continued use of) a particular strategy or follow up with an agency or provider. So think of these as two parts, next steps in the process and major recommendations or follow-up needed.
Why are outcomes written for 6 to 12 months?	An IFSP may be written for a maximum of 12 months, so all IFSP outcomes should be achievable within the duration of the IFSP – or less. The timeline for accomplishing an outcome is a team decision, based on their projection of when it will likely be achieved. Family-centered practices would encourage outcomes to be written and activities designed so that families have a sense of mastery over time in achieving outcomes. The time period for outcomes will vary with each family, child situation, and intervention plan. The 6-12 month benchmark should be used when developing outcomes.
What's an example of writing an outcome for extinguishing a behavior (e.g., head banging)?	Think about when the head banging occurs and what might the child be able to do to replace the head banging (or other non-desirable behavior). For example: Fabio will participate in bedtime by lying down in his bed with a soft toy and without banging his head. We'll know he can do this when he can lay down with a favorite toy and go to sleep without head banging for 7 consecutive nights.
Why is it important to have more than three outcomes?	The number of outcomes generated through the RBI is a quality marker of the RBI. More importantly the outcomes (generally 6-10) generated through quality RBIs are specific to family routines, activities, and desires, meaningful to the family, and understandable to all. Having more clearly specific outcomes is always better than having a few broad outcomes that are often nebulous. In addition, outcomes guide the intervention and ensure that services and support are matched to family priorities. They are also critical for measuring progress and achievement. It is problematic to measure progress, let alone accomplishment of vague and/or broadly stated domain based outcomes. Therefore, it is better to have beyond 3 (say 6+) outcomes that are specific, functional, and meaningful in the context of the family's day to day life than a few indistinct outcomes.

When an outcome states the timeline as 3 months, do we need to complete the Review/Change form at 3 months? Or is it sufficient to document in a note and at the bottom of the outcome sheet that it was addressed?	It is sufficient to reference progress at the bottom of the outcome page AND in a progress note. However, if changes are made (i.e., adding a new outcome, changing services) then a Review/Change) form is needed. NOTE: If changes to services are anticipated then a Notice of Proposed Action is also needed.
If the outcome was met, is a formal review needed to document that it was met or can it be noted on the outcome sheet and documented in a note?	If an outcome is met it is sufficient to reference that the outcome was met on the bottom of the outcome page AND in a progress note. However, if changes are made (i.e., adding a new outcome, changing services) then a Change/Review form is needed. NOTE: If changes to services are anticipated then a Notice of Proposed Action is also needed.
Is it necessary to enter the end dates on the service page when a child transitions (to school) before the end date of services listed on the IFSP?	The service end dates on the IFSP for a child approaching the age for transition to school should be the child's third birthday. On occasion the services may extend briefly (i.e., a week or two) beyond the child's third birthday, to accommodate junctures in the school year. If the child has a summer birthday the services might extend 3 months (maximum) past his/her birthday. Under these circumstances it is not necessary to enter end dates on the IFSP as the services are ending as part of the organized transition plan. However, if services are discontinued before the planned transition, then the discontinued dates must be entered and the reason for discontinuing service must be documented on the IFSP Change/Review form.
If a plan ends and the child only has 1 more month in the program before turning three and transitioning, can the plan be extended?	Yes. However, a Change/Review form must be completed and it must document why and how the extension is to occur. Such an extension can never go more than 3 months. The team must also consider the need for new outcomes as part of the transition plan.
Services	
If a child receives services that are not delivered by EDIS, but EDIS holds the IFSP and provides service coordination, how are services received from outside agencies entered on the IFSP and how are they entered in SNPMIS?	*"Intervention"* services provided are included on the IFSP and in SNPMIS and the agency/agencies providing those services is/are listed. Medical based services would be included under the support services section of the IFSP and in SNPMIS. The provider selection would be "*Other, Physical Therapy,"* or whatever is appropriate to the discipline. It may require additional entry in the Provider Table.
How are services provided by other agencies/providers listed on the IFSP (i.e., by medical providers, by state services, by ACS or others)?	If it is a support service (i.e., one that is already in place or one that will not be paid for by EDIS, for example respite care) then it is listed in the *"Support Services"* section of the IFSP (section 12). Although rare in EDIS, if an external source is providing an "early intervention" service (one that EDIS has arranged for) per the IFSP, then that service is listed on the services page of the IFSP and the service source is documented in the additional information section under the services. This agency provider of the service is also documented in SNPMIS. The provider selection would be *"Other, Physical Therapy"* or whatever is appropriate to the discipline. It may require additional entry in the Provider Table.

If EDIS is paying for a service, where does that service go on the IFSP?	See question above. If EDIS is paying for the provision of an "early intervention" services then that service is listed on the services page of the IFSP. Include information about the service provider/agency/arrangement in the additional information section under the service on the IFSP services page.
Is it OK to list services on the IFSP for less than a year?	Yes, sometimes this in necessary if "front loading" a service that will decrease later. It may also be necessary to list one service model (e.g., monitoring) for one duration then change the service model (e.g., consultation) for another duration. You may also have an outcome on the IFSP that can be accomplished in less than a year.
What is documented in the services box if a particular discipline is addressing IFSP outcomes that are not a direct match to their discipline (e.g., motor skills addressed by an OT; speech skills addressed by an SLP…)?	If the IFSP outcomes are functional, the plan would not include discipline-specific OT, PT, SLP… outcomes. Service delivery uses a primary service provider approach, whereby one consistent provider understands and keeps abreast of the changing circumstances, needs, interests, strengths, and demands in the family's life and brings in, or consults with, other disciplines/providers as needed. On the services page, the primary provider addresses all IFSP outcomes. That service is listed by provider discipline. Support providers are also listed on the services page by discipline.
What are examples of AT that we'd include on the AT section of the IFSP?	AT needs can range from low tech to high tech devices for young children. AT may include picture schedules, picture boards, single pictures, switches of various makes and models, special spoons, supports added to a chair. Essentially, anything that can help a child perform a skill or participate in an activity is AT.
Eligibility	
When calculating a DQ score to a Z score *[with a standard deviation of 15 and a mean of 100],* what is -1.5 SD from the norm? Is it 77 or 78?	The actual formula is: Standard score (DQ) minus the mean (100) divided by the standard deviation (15). So using a DQ of 78 (with a mean of 100 and standard deviation of 15): 78-100/15 = -1.466 [-1.466 is the Z score – rounded up this is 1.47 and not -1.5) 77-100/15= -1.533 [-1.533 is the Z score and the cut off score] So for tests using a mean of 100 and standard deviation of 15, like the DAYC, a DQ of 77 is equivalent to a Z score of -1.5. If the DQ is 78 (or higher for that matter) and the team continues to have concerns then consider gathering more information and using the informed opinion process. NOTE: When calculating Z scores from DQ be sure to look at the test manual to determine the standard deviation and mean.
Do any of the following count for automatic eligibility: congenital hip dysplasia; feeding difficulty with diagnosis of feeding disorder in infancy; unilateral hearing loss; torticollis; autism; anxiety disorder; failure to thrive; thyroid disorder.	Eligibility under biological risk requires a diagnosed physical or mental condition which has a high probability of resulting in developmental delay. Determination of biological risk must be based on a physician's diagnosis. When there is question about the probability of the condition resulting in a developmental delay the team must consult a physician to help determine if the individual child's condition has a high probability of resulting in a developmental delay, and include that documentation in the EDIS record. **NOTE:** The process of informed opinion is not applicable for determining eligibility under biological risk. Regarding the specific conditions included in this question… · Diagnosed conditions with a high probability of developmental delay (automatic eligibility) include but are not limited to the following:

	o Autism/PDD · Other health impairments that **may** qualify for eligibility under biological risk include but are not limited to the following: [Note that these conditions do not result in automatic eligibility, but require further exploration with a physician. Also keep in mind that EDIS does not classify a short-term medical problem as health impairment.] o Feeding difficulty with diagnosed feeding disorder in infancy o Congenital Hip Dysplasia o Thyroid Disorder o Unilateral hearing loss o Failure to thrive o Torticollis alone does not qualify for eligibility under biological risk. The team must consider if medial therapy has been provided. NOTE: The severity of the condition must be considered as well as any other conditions the child may have. When preparing for a determination of eligibility under biological risk it is helpful to consider the following information: o The names of all the diagnoses, conditions or disorders from the physician. Having all is important to get a complete picture of the child when making the eligibility determination. o Verbal confirmation of the diagnosis/condition/disorder from the physician is required prior to determining eligibility. Documented confirmation must be included in the EDIS record. o Do some research on the condition, review the literature available. o Consult a physician to confirm that the condition/s has/have a high probability of resulting in a developmental delay. The following link provides a listing developed by the Texas Early Childhood Intervention Program. This is a helpful resource. http://www.dars.state.tx.us/ECIS/resources/diagnoses.asp?letter=h Social/Emotional Conditions from the Diagnostic Classification 0-3 (as diagnosed by a licensed clinical psychologist) including anxiety disorders and adjustment disorders can be used supportively when looking at developmental delay and informed opinion.
Can the ITSEA and/or TABS be used for determining eligibility?	In accord with best practices in assessment of young children in general evaluation should rely on multiple informants, uses multiple methods, and occurs in multiple settings (Fenichel & Meisels, 1999; Bagnato, Neisworth, and Munson, 1999). The ITSEA and TABS are tools that can be used to assist teams with determining a child's eligibility for EDIS early intervention services.
Does a cleft palate alone meet eligibility criteria for biological risk?	Cleft palate is a congenital condition that has a high probability of later delay if early intervention services were not provided. A child would be eligible under biological risk. However, early intervention services alone do not adequately address this condition. It is critical to have the medical community also address this condition. **NOTE:** EDIS is not a payment source for the medical treatment necessary to address this condition.

What are the eligibility considerations for a child with feeding issues?	If the child has a diagnosed feeding/swallowing disorder with a high probability of resulting in a developmental delay, he/she could be eligible under biological risk. However, if there is no diagnosis the team should determine if there is a significant delay in the adaptive domain of development. If there is not a significant measurable delay using a standardized instrument, but the team has concerns, then gather more information and determine if a significant delay in development is present using the informed opinion process. Remember though that the informed opinion process guides the process for gathering and considering additional information; it alone is not the "ticket" to eligibility. Considering all the information available there has to be a significant delay before a child is determined eligible using the informed opinion process. If still not eligible then tracking is always an option.
Informed opinion – do I need to do 2 additional items or just one beyond the standardized testing that was done?	The informed opinion process requires the use of at least one measure in addition to the standardized testing that was initially administered.
Do I need to use the Informed Opinion process and form for determining a child eligible based upon articulation?	For children over two years of age, if you administer a standardized evaluation of articulation and the child is demonstrating at least a 2 standard deviation below the mean score then the Informed Opinion form and process is not needed. However, if standardized testing is not possible or if standardized testing does not capture the child's skills/delays then the Informed Opinion form and process must be used. Remember though that all five areas of development must be evaluated (see page 18 of MEDCOM 40-53).
RBI	
Must the RBI worksheet be used to document the RBI?	No. Teams may document the RBI on other forms they have or simply use a blank sheet of paper. However, when filing the RBI documentation in the EDIS record, attach the RBI worksheet to the top of the paperwork. Include the following information on the RBI worksheet (which serves as the cover page for RBI documentation): Child's Name, Date of the RBI, EDIS staff conducting the RBI (e.g., interviewer and note taker).
If mom and dad are separated and the child attends CDC how many RBIs are needed?	Potentially three RBIs could be conducted. However, it is best to ensure that the RBI is done with the child's primary caregivers. If the child shares time with both parents it will be important to understand the concerns and priorities of both parents.
Does the RBI need to be done by two disciplines or is one sufficient?	It is possible for one EDIS provider to conduct the RBI. Typically two providers are involved and one focuses on taking notes and the other conducts the interview. Generally, the two providers are of different disciplines, however that is not required. In larger programs with more providers of the same discipline it would be possible to have two providers of the same discipline conduct the RBI. When planning the RBI make every effort to involve the most likely ongoing service provider/s.
Other forms	
When completing the Notice of Proposed Action for an annual review what boxes need to be checked?	Check evaluation (to assist with progress review and intervention planning) and IFSP.

Do you need prior written notice for a new outcome?	If the plan is only to add a new outcome to the IFSP and no other changes are being made or proposed then prior written notice is not needed. However, if any changes to services, placement, or eligibility are proposed or anticipated then a prior written notice is required.
When obtaining a release of information, what exactly do each of the areas encompass and are we to be explicit in the other category when describing the information shared?	Being as specific as possible in the "other" category is required. The release should cover the information that is to be shared.
Process	
Do you complete the first section of the IFSP-PD when you are doing a mass child find screening? How do you get permission for those activities?	The IFSP-PD is not used for mass child find screening activities. This is considered a "child find" activity and is therefore more of an EDIS administrative function, not a clinical function. Permission may be documented on program level forms. If the event is sponsored by another agency such as Pediatrics, CYS, or ACS, they may require specific forms.
What is the difference between a new screening and a re-screening. How are they (or are they) documented differently?	A new screening results from a referral and is documented as a new referral using the Entry/Entitlement and IFSP paperwork. A re-screening can be conducted as a child find activity. This is documented under "child find" in SNPMIS. If concerns are identified during the re-screening and an evaluation is needed, then a new referral is made and Entry/Entitlement and IFSP paperwork are used. The date of this new referral is the date of the re-screening. A child who is going to be re-screened should be discharged from IDEA in SNPMIS. When the child is re-screened and it is determined that the child needs an evaluation, then the information is entered as a new referral in SNPMIS under IDEA.
How often can you re-screen a child?	There is no limit on the number times or frequency of re-screenings for a child. With that said, typically re-screening would not occur more often than two months from the prior screening. This may be a bit sooner for very young babies.
Does an evaluation done as part of the annual reassessment count as service delivery or should it be entered as evaluation session?	The annual re-evaluation does not take the place of service delivery, but much information is learned/gathered through service delivery visits with the family. The re-evaluation and associated time is documented in SNPMIS as an "evaluation session." **NOTE:** If additional time is taken during the same visit to provide services, then you also document that as a service session.
How long can a child be in tracking? Do they have to be re-evaluated after a period of time?	There is no limit to how long a child can remain in tracking. However, the child must be removed from tracking when he/she turns three or moves to another location. **NOTE:** Re-evaluation is not necessary before discharge from tracking.
Is a copy of the child's last physical needed in the EDIS record?	No, it is not required. If available it may be included in the EDIS record under section 2. Reference to the child's most recent physical must be documented in section 4 of the IFSP.
Can we take direct referrals from Family Advocacy Program (FAP).	Not only can we – we must. *IDEA requires a referral for early intervention "of a child under the age of 3 who--* *(A) is involved in a substantiated case of child abuse or neglect; or* *(B) is identified as affected by illegal substance abuse, or withdrawal symptoms resulting from prenatal drug exposure" (Sec. 637.6.A.B.)*

	Note that the 40-53 (p. 14) broadens this by stating that EDIS will accept referrals for children referred to Family Advocacy Program for suspected child abuse or neglect. The requirement is for a referral and screening, and evaluation if needed. Essentially, the early intervention process kicks in when the referral is received. The change is that that the referral must be made - for all children with substantiated abuse (as in A and B above). Why is this now a requirement… Because the highest rates of abuse and neglect occur in infants and toddlers and there are high rates of developmental delay in this population.
How do we deal with a doctor's report that directs specific services (e.g., 2 times a week of speech therapy)?	This is a twofold question – how to respond to doctors as well as how to respond to parents. Educating doctors about the legal requirements of IDEA is important to facilitating this common understanding for the benefit of children and families. It is important to educate them that IDEA directs that service decisions are based upon the unique needs of the child and family – not specific doctor's orders. Similarly, when a doctor refers a child for a speech evaluation or services, for example, early intervention does not just conduct a speech evaluation, but a complete multidisciplinary evaluation of all domains of development. If the child does not qualify for services through EDIS, that does not mean that the child may not need "speech therapy" for medical reasons, and the physician's referral must be re-routed to appropriate sources. With regard to parents, it is important to let them know that service decisions are based upon their priorities for their child and family, not simply the child's diagnosis. Reinforce how young children learn in the context of day to day activates and how early intervention works with families to identify and enhance those learning opportunities. Let them know that this approach ultimately equates to more intervention than the 2 times a week of medical therapy that the doctor recommended. In the end, all decisions about service must be family-centered taking into account the unique and dynamic circumstances including family concerns, priorities, resources, and demands.
How is it uniform if some programs provide EDIS funded day care and others do not? Are there consistent criteria for who gets in and who does not?	First of all, **EDIS does not fund day care**. It is illegal to use appropriated funds for day care. All EDIS program should have an option to provide supplemental developmental services in group settings for those children who need that setting. However, it is not a service that all children need. The use of an EDIS paid placement in a child development center should be a last resort, after exploring all other options that will give the child the same benefit (e.g., community-sponsored play groups, local play grounds, etc.). The following criteria (published in the October 2008 Questions & Answers) apply to CDC placement consideration: a) *Consider CDC placement only if a family has no other options for their child to interact with typically developing children. Explore existing local community activities, such as the neighborhood playground, KinderGym, and other community venues.* b) *If a CDC placement is desired, explore any and all other funding*

	options for this service, including Family resources, before considering payments through EDIS. *c) The IFSPs must clearly state the purpose and desired outcomes of the CDC placement.* *d) EDIS must schedule the service, in coordination with the parents, and be scheduled at a specific time for a specific child. This requires a contract or a memorandum of agreement with the CDC to have the space consistently available for the specific Family needing CDC placement.* *e) The placement should be no more than twice per week and not exceed 4 hours each time.* *f) Placement should occur during activity time, including meal and/or snack time, but not during nap time.* *g) EDIS providers must have a role in each CDC placement, either through individual services to the child and CDC staff, or monitoring progress toward the outcome/s.* *h) Progress toward the outcomes must be documented in EDIS case records.*
Will the IFSP be translated in different languages?	Military OneSource provides a translation service for completed IFSPs if needed. At this time the IFSP form is not being translated into other languages.
What are we supposed to enter in AHLTA – sometimes the folks purge it – what are we held responsible for doing?	It remains the responsibility of EDIS to close the loop on referrals to early intervention from the MTF. This may be done via secured email or other means and must be documented in the EDIS record. When EDIS receives a referral from the MTF EDIS must respond back to the referring physician letting him/her know the status of the referral. If the referral comes from the family directly EDIS should alert the child's PCM if the child has a delay and is eligible for early intervention – this too can be done via secured electronic contact with the PCM.
The MEDCOM 40-53 requires the entry of quarterly notes in the EDIS record. However, this is difficult to operationalize. If the records are maintained in SNPMIS is it absolutely necessary to print quarterly notes for the record?	*No, but read on… The IFSP is a dynamic document that changes as circumstances change in a family's life. All of the changes made to the IFSP, including progress made toward outcomes must be documented in SNPMIS per regularly scheduled contacts with the family. The documented notes must tell the story of intervention with each family. Each session note must address the IFSP outcomes. In addition, at least on a quarterly basis the progress note must explicitly address the progress toward each IFSP outcome. However, it is not necessary to print and file a paper copy of the note in the record. The intent of quarterly note is not simply to have something in the record, but to ensure that progress toward IFSP outcomes is intent fully reviewed at regular intervals. Within the primary service provider model – it is sufficient for the primary service provider (with input from other providers) to document the periodic reviews of all IFSP outcomes – rather than expecting each provider on a plan to address every IFSP outcome in a periodic review. The periodic reviews are entered in SNPMIS under progress notes as part of ongoing intervention.* *The Change/Review Form remains a requirement per guidance in the MEDCOM 40-53 and the IFSP handbook page 80.*
Can the entry of family outcomes be extended to more days after the discharge?	*The collection of family outcomes should occur prior to discharge. If a child turns three the outcomes cannot (at this time) be entered into SNPMIS under the IFSP or the Outcomes window under child/student functions. However, if the discharge has not yet been entered, then the child and family outcomes can be entered with the discharge. There are no second chances though after the discharge. So be sure that outcomes are entered BEFORE discharge. Be sure to ask the family to complete the Family Outcomes Survey well before their final visit.*